



Urology Services Inquiry

Urology Services Inquiry | 1 Bradford Court | Belfast BT8 6RB
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Dr Maria O'Kane
Chief Executive
Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

29 June 2022

Dear Madam,

Re: The Statutory Independent Public Inquiry into Urology Services in the
Southern Health and Social Care Trust

Provision of a Section 21 Notice requiring the provision of evidence in the
form of a written statement

I am writing to you in my capacity as Solicitor to the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust (the Urology Services Inquiry) which has been set up under the Inquiries Act 2005 ('the Act').

I enclose a copy of the Urology Services Inquiry's Terms of Reference for your information.

You will be aware that the Inquiry has commenced its investigations into the matters set out in its Terms of Reference. The Inquiry is continuing with the process of gathering all of the relevant documentation from relevant departments, organisations and individuals. In addition, the Inquiry has also now begun the process of requiring individuals who have been, or may have been, involved in the range of matters which come within the Inquiry's Terms of Reference to provide written evidence to the Inquiry panel.

The Urology Services Inquiry is now issuing to you a Statutory Notice (known as a Section 21 Notice) pursuant to its powers to compel the provision of evidence in the form of a written statement in relation to the matters falling within its Terms of Reference.

This Notice is issued to you due to your held posts, within the Southern Health and Social Care Trust, relevant to the Inquiry's Terms of Reference. The Inquiry is of the

view that as you hold this role you will have an in-depth knowledge of matters that fall within our Terms of Reference. The Inquiry understands that you will have access to all of the relevant information required to provide the witness statement required now or at any stage throughout the duration of this Inquiry. Should you consider that not to be the case, please advise us of that as soon as possible.

The Schedule to the enclosed Section 21 Notice provides full detail as to the matters which should be covered in the written evidence which is required from you. As the text of the Section 21 Notice explains, you are required by law to comply with it.

Please bear in mind the fact that the witness statement required by the enclosed Notice is likely (in common with many other statements we will request) to be published by the Inquiry in due course. It should therefore ideally be written in a manner which is as accessible as possible in terms of public understanding.

You will note that certain questions raise issues regarding documentation. As you are aware the Trust has already responded to our earlier Section 21 Notice requesting documentation from the Trust as an organisation. However if you in your personal capacity hold any additional documentation which you consider is of relevance to our work and is not within the custody or power of the Trust and has not been provided to us to date, then we would ask that this is also provided with this response.

If it would assist you, I am happy to meet with you and/or the Trust's legal representative(s) to discuss what documents you have and whether they are covered by the Section 21 Notice.

You will also find attached to the Section 21 Notice a Guidance Note explaining the nature of a Section 21 Notice and the procedures that the Inquiry has adopted in relation to such a notice. In particular, you are asked to provide your evidence in the form of the template witness statement which is also enclosed with this correspondence. In addition, as referred to above, you will also find enclosed a copy of the Inquiry's Terms of Reference to assist you in understanding the scope of the Inquiry's work and therefore the ambit of the Section 21 Notice.

Given the tight time-frame within which the Inquiry must operate, the Chair of the

Inquiry would be grateful if you would comply with the requirements of the Section 21 Notice as soon as possible and, in any event, by the date set out for compliance in the Notice itself.

If there is any difficulty in complying with this time limit you must make application to the Chair for an extension of time before the expiry of the time limit, and that application must provide full reasons in explanation of any difficulty.

Finally, I would be grateful if you could acknowledge receipt of this correspondence and the enclosed Notice by email to [Personal Information redacted by the USI].

Please do not hesitate to contact me to discuss any matter arising.

Yours faithfully

[Personal Information redacted by the USI]

Anne Donnelly
Solicitor to the Urology Services Inquiry

Tel: [Personal Information redacted by the USI]

Mobile: [Personal Information redacted by the USI]

THE INDEPENDENT PUBLIC INQUIRY INTO
UROLOGY SERVICES IN THE
SOUTHERN HEALTH AND SOCIAL CARE TRUST

Chair's Notice

[No 64 of 2022]

pursuant to Section 21(2) of the Inquiries Act 2005

WARNING

If, without reasonable excuse, you fail to comply with the requirements of this Notice you will be committing an offence under section 35 of the Inquiries Act 2005 and may be liable on conviction to a term of imprisonment and/or a fine.

Further, if you fail to comply with the requirements of this Notice, the Chair may certify the matter to the High Court of Justice in Northern Ireland under section 36 of the Inquiries Act 2005, where you may be held in contempt of court and may be imprisoned, fined or have your assets seized.

TO: Dr Maria O’Kane
 Chief Executive

 Southern Health and Social Care Trust
 Headquarters
 68 Lurgan Road
 Portadown
 BT63 5QQ

IMPORTANT INFORMATION FOR THE RECIPIENT

1. This Notice is issued by the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust on foot of the powers given to her by the Inquiries Act 2005.
2. The Notice requires you to do the acts set out in the body of the Notice.
3. You should read this Notice carefully and consult a solicitor as soon as possible about it.
4. You are entitled to ask the Chair to revoke or vary the Notice in accordance with the terms of section 21(4) of the Inquiries Act 2005.
5. If you disobey the requirements of the Notice it may have very serious consequences for you, including you being fined or imprisoned. For that reason you should treat this Notice with the utmost seriousness.

WITNESS STATEMENT TO BE PRODUCED

TAKE NOTICE that the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust requires you, pursuant to her powers under section 21(2)(a) of the Inquiries Act 2005 ('the Act'), to produce to the Inquiry a Witness Statement as set out in the Schedule to this Notice by noon on **10th August 2022**.

APPLICATION TO VARY OR REVOKE THE NOTICE

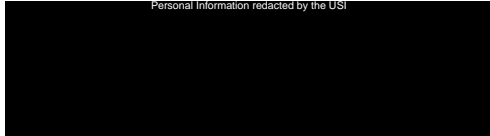
AND FURTHER TAKE NOTICE that you are entitled to make a claim to the Chair of the Inquiry, under section 21(4) of the Act, on the grounds that you are unable to comply with the Notice, or that it is not reasonable in all the circumstances to require you to comply with the Notice.

If you wish to make such a claim you should do so in writing to the Chair of the Inquiry at: **Urology Services Inquiry, 1 Bradford Court, Belfast, BT8 6RB** setting out in detail the basis of, and reasons for, your claim by noon on **3rd August 2022**.

Upon receipt of such a claim the Chair will then determine whether the Notice should be revoked or varied, including having regard to her obligations under section 21(5) of the Act, and you will be notified of her determination.

Dated this day 29th June 2022

Signed:

Personal Information redacted by the USI


Christine Smith QC

Chair of Urology Services Inquiry

SCHEDULE
[No 64 of 2022]

Preamble

We refer to the Trust's Amended Responses to Section 21 No. 1 / 2022 ("the Amended No. 1 response") and No. 1A/2022 ("the Amended 1A response"). You are now required to address the following matters arising out of those responses.

Patient Review Forms

1. Set out the process for the initial development and introduction of the 10-question (erroneously referred to as the '9-question') Review Form. Were HSCB consulted at the initial development stage?
2. At page 13 of the Amended No.1 response, in reference to review patients, it is indicated that the Trust 'will now ascertain whether their care in the past should also be reviewed using the 9-question questionnaire'. Give full details of how it is intended that this will be ascertained and why this approach has been adopted. To the extent that this work has commenced, give full details of progress to date and state the approximate date by which it is anticipated that these reviews will have been completed.

Screening

3. In the Amended 1A response, the tables relating to the screening meetings were updated to reflect that Mr Patient 78 had been 'screened out' in the screening meeting of 7 February 2022. Please explain why this was not reflected in the initial 1A response, received by the Inquiry in March 2022.



4. In the Amended 1A response, [Personal Information redacted by the USI] (HCN: [Personal Information redacted by the USI]) is recorded as having been screened out at a screening meeting on 11 April 2022. The record indicates that Mr [Personal Information redacted by the USI] had been discussed at a screening meeting on 29 November 2021. Mr [Personal Information redacted by the USI] was not indicated as an SCRR patient in Excel Spreadsheet *211203-S 21 No 4 Para 58 (13) Spreadsheet AOB patients (002)*, received by the Inquiry on 6 December 2021. Please explain this omission and confirm when Mr [Personal Information redacted by the USI] was initially 'screened in' to the SCRR process.

5. In the Amended 1A response, [Personal Information redacted by the USI] (HCN: [Personal Information redacted by the USI]) is recorded as having been screened out at a screening meeting on 11 April 2022. The record indicates that Ms [Personal Information redacted by the USI] was discussed at a screening meeting on 22 November 2021. Ms [Personal Information redacted by the USI] was not indicated as an SCRR patient in Excel Spreadsheet *211203-S 21 No 4 Para 58 (13) Spreadsheet AOB patients (002)*, received by the Inquiry on 6 December 2021. Please explain this omission and confirm when Ms [Personal Information redacted by the USI] was initially 'screened in' to the SCRR process.

6. The entry relating to Ms [Personal Information redacted by the USI] in the Amended 1A response (referred to at 5 above) states 'Highlighted in SAI 2020'. Please clarify what this refers to, giving full details.

7. In Excel Spreadsheet *211203-S 21 No 4 Para 58 (13) Spreadsheet AOB patients (002)*, [Patient 54] (HCN: [Personal Information redacted by the USI]) is indicated as an SCRR patient. Mr [Patient 54] does not appear in any of the 'screening in' or 'screening out' tables in the Amended 1A response. In respect of Mr [Patient 54], Excel Spreadsheet *20220628 Master of All Patients Spreadsheet*, states 'Outpatient Review (T) & reviewed by Prof Sethia Jan 22' and indicates that Mr [Patient 54] is 'Awaiting Review Date'.
 - i. Please clarify what the reference to 'review' in the extract quoted above refers to.
 - ii. Please confirm the status of Mr [Patient 54] and give full details of all relevant

screening decisions taken in respect of his case.

8. See paragraph 13 of the Amended 1A response. Confirm whether there are any written records of the decision-making of Mr Haynes and Mrs Corrigan at this stage of the screening process.
9. Describe the various stages of the process of Lookback, leading to 'screening in' or 'screening out' for SCRR in chronological order. In addressing this question the Trust should pay particular attention to explaining the screening arrangements, and where there are different stages to screening, the purpose of each stage and the difference between the stages.
10. At page 27 of the Amended No.1 response, it is indicated that, at the time of writing, 300 patients' records remained to be screened and that 'these are records screened initially by Prof Sethia but were screened out. For purpose of robust process all these records are being screened through the internal screening process.'
 - i. Confirm when these records were screened out and by whom.
 - ii. Confirm what the 'internal screening process' refers to.
 - iii. Confirm whether it is correct that only records initially screened by Professor Sethia are to be further screened in this manner and, to the extent that the answer is 'yes', explain why this is the case.

RQIA

11. Under 'Any Other Business', at paragraph 21 of the Draft Minutes of the Urology Assurance Group meeting of 1 November 2021, it is recorded that 'The Trust noted the use of the SJR process for aspects not falling under SAI was non-routine practice, and suggested quality assurance of its use would be appropriate.' Identify the "aspects" referred to in explaining the meaning of this statement and identifying how this issue arose. The Inquiry is particularly

concerned to understand what it was that was said to be falling within the SJR process when it was not falling under SAI, why this was said to amount to “non-routine practice” and why this was a quality assurance issue.

Bicalutamide Audit

12. Explain why the Bicalutamide audit was confined to the period March – August 2020.
13. Confirm whether the Trust has considered retrospectively reviewing Bicalutamide prescribing over a greater time period.
14. Confirm whether there are any relevant historic audits considering Bicalutamide prescribing and provide copies of same.
15. The Amended No. 1 response states: ‘While in the process of conducting this audit many patients’ care was assessed. A detailed review of their entire urological care was not performed and it is possible as work continues additional concerns regarding historic care delivery may be identified.’ Set out in detail how it is envisaged that the ongoing work referred to may capture additional concerns regarding historic care delivery.
16. Confirm whether this audit identified concerns with the Bicalutamide prescribing of any consultant other than Mr O’Brien. To the extent that the answer is ‘yes’, please give full details in respect of same.
17. At page 19 of the Amended No. 1 response, it is indicated that 31 patients had been identified as having been incorrectly treated with low-dose Bicalutamide by Mr O’Brien. At page 21 of the Amended No. 1 response, it is indicated that a further 26 patients who were prescribed high-dose Bicalutamide by Mr O’Brien were identified with concerns. Has the Trust reached any further conclusions about Mr O’Brien’s prescribing practices,

what his intentions or objectives were, and how this practice was permitted to develop without scrutiny or identification?

NOTE:

By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include, for instance, correspondence, handwritten or typed notes, diary entries and minutes and memoranda. It will also include electronic documents such as emails, text communications and recordings. In turn, this will also include relevant email and text communications sent to or from personal email accounts or telephone numbers, as well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

**UROLOGY SERVICES INQUIRY****USI Ref:** Notice 64 of 2022**Date of Notice:** 29th June 2022

Witness Statement of: Dr Ellen Maria O’Kane

I, Ellen Maria O’Kane, will say as follows: -

In responding to these questions, I have liaised with:

Name	Answer
Mr Stephen Wallace	1,11
Mrs Martina Corrigan	2,10,15
Mrs Margaret O’Hagan	2-10, 15,16
Mrs Ann McCorry	17
Mr Chris Walmsley	3

All documents referenced in this statement can be located in S21 64 of 2022 Attachments.

We refer to the Trust’s Amended Responses to Section 21 No. 1 / 2022 (“the Amended No. 1 response”) and No. 1A/2022 (“the Amended 1A response”). You are now required to address the following matters arising out of those responses.



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Patient Review Forms

1. *Set out the process for the initial development and introduction of the 10-question (erroneously referred to as the '9-question') Review Form. Were HSCB consulted at the initial development stage?*

1.1 The following table sets out the chronology of the development of the Urology Patient Review Form which includes details of external input into creation and approval of same.

1.2

Date	Description
17th November 2020	<p>After the identification of concerns following the email from Mr O'Brien to Mr Haynes on the 7th June 2020 the Trust engaged with both the Department of Health and the Health and Social Care Board to further scope the extent of the potential areas for concern identified and any required actions. One of the actions agreed was to progress a group of 9 SAls led by Dr Dermot Hughes. Interim findings from this group of SAls was provided to the Trust by Dr Hughes on 27th October 2020. In my role as Medical Director I had a telephone discussion with him to ensure that I understood the recommendations for learning and to ascertain that the concerns that we had identified were similar to those that were being reported in the SAls. This also helped clarify the Trust's understanding that a wider systemic review of clinical care would need to be undertaken beyond the patients about whom we were currently concerned including the potential for a comprehensive Lookback review.</p> <p>Given that the Belfast Trust had been through a similar experience recently in relation to the Neurology Inquiry, Stephen Wallace, Interim Assistant Director Clinical and Social Care Governance, and I arranged an initial discussion on approaches to a patient lookback with Dr Cathy Jack and Bernie Owens from the Belfast Health and Social Care Trust, based on their learning from their similar exercise regarding the Neurology Lookback. The discussion included consideration of the</p>



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	<p>structure of the Neurology lookback patient review form. The Trust was informed that this was formed around three questions, namely:</p> <ol style="list-style-type: none"> 1. Is the diagnosis secure? 2. Is a proper management plan in place? 3. Is the prescribing appropriate? <p>The questions used in the neurology lookback were focused on current treatment (is the patient currently being treated correctly). The potential limitations on the questions asked were that, if any of the answers were 'No', it did not necessarily mean unsatisfactory or negligent care, for example, a diagnosis which was considered at the recall not to be secure did not automatically equate to a misdiagnosis. The reviewing neurologist was not asked to express a judgment on what had happened before but rather address what needed to happen next.</p> <p>With the learning from this in mind the Trust set about developing a more comprehensive form that allowed for the consideration of additional factors regarding previous care. Please see:</p> <p><i>1. 2020 MNOTES - 17.11.2020 14.30pm BHSCT Learning from Neurology UPDATED</i></p>
<p>8th December 2020</p>	<p>The Trust Patient Review Form was developed in several draft iterations, the first following initial discussions with Directorate of Legal Services (DLS) regarding the form content which resulted in a 6-question draft form. This version was discussed at the Trust Internal Urology Review meeting on 8th December 2020. The form did not have separate sections for current and past care.</p> <p>The Trust intention at this time was to issue the form with a cover memo to current Trust Consultant Urologists to commence using the form when reviewing patients who were assigned to them who had previously been</p>



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	<p>under the care of Mr O'Brien. However, following conversations with the operational directorate team and Mrs McClements it was accepted that, given current workload, this was not possible. Please see:</p> <p><i>AGENDA Internal Urology Group Meeting 08.12.2020 – please see 2. 20201208 Meeting.</i></p> <p><i>MINUTES Internal Urology Group Meeting 08.12.2020 – please see 3. 20201215 Meeting</i></p> <p><i>DRAFT 6 Question Patient Review Form – please see 4. Agenda - Incident Group 08.12.2020 Patient Review Form</i></p> <p><i>DRAFT Memo to Urology Consultants – please see 5. Agenda - Incident Group 08.12.2020 Memo</i></p>
January 2021	<p>January 2021 was a challenging month for the Southern Health and Social Care Trust regarding COVID-19 winter pressures; therefore, the frequency of internal Urology Meetings was lessened for this period.</p>
27th January 2021	<p>The 6 question form was issued to Michael O'Neill, General Healthcare Policy, Department of Health, and Paul Cavanagh, Director of Commissioning, HSCB, for review and comment. Please see:</p> <p><i>6. 20210127 Urology Patient Review Form</i></p> <p><i>7. 20210127_Urology Patient Review Form_ATTACHMENT</i></p> <p><i>8. 20210202 RE Urology Patient Review Form</i></p>
3rd February 2021	<p>The Draft Patient Review Form was discussed at Trust Urology Oversight Group meeting. Please see:</p> <p><i>10. 20210203-MINUTES - Incident Group</i></p>



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<p>8th February 2021</p>	<p>Following further discussions with DLS, and internally with Mr Ted McNaboe, the Trust redrafted the form to feature two sections with 9 questions. The first section (3 questions) dealing with present and future care and the second section dealing with the lookback element in terms of reasonableness and harm (6 questions).</p> <p>The Trust Urology Oversight Group meeting discussed the Urology Patient Review Form and suggested amendments. There was agreement that this redrafted form should be shared with HSCB and DoH for comment. The draft Patient Review Form was also shared with Professor Krishna Sethia, Independent Urology Subject Matter Expert for comment. Please see:</p> <p><i>11. 20210208 UPDATED UROLOGY PATIENT REVIEW FORM</i> <i>12. 20210208 UPDATED UROLOGY PATIENT REVIEW FORM ATTACHMENT</i> <i>13. 20210208 - E Updated Urology Patient Review Form reply from MC</i> <i>14. 20210208 - E Updated Urology Patient Review Form reply from MC att1</i> <i>15. 20210208 - E Updated Urology Patient Review Form reply from MC att2</i> <i>16. 20210208 - E Updated Urology Patient Review Form reply</i> <i>17. 20210212 - E updated Urology Patient Review Form</i> <i>AGENDA Trust Urology Oversight Group 10.02.2021 – please see 18. 20210210 Meeting</i> <i>MINUTES - Trust Urology Oversight Group 10.02.2021 – please see page 372 of 18. 20210210 Meeting</i> <i>19. DRAFT 9 Question Patient Review Form – please see 19. 20210210 UROLOGY PATIENT REVIEW FORM v4 ATTACHMENT UROLOGY PATIENT REVIEW FORM v3 (2)</i></p>
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<p>11th February 2021</p>	<p>The further revised Patient Review Form circulated to Michael O'Neill, General Healthcare Policy, Department of Health, and Paul Cavanagh, Director of Commissioning, HSCB, for review and comment.</p> <p>This Form was also discussed at the HSCB Southern Urology Coordination Group 11th February 2021 with agreement that the HSCB would share the updated Patient Review Form for final agreement with HSCB/PHA colleagues. Please see:</p> <p>20. 20210211_Urology Patient Review Form 21. 20210211_Urology Patient Review Form_ATTACHMENT 22. 20210211_FW Urology Patient Review Form</p>
<p>18th February 2021</p>	<p>HSCB advised at the Southern Urology Coordination Group 18th February 2021 that the updated form had been shared with HSCB/PHA colleagues within the group for comments and also Dr Miriam McCarthy, PHA. As no further comments had been received, subject to DoH approval, the template could now be used <i>as part of the patient review process</i>. Please see:</p> <p>23. 20210218 Uro HSCB SHSCT Agenda 24. 20210218 Uro HSCB SHSCT Agenda ATTACHMENT UrologyPatientReviewForm(V5) 25. 20210218 Uro HSCB SHSCT Minutes 26. 20210222 Urology Patient Review Form 27. 20210222 Urology Patient Review Form ATTACHMENT Patient Review Form v5</p>
<p>1st March 2021</p>	<p>Confirmation email from Michael O'Neill (DoH) to Paul Cavanagh (HSCB) confirming comments from Deputy Chief Medical Officer Dr Lourda Geoghegan regarding the Patient Review Form. Please see:</p>



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	<p>28. 20210301 FW Urology Patient Review Form</p> <p>29. 20210301 FW Urology Patient Review ATTACHMENT</p> <p>30. 20210301 RE Urology Patient Review Form and UAG query for meeting on 5th March</p> <p>31. 20210226_FW Urology Patient Review Form and UAG query for meeting on 5th March</p>
3rd March 2021	<p>Email confirmation to HSCB and Department of Health containing updated 10 Question Form with changes suggested by Deputy CMO included. The tenth question added to the form asks regarding current care: <i>'If there is not a secure clinical management plan in place please document immediate actions required to be taken'</i>. Please see:</p> <p>32. 20210303 RE Urology Patient Review Form</p> <p>33. 20210303 RE Urology Patient Review Form ATTACHMENT</p> <p>34. 20210303 Urology Patient Review Form v6</p> <p>35. 20210303 Urology Patient Review Form v6 ATTACHMENT</p>
4th March 2021	<p>At the Southern Urology Coordination Group Meeting 4th March 2021, HSCB advised the group that the updated form had been shared with HSCB/PHA colleagues within the group for comments and also Dr Miriam McCarthy, PHA. As no further comments had been received, subject to DoH approval, the HSCB confirmed the 10 Question Patient Review Form could now be used as part of the patient review process. Please see:</p> <p>36. 20210304 Uro HSCB SHSCT Agenda</p> <p>36a. 20210304 Uro HSCB SHSCT Agenda A1</p> <p>36b. 20210304 Uro HSCB SHSCT Agenda A2</p> <p>36c. 20210304 Uro HSCB SHSCT Agenda A3</p> <p>37. 20210304 Uro HSCB SHSCT Minutes</p>



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<p>8th March 2021</p>	<p>Internal Urology Oversight group minutes confirm the 10 Question Patient Review Form is signed off for use. Please see:</p> <p><i>38. AGENDA - Incident Group 08.03.2021 – please see 38. 20210308 Meeting</i></p> <p><i>39. MINUTES - Incident Group 08.03.2021 – please see 39. 20210308-MINUTES - Incident Group</i></p>
<p>March 2021</p>	<p>Deployment of the Patient Review Form occurred and used by Professor Krishna Sethia and Mr Mark Haynes. Please see</p> <p><i>40. 20210310 - E Urology Patient Review Form v6 and first set of patients for reviewing</i></p> <p><i>41. 20210310 - E Urology Patient Review Form v6 and first set of patients for reviewing att1</i></p> <p><i>42. 20210310 - E Urology Patient Review Form v6 and first set of patients for reviewing att2</i></p>
<p>31st May 2022</p>	<p>An investigation took place into the errors in the letters from Mr Devlin sent to patient between November 2021 and early February 2022, regarding the Trust's Lookback Review and the Urology Services Inquiry. During the course of that investigation it was discovered that the PRF was erroneously referred to as the "9 Question" review form when it actually had 10 questions. Questions 1-4 applied to current care. Questions 5-9 applied to historical care and question 10 was a question on whether treatment resulted in harm. In the version that was reviewed for the investigation there were two "Number 4" questions.</p> <p>As soon as this was discovered on or around 5th May 2022, the investigator, Margaret O'Hagan, brought it to the attention of Melanie McClements, Director responsible for the Urology Service, and Sarah Ward, Head of the Lookback. The PRF template was redrafted and</p>



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	<p>properly numbered. It also ceased to be known as the 9 Question Patient Review Form and was subsequently referred to as the 10 Question Patient Review Form</p> <p>My Amended No.1 of 2022 response was drafted prior to this discovery and it therefore references the “9-Question” document even though it does, in fact, set out all 10 questions.</p>
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2. At page 13 of the Amended No. 1 response, in reference to review patients, it is indicated that the Trust ‘will now ascertain whether their care in the past should also be reviewed using the 9-question questionnaire’. Give full details of how it is intended that this will be ascertained and why this approach has been adopted. To the extent that this work has commenced, give full details of progress to date and state the approximate date by which it is anticipated that these reviews will have been completed.

2.1 The Trust began to review the case notes of all patients in the 2019/2020 cohort against the 10-question Patient Review Form (*erroneously referred to as the ‘9-question’ and clarified above, 31st May 2022*), in order to review current as well as historical care.

2.2 At a UAG meeting on 1 November 2021, a decision was taken to restrict the patient review form to 4 questions to reflect the methodology of the Belfast Trust’s Neurology Lookback (which, in essence, reviewed the efficacy of current care but not historic care). Following that decision, two Southern Trust urologists, Mr O’Donoghue and Mr Young, proceeded in this vein, which resulted in 126 patients being reviewed using the 4 Question Patient Form.



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2.3 Meanwhile, Professor Sethia and Mr Haynes, who had already started to review patients before the 1st November decision, continued to review patients with 10 Questions as, based on their experience to date, they were concerned that patients may have had historical issues with care received even if current care was correct. Given these concerns, and given that it was important that the review methodology was consistent for the Lookback, the Trust therefore reverted to the 10 Question Patient Form in March 2022. This meant that the 126 patients who had had a 4-question review required a re-review to assess historical care.

2.4 In June 2022 Professor Sethia, the Trust's external reviewer, commenced considering these cases against the 10 Question Form, to provide a consistent view and approach to the review exercise.

2.5 As of 26 August 2022, Professor Sethia has returned 54 of these to the Trust. He had committed to completing them by the end of August 2022 however he emailed on 26 August 2022 to advise he has an issue accessing documents from NIECR. At the time of drafting this document, the technical issues have been resolved and Professor Sethia has committed to return these ASAP.

Screening

3. In the Amended 1A response, the tables relating to the screening meetings were updated to reflect that Mr Patient 78 had been 'screened out' in the screening meeting of 7 February 2022. Please explain why this was not reflected in an earlier response, received by the Inquiry in March 2022.

3.1 For background information of process at that time, (note this process has been adapted and is reflected in the table at Question 9 on pages 9 & 10 below), was that when Professor Sethia returned his 10-Question Patient Review Forms they were considered by Mr Haynes and Mrs Corrigan who organised the patients into 3 groups:



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- a. Group 1 - Patients about whose care Professor Sethia had clearly no concerns
- b. Group 2 - Patients for whom Professor Sethia had indicated that there seemed to be serious concerns about their care and for whom there was a high suspicion of harm (which appeared to meet the threshold of a SAI);
- c. Group 3 - Patients for whom there were issues with their care but where there was no suspicion of harm.

3.2 For patients in Group 2 and Group 3 above – those patients' 10-Question patient review forms were forwarded for an SCRR screening meeting. In preparation for that meeting and to focus the screening process, an individual summary form called "UROLOGY RECORD OF SCREENING" was created by the acute governance team to include detail of the Datix number and a summary from the Professor's PRF of that patient's case. After the screening meeting took place the screening outcome was recorded.

3.3 In the case of Mr Patient 78 - the detail required for my response in March 2022 was collated on my behalf by the Head of Acute Governance, Mr Chris Walmsley. To do this he used the *Urology Record of Screening* and copied the information across to the table being collated. I regret to advise he accidentally omitted to copy the SCRR screening decision for Mr Patient 78 taken on 7 February 2022, i.e.; "NOT SJR".

3.4 I have since been informed by the Head of Acute Governance, Chris Wamsley, that when he was completing the table relating to the screening meetings for my March 2022 response, he did not check each individual *Urology Record of Screening* against the screening meeting



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form and therefore the error he believes rests with him not undertaking this double check.

4. ***In the Amended 1A response, [Personal Information redacted by the USI] (HCN: [Personal Information redacted by the USI]) is recorded as having been screened out at a screening meeting on 11 April 2022. The record indicates that Mr [Personal Information redacted by the USI] had been discussed at a screening meeting on 29 November 2021. Mr [Personal Information redacted by the USI] was not indicated as an SCRR patient in Excel Spreadsheet 211203-S 21 No 4 Para 58 (13) Spreadsheet AOB patients (002), received by the Inquiry on 6 December 2021. Please explain this omission and confirm when Mr [Personal Information redacted by the USI] was initially 'screened in' to the SCRR process.***

- 4.1 Following completion of the 10-question Patient Review form (which was not dated), Mr [Personal Information redacted by the USI] (HCN: [Personal Information redacted by the USI]) was flagged as requiring screening for SCRR. He was discussed at the screening meeting on 29 November 2021. It is recoded in the screening notes that “*Sarah Ward to ask Chris [Wamsley, Head of Acute Governance] for update on concerns*” Mr Haynes reviewed Mr [Personal Information redacted by the USI]'s notes and was unable to identify any particular concern, therefore, the decision was taken to discuss this with Chris Wamsley. At that screening meeting on 29 November 2021, the fact Mr [Personal Information redacted by the USI] was on low dose bicalutamide was discussed but collectively the team decided that, on the basis of the extent of his disease, other treatment options were not suitable and bicalutamide 50mg for short term – 3 month - treatment did not put him at risk of harm. The team did not consider Mr [Personal Information redacted by the USI] to be an SCRR but they left the decision as *undetermined* on that date to await information from Chris Wamsley. Mr [Personal Information redacted by the USI] was therefore not an omission from the Excel Spreadsheet 211203-S 21 No 4 Para 58 (13) Spreadsheet AOB patients (002). He was not included because it was not yet determined if he was an SCRR patient when that document was submitted to the USI.



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4.2 As SCRR status remained undetermined, Mr [Personal Information redacted by the USI]'s case was discussed again at a screening meeting on 11 April 2022. Chris Wamsley advised he did not have any concerns and was unsure why he was asked to comment. At the screening meeting on 11 April 2022, the team did a further examination of Mr [Personal Information redacted by the USI]'s clinical case note and confirmed definitively that he was not an SCRR patient. Hence, at that meeting it was recorded that he was screened out, i.e., his case did not require an SCRR.

5. In the Amended 1A response, [Personal Information redacted by the USI] (HCN: [Personal Information redacted by the USI]) is recorded as having been screened out at a screening meeting on 11 April 2022. The record indicates that Ms [Personal Information redacted by the USI] was discussed at a screening meeting on 22 November 2021. Ms [Personal Information redacted by the USI] was not indicated as an SCRR patient in Excel Spreadsheet 211203-S 21 No 4 Para 58 (13) Spreadsheet AOB patients (002), received by the Inquiry on 6 December 2021. Please explain this omission and confirm when Ms [Personal Information redacted by the USI] was initially 'screened in' to the SCRR process.

5.1 [Personal Information redacted by the USI] (HCN: [Personal Information redacted by the USI]) was discussed at the screening meeting on 22 November 2021 and was determined not to be an SCRR. It is for this reason that her case was not recorded as an SCRR in the Excel Spreadsheet 211203-S 21 No 4 Para 58 (13) Spreadsheet AOB patients (002).

5.2 A record that Ms [Personal Information redacted by the USI]'s case was "not for SCRR" was made at the meeting 22 November 2021 by Sarah Ward, Head of the Lookback who was taking the notes. A second officer at the meeting, Carly Connelly, Acute Governance Officer, also took notes and recorded that the case was for an SCRR. Due to this conflict of information, the patient's case was re-discussed at the screening meeting on 11 April 2022. It was determined again that Ms [Personal Information redacted by the USI]'s case was *not* an SCRR – this now being the resolved position. Ms [Personal Information redacted by the USI] was therefore not an omission in the Excel Spreadsheet 211203-S 21 No



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4 Para 58 (13) Spreadsheet AOB patients (002). She was not included as she was not an SCRR patient.

6. The entry relating to Ms [Personal Information redacted by the USI] (referred to at 5 above) states 'Highlighted in SAI 2020'. Please clarify what this refers to, giving full details.

6.1 The summary included in the excel Spreadsheet 211203-S 21 No 4 Para 58 (13) could lead to the conclusion that Ms [Personal Information redacted by the USI]'s case was one of the original SAIs, however, this is not the case. Having considered the matter and the relevant papers, I have come to the conclusion that the statement in question, 'Highlighted in SAI 2020', which is more fully recorded on the LBR SCRR screening document as, "Highlighted in SAI 2020- Imaging not actioned - had investigation June/ Oct 2018", refers to the fact that there was a theme of "not following up on investigations" identified as learning from the 2020 group-SAI. This theme was present in Ms [Personal Information redacted by the USI]'s case because she had had an investigation ordered but it was not followed up by the consultant.

6.2 Her case was being considered / screened for an SCRR to establish if she experienced harm as a result of this follow-up omission. It was determined at the screening meeting that she did not suffer harm as a result of that omission; therefore, her case was screened out of requiring an SCRR at the meeting on 22 November 2021 and again at the meeting on 11 April 2022, as described at Q5 above.

7. In Excel Spreadsheet 211203-S 21 No 4 Para 58 (13) Spreadsheet AOB patients (002), [Patient 54] (HCN: [Personal Information redacted by the USI]) is indicated as an SCRR patient. Mr [Patient 54] does not appear in any of the 'screening in' or 'screening out' tables in the Amended 1A response. In respect of Mr [Patient 54], Excel Spreadsheet 20220628 Master of All Patients Spreadsheet,



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states 'Outpatient Review (T) & reviewed by Prof Sethia Jan 22' and indicates that Mr [Patient 54] is 'Awaiting Review Date'.

7.1 Mr [Patient 54] does not appear in any of the 'screening in' or 'screening out' tables in the Amended 1A response because, when these tables were collated, his case had not yet been determined in that he had neither been screened in nor screened out. More detail of this is documented at 7.5 and 7.6 below.

i. Please clarify what the reference to 'review' in the extract quoted above refers to.

7.2 Mr [Patient 54] is a deceased patient (RIP [Personal Information redacted by the USI]). His 10-question Patient Review Form was undertaken by Professor Sethia and returned to the Trust in January 2022, hence the reference to "...reviewed by Prof Sethia Jan 22".

7.3 Practice has been, and still is, that, in a case where concerns about incorrect treatment were found in the Patient Review Form, the patient is invited to an outpatient recall appointment to check if treatment requires to be altered and also to inform the patient of the Patient Review Form findings. If a patient is deceased, the appointment with the consultant is offered to their next of kin.

7.4 In Mr [Patient 54]'s case, as he is deceased, that appointment which is referred to in **Excel Spreadsheet 20220628 Master of All Patients Spreadsheet** as Outpatient Review (T)" was offered to his wife. The 'Outpatient Review (T)...' and "Awaiting Review Date" references refer to the telephone appointment made for Mrs [Patient's Wife] to speak to the consultant which was subsequently scheduled for 27 July 2022 although has since required to be rebooked due to the cancellation of that clinic.



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ii. Please confirm the status of Mr [Patient 54] and give full details of all relevant screening decisions taken in respect of his case.

7.5 Mr [Patient 54]'s case was discussed at a screening meeting on 15 November 2021, 10 January 2022, and again on 11 April 2022. At the first two discussions, i.e. on 15 November 2021 and 10 January 2022, a decision on SCRR was *indeterminate* due to insufficient knowledge of MDM situation in 2010 – more regional information was sought before it was decided if Mr [Patient 54]'s case was an SCRR or not.

7.6 At the screening meeting on 11 April 2022, the 2010 guidelines had been reviewed. The screening team concluded that, as Mr [Patient 54] was not fit for active treatment, the decision at that time to treat him with hormone treatment alone was considered to be reasonable. They noted that adequate assessment was made and treatment was reasonable; therefore, Mr [Patient 54]'s case was screened out, i.e., not an SCRR, on 11 April 2022.

8. See paragraph 13 of the Amended 1A response. Confirm whether there are any written records of the decision-making of Mr Haynes and Mrs Corrigan at this stage of the screening process in 1a response, para 13.

8.1 I have checked with Mr Haynes and Mrs Corrigan and both confirm there are no written records of the process of this decision-making.

9. Describe the various stages of the process of Lookback, leading to 'screening in' or 'screening out' for SCRR in chronological order. In addressing this question clearly explain the screening arrangements, and where there are different stages to screening, the purpose of each stage and the difference between the stages.



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9.1 The Southern Trust Urology Lookback Review process has four stages in line with the Regional Lookback Review Guidance. Below is a summary of the stages and a description of how it currently applies to urology patients.

9.2 To note: Stage 1-4(a) below would be repeated for future phases / cohorts of patients requiring a Lookback Review.

SOUTHERN TRUST UROLOGY LOOKBACK REVIEW	
STAGE	DESCRIPTION
<u>STAGE 1</u> PRELIMINARY INVESTIGATION	i. Identified need for Lookback Review – initial cohort– Mr O'Brien's patients January 2019 to June 2020.
<u>STAGE 2</u> REVIEW	ii. Patient identified as being within the identified cohort. iii. Cancer patients (N=68) reviewed via Orthoderm. iv. Remainder of patients reviewed using the 10-Questions - these questions are included in a document that is called the Patient Review Form (PRF) – this is done in one of two ways: a) In a face-to-face or telephone appointment with patient and / or family present (a Trust consultant); b) Virtually by an independent urologist using clinical records in NIECR to complete the 10-Question PRF. v. The Patient Review Forms which were completed virtually and returned to Trust - these are triaged by the Head of the Lookback Review and outcomes noted, i.e., (a) No Concerns ,



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	<p>(b) No Concerns but issues with care, (c) Undetermined, or (d) Concerns and actions to be taken are recorded and taken.</p> <p>vi. These actions are:</p> <p>a) “No concerns” - patients are advised in writing of the outcome.</p> <p>b) “No concerns but issues with care” - patients are advised in writing of the outcome including full disclosure of the “issues with care”.</p> <p>c) “Undetermined” – these patients go through a second level triage undertaken by Urology Clinical Nurse Specialists to determine next steps. If required, a third level triage can be undertaken by the consultants. An example of this is when the PRF notes an investigation is recommended but had not be ordered. The consultant will review the patient’s case to establish if the investigation is still required and, if so, order this. If there is possible harm experienced by the patient or if there is “learning” these cases go to screening meeting to identify if new learning exists.</p>
<p><u>STAGE 3(a)</u></p> <p>RECALL</p>	<p>d) “Concerns” - patients are recalled and reviewed by a urologist in an outpatient (‘OP’) setting (either in person or by telephone, whichever suits the patient best). If it’s clear that the concerns identified reflect the issues found in the Urology group-SAI reported in 2021 the patient’s case is put on list for screening for SCRR.</p>



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	<p>If the concern raised is not one of the SAI themes, but there is suspicion of patient experiencing possible harm, the patient case is added to the SCRR screening list also.</p>
<p><u>STAGE 3(b)</u></p> <p>SCREENING FOR SCRR</p>	<p>vii. At the SCRR screening meeting, the case is discussed by senior consultants to determine if the case meets the threshold for SCRR. On occasion, there is insufficient information to finalise an outcome – in this situation an individual case may be discussed at a second or even third screening meeting before a final conclusion is made for SCRR i.e. “<i>screened in</i>” or not for SCRR i.e. “<i>screened out</i>”.</p> <p>viii. Patients that have been screened in for SCRR – the rationale for SCRR is recorded on a SCRR template and forwarded to the identified SCRR Urologist external to the Trust for a structured judgement review and return to the Trust.</p>
<p><u>STAGE 4(a)</u></p> <p>SCRR REPORTING</p>	<p>ix. SCRR Urologists return report to Trust. These are reviewed to ensure they are complete and correspondence is drafted to share outcomes of this report with patients / families.</p>
<p><u>STAGE 4(b)</u></p> <p>THEMES & LEARNING</p>	<p>x. When all original 53 SCRRS are returned they will be considered to identify themes in terms of reasons for SCRR and aspects of practice that require attention if not having been already identified.</p> <p>xi. A thematic report will be drafted to reflect the above.</p> <p>xii. Report also to be drafted to summarise the outcomes of the entire Lookback Review process.</p>



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<u>STAGE 4(c)</u> CLOSE OF LOOKBACK REVIEW	xiii. Sharing of reports and learning across Northern Ireland. xiv. Closure of the Urology Lookback Review.
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10 At page 27 of the Amended No.1 response, it is indicated that, at the time of writing, 300 patients' records remained to be screened and that 'these are records screened initially by Prof Sethia but were screened out. For purpose of robust process all these records are being screened through the internal screening process.'

i. Confirm when these records were screened out and by whom.

10.1 The records referred to are the 10-question Patient Review Forms completed by Professor Sethia which Mr Haynes and Mrs Corrigan determined had issues with their care but no suspicion of harm but which, however, may have learning for the urology service. It is for this reason they were to be discussed at a Screening Meeting.

ii. Confirm what the 'internal screening process' refers to.

10.2 It is normal practice in the Acute Directorate to hold an "Incident Screening Meeting" for all / any service where there are clinical incidents that may not meet the threshold of an SAI but may have learning for the service. This is a valuable process to identify and share learning. It is this directorate "Incident Screening Meeting" which was referred to as the "*internal screening process*".



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10.3 The “300 patients’ records” were identified for “internal screening” much earlier in the Lookback process. As these are now being considered within the current Lookback framework, the PFR forms are in the category of “undetermined”. Sarah Ward, Head of the Lookback, is planning to work with one of the urology Clinical Nurse Specialists to review each individual case to establish next steps and if their cases are identifying “new learning”. Due to capacity issues, this work is yet to start. However, when it commences it will proceed with haste. The detail of this will be provided to the Inquiry when complete.

iii. Confirm whether it is correct that only records initially screened by Professor Sethia are to be further screened in this manner and, to the extent that the answer is ‘yes’, explain why this is the case.

10.4 In my response at page 27 of the Amended No.1, my use of incorrect terminology has caused confusion. I wrongly refer to “records screened initially by Professor Sethia”. I was referring to the 10-Question Patient Review forms which the Professor uses to record his assessment of the case notes and wrongly stated that he screened the records. The inappropriate use of the word “screening” in this scenario has led to understandable confusion, for which I am very sorry.

10.5 Professor Sethia was, and remains, the main provider of the 10-Question PRF. When Mr Haynes and Mrs Corrigan were sorting through the Professor’s returned PRFs they were able to action definitively those in respect of whom the Professor found no concerns and those he found had concerns in keeping with SAI themes. It was a group of approximately 300 (where there was no suspicion of harm) that they actioned for internal screening to establish if there was nonetheless an issue with care and/or further learning to be identified.



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10.6 Professor Sethia is still the predominant reviewer of the patient review element of the Lookback. There is a clear triage process for his returned PRFs which includes, when appropriate, screening to ensure we deal with each patient correctly.

RQIA

11. Under 'Any Other Business', at paragraph 21 of the Draft Minutes of the Urology Assurance Group meeting of 1 November 2021, it is recorded that 'The Trust noted the use of the SJR process for aspects not falling under SAI was non-routine practice, and suggested quality assurance of its use would be appropriate.' Identify the "aspects" referred to in explaining the meaning of this statement and identifying how this issue arose. The Inquiry is particularly concerned to understand what it was that was said to be falling within the SJR process when it was not falling under SAI, why this was said to amount to "non-routine practice" and why this was a quality assurance issue.

- 11.1 Issues identified early in the Lookback process highlighted 9 SAIs which were investigated using Root Cause Analysis (RCA) methodology with an independent chair of the SAI panel. This was complex work which took a considerable length of time.
- 11.2 In October 2021, findings from the 10-question Patient Review Form used to review the treatment and care of Mr O'Brien's patients, highlighted that many more patients were meeting the threshold of an SAI, which meant that they needed further examination to establish learning and identify what improvements were required to practice, systems and processes to provide assurances that practice from the past does not occur in the future. If the Trust had used normal SAI review methodology to do this the process of examination would have been a RCA of each patient's case.



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11.3 The Trust raised with UAG the challenge of doing a RCA for each of the then 50+ cases that met the threshold of an SAI. It was agreed by the UAG, which included representation from SPPG, that this would be an unwieldy and slow exercise in yielding learning and improvement, i.e., if a SAI review on each case that met the threshold for a SAI was undertaken.

11.4 The Trust was asked to suggest an alternative process. They discussed with the Royal College of Physicians, the use of their Structured Judgement Review (SJR) process and opted for this methodology to underpin the SCRR process. The SJR documentation was adapted for the SCRR in order to take into consideration the relevant phases of care, i.e.:

- a) Triage;
- b) Initial assessment or review;
- c) Review of Diagnostics;
- d) Ongoing Outpatient Care;
- e) Admission and Initial Management;
- f) Ongoing Inpatient Care;
- g) Care during a procedure (excluding IV cannulation);
- h) Perioperative care; and
- i) Discharge plan of care.

11.5 In respect of the wording of the minute, i.e., *'The Trust noted the use of the SJR process for aspects not falling under SAI was non-routine practice, and suggested quality assurance of its use would be appropriate'* – it is potentially misleading and almost conveys the opposite message to what was intended. This minute was not meant to reflect or suggest that something was falling within the SJR process when it was not falling under SAI.



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- 11.6 I believe that the word “*aspects*” in this sentence refers to the wider investigation that a SAI offers, i.e., trying to establish “why something happened” as well “what had happened” and “is there learning”. The ambit of the SJR / SCRR process was, in fact, narrower than that of an SAI because it did not address the “why” question; rather, it focused on what had happened and the learning.
- 11.7 The Trust noted that using an SJR / SCRR process, as an alternative to undertaking a RCA, in a case that meets the threshold of an SAI, was not routine in that it had not been done before. Therefore, the Trust suggested it be “quality assured”, i.e., reviewed, to ensure that the SJR methodology was fit for the purpose of establish learning. The Department agreed with that suggestion and requested RQIA review the SCRR process to provide assurance in this regard.

Bicalutamide Audit

12. Explain why the Bicalutamide audit was confined to the period March – August 2020.

- 12.1 In August 2020, it was brought to the Trust’s attention by Dr Hughes through his work on SAIs that there were concerns in relation to Mr O’Brien’s prescription of Bicalutamide.
- 12.2 This information presented a major patient safety concern that some patients may be receiving suboptimal care that might be amenable to corrective action and hence potentially reduce the likelihood of preventable harm.
- 12.3 On the basis of this, a Bicalutamide Audit was carried out for the period March 2020 to August 2020 to identify the number of people currently



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being prescribed this medication regionally and to ascertain whether all were on the correct amount for their clinical condition.

- 12.4 The aim of the audit was to identify any patients currently receiving Bicalutamide 50mg prescriptions and who required changes to their treatment. This 6-month period was selected given that the duration of prescriptions (before repeat issued) from GPs is generally 4-12 weeks, and this time period would therefore comfortably identify any patients currently taking this medication. The data was provided by the HSCB prescribing team for all patients prescribed Bicalutamide by primary care. Private scripts were not included in this by the HSCB.

13. Confirm whether the Trust has considered retrospectively reviewing Bicalutamide prescribing over a greater time period.

- 13.1 Bicalutamide prescribing that was out of line with recognised standard clinical practice, is an aspect of care that has emerged as a key theme during the Lookback exercise to date. The Trust is currently preparing an Options' Paper, which will be discussed with and agreed on by UAG, to inform the decision on a second phase of the Lookback Review. Each of the options in that paper will include patients with prostate cancer. Therefore, a review of Bicalutamide prescribing during a time period further back will take place as part of that phase of the Lookback Review. The options' paper and the UAG discussion and outcome will be shared with the Inquiry team when confirmed.

14. Confirm whether there are any relevant historic audits considering Bicalutamide prescribing and provide copies of same.

- 14.1 I am not aware of any such audit and cannot find any evidence that any such audits were completed.



15. The Amended No. 1 response states: *'While in the process of conducting this audit many patients' care was assessed. A detailed review of their entire urological care was not performed and it is possible as work continues additional concerns regarding historic care delivery may be identified.'* Set out in detail how it is envisaged that the ongoing work referred to may capture additional concerns regarding historic care delivery.

15.1 The statement above refers to the fact that at the time the Bicalutamide audit was ongoing there were patients (N=126) who had had current care only assessed (4-Question Patient Review Forms). These patients were to have an extended 10-Question Review which is why I advised that it is possible, as work continues (i.e., 10-Questions), that additional concerns regarding historic care delivery may be identified. This extended 10-Question review was commenced by Professor Sethia in June 2022. If this extended review discovers inappropriate bicalutamide prescribing in the past, Professor Sethia will record this as he has done before.

16. Confirm whether this audit identified concerns with the Bicalutamide prescribing of any consultant other than Mr O'Brien. To the extent that the answer is 'yes', please give full details in respect of same.

16.1 The audit identified Bicalutamide prescribing concerns by three doctors as well as Mr O'Brien. A summary of the audit:

- A total of 466 patients were identified within the Bicalutamide audit as having received a prescription for Bicalutamide 50mg. Of these:
 - a) **432** patients had Bicalutamide 50mg prescribed correctly.
 - b) **34** were identified as not meeting the recognised indications. Of these:



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- I. 31 patients had been commenced incorrectly on the low dose Bicalutamide by Mr O'Brien.
- II. The remaining 3 patients had their medication commenced by other doctors, namely:
 - i. 1 by their GP;
 - ii. 1 in South Africa;
 - iii. 1 patient had been on combined androgen blockade (LHRHa and 50mg Bicalutamide) and had been switched to intermittent treatment by Mr Personal
information
redacted by (locum consultant) but only the LHRHa had been stopped at the time of this switch. This patient had subsequently been reviewed by the oncology team and the Bicalutamide discontinued.

17. At page 19 of the Amended No. 1 response, it is indicated that 31 patients had been identified as having been incorrectly treated with low-dose Bicalutamide by Mr O'Brien. In response, it is indicated that a further 26 patients who were prescribed high-dose Bicalutamide by Mr O'Brien were identified with concerns. Has the Trust reached any further conclusions about Mr O'Brien's prescribing practices, what his intentions or objectives were, and how this practice was permitted to develop without scrutiny or identification?

17.1 In cases reviewed to date, Mr O'Brien did not in most cases record reasons for deviating from standard practice. As such, it is not possible for the Trust to fully reach conclusions about the intentions behind his prescribing practice. Robust medication audits had not been carried out. There had not been a cycle of audits of medication set regionally and in the absence of prescribing being identified as a problem in Mr O'Brien's practice, these were not carried out internally. The assumption appears to have been that best practice guidance was



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being followed but this assumption was not tested through audit even on samples of patients.

17.2 In the absence of these, the Trust relied on prescribing inaccuracies being identified and reported by GPs or hospital medical colleagues asked to review Mr O'Brien's patients. In a high-volume speciality, given the relatively small number of patients at any given point in time on the wrong dosage of Bicalutamide, it is possible that, where discrepancies were noted, this was dismissed by clinicians as being within the usual margin of error typically recognised. Had a longitudinal audit been carried out on prescribing practices, however, this trend would likely have been identified.

17.3 Following email exchange and discussion with Dr Brid Farrell in August 2020 and at a meeting of the UAG in late 2020 it was brought to my attention by Dr Brid Farrell that there had been a number of concerns years previously in relation to Mr O'Brien's prescribing of antibiotics in the treatment of patients presenting with symptoms of cystitis. On reflection, this should have triggered the system at an earlier point to consider a review of his prescribing practices. Please see:

43. 20200820_telephone call follow up

44. - 55. 20200820_telephone call follow up Attachment 1 to Attachment 12

17.4 In relation to how this practice was permitted to develop without scrutiny or identification, I have drawn some conclusions. My opinion is that there was no rigorous process, audit or otherwise, for following up on MDM recommendations that would flag incorrect medication doses. This is currently being addressed with a new MDM audit process being implemented across all tumour groups.



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17.5 Within the NHS, medicine-reconciliation ('meds-rec') is undertaken by specifically trained hospital pharmacists when a patient is admitted to and discharged from hospital. Many prostate cancer patients are managed at outpatient level where the meds-rec is not performed. Due to the large volumes of patients that pass through the Outpatient Department it would likely not be possible to carry out a meds-rec on all patients. However, it is anticipated that, with the introduction of the EPIC programme "Encompass" for Trust records in 2025, this will be possible then.

17.6 I have asked the Director for Hospital Pharmacy, Ms Ann McCorry in August 2022, to consider what requires to be put in place with Primary Care and Community Pharmacy colleagues who receive and 'cash' these scripts for the patient in the community, in relation to quality assuring the efficacy and appropriateness of Outpatient Prescriptions as these do not come through Hospital Pharmacy unless they are Red List drugs. None of the drugs used in urology is a Red list drug. Mrs McCorry is exploring this with community colleagues throughout the month of September.

17.7 Furthermore, Bicalutamide is prescribed by GPs as directed by the consultant urologist. As patients have been referred from across all of the Southern Trust area, there are many GPs prescribing this medication and it is not expected that every GP should know in detail the appropriate licence indications or standard practice guidelines and therefore would not know to question the dose dictated by the consultant. I am working with the Trust's Associate Medical Director for Primary Care to consider options on how this can be addressed going forward with regards to primary care and / or community pharmacy.



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Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed: _____
Personal Information redacted by the USI

Date: 22nd September 2022

S21 64 of 2022**Witness statement of: Maria O’Kane****Table of Attachments**

Attachment	Document Name	Paragraph
1	17.11.2020 NOTES - 17.11.2020 14.30pm BHSCT Learning from Neurology UPDATED	
2	20201208 Meeting	
3	20201215 Meeting	
4	Agenda - Incident Group 08.12.2020 Patient Review Form	
5	Agenda - Incident Group 08.12.2020 Memo	
6	20210127 Urology Patient Review Form	
7	20210127_Urology Patient Review Form_ATTACHMENT	
8	20210202 RE Urology Patient Review Form	
10	20210203-MINUTES - Incident Group	
11	20210208 UPDATED UROLOGY PATIENT REVIEW FORM	
12	20210208 UPDATED UROLOGY PATIENT REVIEW FORM ATTACHMENT	
13	20210208 - E Updated Urology Patient Review Form reply from MC	
14	20210208 - E Updated Urology Patient Review Form reply from MC att1	
15	20210208 - E Updated Urology Patient Review Form reply from MC att2	

16	20210208 - E Updated Urology Patient Review Form reply	
17	20210212 - E updated Urology Patient Review Form	
18	20210210 Meeting	
19	20210210 UROLOGY PATIENT REVIEW FORM v4 ATTACHMENT UROLOGY PATIENT REVIEW FORM v3 (2)	
20	20210211_Urology Patient Review Form	
21	20210211_Urology Patient Review Form_ATTACHMENT	
22	20210211_FW Urology Patient Review Form	
23	20210218 Uro HSCB SHSCT Agenda	
24	20210218 Uro HSCB SHSCT Agenda ATTACHMENT UrologyPatientReviewForm(V5)	
25	20210218 Uro HSCB SHSCT Minutes	
26	20210222 Urology Patient Review Form	
27	20210222 Urology Patient Review Form ATTACHMENT Patient Review Form v5	
28	20210301 FW Urology Patient Review Form	
29	20210301 FW Urology Patient Review ATTACHMENT	
30	20210301 RE Urology Patient Review Form and UAG query for meeting on 5th March	
31	20210226_FW Urology Patient Review Form and UAG query for meeting on 5th March	
32	20210303 RE Urology Patient Review Form	
33	20210303 RE Urology Patient Review Form ATTACHMENT	
34	20210303 Urology Patient Review Form v6	
35	20210303 Urology Patient Review Form v6 ATTACHMENT	
36	20210304 Uro HSCB SHSCT Agenda	

36a	20210304 Uro HSCB SHSCT Agenda A1	
36b	20210304 Uro HSCB SHSCT Agenda A2	
36c	20210304 Uro HSCB SHSCT Agenda A3	
37	20210304 Uro HSCB SHSCT Minutes	
38	20210308 Meeting	
39	20210308-MINUTES - Incident Group	
40	20210310 - E Urology Patient Review Form v6 and first set of patients for reviewing	
41	20210310 - E Urology Patient Review Form v6 and first set of patients for reviewing att1	
42	20210310 - E Urology Patient Review Form v6 and first set of patients for reviewing att2	
43	20200820_telephone call follow up	
44	20200820_telephone call follow up_Attachment_1	
45	20200820_telephone call follow up_Attachment_2	
46	20200820_telephone call follow up_Attachment_3	
47	20200820_telephone call follow up_Attachment_4	
48	20200820_telephone call follow up_Attachment_5	
49	20200820_telephone call follow up_Attachment_6	
50	20200820_telephone call follow up_Attachment_7	
51	20200820_telephone call follow up_Attachment_8	
52	20200820_telephone call follow up_Attachment_9	
53	20200820_telephone call follow up_Attachment_10	
54	20200820_telephone call follow up_Attachment_11	
55	20200820_telephone call follow up_Attachment_12	

Wallace, Stephen

From: Wallace, Stephen
Sent: 17 November 2020 17:16
To: Wallace, Stephen
Subject: MNOTES - 17.11.2020 14:30pm BHSCT Learning from Neurology

Cathy Jack
Bernie Owens
Maria O’Kane
Stephen Wallace

MOK gave the background to the meeting. CJ Engaged DoH early is important. Engaged the HSCB and PHA also early. Received a RCP report, suggested we review the patients over 6 month periods for risk. 627 who required review. Require to see the patients. Kept more at risk patients with protected clinical slots. Letter issued to patients. 9 helplines for appointments and separate lines for occ heath. BO – earmarked who we needed to see early. CJ we could monitor the number of the longest stay waiting. GP separate phone line for any immediate problems. Margaret O’Brien wrote to GP’s with information on contact lines. Each GP got an individual letter for each patent that was recalled. Didn’t use recorded delivery as signing for presented issues. Performed a last minute check on patients who have died. MOK – did the RCP give advice on timescales? There has been a full audit completed on Bicalutamide and differences in what MDM has discussed and treatments offered. CJ When the areas of concern clinics were ran, but also ran clinics on his general caseload. BO the second recall was based on the outcomes of the first recall. MMcB – significant levels of private practice. Reviewed 100’s of patients at his own home. MW complied with the RCS request for notes. Inform the GP of any concerns to consultants mental health. CJ – RCP created a template and each appointment was 45 mins. Was the investigations secure, was there a proper treatment now. MOK – A&R will be subject to review.







CJ Traumatic for the staff. Psychology was required. A senior service manager was placed for each clinic. This allowed to release the medic for the next patient. Inundated with complaints, FOI’s and AQ’s. BO – review work should not displace ongoing review activity.




Incident Oversight Group

Tuesday 8th December 2020, 4:00pm

Via Zoom

AGENDA

1	Apologies	
2	Minutes	 MINUTES - Incident Group 01.12.2020 DF
3	DoH Oversight Meeting Update (4 th December 2020)	
4	Private Practice <ul style="list-style-type: none"> - Private Practice Audit - Private Practice Patients transferred to HSC 	
5	Update on Radiology and MDM Review	
6	IPT for Review Process	 Urology Inquiry IPT - draft 7 (8 december)
7	Additional Subject Matter Expertise <ul style="list-style-type: none"> - British Association of Urological Surgeons - British Association of Urological Nurses 	 Independent Consultant Urology S
8	Royal College of Surgeons Engagement	 Terms of Reference CLINICAL RECORD R
9	Bicalutamide Patient Review	 Clinical And Social Care Audit Registrat
10	Engagement of ISP to undertake waiting list work	
11	Telephone Support Service / Patient Triage Update	
Professional Governance		
12	GMC Discussions	
13	Litigation / DLS Update	
14	Grievance Process	
15	Professional Alert Letter	
16	Administration Review Update	
Serious Adverse Incident (SAI) Reviews		
17	Update on Current SAI Progress	
18	Initial SAI Recommendations	 Action plan Personal Information redacted.docx
19	Structured Judgement Review Process	
20	Family Liaison Role	
Communications		
21	Media / Assembly Questions	
Any Other Business		

22	Coronial Processes	WIT-55920
23	Letter to Staff re AOB Patient Reviews	  07.12.2020 - Memo - UROLOGY PATIENT Identification of Varia REVIEW FORM v1.do
24	Declaration re CURE	 DECLARATION OF INTERESTS FORM.do
25	Securing Records for Public Inquiry	
Date of Next Meeting		
23	Via Zoom – 15 th December 2020	

Urology Oversight Group Minutes

Tuesday 8th December 2020, 4:00pm

Via Zoom

	Item	Actions
1	In Attendance Stephen Wallace Melanie McClements Martina Corrigan Dr Maria O'Kane Dr Damian Gormley Jane McKimm Siobhan Hynds Mr Mark Haynes Patricia Kingsnorth	
2	Apologies Vivienne Toal Ronan Carroll	
3	Weekly DoH Update Melanie updated on the meeting. Main update was to suggest that the SJR methodology would be a potentially viable vehicle going forward. Public Inquiry isn't likely to commence until March 2021. DOH meetings will now be two weekly. Prof Krishna to quality assure work to date. Second victim discussion regarding supports required.	
Management of Patient Reviews		
4	Private Practice Martina updated on another case identified via GP practice. DLS have identified that AOB has still been liaising with DLS regarding medico-legal cases. Further information on this has been sought.	DLS to update on AOB work
5	Update on Radiology and MDM Review No update this meeting, to follow next week	Update next meeting
6	IPT for Review Process Martina reviewed IPT with the HSCB and costed at 2.3 million for 15 months. Costs in year to be met with 200k urology funding. Further funding required for 2021/22 via IPT process.	To be discussed at HSCB meeting
7	Additional Subject Matter Expertise Group reviewed the role description and agreed content.	
8	Royal College of Surgeons Engagement Group reviewed the terms of reference, broadly agreed content. Sampling strategy to be agreed. Group felt 5 years may be appropriate.	
9	Bicalutamide Patient Review No further update	
10	Engagement of ISP to undertake waiting list work Martina and Mark to speak to Patrick Keane to agree if he will be willing to engage beyond December.	Martina / Mark to discuss with

11	Information Telephone Line Martina stated that the information line has been quiet this week. Martina referenced a recent communication from a patient who received a letter from an unknown source regarding the care provided by AOB asking to contact the information line, this was not issued by the SHSCT. Group discussed producing a holding letter to patients regarding those patients who will not be part of the review going forward. Group agreed holding letters should be issued.	Holding letter to patients to be issued
Professional Governance		
12	GMC Discussions Maria updated on the meeting with the GMC ELA. AOB will be going to interim orders on 15 th December 2020.	
13	Litigation / DLS Update Next meeting – update covered in item 4	
14	Grievance Process Next meeting	
15	Professional Alert Letter Next meeting	
16	Administration Review Update Next meeting	
Serious Adverse Incident Reviews		
17	Update on Current SAIs Communications are ongoing, a letter has been drafted to AOB via Tughans to invite AOB to take part. Summary position is expected on Friday. Maria asked that for responses are to be submitted by set deadlines.	Patricia to write to AOB on SAI Chair behalf
18	Initial SAI Recommendations Recommendations are in progress, update to be provided at a future meeting	SJR model to be discussed with the HSCB
19	Structured Judgement Review Process Next meeting	
20	Family Liaison Role Liaison role closes on Friday this week.	
Communications		
21	Media / Assembly Questions No update this week	
Any Other Business		
22	Coronial Processes Next meeting	
23	Letter to Staff re AOB Patient Reviews Letter agreed	
24	Declaration re CURE	
25	Securing Records for Public Inquiry	
Date of Next Meeting		
26	Via Zoom – 15th December 2020	

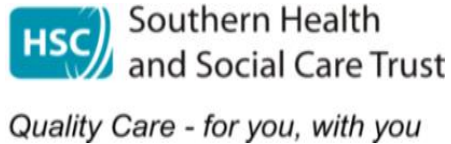
Urology Oversight Group Minutes

Tuesday 1st December 2020, 4:00pm

Via Zoom

	Item	Actions
1	In Attendance Stephen Wallace Melanie McClements Martina Corrigan Dr Maria O’Kane Dr Damian Gormley Ronan Carroll Siobhan Hynds Vivienne Toal Patricia Kingsnorth	
2	Apologies Jane McKimm Mr Mark Haynes	
3	Ministerial Statement Update Melanie updated that AOB solicitor has advised due to Personal Information redacted by the USI that no communications will be received for 10 days. A report was also issued to the DoH meeting updating on weekly Trust progress.	
Management of Patient Reviews		
4	Private Practice Melanie advised that a letter had been issued to AOB requesting information however a response has not been received as per Personal Information redacted by the USI notification.	
5	Update on Radiology Review Engagement with Subject Matter Experts to be progressed to support radiology review work	Role description for SME to be developed
6	IPT for Review Process Martina referred to the £200k for an additional consultant. Group discussed the potential for this to be diverted to Inquiry IPT.	To be discussed at HSCB meeting
7	Additional Subject Matter Expertise / Royal College of Surgeons Engagement Meeting took place with the RCS on 30 th November to discuss potential engagement and invited review. Trust to outline terms of reference for consideration by HSCB / DoH then onward submission to RCS.	Terms of reference to be developed
	Bicalutamide Patient Review Engagement with Subject Matter Experts to be progressed to quality assure bicalutamide audit	Role description for SME to be developed
	Engagement of ISP to undertake waiting list work Group discussed Mr Keane’s availability to undertake additional work beyond the oncology reviews.	Martina / Mark to discuss with Mr Keane
	Information Telephone Line Martina provided an update on this work, group discussed the need for additional clinical input to support this. Group discussed calls from MLAs that went through directly to CX office regarding urology incident. Group to speak to Jane McKimm to	Standardised communication to be developed

	agree a communication to MLA's to standardize methods of contact.	WIT-55924
Professional Governance		
8	GMC Discussions Stephen advised that the final set of requested information is being issued to the GMC this week. A meeting with the new GMC ELA is being arranged for Dr O'Kane and Stephen.	Stephen to issue information to the GMC
9	Administration Review Update Martina and Anita meeting with Denise Lynd tomorrow, update to be provided next meeting	Update for next meeting
Serious Adverse Incident Reviews		
12	Process for Managing SAI's Dr O'Kane referred to the model of Structured Judgement Reviews and its potential applicability in the absence of a formal SAI process while the Public Inquiry commences. Proposal to be discussed with the HSCB	SJR model to be discussed with the HSCB
13	Initial Feedback from SAI Chair Patricia advised that the chair had requested information regarding NIMDTA surveys / feedback. Patricia to go back and clarify the rationale / reason for information. Chair also proposed a meeting with AOB, group agreed the route would be via AOB solicitors, questions are to be set by Subject Matter Expert prior to engagement.	Patricia to contact chair to discuss
14	Family Liaison Role Post to be advertised for 6 months temporary via EOI process.	
Communications		
17	Media / Assembly Questions Stephen referred the FAQ, asked the group to review prior to submission to the DoH	
Any Other Business		
19	Any Other Business Vivienne asked for Grievance Appeal to be added to agenda.	
Date of Next Meeting		
20	Via Zoom – 8th December 2020	



Strictly Confidential

Staffing Support Requirement for Serious Adverse Incident /Inquiry - Urology

3 December 2020

1.0 Introduction

There have been significant clinical concerns raised in relation to Consultant A which require immediate and coordinated actions to ensure patient safety is maintained. Comprehensive plans need to be put into place to undertake the following:

- Review of professional governance arrangements
- Liaison with professional bodies
- Review of patient safety and clinical governance arrangements
- Commencement of operational support activities including
 - Offering additional clinical activity
 - Provide complaints resolution
 - Media queries, Assembly Questions responses
 - Managing the volume of patients who require to be reviewed
 - Patient Support (Psychology / Telephone Support / Liaison)
 - Staff Support
 - Claim handling / medico-legal requests

This proposal identifies the staffing requirements and costs required to support the Serious Adverse Incident (SAI) Investigation/Inquiry for Urology in the Southern Trust.

This proposal will require revision as demands change over time.

2.0 Needs Assessment

A comprehensive review of patients who have been under the care of Consultant A will be required and this may likely number from high hundreds to thousands of patients.

Following discussions with the Head of Service the following clinics have initially been proposed and have been estimated in the first instance to continue for one year.

Clinics will commence in December 2020 and continue throughout 2021. A putative timetable has been included. We will require that consultants have access to records, have reviewed the contents and results and are familiar with each patient's care prior to face to face review where required. Each set of patient records will require 10-30 minutes to review depending on complexity. In addition, each of the patients reviewed will require 45 minute consultant urologist appointments to include time for administration/ dictation in addition to 15 mins preparation time on average. That is 8 patients require 8hrs Direct Clinical Contact (DCC) Programmed Activity (PA). 800 patients require 800 hours of Direct Clinical and so on. (Each consultant DCC PA is 4hrs).

The purpose of the clinical review is to ascertain if the:

1. diagnosis is secure
2. patient was appropriately investigated
3. Investigations, results and communications were requested in a timely fashion
4. Investigations, results and communications were responded to/ processed in a timely fashion
5. Patient was prescribed / is receiving appropriate treatment
6. Overall approach taken is reasonable
7. Patient has, is or likely to suffer harm as a result of the approach taken.

In addition, it will be expected that where there are concerns in relation to patient safety or inappropriate management that these will be identified and a treatment plan developed by the assessing consultant and shared with the urology team for ongoing oversight or with the patient's GP.

Table 2-1 Suggested timetable

Day	Clinic Session	Number of Patients
Monday	AM	8
Monday	PM	8
Tuesday	AM	8
Tuesday	PM	8
To be confirmed	AM	8
To be confirmed	PM	8
Total no of patients per week		48

3.0 Staffing Levels Identified

3.1 Information Line – First Point of Contact

An information line will be established for patients to contact the Trust to speak with a member of staff regarding any concerns they may have and will operate on Monday to Friday from 10am until 3pm. A call handler will receive the call and complete an agreed Proforma (appendix 1) with all of the patient's details and advise that a colleague will be in contact with them. The PAS handler will take the information received and collate any information included on PAS/ECR and this will be examined in detail by the Admin/Information Handler. The following staff have been identified as a requirement for this phase. It must be noted that the WTE is an estimate and will be adjusted dependent on the volume of calls received. Costs are included in Appendix 1.

Table 3-1 – Information Line Initial Staffing Requirements

Title	Band	WTE
Call Handlers	4	2
Admin Support for identifying notes/ looking up NIECR etc	4	2
Admin/Information Handler	5	1

3.2 Clinic Requirements

To date a clinical process audit has been carried out in relation to aspects of the Consultant's work over a period of 17 months.

In addition to this 236 urology oncology patients are being rapidly and comprehensively reviewed in the private sector. [\(Patients returned with management plan are included in Table 3.2/Table 3.4\)](#)

A further 26 urology oncology patients have been offered appointments or reviewed in relation to their current prescription of Bicalutamide.

Given the emerging patterns of concerns from these reviews and Multi-Disciplinary Meetings (MDMS) which have resulted in 9 patients' care meeting the standard for SAI based on this work to date, it is considered that a comprehensive clinical review of the other patients is required. The Royal College of Surgeons has advised that this includes 5 years of clinical activity in the first instance.

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The numbers and clinical prioritisation will be identified collectively by the Head of Service, Independent Consultant and the Clinical Nurse Specialist either face to face or via virtual clinics. The volume of patients is 2327 for 18 months in the first instance and the number of DCC PA has been identified as **. The staffing required to operate these clinics is detailed below. This work will be additionality and should not disrupt usual current urology services. It must be noted that again this is an estimate and will be dependent on the volume of patients involved. .

Clinic Requirements Staffing – 6 sessions as detailed in Section 2. Costs are included in Appendix 1.

Table 3-2 – Clinic Staffing Requirements

Title	Band	WTE
Outpatient Manager	7	0.7
Medical Secretarial Support	4	0.5
Booking clerk	3	0.7
Audio Typist	2	0.7
Medical Records	2	0.7
Nursing staff	5	0.7
Nurse Clinical Specialist	7	0.7
Health Care Assistant	3	0.7
Receptionist	2	0.7
Consultant		DCC
Pharmacist	8a	0.7
Psychology Band 8B and above		1 present per clinic
Domestic Support	2	0.7

3.3 Procedure Requirements

If the outcome of the patient review by the Independent consultant urologist is that the patient requires further investigation, this will be arranged through phlebotomy, radiology, day procedure, and pathology / cytology staff. The provision will be dictated by clinical demand. The following staffing levels have been identified as below for each 1 day sessions. Costs are included in Appendix 1.

Table 3-3 – Procedure Staffing Requirements

Title	Band	WTE
Secretary	4	
Reception	2	
Nurses	5	0.64

Title	Band	WTE
Health Care Assistant	3	0.22
Sterile Services	3	0.22
Consultant - locum		2 PAs
Anaesthetic cover		1 PA
Domestic Support	2	0.22

3.4 Multi-Disciplinary Weekly Meetings Requirements

In order to monitor and review the number of patients contacting the following multi-disciplinary team has been identified as a requirement. Costs are included in Appendix 1.

Table 3-4 --Staffing Requirements for Multi-Disciplinary Meetings (weekly)

Title	Band	WTE
Cancer Tracker	4	0.4
Nurse Clinical Specialist	7	0.1
Consultant Urologist x 2		2 PAS
Consultant Oncologist		1 PA
Consultant Radiologist		1 PA
Consultant Pathologist		1 PA

3.5 Serious Adverse Incident Requirements

Work has commenced on 9 SAI's and the following staff have been identified as a requirement to support the SAI and the Head of Service to enable investigative work to take place and to enable current provision to continue. Costs are included in Appendix 1.

Table 3-5 -Additional staffing and Services required to support SAI

Title	Band	WTE
Head of Service (Acute) – SAI backfill	8b	1
Chair of Panel	N/A	sessional
Band 5 admin support	5	1
Governance Nurse/ Officer	7	2
Admin support to the panel	3	1
Psychology support	Inspire	sessional
Family Liaison SLA	7	1

3.6 Inquiry Requirements

Costs are included in Appendix 1.

Table 3-6 - Additional staffing and Services required to Support Inquiry

Title	Band	WTE
Head of Service Backfill	8b	1
Clinical Nurse Specialist	7	1
Admin Support for HOS	4	1
Admin Support to respond and collate requests for information for inquiry team	5	2
Health records staff to prepare notes for Inquiry Team	2	4
Urology Experts – WL Initiative Funding £138 per hour	Consultant	Sessional
Media queries, Assembly Questions responses	8a (uplift from Band 7's)	2
Admin Support for media queries/Assembly questions	4	1

3.7 Professional and Clinical Governance Requirements to Support the SAI/ Inquiry

Investigations involving senior medical staff are resource intensive due to the many concerns about patient safety, professional behaviours, demands on comprehensive information and communications with multiple agencies. In particular this case has highlighted the need for clinical and professional governance processes across clinical areas within the Trust, to develop these systems and to embed and learning from the SAIs and Inquiry. This work should be rigorous and robust and develop systems fit for the future.

This strand will have responsibility for undertaking activities to ensure embedding of learning, improvement and communication of Trust response to the Urology incidents. This includes providing assurance that improvement efforts are benchmarked outside the Trust from both a service development and national policy perspective [and the acquired learning process and may include:-](#)

- Revision of Appraisal and Revalidation processes
- Quality Assurance of information processes in relation to Appraisal and Revalidation
- Development of systems and processes that marry professional and clinical governance
- Embedding and providing assurance regarding learning, improvement and communication
- Provide support on Trust communications regarding incident response
- Support triangulation of clinical and social care governance and professional governance information to improve assurance mechanisms
- Support the benchmarking of Trust service developments against regional and national perspectives
- Support liaison and communications with PHA / HSCB and Department of Health on matters relating to the urology incidents

-
- Support for corporate complaints department

Costs are included in Appendix 1.

Table 3-7 - Professional Governance, Learning and Assurance

Title	Band	WTE
AD Professional Governance, Learning and Assurance	8c	1
Project Lead	7	1
Administrative Support	4	1

Table 3-8 – Claims Management / Medico – Legal Requests (DLS 20%)

It is anticipated that the number of medico-legal requests for patient records and the number of legal claims will significantly increase as a result of the patient reviews and SAs. This will require support for claims handling, responses to subject access requests and redaction of records.

Title	Band	WTE
Head of Litigation (uplift from band 7)	8a (uplift from band 7)	1
Specialist Claims Handler	7	1
Claims Administrative Support	4	1
Medico – Legal Admin Support	3	1
Service admin support – redaction	4	1
Support Health Professional for redaction – Clinical Nurse Specialist	7	1
2 x Solicitor Consultants (DLS)	sessional	

4.0 Identified Risks

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

Risk Identified	Mitigation Measure
	documentation as soon as possible • Liaise with Human Resources
• Securing Funding	• Liaise with PHA and HSCB regarding additional funding required to support the SAI/Inquiry.
• Volume of calls received by the information line will exceed expectations leading to further complaints	• Monitoring of call volumes • Extending the operational hours to receive calls • Increasing the number of call handlers
• Number of clinics is insufficient to cope with the demand for review appointments	• Monitoring the number of review appointments required • Monitoring clinics and virtual clinics • Increasing the number of virtual clinics
• Current Service Provision will be impacted by the additional clinics being taken forward and Waiting Lists will continue to grow.	• Current provision continues • Utilise independent resources • Provide evening/weekend clinics
• Red flag appointments will not be seen within the required timeframe	• Monitor all current referrals and red flag appointments
• Reputation of Trust	• Provide a response within an agreed timeframe

5.0 Monitoring

Monitoring and reporting will continue throughout the investigation period and will be provided on a weekly basis. Meetings are scheduled on a weekly basis.

ROLE DESCRIPTION

JOB TITLE	Independent Consultant Urology Subject Matter Expert
REPORTS TO OPERATIONALLY	Melanie McClements, Acute Director
REPORTS TO PROFESSIONALLY	Dr Maria O’Kane, Medical Director
TIME COMMITMENT	Sessional Work on an ongoing basis

ROLE SUMMARY

To support the ongoing review of urology patients the Southern Health and Social Care Trust requires an independent Consultant Urologist to undertake a range of clinical review and quality assurance processes. The Subject Matter Expert will report operationally to the Director of Acute Services and Professionally to the Medical Director.

ROLE DUTIES

1. To review and quality assure the Trust audit of patients prescribed the medication Bicalutamide taking into account the audit methodology employed, audit findings and where appropriate the proposed changes in medication.
2. To chair a weekly extraordinary Multidisciplinary Team Meeting (MDT) to discuss and review patients which have been identified by independent Consultant Urologist as requiring MDT discussion. MDT will be supported by one additional Consultant Urologist, Consultant Oncologist and where required Consultant Radiologist / Pathologist.

3. To review radiology results (1028 patients) held on Electronically (NIECR System) to ascertain if appropriate action has been taken in response to the radiology results.
4. To review MDT meeting outcomes (271 patients) held on Electronically (NIECR System) to ascertain if appropriate action has been taken in response to the MDT discussions.
5. To quality assure the outcomes and conclusions for all patients that have been reviewed at clinic as part of the urology review to date from all identified workstreams.
6. To assist in the development on parameters for use when triaging patients who contact the patient information line including identification of what constitutes a potential delay in actioning treatments, reviews, referrals and reviews.



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

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

Division:

Auditor's name: Mr Mark Haynes

Audit Supervisor's Name : Not Applicable

Contact details: Personal Information redacted by the USI
(email)

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

Proposed audit commencement date 27th October 2020

Proposed audit completion date .../.../....

Audit Aims

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

Audit Objectives

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

Audit Standards

The following audit standards obtained from NICE guideline [NG131] Prostate cancer: diagnosis and management
Published date: 09 May 2019.

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

Audit Methodology

The following audit methodology will be followed:

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

Rationale for the audit (please tick all that apply)

Topic is included in the Directorate's clinical audit work-plan

☐ Compliance with standards & guidelines



National Healthcare Quality Improvement Partnership (HQIP) audit	<input type="checkbox"/>	Regional RQIA/GAIN audit	<input type="checkbox"/>
Other national / international audit	<input type="checkbox"/>	Trust based audit topic important to team/division	<input checked="" type="checkbox"/>
Clinical risk	<input checked="" type="checkbox"/>	Recommendation from national / regional report	<input type="checkbox"/>
Serious Adverse Incident or Adverse Incident review	<input checked="" type="checkbox"/>	Clinician / personal interest	<input type="checkbox"/>
Incident reporting	<input type="checkbox"/>	Educational audit	<input type="checkbox"/>
Other – please specify			
Level 1 <input type="checkbox"/> Level 2 <input checked="" type="checkbox"/> Level 3 <input type="checkbox"/> Level 4 <input type="checkbox"/>			
Has this audit been approved based on the priority level? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Level 1 - Approval required by Associate Medical Director or Clinical Director or Directorate Governance Forum Level 2 - Approval required by Associate Medical Director or Clinical Director or Directorate Governance Forum Level 3 – Approval required by Supervising Consultant Level 4 – Approval required by Supervising Consultant Please be advised that the audit cannot proceed without approval as above.			
Please Note: The Information Team have advised they will not release data to the requestor unless the clinical audit has been approved as above. The clinical audit team will also advise contact with Information Governance for any advice required.			
The clinical audit team can be contacted via: Email: Personal Information redacted by the USI Tel: <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div> Raymond Haffey Terri Harte Sandra McLoughlin </div> <div style="background-color: black; color: black; text-align: center; width: 100px;"> Personal Information redacted by the USI Personal Information redacted by the USI Personal Information redacted by the USI </div> <div> Mary Markey Roisin Feely Philip Sullivan </div> <div style="background-color: black; color: black; text-align: center; width: 100px;"> Personal Information redacted by the USI Personal Information redacted by the USI Personal Information redacted by the USI </div> </div>			
<i>In submitting this audit registration form, I agree to share the audit findings, recommendations and audit summary template with: the Audit Supervisor, appropriate Divisional/Directorate Committee and the Trust's Clinical audit team</i>			
Please submit your audit registration form to: Personal Information redacted by the USI			







Priority levels for clinical audit






Level	Audit type - projects identified through	
Level 1 audits, "external must dos" (where the service is applicable to SHSCT)	<ul style="list-style-type: none"> National audits (NHS England Quality Accounts List (HQIP), including the National Confidential Enquiry into Patient Outcomes and Deaths (NCEPOD) / Other Confidential Inquires 	1
Level 2 audits, other national audits and 'internal must dos'	<ul style="list-style-type: none"> National audits not contained within the HQIP list, or other clinical audits arising from: Clinical risk Serious untoward incident / internal reviews National Institute of Clinical Excellence Standards & Guidelines Complaints Re-audit Regional audits initiated by RQIA / GAIN 	2
Level 3 audits, 'divisional priorities'	<ul style="list-style-type: none"> Local topics important to the division 	3
Level 4 audits	<ul style="list-style-type: none"> Clinician / personal interest Educational audits 	4

Action Plan Urology

 Personal
Information
redacted by the USI

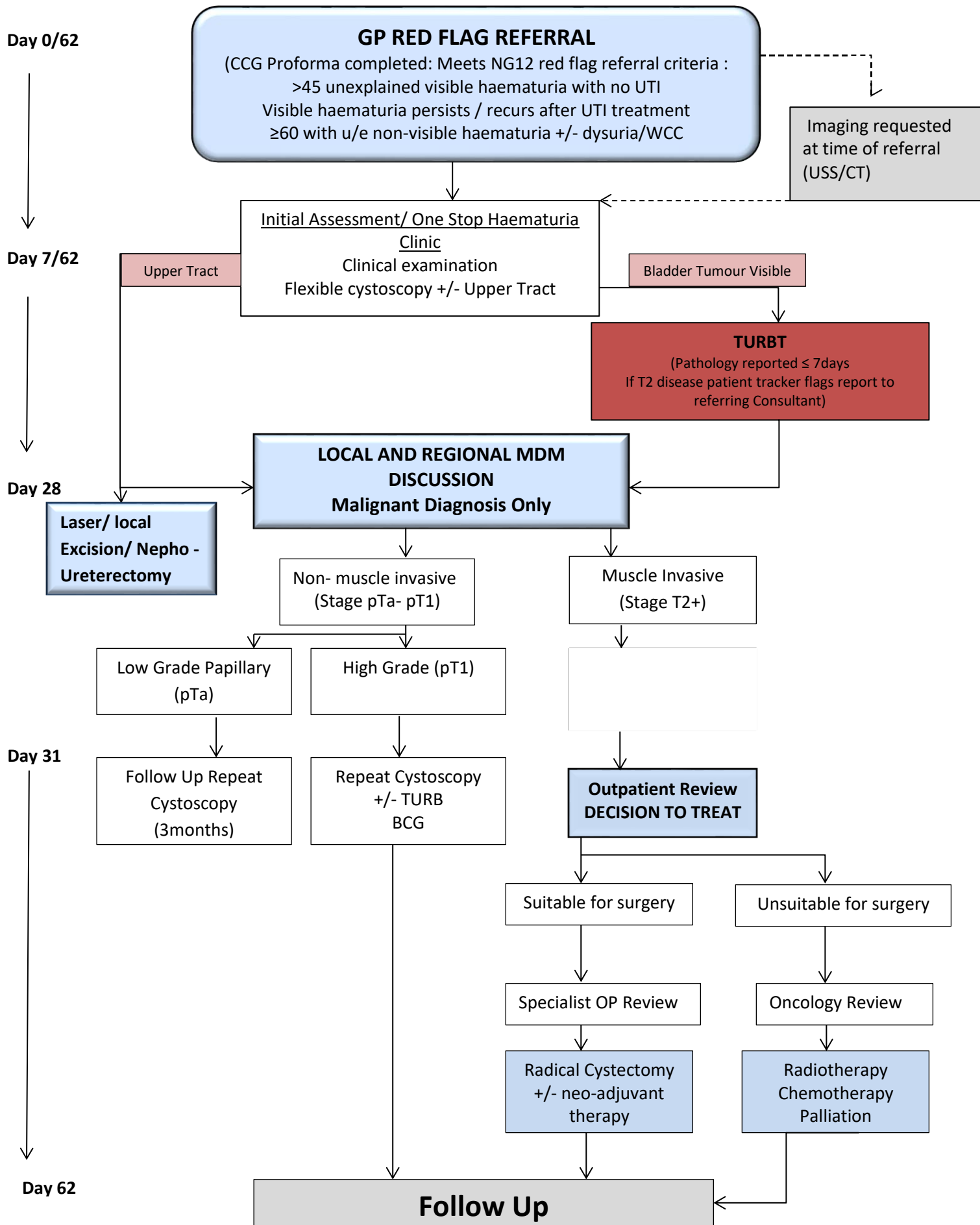
Reference number	Recommendations	Designated responsible person	Action required	Date for completion / timescale	Date recommendation completed with evidence
1	HSCB should link with the electronic Clinical Communication Gateway (CCG) implementation group to ensure it is updated to include NICE/NICaN clinical referral criteria. These fields should be mandatory.	HSCB	See recommendation 5		
2	HSCB should consider GP's providing them with assurances that the NICE guidance has been implemented within GP practices	HSCB			
3	HSCB should review the implementation of NICE NG12 and the processes surrounding occasions when there is failure to implement NICE guidance, to the detriment of patients.	HSCB			
4	GPs should be encouraged to use the electronic CCG referral system which should be adapted to allow a triaging service to be performed to NICE NG12 and NICaN standards. This will also mean systems should be designed that ensure electronic referral reliably produces correct triaging e.g. use of mandatory entry fields.	HSCB			

5	<p>TRUST</p> <p>Work should begin in communicating with local GPs, perhaps by a senior clinician in Urology, to formulate decision aids which simplify the process of Red-flag, Urgent or Routine referral. The triage system works best when the initial GP referral is usually correct and the secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence the norm.</p>	AD surgical/ AMD Primary Care	The urology service hold the view that to enable the referral process to be efficient and effective, the CCG form requires to have mandatory fields which require it to be completed prior to referral from Primary Care.		<p>NiCan pathway.</p> <p> Bladder Cancer Pathway March 2020</p> <p> Revised Prostate Diagnostic Pathway C</p> <p> Female Lower Urinary Tract Sympto</p> <p> Female Urinary Tract Infection.docx</p> <p> Male Lower Urinary Tract Symptoms.docx</p> <p> male urinary tract infections.docx</p>
6	The Trust should re-examine or re-assure itself that it is feasible for the Consultant of the Week (CoW) to perform both triage of non-red flag referrals and the duties of the CoW.	AD Surgery/ AMD Surgery	Time needs to be made available in consultant job plans to undertake the task of triaging referral letters. Discussions are ongoing with MD and AD	Jan 2021	

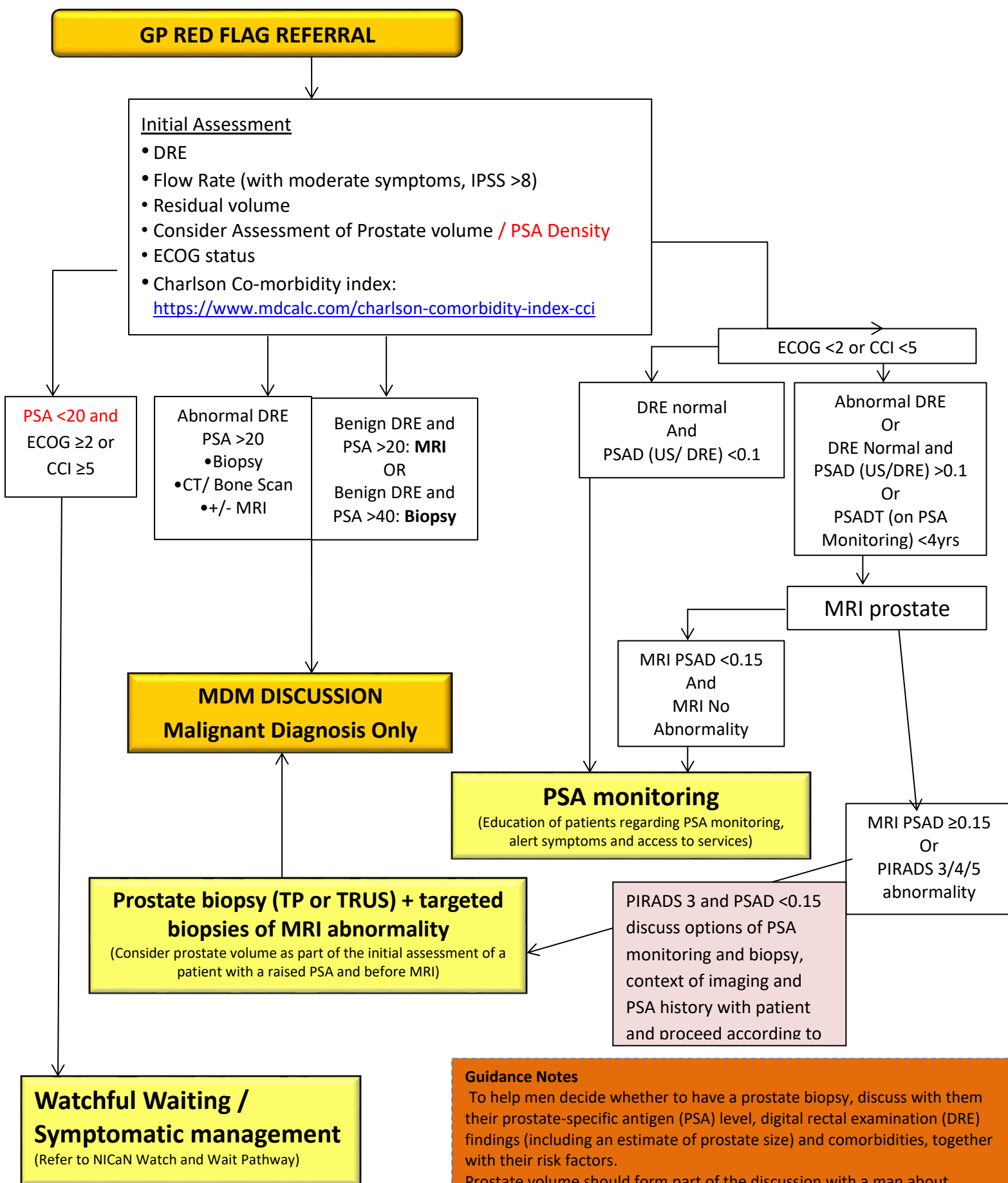
7	The Trust will develop written policy and guidance for clinicians on the expectations and requirements of the triage process. This guidance will outline the systems and processes required to ensure that all referrals are triaged in an appropriate and timely manner.	AD surgery	Currently the IEAP protocol is followed The current regional protocol is being updated.	Jan 2021	 Integrated Elective Access Protocol - Apr  Integrated Elective Access Protocol Draft  FW IEAP referral.msg  Booking Centre SOP manual.doc  TRIAGE PROCESS 2. Imca.docx
8	The current Informal Default Triage (IDT) process should be abandoned. If replaced, this must be with an escalation process that performs within the triage guidance and does not allow Red-flag patients to wait on a routine waiting list.	AD Surgery		Nov 2020	
9	Monthly audit reports by Service and Consultant will be provided to Assistant Directors on compliance with triage. These audits should be incorporated into Annual Consultant Appraisal programmes. Persistent issues with triage must be escalated as set out in recommendation 10.	AD surgery	Reports will be sent to AD and AMD/ CD	Nov 2020	
10	The Trust must set in place a robust system within its medical management hierarchy for highlighting	MD			

	and dealing with 'difficult colleagues' and 'difficult issues', ensuring that patient safety problems uncovered anywhere in the organisation can make their way upwards to the Medical Director's and Chief Executive's tables. This needs to be open and transparent with patient safety issues taking precedence over seniority, reputation and influence.				
11	Consultant 1 needs to review his chosen 'advanced' method and degree of triage, to align it more completely with that of his Consultant colleagues, thus ensuring all patients are triaged in a timely manner.	MD			
12	Consultant 1 needs to review and rationalise, along with his other duties, his Consultant obligation to triage GP referrals promptly and in a fashion that meets the agreed time targets, as agreed in guidance which he himself set out and signed off. As he does this, he should work with the Trust to aid compliance with recommendation 6.	MD			

NICaN SUSPECT BLADDER CANCER REFERRAL AND DIAGNOSTIC PATHWAY



NICA SUSPECT PROSTATE CANCER DIAGNOSTIC PATHWAY

**Guidance Notes**

To help men decide whether to have a prostate biopsy, discuss with them their prostate-specific antigen (PSA) level, digital rectal examination (DRE) findings (including an estimate of prostate size) and comorbidities, together with their risk factors.

Prostate volume should form part of the discussion with a man about whether further investigation (eg MRI +/- biopsy) or monitoring.

Give men and their partners or carers information, support and adequate time to decide whether or not they wish to undergo prostate biopsy.

Female Lower Urinary Tract Symptoms

History;

- Storage symptoms – Frequency, Urgency, Nocturia, Incontinence
- Voiding symptoms – Hesitancy, Poor flow, Straining, Stop-start void.
- Assessment of Fluid intake

Examination;

- Abdomen
 - Palpable bladder?
- External Genitalia/Pelvic Examination
 - Atrophic Vaginitis
 - Pelvic Organ Prolapse

Investigations;

- Urine Dipstick
 - Glucose
 - Nitrite and Leukocytes
 - Haem
- Blood test
 - Renal profile
 - Glucose (found on Dipstick)
- USS Urinary tract
 - Hydronephrosis?
 - Residual Volume?
 - Pelvic organs?

Primary Care management;

- Lifestyle advice
 - Reduce Caffeine
 - Timing of fluid intake
- Palpable Bladder
 - refer to Urology
- Atrophic Vaginitis
 - Consider oestrogens therapy
- Pelvic Organ Prolapse
 - Refer to Gynae
- Leukocytes
 - manage infection as per Guidelines.
- If Renal Impairment
 - see Nephrology Guidelines

- Ultrasound Urinary tract
 - Hydronephrosis - refer to Urology
 - Residual Volume >150ml – refer to Urology
- Incontinent, residual volume <150ml, storage symptoms
 - If incontinent consider Anticholinergic treatment
 - Symptom review after 3/12 treatment

If urinary incontinent,

- If mainly stress incontinent, refer to community
- Consider anticholinergice treatment – and reassessment after three months

- Others – patients who do not fit into the above two categories
 - Refer to Urology
 - Treat with topical oestrogens.
 - Hydronephrosis → Refer Urology
 - Residual Volume ≥ 300ml → Refer Urology
 - Residual volume 150ml – 300ml → Refer community continence team

Referral;

- Abnormal findings as above
- No symptomatic improvement after 3/12 of medical treatment refer to Urology

Female Urinary Tract Infection**History;**

- First, recurrent or persistent UTI
- Symptoms suggestive of sepsis
- Cystitis (lower UTI) or pyelonephritis (upper UTI)?

Examination;

- Sepsis - Temperature? Heart Rate? Respiratory Rate? Blood Pressure?
- Abdomen – Is the bladder palpable?
- External Genitalia - consider the possibility of
 - Atrophic Vaginitis
 - Urethral pathology
- Pelvic Examination - consider the possibility of
 - Pelvic Mass
 - Cervix
 - Pelvic Organ Prolapse

Investigations;

- MSU for all patients suspected of having UTI.
- USS Urinary tract for recurrent or persistent UTI
 - Hydronephrosis? Residual Volume? Pelvic Organs?

Primary Care treatment;

- UTI with Sepsis
 - Refer to secondary care for admission
- Simple, Single Lower UTI
 - Antibiotics as per microbiology guidelines.
 - Repeat MSU 2/52 post treatment.
- Recurrent Lower UTI
 - 7 day course antibiotics as per microbiology guidance followed by 3 month course of low dose antibiotics.
 - Repeat MSU after 1/12 of treatment.
- Upper UTI no sepsis
 - 14 day course antibiotics as per microbiology guidance

Referral to Urology;

- Abnormal findings as above
- UTI with Sepsis
 - Refer to secondary care for admission
- Upper UTI no sepsis
 - Refer to Urology 'Hot clinic'
- Recurrent Lower UTI
 - Further UTI while on low dose antibiotics.
 - 3rd UTI within 12 months of first presentation.

Male Lower Urinary Tract Symptoms

History

Storage symptoms – Frequency, Urgency, Nocturia

Voiding symptoms – Hesitancy, poor flow, straining, intermittent stream

Incontinence

Comorbidities – constipation, review of relevant medication

Consider IPSS record and frequency / volume chart.

Examination

External genitalia specifically foreskin and meatus

Abdomen specifically to exclude a palpable bladder

DRE

Investigation

Urine Dipstick test for glucose, haem and nitrites/leucocytes

MSU if indicated

Blood tests – renal function, (glucose if indicated by dipstick test)

- PSA if 40+yrs, abnormal DRE, concern re prostate cancer

Ultrasound Urinary Tract specifically pre and post void bladder volumes and prostate volume

Refer if:

urinary incontinence

suspect urological cancer – raised PSA, abnormal DRE

palpable post void bladder

bothersome phimosis, meatal stenosis

haematuria (see Red Flag guidelines)

recurrent or persisting UTI

Hydronephrosis or bladder residual more than 200mls

Renal impairment if suspected if relating to lower urinary tract dysfunction

Primary care management

Lifestyle advice : - Timing / content of fluid intake (eg evening time fluids and caffeine)

- Co-morbidity issues (eg constipation)

Medication : Initial 3 month prescription (and continue if symptomatic improvement)

- Alpha blocker
- Consider 5-Alpha reductase inhibitor if prostate more than 30cc volume or PSA more than 1.4ng/ml (these medications can be given in combination)
- Consider anticholinergic medication if frequency / urge symptoms continue after trial of alpha blocker medication.

Refer if :

Initial concerns met

Lack of response to initial management plan

Male Urinary Tract Infection

History;

- Red Flag symptoms? – See Red Flag Guidance
- Lower UTI or Upper UTI?
- 'Normal' lower Urinary tract symptoms?

Examination;

- Sepsis Response – Temperature? Heart Rate? Respiratory Rate? Blood Pressure?
- Abdomen – Is the bladder palpable?
 - Palpable bladder → Refer Urology
- External Genitalia – Foreskin, Glans / Meatus
 - Phimosis, Meatal stenosis → Refer Urology
- Digital Rectal Examination – Prostate
 - Malignant feeling prostate → Refer (see red flag guidance)
 - Tender Prostate without sepsis → Refer Urology 'Hot' clinic

Investigations;

- MSU – All patients suspected of having UTI.
- Blood – Renal profile and glucose.
- USS Urinary tract – Hydronephrosis? Residual Volume?
 - Hydronephrosis >> Refer Urology
 - Residual Volume \geq 300ml >> Refer Urology
 - Residual volume 150ml – 300ml ??

Primary Care treatment;

- UTI with Sepsis;
- Lower UTI;
 - 7 day course antibiotics as per microbiology guidelines.
 - Repeat MSU 2/52 post treatment.
- Upper UTI no sepsis;
 - 14 day course antibiotics as per microbiology guidance.

Referral;

- Abnormal findings as above
- UTI with Sepsis;
 - Refer acutely to on-call team
- Upper UTI no sepsis;
 - Refer to Urology 'Hot clinic'
- Lower UTI;
 - Refer to Urology.



Department of
**Health, Social Services
and Public Safety**

An Roinn

**Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí**

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**INTEGRATED ELECTIVE ACCESS PROTOCOL
30th April 2008**

DOCUMENT CONTROL			
INTEGRATED ELECTIVE ACCESS PROTOCOL			
Authors	Michelle Irvine – Programme Director, Elective Workstream Maria Wright – Associate Director, Outpatients Rosemary Hulatt – Associate Director, Diagnostics		
Issue Date 1st Draft	Wednesday 20 th February 2008		
Comments by	Close of Play - Friday 7 th March 2008		
2nd Draft	27 th March 08		
Final Protocol Date Approved	30 th April 08		
Issue Date	Friday 9 th May 2008		
Screened By	Service Delivery Unit, DHSSPSNI		
Approved By		Signature	
Distribution	Trust Chief Executives; Directors of Planning and Performance; Directors of Acute Care; DHSSPS		
Review Date	April 2009		

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ABBREVIATIONS

AHP	Allied Health Professional
BCC	Booking and Contact Centre (ICATS)
CNA	Could Not Attend (Admission or Appointment)
DHSSPSNI	Department of Health, Social Services and Public Safety
DNA	Did Not Attend (Admission or Appointment)
DTLs	Diagnostic Targeting Lists
ERMS	Electronic Referrals Management System
GP	General Practitioner
HIC	High Impact Changes
HROs	Hospital Registration Offices
ICATS	Integrated Clinical Assessment and Treatment Services
ICU	Intensive Care Unit
LOS	Length of Stay
PAS	Patient Administration System
PTLs	Primary Targeting Lists
SDU	Service Delivery Unit
TCI	To Come In (date for patients)

SECTION 1

CONTEXT

1.1 INTRODUCTION

- 1.1.1 This protocol has been developed to encompass the elective pathway within a hospital environment. The principles can be applied to primary and community settings, however it is recommended that guidance is developed which recognises the specific needs of the care pathway provided in these settings.
- 1.1.2 The length of time a patient needs to wait for elective treatment is an important quality issue and is a visible public indicator of the efficiency of the hospital services provided by the Trust. The successful management of patients who wait for outpatient assessments, diagnostic investigations and elective inpatient or day case treatment is the responsibility of a number of key individuals within the organisation. General Practitioners, commissioners, hospital medical staff, managers and clerical staff have an important role in ensuring access for patients in line with maximum waiting time guarantees, managing waiting lists effectively, treating patients and delivering a high quality, efficient and responsive service. Ensuring prompt timely and accurate communications with patients is a core responsibility of the hospital and the wider local health community.
- 1.1.3 The purpose of this protocol is to define those roles and responsibilities, to document how data should be collected, recorded and reported, and to establish a number of good practice guidelines to assist staff with the effective management of outpatient, diagnostic and inpatient waiting lists. It will be a step-by-step guide to staff, and act as a reference work, for the successful management of patients waiting for hospital treatment.
- 1.1.4 This protocol will be updated, as a minimum, on an annual basis to ensure that Trusts' policies and procedures remain up to date, and reflect best practice locally and nationally. Trusts will ensure a flexible approach to getting patients treated, which will deliver a quick response to the changing nature of waiting lists, and their successful management.
- 1.1.5 This protocol will be available to all staff via Trusts' Intranet.

- 1.1.6 The DHSSPSNI has set out a series of challenging targets for Trusts in Northern Ireland in the field of elective treatment management. Trusts will recognise the need to move the treatment agenda forward in the context of its shared responsibility for the delivery of these goals.
- 1.1.7 There is an imperative to identify capacity constraints that could threaten the delivery of these key access targets and speed up the planning and delivery of extra capacity, where it is needed, to address these constraints. The health community will need to develop a co-ordinated approach to capacity planning taking into account local capacity on a cross Trust basis and independent sector capacity on an on-going partnership basis.
- 1.1.8 In this context, this protocol has been prepared to provide clarity of purpose within Trusts with a view to merging seamlessly with the policies of other agencies in the wider health community as they emerge.
- 1.1.9 The intention is that this protocol will be further developed to consider all aspects of access to a range of quality healthcare at a date and time of the patients' choice.
- 1.1.10 This protocol has been prepared to clarify Trusts' medium and long-term objectives, set the context in which they will be delivered and establish the parameters within which staff at divisional, specialty and departmental levels will operate.
- 1.1.11 Delivery of this protocol will require a step change in the way Trusts function. Trusts will need to transform themselves and this can only be achieved through a change in the way its staff approach their work on a day-to-day basis. Through this protocol, Trusts will aspire to work with patients and staff to raise expectations basing them not on where we are but on where we need to be.
- 1.1.12 For the purposes of this protocol, the term inpatient refers to inpatient and day case elective treatment. The term 'PAS' refers to all patient

administration systems, whether in a hospital or community setting, or an electronic or manual system.

- 1.1.13 All staff involved in the administration of waiting lists will ensure that Trusts' policies and procedures with respect to data collection and entry are strictly adhered to. This is to ensure the accuracy and reliability of data held on PAS and the waiting times for treatment. All staff involved in the implementation of this protocol, clinical and clerical, will undertake initial training and regular annual updating. Trusts will provide appropriate information to staff so they can make informed decisions when implementing and monitoring this protocol. All staff involved in the administration of waiting lists will be expected to read and sign off this protocol.

1.2 UNDERPINNING PRINCIPLES

- 1.2.1 Patients will be treated on the basis of their clinical urgency with urgent patients seen and treated first. The definition of clinical urgency will be defined specifically by specialty / procedure / service.
- 1.2.2 Patients with the same clinical need will be treated in chronological order on grounds of fairness, and to minimise the waiting time for all patients.
- 1.2.3 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to admit, i.e. if there was a bed available tomorrow in which to admit a patient - they are fit, ready, and able to come in.
- 1.2.4 Trusts should design processes to ensure that inpatient care is the exception for the majority of elective procedures, not the norm. The principle is about moving care to the most appropriate setting, based on clinical judgement. This means moving day case surgery to outpatient care, and outpatient care to primary care or alternative clinical models where appropriate.

- 1.2.5 Change No 1 within the publication “10 High Impact Changes for Service Improvement and Delivery”¹ focuses on day surgery and the document provides Trusts with tools and resources to help implement this high impact change.
- 1.2.6 Trusts will introduce booking systems aimed at making hospital appointments more convenient for patients. Booking systems are chronologically based and will move Trusts onto a system of management and monitoring that is chronologically as opposed to statistically based.
- 1.2.7 As part of a plan for the implementation of booking, Trusts must ensure their elective admission selection system is managed on a chronological basis within clinical priority with immediate effect. The intention is to provide patients with certainty and choice enabling them to access services that are sensitive to their needs.
- 1.2.8 This will require changes in working practices. It will also require technological change to information systems to enable provision of quality information to support the booking process.
- 1.2.9 There is a need to balance the flow of patients from primary care through outpatients and on to booking schedules should they need elective admission. It follows that the level of activity in the Service and Budget Agreements and the level of provision of outpatient and inpatient capacity must be linked. If one changes, all should change.
- 1.2.10 This “bottom up” approach is based on the belief that services need to be built on firm clinical foundations. Trusts need a clinical vision built up specialty by specialty and department by department through debate and agreement between clinicians across the health community as to the best way to meet patient needs locally.
- 1.2.11 It is essential that patients who are considered vulnerable for whatever reason have their needs identified at the point of referral.

¹ “10 High Impact Changes for Service Improvement and Delivery” – September 2004, NHS Modernisation Agency, www.modern.nhs.uk/highimpactchanges

- 1.2.12 All relevant information must be recorded to ensure that when selecting a vulnerable patient for admission, their needs are identified early and appropriate arrangements made. This information should be recorded in detail in the episodic comment field of PAS relating to the listing. The patient master index comment field should not be used due to confidentiality issues.
- 1.2.13 Communication with this patient group will recognise their needs and, where appropriate, involve other agencies.
- 1.2.14 An operational process should be developed by Trusts to ensure that children and vulnerable adults who DNA or CNA their outpatient appointment are followed up by the most appropriate healthcare professional and a clear link to the referring clinician established.
- 1.2.15 In implementing this protocol the needs of ethnic groups and people with special requirements should be considered at all stages of the patient's pathway.

1.3 OWNERSHIP

- 1.3.1 Ownership is key to delivering quality of care. Trusts must ensure that all staff are conversant with the Departmental targets and standards and are comfortable with the local health communities' approach to their delivery.
- 1.3.2 These targets and standards must be seen to be core to the delivery of all aspects of care provision by all levels of staff within the Trust.
- 1.3.3 This is a major change agenda requiring significant commitment and investment at corporate and individual level. An Executive Director will take lead responsibility for ensuring all aspects of this Protocol are adhered to.

- 1.3.4 Trusts must be committed to training and developing staff and providing the supporting systems to ensure that together we can bring about the improvement in patient care.

1.4 REGIONAL TARGETS

- 1.4.1 The targets in respect of elective treatments are:

- A maximum waiting time of 13 weeks for inpatient and daycase admissions by March 2009
- A maximum waiting time of 9 weeks for a 1st outpatient appointment by March 2009
- A maximum waiting time of 9 weeks for a diagnostic test by March 2009
- A maximum waiting time of 13 weeks from referral to treatment by an Allied Health Professional (AHP) by March 2009
- By March 2009, sustain the target where 98% of patients diagnosed with cancer should begin treatment within a maximum of 31 days of the diagnosis
- By March 2009, 95% of patients with suspected cancer who have been referred urgently should begin their first definitive treatment within a maximum of 62 days

1.5 DELIVERY OF TARGETS

- 1.5.1 The waiting time targets are based on the “worst case” i.e. they reflect the minimum standards with which every Trust must comply.
- 1.5.2 The expectation is that these targets are factored into plans at Trust Board, divisional, specialty and departmental levels as part of the normal business

and strategic planning processes. Divisional, specialty and departmental managers will be expected to have produced implementation plans setting out the key steps they need to take to ensure the delivery of the Trust and Departmental protocol objectives within the area(s) of their responsibility. Trusts will manage implementation through a regular review of “local” divisional, specialty and departmental plans for the implementation of waiting and booking targets.

- 1.5.3 It is expected that Trusts will develop robust information systems to support the delivery of these targets. Daily management information should be available at both managerial and operational level so that staff responsible for selecting patients are working from up to date and accurate information. Future developments should also look towards a clinic management system which will highlight the inefficiencies within the outpatient setting.

1.6 CAPACITY

- 1.6.1 It is important for Trusts to understand their baseline capacity, the make-up of the current cohort of patients waiting and the likely changes in demand that will impact on their ability to treat patients and meet the Departmental Targets.
- 1.6.2 To manage at specialty and departmental level it is anticipated that managers will have, as a minimum, an overview of their core capacity including:
- Number of clinic and theatre sessions
 - Session length
 - Average procedure / slot time
 - Average length of stay
- 1.6.3 It is expected that similar information will be available at consultant level. For inpatients this is at procedure level, and for outpatients and diagnostics at service level.

- 1.6.4 This information will enable Trusts to evaluate its waiting/booked lists in terms of theatre sessions (time in hours) and length of stay (time in bed days).
- 1.6.5 Each specialty should understand its elective bed requirements in terms of both inpatients and daycases, setting challenging daycase and LOS targets and agreeing plans to deliver them. In addition, systems must be developed to ensure assessment can be made of available capacity and flexible working arrangements developed accordingly.
- 1.6.6 Theatre sessions should be seen as corporate resources and used flexibly to ensure the delivery of waiting list and waiting time targets across consultants within the same specialty and specialties within the same Trust. This ties in with the Real Capacity Paper which also requires commissioners to demonstrate that they have used capacity flexibly across Trusts. The expectation is that divisions and/ or specialties will be able to demonstrate that they have optimised the use of existing capacity to maximise the treatment of patients within existing resources.
- 1.6.7 Trusts will treat patients on an equitable basis across specialties and managers will work together to ensure consistent waiting times for patients of the same clinical priority.
- 1.6.8 Trusts will set out to resource enough capacity to treat the number and anticipated casemix of patients agreed with commissioners. The Real Capacity Planning exercise will support this process locally.
- 1.6.9 Divisions/specialties will monitor referrals and additions to lists in terms of their impact on clinic, theatre time, bed requirements and other key resources e.g. ICU facilities, to ensure a balance of patients in the system and a balance between patients and resources.
- 1.6.10 When the balance in the system is disturbed to the extent that capacity is a constraint, divisional/specialty managers will be expected to produce plans

to expedite solutions and agree these through the accountability review process.

- 1.6.11 It is important for all services to understand their baseline capacity, the make-up of the cohort of patients waiting to be treated and the likely changes in demand that will impact on their ability to initiate treatment and meet the maximum waiting time guarantees for patients.
- 1.6.12 Trusts should ensure that robust prospective capacity planning arrangements are in place, with clear escalation procedures to facilitate capacity gaps to be identified and solutions found in a timely manner to support operational booking processes and delivery of the targets.
- 1.6.13 In summary, the intention is to link capacity to the Service and Budget Agreement i.e. to agree the plan, put in place the resources to achieve the plan, monitor the delivery of the plan and take corrective action in the event of divergence from the plan proactively. The existing arrangements whereby patients are added to waiting lists irrespective of whether Trusts have the capacity to treat them must change.

1.7 BOOKING PRINCIPLES

- 1.7.1 These booking principles have been developed to support all areas across the elective pathway where appointment systems are used.
- 1.7.2 Offering the patient choice of date and time is essential in agreeing and booking appointments with patients. Trusts should ensure booking systems enable patients to choose and agree hospital appointments that are convenient for them. This takes away the uncertainty of not knowing how long the wait will be as patients are advised of their expected wait. Advanced booking in this way also gives patients notice of the date so that they can make any necessary arrangements, such as child care or work arrangements.

- 1.7.3 Facilitating reasonable offers to patients should be seen within the context of robust booking systems being in place.
- 1.7.4 Booking development work within Trusts should be consistent with regional and local targets, which provide a framework for progress towards ensuring successful and consistent booking processes across the health community in Northern Ireland.
- 1.7.5 All booking processes should be underpinned with the relevant local policies and procedures to provide clarity to operational staff of the day to day requirements and escalation route, for example: management of patients who cancel / DNA their appointment, process for re-booking patients, and monitoring of clinical leave and absence.
- 1.7.6 Trusts should ensure booking processes are continually reviewed and updated as required to reflect local and regional requirements at an operational level.
- 1.7.7 The definition of a booked appointment is:
- a) The patient is given the choice of when to attend.
 - b) The patient is advised of the total waiting time during the consultation between themselves and the healthcare provider / practitioner or in correspondence from them.
 - c) The patient is able to choose and confirm their appointment within the timeframe relevant to the clinical urgency of their appointment
 - d) The range of dates available to a patient may reduce if they need to be seen quickly, e.g. urgent referrals or within 2 weeks if cancer is suspected.
 - e) The patient may choose to agree a date outside the range of dates offered or defer their decision until later

1.7.8 Booking Process

1.7.9 There are 3 main patient appointment types to be booked. Booking systems for these appointments should be designed around an agreed patient pathway and accepted clinical practice. They are:

- a) New Urgent patients (including suspected cancer)
- b) New Routine patients
- c) Review patients

1.7.10 Clinic templates should be constructed to ensure that sufficient capacity is carved out to meet the local and maximum waiting time guarantees for new patients, and the clinical requirements of follow-up patients.

1.7.11 Principles for booking Cancer Pathway patients

- a) All suspected cancer referrals should be booked in line with the agreed clinical pathway requirement for the patient and a maximum of 14 days from the receipt of referral
- b) Dedicated registration functions for red flag and suspected cancer referrals should be in place within centralised HROs
- c) Clinical teams must ensure triage is undertaken daily, irrespective of leave, in order to initiate booking patients
- d) Patients will be contacted by telephone twice (morning and afternoon)
- e) If telephone contact cannot be made, a fixed appointment will be issued to the patient within a maximum of 3 days of receipt of referral
- f) Systems should be established to ensure the Patient Tracker / MDT Co-ordinator is notified of the suspected cancer patient referral, to allow them to commence prospective tracking of the patient

1.7.12 Principles for booking Urgent Pathway patients

- a) Local agreements should be in place with consultants to determine the timeframe within which urgent patients should be booked, and made explicit to booking teams

- b) Referrals will be received, registered within one working day and forwarded to consultants for prioritisation
- c) If clinical priority is not received from consultants within 72 hours, processes should be in place to initiate booking of urgent patients according to the GP's classification of urgency
- d) Patients will be issued with a letter inviting them to contact the Trust to agree and confirm their appointment in line with the urgent booking process.
- e) In exceptional cases, some patients will require to be appointed to the next available slot. A robust process for telephone booking these patients should be developed which should be clearly auditable.

1.7.13 Principles for booking Routine Pathway patients

- a) Patients should be booked to ensure appointment within the maximum waiting time guarantees for routine appointments
- b) Referrals will be received, registered within one working day at HRO's and forwarded to consultants for prioritisation
- c) Patients will receive an acknowledgement from the Trust indicating their expected length of wait and information on the booking process they will follow
- d) Approximately eight weeks prior to appointment, Trusts should calculate prospective slot capacity and immediately implement escalation policy where capacity gaps are identified
- e) Patients should be selected for booking in chronological order from the PTL
- f) Six weeks prior to appointment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment

1.7.14 Principles for Booking Review Patients

- a) Patients who need to be reviewed within 6 weeks will agree their appointment before they leave the clinic

- b) Patients who require a review appointment more than 6 weeks in advance will be added to and managed on a review waiting list
- c) Patients will be added to the review waiting list with an indicative date of treatment and selected for booking according to this date
- d) Six weeks prior to the indicative date of treatment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment within a clinically agreed window either side of the indicative date of treatment

1.7.15 It is recognised that some groups of patients may require booking processes that have additional steps in the pathway. These should be designed around the principles outlined to ensure choice and certainty as well as reflecting the individual requirements necessary to support their particular patient journey. Examples of this include:

- a) midwives contacting patients directly by telephone to arrange their appointment
- b) clinical genetics services where family appointments are required
- c) mental health or vulnerable children's services where patients may need additional reminders or more than one professional contacted if patients fail to make an appointment.

SECTION 2

GUIDANCE FOR MANAGEMENT OF ICATS SERVICES

2.1 INTRODUCTION

- 2.1.1 The administration and management of ICATS referrals and ICATS requests for diagnostics must be consistent, easily understood, patient focused, and responsive to clinical decision-making.
- 2.1.2 ICATS services are managed in accordance with the Data Definitions and Guidance Document for Monitoring of ICATS Services Sept 2007 (**Appendix 1**).
- 2.1.3 The level of functionality available on the Electronic Referral Management System to support the administration of patients in an ICATS setting is developmental. Achievement of the standards outlined will be where functionality permits.
- 2.1.4 Referrals will be managed through a centralised registration process in the nominated Hospital Registration Offices (HRO's) within Trusts to receive, register and process all ICATS referrals. The Trust should ensure that a robust process is in place to ensure that referrals received outside the HRO are date stamped, forwarded to the HRO and registered onto ERMS according to the date received by the Trust.
- 2.1.5 All new patients should be able to book their appointment in line with the guidance outlined in Booking Principles Section 1.7 The expectation is that follow up patients should also be offered an opportunity to choose the date and time of their appointment.

2.2 KEY PRINCIPLES

- 2.2.1 Where ICATS is in place for a specialty, all referrals should be registered and scanned onto Electronic Referral Management System (ERMS) within 24 hours of receipt.
- 2.2.2 Each ICATS must have a triage rota to ensure that every referral is triaged and the appropriate next step is confirmed, according to the clinically agreed

rules, within three working days of receipt in any Hospital Registration Office (HRO). Triage rotas must take multi-site working into account. A designated officer in ICATS should oversee the triage arrangements.

- 2.2.3 The outcome of the triage will be confirmed by letters to the GP and patient within a further two working days of triage (five working days in total from receipt).
- 2.2.4 ICATS clinical staff will be aware of all exclusions that prevent patients from being assessed or treated within the ICATS setting.
- 2.2.5 Patients of equal clinical priority will be selected for booking in chronological order in order to meet the maximum waiting time guarantee for patients and local access standards.
- 2.2.6 All patients deemed appropriate will be offered an ICATS appointment within six weeks from the triage date.
- 2.2.7 Data collection should be accurate, timely, complete and subject to regular audit and validation.
- 2.2.8 Staff should be supported by appropriate training programmes.

2.3 CALCULATION OF THE WAITING TIME

- 2.3.1 The waiting time clock for ICATS starts after the triage decision has been taken that an appointment in ICATS clinic is the appropriate next step.
- 2.3.2 The ICATS clock stops when the patient attends for first appointment or when the patient has been discharged from ICATS.
- 2.3.3 Patients who cancel an appointment will have their waiting time clock reset to the date the hospital was informed of the cancellation. Patients who refuse a reasonable offer of an appointment will also have their waiting time clock reset to the date the reasonable offer was refused. To ensure the

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

- 2.3.4 Patients who fail to attend their appointment without giving prior notice (DNA) will have their waiting time clock reset to the date of the DNA.
- 2.3.4 No patient should have his or her appointment cancelled. If the ICATS service cancels a patient's appointment, the patient's waiting time clock will not be reset and the patient should be offered another appointment, ideally at the time of the cancellation, and which is within six weeks of the original appointment date.

2.4 NEW REFERRALS

- 2.4.1 All ICATS referrals will be registered and scanned onto ERMS within 24 hours of receipt. All referrals forwarded for ICATS triage must be triaged or assessed to make a clear decision on the next step of a referral within three working days of the referral being logged by the HRO onto ERMS.
- 2.4.2 Within five working days of the referral being recorded onto ERMS, the GP and patient must be issued with written confirmation of the next stage of the patient's treatment.
- 2.4.3 Where there is insufficient information for the professional to make a decision, they have the option to either return the referral to the referrer requesting the necessary information or contact the referrer in the first instance to access the necessary information. If this cannot be gained, the referral should be returned to the referrer requesting the necessary information and a new referral may be initiated.
- 2.4.4 Those patients identified for outpatients and diagnostic services following triage will be managed in line with the relevant sections of this IEAP.

Flowcharts illustrating the Triage Outcomes Process can be found in **Appendix 2.**

2.5 BOOKING

- 2.5.1 All patients requiring an appointment in an ICATS will have the opportunity to agree the date and time of their appointment, in line with the booking principles outlined in Section 1.7.
- 2.5.2 If a patient requests an appointment beyond the six week ICATS standard the patient will be discharged and told to revisit their GP when they are ready to be seen at the ICATS clinic. This will ensure that all patients waiting for an ICATS appointment are fit and ready to be seen. It is accepted that local discretion may be required where short periods of time are involved, for example, if patients are requesting dates up to a week over their breach date. Trusts should ensure that reasonableness is complied with to facilitate recalculation of the patient's waiting time and to facilitate booking the patient into the date they requested.
- 2.5.3 Trusts must ensure that all communication to patients is clear, easily understood and complies with all relevant legislation.

2.6 REASONABLE OFFERS

- 2.6.1 All patients must be offered reasonable notice. A reasonable offer is defined as an offer of appointment, irrespective of provider, that gives the patient a minimum of three weeks' notice and two appointments. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date of the second appointment date declined.
- 2.6.2 If the patient is offered an appointment within a shorter notice period and it is refused, the waiting time cannot be recalculated.

2.6.3 If the patient however accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date the service was notified of the cancellation, as the patient has entered into an agreement with the Trust.

2.6.4 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above. The Implementation Procedure on Reasonableness can be found in **Appendix 3**.

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

2.7.1 If a patient DNAs their first ICATS appointment the following process must be implemented.

- Where a patient has had an opportunity to agree the date and time of their appointment, they will not normally be offered a second appointment. These patients will be referred back to the care of their referring clinician.
- Under exceptional circumstances a clinician may decide that a patient should be offered a second appointment. The second appointment must be booked.

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

- The patient will be given a second opportunity to book an appointment, which should be within six weeks of the original appointment date.
- If a second appointment is cancelled, the patient will not normally be offered a third opportunity and will be referred back to their referring clinician.

- 2.7.3 If a patient has been referred back to their referring clinician and the referrer still wishes a patient to be seen in ICATS, a new referral is required.
- 2.7.4 The Implementation Procedure for the Management of Patients who DNA or Cancel can be found in **Appendix 4**.

2.8 MAXIMUM WAITING TIME GUARANTEE

- 2.8.1 If a patient requests an appointment date that is beyond the maximum waiting time guarantee, the patient will be discharged and advised to revisit their GP when they are ready to be seen. This will ensure that all patients waiting for an appointment are fit and ready to be seen. It is accepted that local discretion may be required where short periods of time are involved, for example, if patients are requesting dates up to a week over their breach date. Trusts should ensure that reasonableness is complied to facilitate re-calculation of the patient's waiting time, and to facilitate booking the patient into the date they requested.

2.9 COMPLIANCE WITH TRUST LEAVE PROTOCOL

- 2.9.1 It is essential that leave/absence of ICATS practitioners is organised in line with Trusts' notification of leave protocol. It is also necessary for Trusts to have robust policies and procedures that minimise the cancellation/reduction of ICATS clinics.
- 2.9.2 The protocol should require a minimum of six weeks' notification of intended leave. A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

2.10 CLINIC OUTCOME MANAGEMENT

- 2.10.1 There are a number of locations within Trusts where patients present for their ICATS consultation. This protocol applies to all ICATS locations. It is the responsibility of the ERMS user managing the attendance to maintain data quality.
- 2.10.2 Changes in the patient's details must be updated on ERMS and the medical records on the date of clinic.
- 2.10.3 When the assessment has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on ERMS.

2.11 REVIEW APPOINTMENTS

- 2.11.1 All review appointments must be made within the time frame specified by the ICATS practitioner. If a review appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the ICATS practitioner.
- 2.11.2 As previously stated, the Booking Centres will be responsible for partially booking all new appointments. Booking Centres will also book review appointments that are required to be more than 6 weeks in the future. ICATS administration staff will make bookings directly with the patient at the clinic for any further appointments needing to occur within 6 weeks.

2.12 TEMPLATE CHANGES

- 2.12.1 Templates should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement.

- 2.12.2 Templates will identify the number of slots available for new and follow up appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated to each appointment slot.
- 2.12.3 All requests for template and temporary clinic rule changes will only be accepted in writing. A minimum of six weeks notice will be provided for clinic template changes.
- 2.12.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager. The Implementation Procedure for management of Clinic Template Changes can be found in **Appendix 5**.

2.13 VALIDATION

- 2.13.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. Trusts should ensure that all relevant data fields are completed in ERMS. This should be undertaken as a minimum on a monthly basis and ideally on a weekly basis as waiting times reduce.
- 2.13.2 The data validation process will apply to both new and follow up appointments. The Implementation Procedure for data validation can be found in **Appendix 6**.

SECTION 3

GUIDANCE FOR MANAGEMENT OF OUTPATIENT SERVICES

3.1 INTRODUCTION

- 3.1.1 The following protocol is based on nationally recommended good practice guidelines to assist staff with the effective management of outpatient services.
- 3.1.2 The administration and management of the outpatient pathway from receipt of referral to appointment within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.
- 3.1.3 There will be dedicated Hospital Registration Offices (HROs) within Trusts to receive, register and process all outpatient referrals. The HROs will be required to register and scan referrals (where appropriate) onto the Electronic Referrals Management System (ERMS) and PAS.
- 3.1.4 There will be dedicated booking functions within Trusts and all new and review outpatients should have the opportunity to book their appointment. The booking process for non-routine groups of outpatients or those with additional service needs should be designed to identify and incorporate the specific pathway requirements of these patients.

3.2 CALCULATION OF THE WAITING TIME

- 3.2.1 The starting point for the waiting time of an outpatient new referral is the date the clinician's referral letter is received by Trusts. All referral letters, including faxed, emailed and electronically delivered referrals, will be date stamped on the date received into the organisation.
- 3.2.2 In cases where referrals bypass the dedicated HRO's, (e.g. sent directly to a consultant), the Trust must have a process in place to ensure that these are date stamped on receipt, immediately forwarded to the HRO and registered at the date on the date stamp.
- 3.2.2 Patients who cancel an appointment will have their waiting time clock reset to the date the hospital was informed of the cancellation. Patients who

refuse a reasonable offer of an appointment will also have their waiting time clock reset to the date the reasonable offer was refused. To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

- 3.2.3 Patients who fail to attend their appointment without giving prior notice (DNA) will have their waiting time clock reset to the date of the DNA.

3.3 KEY PRINCIPLES

- 3.3.1 Referrals into Trusts should be pooled where possible within specialties. Referrals to a specific consultant by a GP should only be accepted where there are specific clinical requirements or stated patient preference. As a minimum, all un-named referrals should be pooled.
- 3.3.2 All referrals, appointments and waiting lists should be managed according to clinical priorities. Priorities must be identified for each patient on the waiting list, allocated according to urgency of the treatment. Trusts will manage patients in 2 streams, i.e. urgent and routine. Templates should be constructed to ensure enough capacity is available to treat each stream within agreed maximum waiting time guarantees. The Implementation Procedure for Template Redesign can be found in **Appendix 7**.
- 3.3.3 The regional target for a maximum OP waiting time is outlined in Section 1.4. Maximum waiting times for urgent patients should be agreed locally with clinicians.
- 3.3.4 Maximum waiting times for urgent patients should be agreed locally with clinicians, and made explicit to staff booking these patients to ensure that they are appointed within the clinical timeframe indicated by the consultant and capacity issues quickly identified and escalated.

- 3.3.5 Patients of equal clinical priority will be selected for booking in strict chronological order. Trusts must ensure that Department waiting and booking targets and standards are met.
- 3.3.6 Data collection should be accurate, timely, complete and subject to regular audit and validation.
- 3.3.7 Trusts should provide training programmes for staff which include all aspects of this IEAP and its Implementation Procedures. It is expected that training will be cascaded at and by each clinical, managerial or administrative tier within Trusts, providing the opportunity where required, for staff to work through operational scenarios.
- 3.3.8 Trusts will work towards providing a single point of contact for all patients with respect to outpatient appointment services. It is recognised that there may be services which require alternative processes.

3.4 NEW REFERRALS

- 3.4.1 All outpatient referrals sent to Trusts will be received at the dedicated HRO's and registered within one working day of receipt. GP priority status must be recorded at registration.
- 3.4.2 Trusts will work towards a system whereby the location of all letters can be tracked at all times through the referral and appointment system, and that letters sent to be prioritised and which are not returned can be identified.
- 3.4.3 All referrals must be prioritised and clinical urgency must be clearly identified. Clinicians will be responsible for ensuring that cover is provided for referrals to be read and prioritised during their absence. A designated officer should oversee this and a protocol will be required for each department.
- 3.4.5 All outpatient referrals letters will be prioritised and returned to the HRO within 3 working days. It will be the responsibility of the health records

manager or departmental manager to monitor this performance indicator. Monitoring will take place by consultant on a monthly basis. Following prioritisation, referrals must be actioned on PAS and appropriate correspondence issued to patients within 1 working day.

- 3.4.6 Where clinics take place, or referrals can be reviewed less frequently than weekly, a process must be put in place and agreed with clinicians whereby GP prioritisation is accepted in order to proceed with booking urgent patients.
- 3.4.7 Inappropriate and inadequate referrals should be returned to the referral source. A minimum referral criteria dataset has been agreed and is outlined in **Appendix 8**
- 3.4.8 An Effective Use of Resources Policy is in place for some services and Trusts should ensure that this is adhered to. The policy is included for reference in **Appendix 9**.

3.5 URGENT AND ROUTINE APPOINTMENTS

- 3.5.1 All consultant led outpatient appointments where the patient attends the Trust should be booked. The key requirements are that the patient is directly involved in negotiating the appointment date and time, and that no appointment is made more than six weeks into the future.
- 3.5.2 All routine patients must be booked within the maximum waiting time guarantee. Urgent patients must be booked within the maximum wait agreed locally with clinicians, from the date of receipt. It is recognised that there will be occasional exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Trusts should ensure that when accommodating these patients, the appointment process is robust and clinical governance requirements met.
- 3.5.3 Acknowledgment letters will be sent to routine patients within five days of receipt of the referral. The estimated length of wait, along with information on

how the patient will be booked, should be included on the acknowledgement letter.

3.5.4 A minimum of three weeks' notice should be provided for all routine patients. This does not prevent patients being offered earlier appointment dates. Patients refusing short notice appointments (i.e. less than three weeks' notice) will not have their waiting time reset, in line with guidance on reasonable offers.

3.5.5 Trusts must ensure that all communication to patients is clear, easily understood and complies with all relevant legislation.

3.6 BOOKING

3.6.1 All new and review consultant led outpatient clinics should be able to book their appointment. This will entail patients having an opportunity to contact the hospital and agree a convenient date and time for their appointment. The use of the Patient Choice field on PAS is mandatory. The only fields that should be used are 'Y' to indicate that the appointment has been booked or 'N' to indicate that an appointment has not been booked. No other available field should be used as compliance with booking requirements will be monitored via the use of the Patient Choice field. For non-ISOFT and manual administration systems, Trusts should ensure that they are able to record and report patients who have been booked.

3.7 REASONABLE OFFERS

3.7.1 For patients who have been able to book their appointment, a reasonable offer is defined as an offer of appointment, irrespective of provider, that gives the patient a minimum of three weeks' notice and two appointments. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused.

3.7.2 If the patient is offered an appointment within a shorter notice period and it is refused, the waiting time cannot be recalculated.

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

3.7.4 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above. The Implementation Procedure on Reasonableness can be found in **Appendix 3**.

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

3.8.1 If a patient DNAs their outpatient appointment, the following process must be implemented.

- Where a patient has had an opportunity to agree the date and time of their appointment, they will not normally be offered a second appointment. These patients will be referred back to the care of their referring clinician.
- Under exceptional circumstances a clinician may decide that a patient should be offered a second appointment. The second appointment must be booked.

3.8.2 There may be instances for review patients where the clinician may wish to review notes prior to any action to remove a patient because of DNA or failure to respond to partial booking invitation letters. Trusts should ensure that robust and locally agreed rules and processes are in place so that booking clerks are clear about how to administer these patients.

3.8.3 In a transition period where fixed appointments are still being issued, patients should have two opportunities to attend.

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

- The patient will be given a second opportunity to book an appointment, which should be within six weeks of the original appointment date.
- If a second appointment is cancelled, the patient will not normally be offered a third opportunity and will be referred back to their referring clinician.

3.8.5 Following discharge, patients will be added to the waiting list at the written request of the referring GP and within a four week period from the date of discharge. Patients should be added to the waiting list at the date the written request is received.

3.8.6 The Implementation Procedure on DNAs and Cancellations can be found in **Appendix 4.**

3.9 MAXIMUM WAITING TIME GUARANTEE

3.9.1 If a patient requests an appointment date that is beyond the maximum waiting time guarantee, the patient will be discharged and advised to revisit their GP when they are ready to be seen in the Outpatient Clinic. This will ensure that all patients waiting for an outpatient appointment are fit and ready to be seen. It is accepted that local discretion may be required where short periods of time are involved, for example, if patients are requesting dates up to a week over their breach date. Trusts should ensure that reasonableness is complied to facilitate re-calculation of the patient's waiting time, and to facilitate booking the patient into the date they requested.

3.10 COMPLIANCE WITH LEAVE PROTOCOL

3.10.1 Capacity lost due to cancelled or reduced clinics at short notice has negative consequences for patients and on the Trust's ability to successfully

implement booking processes. Clinic cancellation and rebooking of appointments is an extremely inefficient way to use such valuable resources.

- 3.10.2 It is essential that planned medical and other clinical leave or absence is organised in line with an agreed Trust Human Resources (HR) protocol. Thus it is necessary for Trusts to have robust local HR policies and procedures in place that minimise the cancellation/reduction of outpatient clinics and the work associated with the rebooking of appointments. There should be clear medical and clinical agreement and commitment to this HR policy. Where cancelling and rebooking is unavoidable the procedures used must be equitable, efficient, comply with clinical governance principles and ensure that maximum waiting times for patients are not compromised.
- 3.10.3 The protocol should require a minimum of six weeks' notification of intended leave, in line with locally agreed HR policies.
- 3.10.4 A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit. The Implementation Procedure for Compliance with Leave Protocol can be found in **Appendix 10**.

3.11 CLINIC OUTCOME MANAGEMENT

- 3.11.1 There are a number of locations within Trusts where patients present for their outpatient consultation. This protocol applies to all outpatient areas. It is the responsibility of the PAS user managing the attendance to maintain data quality.
- 3.11.2 All patients will have their attendance registered on PAS upon arrival in the clinic. The patient must verify their demographic details on every visit. The verified information must be cross-checked on PAS and the medical records.
- 3.11.3 Changes in the patient's details must be updated on PAS and the medical records on the date of clinic.

- 3.11.4 When the consultation has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic. The implementation procedure for the Management of Clinic Outcomes can be found in **Appendix 11**.

3.12 REVIEW APPOINTMENTS

- 3.12.1 All review appointments must be made within the time frame specified by the clinician. If a review appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the consultant. Trusts should actively monitor patients on the review list to ensure that they do not go past their indicative month of treatment and take the necessary action to ensure capacity is available for this cohort.
- 3.12.2 Review patients who require an appointment within six weeks will negotiate the date and time of the appointment before leaving the department and PAS updated. Patients requiring an appointment outside six weeks will be placed on a review waiting list, with the indicative appointment date recorded, and be booked in line with implementation guidance for review pathway patients.

3.13 CLINIC TEMPLATE CHANGES

- 3.13.1 Clinic templates should be agreed between the consultant and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement and ensure that there is sufficient capacity allocated to enable each appointment type to be booked in line with clinical requirements and maximum waiting time guarantees for patients.

- 3.13.2 Templates will identify the number of slots available for new urgent, new routine and follow up appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated for each appointment slot.
- 3.13.3 All requests for template and temporary clinic rule changes will only be accepted in writing. A minimum of six weeks notice will be provided for clinic template changes.
- 3.13.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager. The Implementation Procedure for the management of Clinic Template Changes can be found in **Appendix 5**.

3.14 VALIDATION

- 3.14.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a weekly basis and continually reviewed as waiting times reduce. This is essential to ensure PTLs are accurate and robust at all times. The Implementation Guidance for Data Validation can be found in **Appendix 6**.
- 3.14.2 As booking processes are implemented and waiting times reduce, there is no longer the need to validate patients by letter.
- 3.14.3 For patients in specialties that are not yet booked, they will be contacted to establish whether they will still require their appointment.

3.15 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

- 3.15.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between hospitals or to Independent Sector Providers. Transfers should not be a feature of an effective scheduled system.

3.15.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant. Administrative speed and good communication are very important to ensure this process runs smoothly. The Implementation Procedure and Technical Guidance for Handling Outpatient Transfers can be found in **Appendix 15a**.

SECTION 4

PROTOCOL GUIDANCE FOR MANAGEMENT OF DIAGNOSTIC SERVICES

4.1 INTRODUCTION

- 4.1.1 The following protocol is based on nationally recommended good practice guidelines to assist staff with the effective management of diagnostic waiting lists. Where possible, the principles of good practice outlined in the Outpatient and Elective Admissions Section of this document should be adopted in order to ensure consistent standards and processes for patients as they move along the pathway of investigations, assessment and treatment. This section aims to recognise areas where differences may be encountered due to the nature of specific diagnostic services.
- 4.1.2 The administration and management of requests for diagnostics, waiting lists and appointments within and across Trust should be consistent, easily understood, patient focused and responsive to clinical decision making.
- 4.1.3 There will be a centralised registration process within Trusts to receive, register and process all diagnostic referrals. It is expected that this will be in a single location, where possible.
- 4.1.4 The Trust should work towards introducing choice of the date and time of tests to all patients. The Booking Principles outlined in Section 1 of this document should be considered in the development of this strategy.

4.2 CALCULATION OF THE WAITING TIME

- 4.2.1 The starting point for the waiting time of a request for a diagnostic test is the date the clinician's request is received into the department, in line with the guidance on Completing Diagnostic Waiting Times Collection (Definitions Document), September 2007. This can be found in **Appendix 14**. All referral letters and requests, including faxed, emailed and electronically delivered referrals, will be date stamped on the date received.
- 4.2.2 Patients who cancel an appointment will have their waiting time clock reset to the date the service was informed of the cancellation.

4.2.3 Patients who refuse a reasonable offer of an appointment will also have their waiting time clock reset to the date the reasonable offer was refused. To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

4.2.4 Patients who fail to attend their appointment without giving prior notice (DNA) will have their waiting time clock reset to the date of the DNA.

4.3 KEY PRINCIPLES

4.3.1 Trusts must have in place arrangements for pooling all referrals unless there is specific clinical information which determines that the patient should be seen by a particular consultant with sub-specialty interest.

4.3.2 All diagnostic requests, appointments and waiting lists should be managed according to clinical priority. A clinical priority must be identified for each patient on a waiting list, and patients managed in 2 streams, i.e. urgent and routine. Session or clinic templates should be constructed to ensure enough capacity is available to treat each stream within the maximum waiting time guarantees outlined in Section 1.4. Maximum waiting times for urgent patients should be agreed locally with clinicians.

4.3.3 Data collection should be accurate, timely, complete and subject to regular audit and validation.

4.3.4 Staff should be supported by appropriate training programmes.

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

4.4 NEW DIAGNOSTIC REQUESTS

- 4.4.1 All diagnostic requests sent to Trusts will be received at a single location within the specialty Department. Trusts should explore the setting of one centralised diagnostic registration centre.
- 4.4.2 All requests will be registered on PAS / relevant IT system within one working day of receipt. Only authorised staff will have the ability to add, change or remove information in the outpatient module of PAS or other diagnostic system.
- 4.4.3 Trusts will work towards a system whereby the location of all letters can be tracked at all times through the referral and appointment system and that letters sent for prioritisation and not returned can be identified. Trusts should consider the introduction of clinical tracking systems similar to that used in patient chart tracking.
- 4.4.4 All requests must be prioritised and clinical urgency must be clearly identified. Clinicians will be responsible for ensuring that cover is provided for requests to be read and prioritised during their absence. A designated officer should oversee this and a protocol will be required for each department.
- 4.4.5 All requests will be prioritised and returned to the central registration point within 3 working days. It will be the responsibility of the health records manager or departmental manager to monitor this performance indicator. Monitoring on a consultant level will take place by consultant on a monthly basis. Following prioritisation, requests must be actioned on PAS / IT system and appropriate correspondence issued to patients within 1 working day.
- 4.4.6 Where clinics take place, or requests can be reviewed less frequently than weekly, a process must be put in place and agreed with clinicians whereby the GP's priority is accepted in order to proceed with booking urgent patients.

- 4.4.7 Inappropriate and inadequate requests should be returned to the referral source. Minimum referral criteria is being developed to ensure the referral process is robust.

4.5 URGENT AND ROUTINE APPOINTMENTS

- 4.5.1 All requests must be booked within the maximum waiting time guarantee. The key requirement is that the patient is directly involved in negotiating the date and time of the appointment and that no appointment is made more than six weeks in advance.
- 4.5.2 Urgent requests must be booked within locally agreed maximum waits from the date of receipt. It is recognised that there will be exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Trusts should ensure that when accommodating these patients, the appointment process is robust and clinical governance requirements met.
- 4.5.3 All routine patients must be booked within the maximum waiting time guarantee. Acknowledgement letters will be issued to routine patients within 5 working days of receipt of request. The estimated wait, along with information on how the patients will be booked should be included on the acknowledgement letter.
- 4.5.4 A minimum of three weeks notice should be provided for all routine patients. This does not prevent patients being offered earlier appointment dates. Patients who refuse short notice appointments (i.e. less than three weeks notice) will not have their waiting time reset in line with guidance on reasonable offers.
- 4.5.5 Trusts must ensure that all communication to patients is clear, easily understood and complies with all relevant legislation.

4.6 CHRONOLOGICAL MANAGEMENT

- 4.6.1 Patients of equal clinical priority will be selected for appointment in chronological order and Trusts must ensure that regional standards and targets in relation to waiting times and booking requirements are met. The process of selecting patients for diagnostic investigations is a complex activity. It entails balancing the needs and priorities of the patient and the Trust against the available resources.
- 4.6.2 It is expected that Trusts will use two prioritisation categories; urgent and routine.

4.7 BOOKING METHODS

- 4.7.1 Booking will enable patients to have an opportunity to contact the service and agree a convenient time for their appointment. As outlined in paragraph 4.1.4, booking strategies should be developed in line with these Booking Principles. In the interim period, while fixed appointments are being issued, Trusts should ensure that the regional guidance is followed in the management of patients.

4.8 REASONABLE OFFERS

- 4.8.1 For patients who have been able to book their appointment, a reasonable offer is defined as an offer of appointment, irrespective of provider, that gives the patient a minimum of three weeks' notice and two appointments. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused. To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

- 4.8.2 If the patient is offered an appointment within a shorter notice period and it is refused, the waiting time cannot be recalculated.
- 4.8.3 If the patient however accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the Trust.
- 4.8.4 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above. The Implementation Procedure on Reasonableness can be found in **Appendix 3**.

4.9 PATIENT CANCELLATIONS (CNAS) AND DID NOT ATTENDS (DNAS)

- 4.9.1 If a patient DNAs their diagnostic test, the following process must be implemented.
- Where a patient has had an opportunity to agree the date and time of their appointment, they will not normally be offered a second appointment. These patients will be referred back to the care of their referring clinician.
 - Under exceptional circumstances a clinician may decide that a patient should be offered a second appointment. The second appointment must be booked.
- 4.9.2 There may be instances for follow-up patients where the clinician may wish to review notes prior to any action to remove a patient because of DNA or failure to respond to booking invitation letters. Trusts should ensure that robust and locally agreed rules and processes are in place so that booking clerks are clear about how to administer these patients.
- 4.9.3 In a transition period where fixed appointments are still being issued, patients should have two opportunities to attend.

4.9.4 If a patient cancels their appointment, the following process must be implemented.

- The patient will be given a second opportunity to book an appointment, which should be within six weeks of the original appointment date.
- If a second appointment is cancelled, the patient will not normally be offered a third opportunity and will be referred back to their referring clinician.

4.9.5 Following discharge, patients will be added to the waiting list at the written request of the referring GP and within a four week period from the date of discharge. Patients should be added to the waiting list at the date the written request is received.

4.10 TRANSFERS BETWEEN HOSPITALS

4.10.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between hospitals. Transfers should not be a feature of an effective scheduled system.

4.10.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant. Administrative speed and good communication are very important to ensure this process runs smoothly.

4.11 COMPLIANCE WITH TRUST LEAVE PROTOCOL

4.11.1 One of the major issues regarding the operation of healthcare services is the capacity lost due to cancelled or reduced clinics at short notice. This has negative consequences for patients and on the ability to successfully implement booking requirements. Clinic or session cancellation and rebooking of appointments is an extremely inefficient way to use such valuable resources.

- 4.11.2 It is therefore essential that leave/absence is organised in line with the Trust's Human Resources leave protocol. It is necessary for Trusts to have robust policies and procedures that minimise the cancellation/reduction of diagnostic sessions and the work associated with the rebooking of appointments. Where cancelling and rebooking is unavoidable the procedures used must be equitable and comply with clinical governance principles.
- 4.11.3 The local absence/leave protocol should require a minimum of six weeks' notification of intended leave, in line with locally agreed policies.
- 4.11.4 A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

4.12 SESSION OUTCOME MANAGEMENT

- 4.12.1 There are a number of locations within Trusts where patients present for their diagnostic tests. This protocol applies to all diagnostic services. It is the responsibility of the PAS / relevant system user administrating the clinic to maintain data quality.
- 4.12.2 All patients will have their attendance registered on PAS / IT system upon arrival at the clinic. The patient must verify their demographic details on every visit. The verified information must be cross-checked on PAS / IT system and the medical record.
- 4.12.3 Changes in the patient's details must be updated on PAS / IT system and the medical record on the date of clinic.
- 4.12.4 When the test has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic.

4.13.1 DIAGNOSTIC TEST OUTCOME

- 4.13.1 The outcome of the diagnostic test must be available to the referrer without undue delay. A standard for the reporting turnaround time of tests will be introduced during 2008 and Trusts will be expected to monitor and report compliance to the standard.

4.14 FOLLOW UP APPOINTMENTS

- 4.14.1 All follow up appointments must be made within the time frame specified by the clinician. If a follow up appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the clinician.
- 4.14.2 Where follow up appointments are not booked, patients who require a review within six weeks will negotiate the date and time of this appointment before leaving the department and PAS / IT system updated. Patients requiring an appointment outside six weeks will have their appointment managed through a 'hold and treat' system. They will be managed on a review waiting list, with an indicative date of treatment and sent a letter confirming their appointment date six weeks in advance.

4.15 TEMPLATE CHANGES

- 4.15.1 Session templates should be agreed with the healthcare professional and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement.
- 4.15.2 Templates will identify the number of slots available for new urgent, new routine, planned and follow up appointments; specify the time each session is scheduled to start and finish; and identify the length of time allocated for each appointment slot.

4.15.3 All requests for template and temporary session rule changes will only be accepted in writing. A minimum of six weeks notice will be provided for session template changes.

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

4.16 VALIDATION

4.16.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a monthly basis and ideally on a weekly basis as waiting times reduce. This is essential to ensure PTLs are accurate and robust at all times.

4.16.2 As booking processes are implemented and waiting times reduce, there is no longer the need to validate patients by letter.

4.16.3 For patients in specialties which still issue fixed appointments, they will be contacted to establish whether they require their appointment.

4.16.4 Until follow-up and planned appointments are booked, the validation process will apply to follow up appointments.

4.17 PLANNED PATIENTS AND DIAGNOSTICS TESTS CLASSIFIED AS DAY CASES

4.17.1 Trusts should ensure that the relevant standards in the Elective Admissions section of this document are adhered to.

4.18 PLANNED PATIENTS

- 4.18.1 Planned patients are those who are waiting to be recalled to hospital for a further stage in their course of treatment or investigation within specific timescales. This is usually part of a planned sequence of clinical care determined on clinical criteria.
- 4.18.2 These patients are not actively waiting for treatment to be initiated, only for planned continuation of treatment. A patient's care is considered as planned if there are clinical reasons that determine the patient must wait set periods of time between interventions. They will not be classified as being on a waiting list for statistical purposes.
- 4.18.3 Trusts should be able to demonstrate consistency in the way planned patients are treated and that patients are being treated in line with the clinical constraints. Planned patients must have a clearly identified month of treatment in which it can be shown that the patients are actually being treated.

4.19 HOSPITAL INITIATED CANCELLATIONS

- 4.19.1 No patient should have his or her admission cancelled. If Trusts cancel a patient's admission, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity, which should must be within the maximum waiting time guarantee.
- 4.19.2 Trusts should aim to have processes in place to have the new proposed admission date arranged before that patient is informed of the cancellation.
- 4.19.3 The patient should be informed in writing of the reason for the cancellation and the date of the new admission. The correspondence should include an explanation and an apology on behalf of the Trust.
- 4.19.4 Trusts will make best efforts to ensure that a patient's admission is not cancelled a second time for non-clinical reasons.

- 4.19.5 Where patients are cancelled on the day of a test as a result of not being fit, they will be suspended, pending a clinical review of their condition. The patient should be fully informed of this process.
- 4.19.6 Hospital initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment as a result of hospital initiated reasons, i.e. equipment failure, a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

4.20 PATIENTS LISTED FOR MORE THAN ONE DIAGNOSTIC TEST

- 4.20.1 Where more than one diagnostic test is required to assist with clinical decision making, the first test should be added to the waiting list with additional tests noted.
- 4.20.2 Where different clinicians are working together will perform more than one test at one time the patient should be added to the waiting list of the clinician for the priority test with additional clinicians noted, subject to local protocols.
- 4.20.3 Where a patient requires more than one test carried out on separate occasions by different (or the same) clinician, the patient should be placed on the active waiting list for the first test and on the planned waiting list for any subsequent tests.
- 4.20.4 Where a patient is being managed in one Trust but has to attend another for another type of diagnostic test, monitoring arrangements must be in place between the relevant Trusts to ensure that the patient pathway runs smoothly.

SECTION 5

GUIDANCE FOR MANAGEMENT OF ALLIED HEALTH PROFESSIONAL (AHP) SERVICES

5.1 INTRODUCTION

- 5.1.1 Allied Health Professionals work with all age groups and conditions, and are trained in assessing, diagnosing, treating and rehabilitating people with health and social care needs. They work in a range of settings including hospital, community, education, housing, independent and voluntary sectors. This guidance provides an administrative framework to support the management of patients waiting for AHP services.
- 5.1.2 Although it is written primarily for services provided in Trusts, it is recognised that there are a number of AHPs who provide services for children with physical and learning disabilities within special schools and with special educational needs within mainstream schools. Operational practices in these settings should be in line with the principles of the IEAP and provide consistency and equity for patients. Trusts should collaborate with colleagues within the Department of Education and the relevant schools to harmonise practices and ensure that children are able to access services equitably and within the maximum waiting time guarantees. A robust monitoring process will be required.
- 5.1.3 For the purposes of this section of the protocol, the generic term 'clinic' will be used to reflect AHP activity undertaken in hospital, community or domiciliary settings as it is recognised that AHPs provide patient care in a variety of care locations.

5.2 KEY PRINCIPLES

- 5.2.1 Trusts should ensure that there is a systematic approach to modernising AHP services which will help to improve access to services and quality of care for patients. This section should be read within the overall context of both the IEAP and the specific section governing the management of hospital outpatient services.

- 5.2.2 When looking at the experience of the patient it is important to consider the whole of their journey, with both the care and administrative pathways designed to support the patient's needs at each stage. The wait to receive outpatient therapy is likely to be one of many they experience in different parts of the system. It is the responsibility of all those involved to ensure that the patient wastes as little time as possible waiting and is seen by the right person as quickly as possible.
- 5.2.3 Booking will enable patients to have an opportunity to contact the hospital and agree a convenient time for their appointment. As outlined in paragraph 4.1.4, booking strategies should be developed in line with these Booking Principles. In the interim period, while fixed appointments are being issued, Trusts should ensure that the regional guidance is followed in the management of patients.

5.3 CALCULATION OF THE WAITING TIME

- 5.3.1 The waiting time clock for an AHP referral commences on the date the referral letter is received by the AHP service within the Trust. All referral letters, including faxed, emailed and electronically received referrals, will be date stamped on the date received.
- 5.3.2 The waiting time clock stops when the first definitive AHP treatment has commenced or when a decision is made that treatment is not required. Further information on definitions and sample patient pathways is contained in the Data Definitions and Guidance Document for AHP Waiting Times and can be found in **Appendix 12**.
- 5.3.3 As booking systems are introduced, patients should be made a reasonable offer, where clinically possible. Patients who refuse a reasonable offer of treatment, or fail to attend an AHP appointment, will have their waiting time clock re-set to the date the service was informed of the cancellation (CNAs) or the date the patient failed to attend (DNAs).

5.4 NEW REFERRALS

- 5.4.1 All AHP referrals will be registered on the relevant information system within 1 working day of receipt.
- 5.4.2 Trusts should work towards a system whereby all AHP referrals sent to the Trust are received at a dedicated registration function (s). Trusts should ensure that adequate systems are in place to deal with multiple referrals for the same patient regarding the same condition from a number of sources.
- 5.4.3 All referrals must be triaged or assessed to make a clear decision on the next step of a referral and clinical urgency (urgent or routine) clearly identified and recorded. All referrals will be prioritised and returned to the registration point with 3 working days.
- 5.4.4 Trusts must ensure that protocols are in place to prevent unnecessary delay from date stamping / logging of referrals to forwarding to the AHP department responsible for referral triage and/or initiation of treatment. It will be the responsibility of the relevant manager to monitor this performance indicator.
- 5.4.5 A robust system should be in place to ensure that cover is provided for referrals to be read and prioritised during practitioners' absence. A designated officer should oversee this and a protocol will be required for each service.
- 5.4.6 Where referrals can be reviewed less frequently than weekly, a process must be put in place and agreed with AHPs whereby the referrer's prioritisation is accepted in order to proceed with booking patients.
- 5.4.7 Following prioritisation, referrals must be updated on the relevant information system and appropriate correspondence issued to patients within 1 working day. Where there is insufficient information for the AHP to make a decision, they should contact the originating referrer in the first instance to access the

necessary information. If this cannot be gained, the referral should be returned to the referral source.

- 5.4.8 Trusts will work towards a system whereby the location of all letters can be tracked at all times through the referral and appointment system, and that letters sent to be prioritised and letters which are not returned can be identified.
- 5.4.9 If at the referral stage the patient / client is identified as being clinically or socially unfit to receive the necessary service the referral should not be accepted (not added to a waiting list) and returned to the originating referrer with a request that they re-refer the patient / client when they are clinically or socially fit to be treated.

5.5 URGENT AND ROUTINE APPOINTMENTS

- 5.5.1 All routine patients should be appointed within the maximum waiting time guarantee. Urgent patients must be booked within locally agreed maximum waits from the date of receipt. Local booking process should be based upon the principles outlined in Section 1.7.
- 5.5.2 For routine waiting list patients, an acknowledgement letter will be sent to patients within 5 working days of receipt of the referral, which should provide information to patients on their anticipated length of wait and details of the booking process.
- 5.5.3 A minimum of three weeks' notice should be provided for all routine patients. This does not prevent patients being offered an earlier appointment. Patients refusing short notice appointments (i.e. less than three weeks notice) will not have their waiting time clock reset, in line with guidance on reasonable offers.
- 5.5.4 Trusts must ensure that all communication to patients is clear, easily understood and complies with all relevant legislation.

5.6 CHRONOLOGICAL MANAGEMENT

- 5.6.1 Patients, within each clinical priority category, should be selected for booking in chronological order, i.e. based on the date the referral was received. Trusts should ensure that local administrative systems have the capability and functionality to effectively operate a referral management and booking system that is chronologically based.

5.7 CAPACITY PLANNING AND ESCALATION

- 5.7.1 It is important for AHP services to understand their baseline capacity, the make-up of the cohort of patients waiting to be treated and the likely changes in demand that will impact on their ability to initiate treatment and meet the maximum waiting time guarantees for patients.
- 5.7.2 Trusts should ensure that robust prospective capacity planning arrangements are in place, with clear escalation procedures to facilitate capacity gaps to be identified and solutions found in a timely manner to support operational booking processes and delivery of the targets.

5.8 REASONABLE OFFERS

- 5.8.1 As booking systems are introduced, patients should be offered reasonable notice, where clinically possible. A reasonable offer is defined as an offer of appointment, irrespective of provider, that gives the patient a minimum of three weeks notice and two appointments. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused. To ensure a verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.
- 5.8.2 If the patient is offered an appointment within a shorter notice period and it is refused, the waiting time cannot be recalculated.

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

5.8.3 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above.

5.9 AHP SERVICE INITIATED CANCELLATIONS

5.9.1 No patient should have his or her appointment cancelled. If Trusts cancel a patient's appointment, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable appointment date, ideally at the time of cancellation, and no more than 6 weeks in advance. The Trust must ensure that the new appointment date is within the maximum waiting time guarantee.

5.9.2 The patient should be informed of the reason for the cancellation and the date of the new appointment. This should include an explanation and an apology on behalf of the Trust.

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

5.9.4 AHP service initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment as a result of AHP service initiated reasons, i.e. equipment failure, staff sickness, a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

5.10 MAXIMUM WAITING TIME GUARANTEE

- 5.10.1 If a patient requests an appointment date that is beyond the maximum waiting time guarantee, the patient will be discharged and advised to revisit their referrer when they are ready to be seen. This will ensure that all patients waiting for an AHP appointment / treatment are fit and ready to be seen.
- 5.10.2 There will undoubtedly be occasions and instances where local discretion is required and sensitivity should be applied when short periods of time are involved; for example, if patients are requesting dates up to a week over their breach date. Trusts should ensure that reasonableness is complied with to facilitate re-calculation of the patient's waiting time, and to facilitate booking the patient into the date they requested.

5.11 COMPLIANCE WITH LEAVE PROTOCOL

- 5.11.1 Capacity lost due to cancelled or reduced clinics or visits at short notice has negative consequences for patients and on the Trust's ability to successfully implement robust booking processes. Clinic cancellation and rebooking of appointments is an extremely inefficient way to use such valuable resources.
- 5.11.2 It is therefore essential that AHP practitioners and other clinical planned leave or absence is organised in line with an agreed Trust Human Resources (HR) protocol. Thus it is necessary for Trusts to have robust local HR policies and procedures in place that minimise the cancellation/reduction of AHP clinics and the work associated with rebooking patient appointments. There should be clear practitioner agreement and commitment to this HR policy. Where cancelling and rebooking is unavoidable the procedures used must be equitable, efficient and comply with clinical governance principles.
- 5.11.3 The protocol should require a minimum of six weeks' notification of planned leave, in line with locally agreed HR policies.

- 5.11.4 A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

5.12 CLINIC OUTCOME MANAGEMENT

- 5.12.1 All patients will have their attendance recorded or registered on the relevant information system upon arrival for their appointment. The patient must verify their demographic details on every visit. The verified information must be cross-checked on information system and the patient records. Any changes must be recorded and updated in the patient record on the date of the clinic.
- 5.12.2 When the assessment/treatment has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic.

5.13 REVIEW APPOINTMENTS

- 5.13.1 All review appointments must be made within the time frame specified by the practitioner. If a review appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the practitioner. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the practitioner.
- 5.13.2 Review patients who require an appointment within six weeks will negotiate the date and time of the appointment before leaving the service and PAS / information system updated. Patients requiring an appointment outside six weeks should be managed on a review waiting list, with the indicative date recorded when appointment is required and booked in line with the booking principles outlined.

- 5.13.3 If domiciliary review appointment is required within 6 weeks, the appointment date should be agreed with the patient and confirmed in writing by the booking office. Where a domiciliary review appointment is required outside 6 weeks, the patient should be managed on a review waiting list, within the indicative date recorded, and booking in line with the booking principles outlined.

5.14 CLINIC TEMPLATE MANAGEMENT

- 5.14.1 Clinic templates should be agreed between the practitioner and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement.
- 5.14.2 Templates will identify the number of slots available for new urgent, new routine and follow up appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated for each appointment slot.
- 5.14.3 All requests for template and temporary clinic rule changes will only be accepted in writing to the relevant service manager. A minimum of six weeks notice will be provided for clinic template changes.
- 5.14.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager.

5.15 ROBUSTNESS OF DATA / VALIDATION

- 5.15.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a weekly basis and continually reviewed as waiting times reduce. This is essential to ensure Primary Targeting Lists are accurate and robust at all times.

- 5.15.2 As booking processes are implemented and waiting times reduce, there is no longer the need to validate patients by letter.
- 5.15.3 For patients in AHP services that are not yet booked, they will be contacted to establish whether they will still require their appointment.

**SECTION 6 PROTOCOL GUIDANCE FOR MANAGEMENT
OF ELECTIVE ADMISSIONS**

6.1 INTRODUCTION

- 6.1.1 The following protocol is based on nationally recommended good practice guidelines to assist staff with the effective management of elective waiting lists.
- 6.1.2 The administration and management of elective admissions within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.

6.2 COMPUTER SYSTEMS

- 6.2.1 To ensure consistency and the standardisation of reporting with Commissioners and the Department, all waiting lists are to be maintained in the PAS system.
- 6.2.2 Details of patients must be entered on to the computer system within two working days of the decision to admit being made. Failure to do this will lead to incorrect assessment of waiting list size when the daily / weekly downloads are taken.
- 6.2.3 As a minimum 3 digit OPCS codes should be included when adding a patient to a waiting list. Trusts should work towards expanding this to 4 digit codes.

6.3 CALCULATION OF THE WAITING TIME

- 6.3.1 The starting point for the waiting time of an inpatient is the date the consultant agrees with the patient that a procedure will be pursued as an active treatment or diagnostic intervention, and that the patient is medically fit to undergo such a procedure.
- 6.3.2 The waiting time for each inpatient on the elective admission list is calculated as the time period between the original decision to admit date and the date

at the end of the applicable period for the waiting list return. If the patient has been suspended at all during this time, the period(s) of suspension will be automatically subtracted from the total waiting time.

- 6.3.3 Patients who refuse a reasonable offer of treatment, or fail to attend an offer of admission, will have their waiting time reset to the date the hospital was informed of the cancellation (CNAs) or the date the patient failed to attend (DNAs). Any periods of suspension are subtracted from the patients overall waiting time.

6.4 STRUCTURE OF WAITING LISTS

- 6.4.1 To aid both the clinical and administrative management of the waiting list, lists should be sub-divided into a limited number of smaller lists, differentiating between active waiting lists, planned lists and suspended patients.
- 6.4.2 Priorities must be identified for each patient on the active waiting list, allocated according to urgency of the treatment. The current priorities are urgent and routine.

6.5 INPATIENT AND DAY CASE ACTIVE WAITING LISTS

- 6.5.1 Inpatient care should be the exception in the majority of elective procedures. Trusts should move away from initially asking “is this patient suitable for day case treatment?” towards a default position where they ask “what is the justification for admitting this patient?” The Trust’s systems, processes and physical space should be redesigned and organized on this basis.
- 6.5.2 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to admit, i.e. if there was a bed available tomorrow in which to admit a patient they are fit, ready, and able to come in.

- 6.5.3 All decisions to admit will be recorded on PAS within two working days of the decision to admit being taken.
- 6.5.4 Robust booking and scheduling systems will be developed to support patients having a say in the date and time of their admission. Further guidance will be provided on this.
- 6.5.5 Where a decision to admit depends on the outcome of diagnostic investigation, patients should not be added to an elective waiting list until the outcome of this investigation is known. There must be clear processes in place to ensure the result of the investigation is timely and in accordance with the clinical urgency required to admit the patient.
- 6.5.6 The statements above apply to all decisions to admit, irrespective of the decision route, i.e. direct access patients or decisions to directly list patients without outpatient consultation.

6.6 COMPLIANCE WITH TRUST HR LEAVE PROTOCOL

- 6.6.1 Trusts should have in place a robust protocol for the notification and management of medical and clinical leave and other absence. This protocol should include a proforma for completion by or on behalf of the consultant with a clear process for notifying the theatre scheduler of leave / absence.
- 6.6.2 The protocol should require a minimum of six weeks' notification of intended leave, in line with locally agreed consultant's contracts.
- 6.6.3 A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

6.7 TO COME IN (TCI) OFFERS OF TREATMENT

- 6.7.1 The patient should be advised of their expected waiting time during the consultation between themselves and the health care provider/practitioner and confirmed in writing.
- 6.7.2 Patients should be made reasonable offers to come in on the basis of clinical priority. Within clinical priority groups offers should then be made on the basis of the patient's chronological wait.
- 6.7.3 All patients must be offered reasonable notice. A reasonable offer is defined as an offer of admission, irrespective of provider, that gives the patient a minimum of three weeks' notice and two TCI dates. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date of the refused admission.
- 6.7.4 If the patient is offered an admission within a shorter notice period and it is refused, the waiting time cannot be recalculated.
- 6.7.5 If the patient however accepts an admission at short notice, but then cancels the admission, the waiting time can be recalculated from the date of that admission as the patient has entered into an agreement with the Trust.
- 6.7.6 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above.

6.8 SUSPENDED PATIENTS

- 6.8.1 A period of suspension is defined as:
- A patient suspended from the active waiting list for medical reasons, or unavailable for admission for a specified period because of family commitments, holidays, or other reasons i.e. a patient may be suspended during any periods when they are unavailable for treatment for social or

medical reasons (but not for reasons such as the consultant being unavailable, beds being unavailable etc).

- A maximum period not exceeding 3 months.
- 6.8.2 At any time a consultant is likely to have a number of patients who are unsuitable for admission for clinical or social reasons. These patients should be suspended from the active waiting list until they are ready for admission. All patients who require a period of suspension will have a personal treatment plan agreed by the consultant with relevant healthcare professionals. One month prior to the end of the suspension period, these plans should be reviewed and actions taken to review patients where required.
- 6.8.3 Every effort will be made to minimise the number of patients on the suspended waiting list, and the length of time patients are on the suspended waiting list.
- 6.8.4 Should there be any exceptions to the above, advice should be sought from the lead director or appropriate clinician.
- 6.8.5 Suspended patients will not count as waiting for statistical purposes. Any periods of suspension will be automatically subtracted from the patient's total time on the waiting list for central statistical returns.
- 6.8.6 No patient added to a waiting list should be immediately suspended. Patients should be recorded as suspended on the same day as the decision was taken that the patient was unfit or unavailable for surgery.
- 6.8.7 No patient should be suspended from the waiting list without a review date. All review dates must be 1st of the month to allow sufficient time for the patient to be treated in-month to avoid breaching waiting times targets.
- 6.8.8 No more than 5% of patients should be suspended from the waiting list at any time. This indicator should be regularly monitored.

- 6.8.9 Trusts should ensure that due regard is given to the guidance on reasonableness in their management of suspended patients.

6.9 PLANNED PATIENTS

- 6.9.1 Planned patients are those who are waiting to be recalled to hospital for a further stage in their course of treatment or surgical investigation within specific timescales. This is usually part of a planned sequence of clinical care determined on clinical criteria (e.g. check cystoscopy).
- 6.9.2 These patients are not actively waiting for treatment, but for planned continuation of treatment. A patient is planned if there are clinical reasons that determine the patient must wait set periods of time between interventions. They will not be classified as being on a waiting list for statistical purposes.
- 6.9.3 Trusts should be able to demonstrate consistency in the way planned patients are treated and that patients are being treated in line with the clinical constraints. Planned patients should have a clearly identified month of treatment in which it can be shown that the patients are actually being treated.
- 6.9.4 Ideally, children should be kept under outpatient review and only listed when they reach an age when they are ready for surgery. However, where a child has been added to a list with explicit clinical instructions that they cannot have surgery until they reach the optimum age, this patient can be classed as planned. The Implementation Procedure for Planned Patients can be found in **Appendix 13**.

6.10 CANCELLATIONS AND DNA'S

6.10.1 Patient Initiated Cancellations

Patients who cancel a reasonable offer will be given a second opportunity to book an admission, which should be within six weeks of the original admission date. If a second admission offer is cancelled, the patient will not normally be offered a third opportunity and will be referred back to their referring clinician.

6.10.2 Patients who DNA

If a patient DNAs their first admission date, the following process must be implemented:

- Where a patient has had an opportunity to agree the date and time of their admission, they will not normally be offered a second admission date.
- Under exceptional circumstances a clinician may decide that a patient should be offered a second admission. The second admission date must be agreed with the patient.

6.10.3 In a period of transition where fixed TCIs are still being issued, patients should have two opportunities to attend.

6.10.4 Following discharge patients will be added to the waiting list at the written request of the referring GP and within a four week period from date of discharge. Patients should be added to the waiting list at the date of the written request is received.

6.10.5 It is acknowledged that there may be exceptional circumstances for those patients identified as being 'at risk' (children, vulnerable adults).

6.10.6 No patient should have his or her operation cancelled prior to admission. If Trusts cancel a patient's admission/operation in advance of the anticipated TCI date, the waiting time clock (based on the original date to admit) will not be reset and the patient will be offered an alternative reasonable guaranteed future date within a maximum of 28 days.

- 6.10.7 Trusts should aim to have processes in place to have the new proposed admission date arranged before the patient is informed of the cancellation.
- 6.10.8 The patient should be informed in writing of the reason for the cancellation and the date of the new admission. The correspondence should include an explanation and an apology on behalf of the Trust.
- 6.10.9 Trusts will make best efforts to ensure that a patient's operation is not cancelled a second time for non clinical reasons.
- 6.10.10 Where patients are cancelled on the day of surgery as a result of not being fit for surgery / high anaesthetic risk, they will be suspended, pending a clinical review of their condition either by the consultant in outpatients or by their GP. The patient should be fully informed of this process.
- 6.10.11 Hospital-initiated cancellations will be recorded and reported to the relevant department on a monthly basis.

6.11 PERSONAL TREATMENT PLAN

- 6.11.1 A personal treatment plan must be put in place when a confirmed TCI date has been cancelled by the hospital, a patient has been suspended or is simply a potential breach. The plan should:
- Be agreed with the patient
 - Be recorded in the patient's notes
 - Be monitored by the appropriate person responsible for ensuring that the treatment plan is delivered.
- 6.11.2 The listing clinician will be responsible for implementing the personal treatment plan.

6.12 CHRONOLOGICAL MANAGEMENT

- 6.12.1 The process of selecting patients for admission and subsequent treatment is a complex activity. It entails balancing the needs and priorities of the patient and the Trust against the available resources of theatre time and staffed beds.
- 6.12.2 The Booking Principles outlined in Section 1.7 should underpin the development of booking systems to ensure a system of management and monitoring that is chronologically as opposed to statistically based.
- 6.12.3 It is expected that Trusts will work towards reducing the number of prioritisation categories to urgent and routine.

6.13 PRE-OPERATIVE ASSESSMENT

- 6.13.1 All patients undergoing an elective procedure (including endoscopy procedures) must undergo a pre-operative assessment. This can be provided using a variety of methods including telephone, postal or face to face assessment. Please refer to the Design and Deliver Guide 2007 for further reference.
- 6.13.2 Pre operative assessment will include an anaesthetic assessment. It will be the responsibility of the pre-operative assessment team, in accordance with protocols developed by surgeons and anaesthetists, to authorise fitness for surgery.
- 6.13.3 If a patient is unfit for their operation, their date will be cancelled and decision taken as to the appropriate next action.
- 6.13.4 Only those patients that are deemed fit for surgery may be offered a firm TCI date.
- 6.13.5 Pre-operative services should be supported by a robust booking system.

6.14 PATIENTS WHO DNE THEIR PRE OPERATIVE ASSESSMENT

6.14.1 Please refer to the guidance outlined in the Outpatient section.

6.15 VALIDATION OF WAITING LISTS

6.15.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a monthly basis, and ideally on a weekly basis as waiting times reduce. This is essential to ensure the efficiency of the elective pathway at all times.

6.15.2 As booking processes are implemented and waiting times reduce, there will no longer be the need to validate patients by letter. For patients in specialties that are not yet booked, they will be contacted to establish whether they will still require their admission.

6.15.3 Involvement of clinicians in the validation process is essential to ensure that waiting lists are robust from a clinical perspective. Trusts should ensure an ongoing process of clinical validation and audit is in place.

6.16 PATIENTS LISTED FOR MORE THAN ONE PROCEDURE

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

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

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

6.17 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

- 6.17.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between hospitals or to Independent Sector Providers. Transfers should not be a feature of an effective scheduled system.
- 6.17.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant. Administrative speed and good communication are very important to ensure this process runs smoothly. The Implementation Procedure and Technical Guidance for Handling Inpatient Transfers can be found in **Appendix 15b**.

INTEGRATED ELECTIVE ACCESS PROTOCOL

DRAFT

June 2020

Integrated Elective Access Protocol

Protocol Summary -

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

Version	2.0 This guidance replaces the Integrated Elective Access Protocol, 30 th April 2008.
Status	Draft for approval
Date	30 June 2020

Integrated Elective Access Protocol**Version**

Version	Date of issue	Summary of change	Author
1.0	25 August 2006	New Regional Guidance: Integrated Elective Access Protocol	M Irvine M Wright S Greenwood
2.0	30 April 2008	Protocol refresh to encompass guidance on all aspects of the elective care pathway	M. Irvine, M. Wright, R. Hullat
3.0		Update and relaunch IEAP to provide updated regional guidance on administration of patients on elective care pathways.	L. Mc Laughlin, Regional IEAP Review Group.

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Integrated Elective Access Protocol**Document control**

The current and approved version of this document can be found on the Department of Health website <https://www.health-ni.gov.uk> and on the Health and Social Care Board and Trusts intranet sites.

Document:	Integrated Elective Access Protocol 3.0
Department:	Department of Health
Purpose:	To advise and inform patients and clinical, administrative and managerial staff of the approved processes for managing patients access to outpatient, diagnostic, elective and elective Allied Health Professional (AHP) services.
For use by:	All clinical, administrative and managerial staff who are responsible for managing referrals, appointments and elective admissions.
This document is compliant with:	Northern Ireland Health and Social Care (NI HSCC) and Department of Health (DOH) Information Standards and Guidance and Systems Technical Guidance. https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Home.aspx
Screened by:	
Issue date:	
Approval by:	
Approval date:	
Distribution:	Trust Chief Executives, Directors of Planning and Performance, Directors of Acute Care, Department of Health.
Review date:	1 April 2021

Monitoring compliance with protocol

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

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Abbreviations

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

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 1

CONTEXT

DRAFT

1.1 INTRODUCTION

- 1.1.1 This protocol has been developed to define the roles and responsibilities of all those involved in the elective care pathway and to outline good practice to assist staff with the effective management of outpatient appointments, diagnostic, elective admissions and allied health professional (AHP) bookings, including cancer pathways and waiting list management.
- 1.1.2 The length of time a patient needs to wait for elective treatment is an important quality issue and is a visible public indicator of the efficiency of the hospital and AHP services provided by the Trust. The successful management of patients who wait for outpatient assessments, diagnostic investigations, elective inpatient or daycase treatment and AHP services is the responsibility of a number of key individuals within the organisation. General Practitioners (GPs), commissioners, hospital medical staff, allied health professionals, managers and clerical staff have an important role in ensuring access for patients in line with maximum waiting time targets as defined in the Department of Health (DOH) Commissioning Plan Direction (CPD) and good clinical practice, managing waiting lists effectively, treating patients and delivering a high quality, efficient and responsive service. Ensuring prompt timely and accurate communication with patients is a core responsibility of the hospital and the wider local health community.
- 1.1.3 The purpose of this protocol is to outline the approved processes for managing referrals to outpatient clinics, diagnostic procedures, elective procedures and operations and AHP booking procedures, through to discharge, to allow consistent and fair care and treatment for all patients.
- 1.1.4 The overall aim of the protocol is to ensure patients are treated in a timely and effective manner, specifically to:
- Ensure that patients receive treatment according to their clinical priority, with routine patients and those with the same clinical priority treated in chronological order, thereby minimising the time a patient spends on the waiting list and improving the quality of the patient experience.

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

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

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

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

1.2 METHODOLOGY

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

- 1.2.2 In this context, this protocol has been prepared to provide clarity of purpose within Trusts with a view to merging seamlessly with the policies of other agencies in the wider health community as they emerge.
- 1.2.3 This protocol has been prepared to clarify Trusts' medium and long-term objectives, set the context in which they will be delivered and establish the parameters within which staff at divisional, specialty and departmental levels will operate.
- 1.2.4 For the purposes of this protocol, the term;
- outpatient refers to a patient who has a clinical consultation. This may be face to face or virtual,
 - elective admissions refer to inpatient and daycase admissions,
 - inpatient refers to inpatient and daycase elective treatment,
 - diagnostic refers to patients who attend for a scan / test or investigation,
 - AHP refers to allied health professionals who work with people to help them protect and improve their health and well-being. There are thirteen professions recognised as allied health professions in Northern Ireland (NI),
 - partial booking refers to the process whereby a patient has an opportunity to agree the date and time of their appointment,
 - fixed booking refers to processes where the patient's appointment is made by the Trust booking office and the patient does not have the opportunity to agree/confirm the date and time of their appointment,
 - virtual appointment refers to any appointment that does not involve the physical presence of a patient at a clinic, (see also 1.5 Virtual Activity).
 - PAS refers to all electronic patient administration systems, including PARIS, whether in a hospital or community setting and those used in diagnostic departments such as NIPACS and systems used for other diagnostics / physiological investigations.

- 1.2.5 Trusts must maintain robust information systems to support the delivery of patient care through their clinical pathway. Robust data quality is essential to ensure accurate and reliable data is held, to support the production of timely operational and management information and to facilitate clinical and clerical training. All patient information should be recorded and held on an electronic system (PAS). Manual patient information systems should not be maintained.
- 1.2.6 All staff involved in the administration of waiting lists will ensure that Trusts' policies and procedures with respect to data collection and entry are strictly adhered to. This is to ensure the accuracy and reliability of data held on electronic hospital/patient administration systems and the waiting times for treatment.
- 1.2.7 Trusts should provide training programmes for staff which include all aspects of this Integrated Elective Access Protocol (IEAP). It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts. Trusts will provide appropriate information to staff so they can make informed decisions when delivering and monitoring this protocol. All staff involved in the administration of waiting lists will be expected to read and sign off this protocol.
- 1.2.8 This protocol will be available to all staff via Trusts' Intranet.

1.3 UNDERPINNING PRINCIPLES

- 1.3.1 Patients will be treated on the basis of their clinical urgency with urgent patients seen and treated first. The definition of clinical urgency will be defined and agreed at specialty / procedure / service level.
- 1.3.2 Patients with the same clinical need will be treated in chronological order on grounds of fairness, and to minimise the waiting time for all patients.

- 1.3.3 As part of a plan for the implementation of booking, Trusts must ensure their elective admission selection system is managed on a chronological basis within clinical priority.
- 1.3.4 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to add the patient to the waiting list, i.e. the patient must be “fit, ready, and able” to come in (TCI).
- 1.3.5 Trusts should design processes to ensure that inpatient care is the exception for the majority of elective procedures and that daycase is promoted. The principle is about moving care to the most appropriate setting, based on clinical judgement. This means moving daycase surgery to outpatient care and outpatient care to primary care or alternative clinical models where appropriate.
- 1.3.6 Referrals into Trusts should be pooled where possible as the norm within specialties.
- 1.3.7 Trusts will maintain and promote electronic booking systems aimed at making hospital appointments more convenient for patients. Trusts should move away from fixed appointments to partially booked appointments.
- 1.3.8 Trusts should also promote direct access services where patients are directly referred from primary and community care to the direct access service for both assessment and treatment. Direct access arrangements must be supported by clearly agreed clinical pathways and referral guidance, jointly developed by primary and secondary care.
- 1.3.9 For the purposes of booking/arranging appointments, all patient information should be recorded and held on an electronic system. Trusts should not use manual administration systems to record and report patient's information.
- 1.3.10 In all aspects of the booking processes, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language**. It is essential that patients who are considered at risk for whatever reason have their needs identified

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

Have we anything in place for 1.3.10

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

1.3.12 Trusts must ensure that the needs of ethnic groups and people with special requirements should be considered at all stages of the patient's pathway.

1.4 BOOKING PRINCIPLES

1.4.1 These booking principles will support all areas across the elective and AHP pathways where appointment systems are used.

1.4.2 Offering the patient choice of date and time where possible is essential in agreeing and booking appointments with patients through partial booking systems. Trusts should ensure booking systems enable patients to choose and agree hospital appointments that are convenient for them.

1.4.3 Facilitating reasonable offers to patients should be seen within the context of robust booking systems being in place.

1.4.4 All booking principles should be underpinned with the relevant local policies to provide clarity to operational staff.

1.4.5 Trusts should ensure booking processes are continually reviewed and updated as required to reflect local and regional requirements at an operational level.

1.4.6 The definition of a booked appointment is:

- a) The patient is given the choice of when to attend or have a virtual appointment.
- b) The patient is able to choose and confirm their appointment within the timeframe relevant to the clinical urgency of their appointment.
- c) The range of dates available to a patient may reduce if they need to be seen quickly, e.g. urgent referrals or within two weeks if cancer is suspected.
- d) The patient may choose to agree a date outside the range of dates offered or defer their decision until later.

1.4.7 Principles for booking Cancer Pathway patients:

- a) All suspected cancer referrals should be booked in line with the agreed clinical pathway requirement for the patient and a maximum of 14 days from the receipt of referral.
- b) Dedicated registration functions for red flag (suspect cancer) referrals should be in place within centralised booking teams.
- c) Clinical teams must ensure triage, where required, is undertaken daily, irrespective of leave, in order to initiate booking patients.
- d) Patients will be contacted by telephone twice (morning and afternoon).
- e) If telephone contact cannot be made, a fixed appointment will be issued to the patient within a maximum of three days of receipt of referral.
- f) Systems should be established to ensure the Patient Tracker / Multidisciplinary Team (MDT) Co-coordinator is notified of the suspected cancer patient referral, to allow them to commence prospective tracking of the patient.

1.4.8 Principles for booking Urgent Pathway patients:

- a) Maximum waiting times for urgent patients should be agreed locally with clinicians and/or service managers and made explicit, through internal processes, to booking office staff.
- b) Referrals will be received, registered within one working day and forwarded to consultants for prioritisation.

- c) If clinical priority is not received from consultants within 72 hours, processes should be in place to initiate booking of urgent patients according to the referrers's classification of urgency.
- d) Patients will be issued with a letter inviting them to contact the Trust to agree and confirm their appointment in line with the urgent booking process.
- e) In exceptional cases, some patients will require to be appointed to the next available slot. A robust process for telephone booking these patients should be developed which should be clearly auditable.

1.4.9 Principles for booking Routine Pathway patients:

- a) Patients should be booked to ensure appointment (including virtual appointment) is within the maximum waiting time guarantees for routine appointments.
- b) Referrals will be received, registered within one working day at booking teams and forwarded to consultants for prioritisation.
- c) Approximately eight weeks prior to appointment, Trusts should calculate prospective slot capacity and immediately implement escalation policy where capacity gaps are identified.
Rotas are not normally available 8 weeks out (annual leave/study leave notification period is 6 weeks. What escalation policy is being followed and where are the capacity gaps being escalated to? If this is an already known and accepted capacity gap, eg, through discussions with HSCB, vacant posts, do we always have to escalate?
- d) Patients should be selected for booking in chronological order from the Primary Targeting List (PTL).
- e) Six weeks prior to appointment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment.

1.4.10 Principles for Booking Review Patients;

- a) Patients who need to be reviewed within 6 weeks will agree their appointment (including virtual appointment) before they leave the clinic, where possible.

- b) Patients who require a review appointment more than 6 weeks in advance will be added to and managed on a review waiting list.
- c) Patients will be added to the review waiting list with a clearly indicated date of treatment and selected for booking according to this date.
- d) Six weeks prior to the indicative date of treatment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment within a clinically agreed window either side of the indicative date of treatment.

1.4.11 It is recognised that some groups of patients may require booking processes that have additional steps in the pathway. These should be designed around the principles outlined to ensure choice and certainty as well as reflecting the individual requirements necessary to support their particular patient journey.

Is there any provision to change date required if patient does not accept reasonable offer?

1.5 VIRTUAL ACTIVITY

1.5.1 Virtual Activity relates to any planned contact by the Trust with a patient (or their proxy) for healthcare delivery purposes i.e. clinical consultation, advice, review and treatment planning. It may be in the form of a telephone contact, video link, telemedicine or telecommunication, e.g. email.

1.5.2 The contact is in lieu of a face-to-face contact of a patient/client, i.e. a face-to-face contact would have been necessary if the telephone/video link/etc. had not taken place.

1.5.3 The call/contact should be prearranged with the patient and /or their proxy. Patients should not be disadvantaged where a decision is made to assess their clinical need through the use of virtual clinics.

Not all patient contact is pre-arranged, there has been a number of virtual clinics following validation when contact is made with the patient at the point of validation and a decision/treatment plan agreed.

- 1.5.4 The contact must be auditable with a written note detailing the date and substance of the contact is made following the consultation and retained in the patient's records.

1.6 COMPLIANCE WITH LEAVE PROTOCOL

- 1.6.1 It is essential that planned medical and other clinical staff leave or absence is organised in line with an agreed Trust Human Resources (HR) protocol. Thus it is necessary for Trusts to have robust local HR policies and procedures in place that minimise the cancellation/reduction of outpatient clinics and the work associated with the rebooking of appointments.
- 1.6.2 There should be clear medical and clinical agreement and commitment to this HR policy. Where cancelling and rebooking is unavoidable the procedures used must be equitable, efficient, comply with clinical governance principles and ensure that maximum waiting times for patients are not compromised.
- 1.6.3 The protocol should require a minimum of six weeks' notification of intended leave, in line with locally agreed HR policies, in order to facilitate Trusts booking teams to manage appointment processes six weeks in advance.
- 1.6.4 The booking team should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

1.7 VALIDATION

- 1.7.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a monthly basis. This is essential to ensure the efficiency of the elective pathway at all times. In addition, Trusts should ensure that waiting lists are regularly validated to ensure that only those patients who want or still require a procedure are on the waiting list.

- 1.7.2 Involvement of clinicians in the validation process is essential to ensure that waiting lists are robust from a clinical perspective. Trusts should ensure an ongoing process of clinical validation and audit is in place.

Have we anything set up for the ongoing clinical validation

DRAFT

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 2

**GUIDANCE FOR MANAGEMENT OF OUTPATIENT
SERVICES**

DRAFT

2.1 INTRODUCTION

- 2.1.1 The following protocol is based on recommended good practice guidelines to assist staff with the effective management of outpatient services, including those patients whose referral is managed virtually.
- 2.1.2 The administration and management of the outpatient pathway from receipt of referral to appointment within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.
- 2.1.3 There will be dedicated booking offices within Trusts to receive, register and process all outpatient referrals.
- 2.1.4 Fixed appointments should only be used in exceptional circumstances.
- 2.1.5 In all aspects of the outpatient booking process, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language**. Local booking policies should be developed accordingly.

Is there anything we need to have n place here?

2.2 KEY PRINCIPLES

- 2.2.1 Referrals into Trusts should be pooled where possible within specialties.
- 2.2.2 All new referrals, appointments and outpatient waiting lists should be managed according to clinical priorities. Priorities must be identified for each patient on the waiting list and allocated according to urgency of the treatment. Trusts will manage patients in three priorities, i.e.
 1. Red flag (suspect cancer),
 2. urgent and
 3. routine.

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

There are currently only 2 priority categories on PAS for referrals – urgent and routine. Red flags are identified by reason for referral code. Is this an opportunity to update PAS with a priority category for red flag? Yes that would make sense

- 2.2.3 Patients of equal clinical priority will be selected for booking in strict chronological order.
- 2.2.4 Patient appointments for new and review should be **partially booked**.
In the case of red flag appointments and 14 day target, it is not always possible to partial book appointments. The principles in section 1 are applied, ie the 2 attempts at telephone contacts and 1 fixed appointment.
- 2.2.5 The regional target for a maximum outpatient waiting time is outlined in the Health and Social Care Commissioning Plan and Indicators of Performance Direction (CPD), <https://www.health-ni.gov.uk/doh-management-and-structure> (see Ministerial Priorities).
- 2.2.6 Maximum waiting times for urgent patients should be agreed locally with clinicians and made explicit, through internal processes, to booking office staff. Booking staff should ensure that patients are appointed within the clinical timeframe indicated by the consultant and capacity issues are quickly identified and escalated.
- 2.2.7 Patients should not be disadvantaged where a decision is made to assess their clinical need through virtual activity.
- 2.2.8 Trusts should ensure that clinical templates are constantly reviewed to meet changes in demand and new clinical practice.
- 2.2.9 Data collection in respect of referrals and waiting times should be accurate, timely, complete and subject to regular audit and validation.
- 2.2.10 Trusts will work towards providing a single point of contact for all patients with respect to outpatient appointment services. It is recognised that there may be services which require alternative processes.

- 2.2.11 Trusts should **not** use manual administration systems to record and report patients who have been booked.
- 2.2.12 Trusts should provide training programmes for staff which include all aspects of IEAP. It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts.

2.3 NEW REFERRALS

- 2.3.1 All outpatient referrals (including those sent via Clinical Communication Gateway (CCG)) sent to Trusts will be registered within **one** working day of receipt. Referrer priority status must be recorded at registration.
- 2.3.2 Trusts will work towards a system whereby the location of all referrals (paper and electronic) not yet prioritised can be identified and tracked.
- 2.3.3 All referrals must be prioritised and clinical urgency must be clearly identified. Clinicians and management will be responsible for ensuring that cover is provided for referrals to be read and prioritised during any absence.
- 2.3.4 All referrals will be prioritised (including those prioritised via E-Triage) within **a maximum of three** working days of date of receipt of referral. Note; Red flag referrals require **daily** triage.
- 2.3.5 Following prioritisation, referrals must be actioned on PAS and appropriate correspondence (including electronic), e.g. acknowledgement or appointment letter, issued to patients within **one** working day.
- 2.3.6 Inappropriate and inadequate referrals should be returned to the referral source immediately and the referral closed and managed in line with the PAS technical guidance.

2.4 CALCULATION OF THE WAITING TIME – STARTING TIME

2.4.1 The starting point for the waiting time of an outpatient new referral is the date the referral is received by the booking office/department.

2.4.2 In exceptional cases where referrals bypass the booking office (e.g. sent directly to a consultant) the Trust must have a process in place to ensure that these are date stamped on receipt, immediately forwarded to the booking office and registered at the date on the date stamp.

2.5 REASONABLE OFFERS

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

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

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

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

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

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

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

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

2.6 REVIEW APPOINTMENTS

- 2.6.1 All review appointments must be made within the time frame specified by the clinician. If a review appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the clinician.
- 2.6.2 Patients must be recorded on PAS as requiring to be seen within a clinically indicated time. Trusts should actively monitor patients on the review list to ensure that they do not go past their indicative time of treatment.
- 2.6.3 Review patients who require an appointment within six weeks will be asked to agree the date and time of the appointment before leaving the department and PAS updated.
- 2.6.4 Patients requiring an appointment outside six weeks will be placed on a review waiting list, with the agreed clinically appropriate appointment date recorded, and be booked in line with implementation guidance for review pathway patients.
- 2.6.5 Virtual review appointments, e.g. telephone or video link, should be partially booked. If the patient cannot be contacted for their virtual review they should be sent a partial booking letter to arrange an appointment.

Not all patient contact is pre-arranged, there has been a number of virtual clinics following validation when contact is made with the patient at the point of validation and a decision/treatment plan agreed.

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

2.7.1 DNAs – New Outpatient

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

- 2.7.1(a) Patients who have been partially booked will **not** be offered a second appointment and should be removed from the waiting list. The patient and referring clinician (and the patient's GP, where they are not the referring clinician) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.
- 2.7.1(b) Under exceptional circumstances a clinician may decide that a patient who DNAs a first appointment should not be removed from the waiting list and should be offered a second appointment. Trusts should put in place local agreements with clinicians, regarding those referrals (e.g. red flag) or specialties where patients may be at risk (e.g. paediatrics or adults at risk) where a second appointment should always be offered.
- 2.7.1(c) Patients who DNA and are not discharged but offered a second appointment will have their waiting time clock reset to the date of the DNA.
- 2.7.1(d) *Where patients are discharged from the waiting list (ref. 2.7.1(a)) they should be advised to contact the Trust booking office within **four** weeks of the original appointment date if they consider that the appointment is still required. Where a patient makes contact within the **four** week deadline, and where the Trust considers that unforeseen or exceptional circumstances meant that the patient was unable to attend, the patient should be added to the waiting list at the date that they have made contact with the Trust. If a patient makes contact after the **four** week period they cannot be reinstated.*

- 2.7.1(e) If the patient DNAs the second appointment offered then the patient should **not** be offered another opportunity to be reinstated. The patient and referring clinician (and the patient's GP, where they are not the referring clinician) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.
- 2.7.1(f) Where a patient DNAs a fixed new appointment (i.e. they have not had the opportunity to agree/confirm the date and time of the appointment) they should be offered another appointment.
- 2.7.1(g) If the patient DNAs this second fixed appointment they will be removed from the waiting list and the steps in 2.7.1(d) should be followed.
- 2.7.1(h) If a patient DNA's a virtual outpatient appointment this should follow the above protocol based on whether the appointment is partially booked or fixed. The Trust should ensure that the contact details of the patient are up to date and available.

2.7.2 DNAs – Review Outpatient

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

- 2.7.2(a) Where a patient has been partially booked and does not attend, a clinical decision should be taken as to whether a second appointment should be offered or whether the patient can be discharged.
- 2.7.2(b) Where the clinical decision is that a second appointment should be offered, this should be partially booked.
- 2.7.2(c) Where the clinical decision is that a second appointment should **not** be offered, Trusts should contact patients advising that as they have failed to attend their appointment they have been discharged from the waiting list. The referring clinician (and the patient's GP, where they are not the referring clinician) should also be informed of this.
- 2.7.2(d) *Patients being discharged from the list should be advised to contact the Trust booking office if they have any queries. Where unforeseen or exceptional circumstances meant that the patient was unable to attend, and the patient makes contact within **four** weeks*

of the original appointment date, a clinical decision may be made to offer a second appointment. Where this is the case, the patient should be added to the review waiting list with a revised clinically indicated date at the date they make contact with the Trust.

- 2.7.2(e) If the patient DNAs the second review appointment which has been partially booked then the patient should **not** be offered another opportunity to be reinstated. The patient and referrer will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.
- 2.7.2(f) Where a patient DNAs a fixed review appointment where they have not had the opportunity to agree/ confirm the date and time of their appointment, they should be offered another appointment. If they DNA this second fixed appointment, the above should be followed.
- 2.7.2(g) If a patient DNA's a virtual outpatient review appointment this should follow the above protocol based on whether the appointment is partially booked or fixed. The Trust should ensure that the contact details of the patient are up to date and available.
- 2.7.2(h) There may be instances for review patients where the clinician may wish to review notes prior to any action to remove a patient because of a DNA or failure to respond to a partial booking letter. Trusts should ensure that there are locally agreed processes in place to administer these patients.

Is there any provision to change date required if patient does not accept reasonable offer/DNA or the consultant changes plan following review of notes?

2.7.3 CNAs – Patient Initiated Cancellations of Outpatient Appointments

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

- 2.7.3(a) The patient will be given a second opportunity to book an appointment (where this is still required), which should be within **six** weeks of the original appointment date.
- 2.7.3(b) Patients who CNA will have their waiting time clock reset to the date the Trust was informed of the cancellation.

- 2.7.3(c) If a second appointment is cancelled, the patient will **not** normally be given another appointment. Where a decision is taken not to offer a further appointment, Trusts should contact patients advising that they have been discharged from the waiting list. The referring clinician (and the GP, where they are not the referring clinician) should also be informed of this.
- 2.7.3(d) However, where unforeseen or exceptional circumstances mean that the patient had to cancel a second appointment, the Trust may exercise discretion to offer a third appointment. This should include seeking a clinical review of the patient's case where this is appropriate.
- 2.7.3(e) If a patient CNA's a virtual outpatient appointment this should follow the above protocol.

2.8 CNAs – HOSPITAL INITIATED CANCELLATIONS

- 2.8.1 No patient should have his or her appointment cancelled. If Trusts cancel a patient's appointment, including a virtual appointment, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity.
- 2.8.2 The patient should be informed of the cancellation and a new appointment partially booked.
- 2.8.3 Trusts will make best efforts to ensure that a patient's appointment is not cancelled a second time for non-clinical reasons.
- 2.8.4 Hospital initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

2.9 CLINIC OUTCOME MANAGEMENT

- 2.9.1 Changes in the patient's details must be updated on PAS and the medical records on the date of the clinic.
- 2.9.2 When the consultation has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic.

2.10 CLINIC TEMPLATE CHANGES

- 2.10.1 Clinic templates should be agreed between the consultant and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement (SBAs).
- 2.10.2 Templates will identify the number of slots available for red flag, urgent, and routine and review appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated for each appointment slot.
- 2.10.3 All requests for template and temporary clinic rule changes will only be accepted in writing. A minimum of **six** weeks' notice will be provided for clinic template changes.
- 2.10.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager.

2.11 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

- 2.11.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between hospitals or to independent sector (IS) providers.
- 2.11.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant and be managed in line with PAS technical guidance, (see also Reasonable Offers, ref. 2.5). Administrative speed and good communication are very important to ensure this process runs smoothly.

2.12 OPEN REGISTRATIONS

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

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

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

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

2.13 TIME CRITICAL CONDITIONS

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

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

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

- 2.13.4 If the patient refuses the first appointment they should be offered a second appointment during the same telephone call. This second appointment should be offered on a date which is within **14** days of the date the initial appointment was offered and refused. In order to capture the correct waiting time the first appointment will have to be scheduled and then cancelled on the day of the offer and the patient choice field updated in line with the technical guidance. This will then reset the patient's waiting time to the date the initial appointment was refused.
- 2.13.5 If the patient cancels **two** agreed appointment dates the relevant clinical team should be advised before a decision is taken to discharge. Where a decision is taken to discharge the patient, the patient's GP should be informed.
- 2.13.6 If the patient has agreed an appointment but then DNAs the relevant clinical team should be advised before a decision is taken to discharge. Where a decision is taken to discharge the patient, the patient's GP should be informed.
- 2.13.7 Where the patient DNAs a fixed appointment they should be offered another appointment.
- 2.13.8 If the patient DNAs this second fixed appointment the relevant clinical team should be advised before a decision is taken to discharge. Where a decision is taken to discharge the patient, the patient's GP should be informed.
- 2.13.9 With regard to 2.13.4 to 2.13.8 above, it is the responsibility of each individual Trust to agree the discharge arrangements with the clinical team.
- 2.13.10 If the patient is not available for up to **six** weeks following receipt of referral, the original referral should be discharged a second new referral should be opened with the same information as the original referral and with a new date equal to the date the patient has advised that they will be available and the patient monitored from this date.

2.14 TECHNICAL GUIDANCE

2.14.1 See also Regional ISB Standards and Guidance

<https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Standards%20and%20Guidance.aspx> re;

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

2.14.2 See also PAS technical guidance

<https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Technical%20Guidance.aspx> for recording;

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

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 3

**GUIDANCE FOR MANAGEMENT OF DIAGNOSTIC
SERVICES**

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3.1 INTRODUCTION

- 3.1.1 A diagnostic procedure may be performed by a range of medical and clinical professionals across many different modalities, including, diagnostic imaging, cardiac imaging and physiological measurement services. These may have differing operational protocols, pathways and information systems but the principles of the IEAP should be applied across all diagnostic services.
- 3.1.2 The principles of good practice outlined in the Outpatient and Elective Admissions sections of this document should be adopted in order to ensure consistent standards and processes for patients as they move along the pathway of investigations, assessment and treatment. This section aims to recognise areas where differences may be encountered due to the nature of specific diagnostic services.
- 3.1.3 The administration and management of requests for diagnostics, waiting lists and appointments within and across Trust should be consistent, easily understood, patient focused and responsive to clinical decision making.
- 3.1.4 It is recognised that diagnostic services are administered on a wide range of information systems, with varying degrees of functionality able to support full information technology (IT) implementation of the requirements of the IEAP. Trusts should ensure that the administrative management of patients is undertaken in line with the principles of the IEAP and that all efforts are made to ensure patient administration systems are made fit for purpose.
- 3.1.5 In all aspects of the diagnostic booking process, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language as well as associated legislative requirements such as Ionising Radiation (Medical Exposure) Regulations**. Local booking policies should be developed accordingly.

3.2 KEY PRINCIPLES

- 3.2.1 Referrals into Trusts should be pooled as the norm where possible.
- 3.2.2 All diagnostic requests, appointments and waiting lists should be managed according to clinical priority. Priorities must be identified for each patient on a waiting list and allocated according to urgency of the diagnostic procedure. Trusts will manage patients in four priorities, i.e.
1. Red flag (suspect cancer),
 2. urgent,
 3. routine and
 4. planned.
- No other clinical priority categories should be used for diagnostic services.
- 3.2.3 Patients of equal clinical priority will be selected for booking in strict chronological order.
- 3.2.4 Trusts should work towards an appointment system where patient appointments are **partially booked** (where applicable). Where fixed appointments are being issued, Trusts should ensure that the regional IEAP guidance is followed in the management of patients.
- 3.2.5 The regional target for a maximum diagnostic waiting time is outlined in the Health and Social Care Commissioning Plan and Indicators of Performance Direction (CPD), <https://www.health-ni.gov.uk/doh-management-and-structure> (see Ministerial Priorities).
- 3.2.6 Maximum waiting times for urgent patients should be agreed locally with clinicians and/or service managers and made explicit, through internal processes, to booking office staff. Booking staff should ensure that patients are appointed within the clinical timeframe indicated and capacity issues are quickly identified and escalated.
- 3.2.7 The outcome of the diagnostic test must be available to the referrer without undue delay and within the relevant DoH targets / standards.

- 3.2.8 Trusts should ensure that specific diagnostic tests or planned patients which are classified as daycases adhere to the relevant standards in the Elective Admissions section of this document.
- 3.2.9 Trusts should ensure that clinical templates are constantly reviewed to meet changes in demand and new clinical practice.
- 3.2.10 Data collection in respect of referrals and waiting times should be accurate, timely, complete and subject to regular audit and validation.
- 3.2.11 Trusts will work towards providing a single point of contact for all patients with respect to diagnostic appointment services. It is recognised that there will be services which require alternative processes.
- 3.2.12 Trusts should **not** use manual administration systems to record and report patients who have been booked.
- 3.2.13 Trusts should provide training programmes for staff which include all aspects of this IEAP. It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts.

3.3 NEW DIAGNOSTIC REQUESTS

- 3.3.1 All diagnostic requests will be registered on the IT system within **one** working day of receipt. Referrer priority status must be recorded at registration.
- 3.3.2 Trust diagnostic services must have mechanisms in place to track all referrals (paper and electronic) at all times.
- 3.3.3 All requests must be prioritised and clinical urgency must be clearly identified. Clinicians and management will be responsible for ensuring that cover is provided for referrals to be read and prioritised during any absence.

- 3.3.4 All referrals will be prioritised (including those prioritised via E Triage) within **three** working days of date of receipt of referral.
- 3.3.5 Following prioritisation, requests must be actioned on the IT system and appropriate correspondence (including electronic) issued to patients within **one** working day.
- 3.3.6 Inappropriate and inadequate requests should be returned to the referral source and the referral closed and managed in line with the PAS/relevant technical guidance, where appropriate.

3.4 CALCULATION OF THE WAITING TIME – STARTING TIME

- 3.4.1 The starting point for the waiting time of a request for a diagnostic investigation or procedure is the date the request is received into the department.
- 3.4.2 All referral letters and requests, emailed and electronically delivered referrals, will have the date received into the department recorded either by date stamp or electronically.

3.5 REASONABLE OFFERS

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

The IT Systems currently being used for the management of the majority of diagnostics do not facilitate partial booking, however, the fixed appointment letters do ask patients to confirm and are issued with 3 weeks' notice where appropriate. The diagnostic booking teams follow this up with telephone calls to patients to confirm attendances.

- 3.5.2 If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused.
- 3.5.3 This does not prevent patients being offered earlier appointment dates. If the patient is offered an appointment within a shorter notice period (i.e. less than three weeks' notice) and refuses it they will not have their waiting time reset.
- 3.5.4 If the patient accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the provider.
- 3.5.5 Providers should have robust audit procedures in place to demonstrate compliance with the above.
- 3.5.6 To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.
- 3.5.7 Urgent patients must be booked within the locally agreed maximum waiting time from the date of receipt. It is recognised that there will be occasional exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Clearly defined booking protocols will be required to support specialties and booking staff.

3.6 FOLLOW UP APPOINTMENTS

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

- 3.6.2 Patients must be recorded on the IT system as requiring to be seen within a clinically indicated time. Trusts should actively monitor follow up patients on the review list to ensure that they do not go past their indicative time of treatment.
- 3.6.3 Follow up patients who require an appointment within six weeks will be asked to agree the date and time of the appointment before leaving the department and the IT system updated.
- 3.6.4 Follow up patients requiring an appointment outside six weeks will be placed on a review waiting list, with the agreed clinically appropriate appointment date recorded, and be booked in line with management guidance for follow up pathway patients.

3.7 PLANNED PATIENTS

- 3.7.1 Planned patients are those who are waiting to be recalled to hospital for a further stage in their course of treatment or investigation within specific timescales. This is usually part of a planned sequence of clinical care determined on clinical criteria.
- 3.7.2 These patients are not actively waiting for treatment to be initiated, only for planned continuation of treatment. A patient's care is considered as planned if there are clinical reasons that determine the patient must wait set periods of time between interventions. They will not be classified as being on a waiting list for statistical purposes.
- 3.7.3 Trusts should be able to demonstrate consistency in the way planned patients are treated and that patients are being treated in line with the clinical constraints. Planned patients must have a clearly identified month of treatment in which it can be shown that the patients are actually being treated.
- 3.7.4 Trusts must ensure that planned patients are not disadvantaged in the management of planned backlogs.

3.8 PATIENTS LISTED FOR MORE THAN ONE DIAGNOSTIC TEST

- 3.8.1 Where more than one diagnostic test is required to assist with clinical decision making, the first test should be added to the waiting list with additional tests noted.
- 3.8.2 Where different clinicians working together perform more than one test at one time, the patient should be added to the waiting list of the clinician for the priority test (with additional clinicians noted) subject to local protocols.
- 3.8.3 Where a patient requires more than one test carried out on separate occasions the patient should be placed on the active waiting list for the first test and on the planned waiting list for any subsequent tests.
- 3.8.4 Where a patient is being managed in one Trust but has to attend another for another type of diagnostic test, monitoring arrangements must be in place between the relevant Trusts to ensure that the patient pathway runs smoothly.

There would be concern that a patient is only added to one waiting list, eg, a patient could require a number of different diagnostic tests to reach diagnosis and treatment plan, with varying waiting times for these tests, eg, a patient could be referred for a CT examination but also be added to the waiting list for an endoscopy procedure. A patient on cancer pathway could require PET and CT – these are different radiology modalities with different waiting lists. Cardiac patients could be listed for different examinations, eg, echo, stress test etc with varying waiting times.

The concern would be the risk that the patient would be closed off the system after the initial investigation or before all tests completed if only added to one waiting list.

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

- 3.9.1 DNAs – Diagnostic Appointment

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

- 3.9.1(a) Patients who have been partially booked will **not** be offered a second appointment and should be removed from the waiting list. The patient and referring clinician (and the patient's GP, where they are not the referring clinician) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.
- 3.9.1(b) Under exceptional circumstances a clinician may decide that a patient who DNAs a first appointment should not be removed from the waiting list and should be offered a second appointment. Trusts should put in place local agreements with clinicians, regarding those referrals (e.g. red flag) or specialties where patients may be at risk (e.g. paediatrics or adults at risk) where a second appointment should be offered.
- 3.9.1(c) Patients who DNA and are not discharged but offered a second appointment will have their waiting time clock reset to the date of the DNA.
- 3.9.1(d) *Where patients are discharged from the waiting list (ref. 3.7.1(a) above) they should be advised to contact the Trust booking office within **four** weeks of the original appointment date if they consider that the appointment is still required. Where a patient makes contact within the **four** week deadline, and where the Trust considers that unforeseen or exceptional circumstances meant that the patient was unable to attend, the patient should be added to the waiting list at the date that they have made contact with the Trust. If a patient makes contact after the **four** week period they cannot be reinstated.*
- 3.9.1(e) If the patient DNAs the second appointment offered then the patient should **not** be offered another opportunity to be reinstated. The patient and referring clinician (and the patient's GP, where they are not the referring clinician) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

- 3.9.1(f) Where a patient DNAs a fixed diagnostic appointment (i.e. they have not had the opportunity to agree/confirm the date and time of the appointment) they should be offered another appointment.
- 3.9.1(g) If the patient DNAs this second fixed diagnostic appointment they will be removed from the waiting list and the above steps in 3.7.1(d) should be followed.

3.9.2 DNAs – Follow up Diagnostic Appointment

If a patient DNAs their follow up diagnostic appointment the following process must be followed:

- 3.9.2(a) Where a patient has been partially booked and does not attend, a clinical decision should be taken as to whether a second appointment should be offered or whether the patient can be discharged.
- 3.9.2(b) Where the clinical decision is that a second appointment should be offered, this should be partially booked.
- 3.9.2(c) Where the clinical decision is that a second appointment should **not** be offered, Trusts should contact patients advising that as they have failed to attend they have been discharged from the waiting list. The referring clinician (and the patients GP, where they are not the referring clinician) should also be informed of this.
- 3.9.2(d) *Patients being discharged from the list should be advised to contact the Trust booking office if they have any queries. Where unforeseen or exceptional circumstances meant that the patient was unable to attend, and the patient makes contact within **four** weeks of the original appointment date, a clinical decision may be made to offer a second appointment. Where this is the case, the patient should be added to the review waiting list with a revised clinically indicated date at the date they make contact with the Trust.*
- 3.9.2(e) If the patient DNAs the second follow up appointment which has been partially booked then the patient should **not** be offered another opportunity to be reinstated. The patient and referrer will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

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

3.9.2(g) There may be instances for follow up patients where the clinician may wish to review notes prior to any action to remove a patient because of a DNA or failure to respond to a partial booking letter. Trusts should ensure that there are locally agreed processes in place to administer these patients.

3.9.3 CNAs – Patient Initiated Cancellations of Diagnostic Appointment

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

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

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

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

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

3.10 **CNAs - HOSPITAL INITIATED CANCELLATIONS**

- 3.10.1 No patient should have his or her appointment cancelled. If Trusts cancel a patient's appointment, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity.
- 3.10.2 The patient should be informed of the cancellation and the date of the new appointment.
- 3.10.3 Trusts will make best efforts to ensure that a patient's appointment is not cancelled a second time for non-clinical reasons.
- 3.10.4 Hospital initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

3.11 SESSION OUTCOME MANAGEMENT

- 3.11.1 Changes in the patient's details must be updated on the IT system and the medical record on the date of the session.
- 3.11.2 When the test has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of session.

3.12 SESSION TEMPLATE CHANGES

- 3.12.1 Session templates should be agreed with the healthcare professional and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement (SBAs).
- 3.12.2 Templates will identify the number of slots available for new red flag, new urgent, new routine, planned and follow up appointments; specify the time each session is scheduled to start and finish; and identify the length of time allocated for each appointment slot.

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

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

3.13 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

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

3.13.2 Transfers to alternative providers must always be with the consent of the patient and the receiving clinician and be managed in line with PAS technical guidance (see also Reasonable Offers, ref. 3.5). Administrative speed and good communication are very important to ensure this process runs smoothly.

3.14 TECHNICAL GUIDANCE

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

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

- Diagnostic waiting time and report turnaround time.
- Patients treated (IP/DC) or seen (OP) by an independent sector provider.
- Rapid angina assessment clinic (RAAC).
- Management of waiting times of patients who transfer between NHS sites (either within NI or the rest of the UK).

- Patients who are to be treated as part of a waiting list initiative / additional in house activity.

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INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 4

**GUIDANCE FOR MANAGEMENT OF ELECTIVE
ADMISSIONS**

DRAFT

4.1 INTRODUCTION

- 4.1.1 The following protocol is based on recommended good practice guidelines to assist staff with the effective management of elective inpatient and daycase admissions.
- 4.1.2 The administration and management of elective admissions within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.
- 4.1.3 In all aspects of the elective admissions booking process, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language**. Local booking policies should be developed accordingly.

Have we anything in place for this?

4.2 KEY PRINCIPLES

- 4.2.1 To aid both the clinical and administrative management of the waiting list, lists should be sub-divided and managed appropriately. Trusts will manage patients on one of three waiting lists, i.e.
1. active,
 2. planned and
 3. suspended.
- 4.2.2 All elective inpatient and daycase waiting lists should be managed according to clinical priorities. Priorities must be identified for each patient on the waiting list and allocated according to urgency of the treatment. Trusts will manage patients in four priorities, i.e.
1. Red flag (suspect cancer),
 2. urgent,
 3. routine and
 4. planned.
- No other clinical priority categories should be used for inpatient and daycase services.

There are currently only 2 priority categories on PAS for referrals – urgent and routine. Red flags are identified by reason for referral code. Is this an opportunity to update PAS with a priority category for red flag? Yes this would make sense

- 4.2.3 Patients of equal clinical priority will be selected for booking in strict chronological order, taking into account planned patients expected date of admission.
- 4.2.4 The regional targets for a maximum inpatient and daycase waiting times are outlined in the Health and Social Care Commissioning Plan and Indicators of Performance Direction (CPD), <https://www.health-ni.gov.uk/doh-management-and-structure> (see Ministerial Priorities).
- 4.2.5 Maximum waiting times for urgent patients should be agreed locally with clinicians and made explicit, through internal processes, to booking office staff. Booking staff should ensure that patients are appointed within the clinical timeframe indicated by the consultant and capacity issues are quickly identified and escalated.
- 4.2.6 Trusts should ensure that clinical templates are constantly reviewed to meet changes in demand and new clinical practice.
Is this relevant to elective? Consultants normally select cases based on clinical priority etc.
- 4.2.7 Data collection in respect of referrals and waiting times should be accurate, timely, complete and subject to regular audit and validation.
- 4.2.8 Trusts should **not** use manual administration systems to record and report patients who have been booked.
- 4.2.9 Trusts should provide training programmes for staff which include all aspects of IEAP. It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts.

4.3 PRE-ASSESSMENT

- 4.3.1 All patients undergoing an elective procedure (including endoscopy procedures) must undergo a pre-assessment. This can be provided using a variety of methods including telephone, video link, postal or face to face assessment.
- 4.3.2 Pre-assessment may include an anesthetic assessment or guidance on how to comply with pre-procedure requirements such as bowel preparation. It will be the responsibility of the pre- assessment team, in accordance with protocols developed by the relevant clinical teams, to authorise fitness for an elective procedure.
- 4.3.3 Only those patients that are deemed fit for their procedure may be offered a TCI date.
- 4.3.4 If a patient is assessed as being unfit for their procedure, their To Come In (TCI) date may be cancelled and decision taken as to the appropriate next action.
- 4.3.5 Pre-assessment services should be supported by a robust booking system.

4.4 CALCULATION OF THE WAITING TIME

- 4.4.1 The starting point for the waiting time of an inpatient/daycase admission is the date the appropriate clinician agrees that a procedure will be pursued as an active treatment or diagnostic intervention, and that the patient is clinically and socially fit to undergo such a procedure.
- 4.4.2 The waiting time for each patient on the elective admission list is calculated as the time period between the original decision to admit date and the date at the end of the applicable period for the waiting list return. If the patient has been suspended at all during this time, the period(s) of suspension will be automatically subtracted from the total waiting time.

4.5 REASONABLE OFFERS - TO COME IN (TCI) OFFERS OF TREATMENT

- 4.5.1 The patient should be advised of their expected waiting time during the consultation between themselves and the health care provider/practitioner.
- 4.5.2 All patients must be offered reasonable notice. Patients should be made reasonable offers to come in (TCI) on the basis of clinical priority. Within clinical priority groups offers should then be made on the basis of the patient's chronological wait.
- 4.5.3 A reasonable offer is defined as:
- an offer of admission, irrespective of provider or location, that gives the patient a minimum of **three** weeks' notice and a choice of **two** TCI dates, and
 - at least **one** of the offers must be within N. I., except for any regional specialties where there are no alternative providers within NI.

The majority of elective procedures are fixed appointments, based on when consultants are available for theatre sessions, availability of ICU capacity if required, volume of predicted in-patient beds etc. This is a complex booking process which can be difficult to adapt with partial booking.
Does there need to be a guidance for fixed elective offers?

- 4.5.4 If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the admission was refused.
- 4.5.5 This does not prevent patients being offered earlier appointment dates. If the patient is offered an admission within a shorter notice period (i.e. less than three weeks' notice) and refuses it they will not have their waiting time reset.
- 4.5.6 If the patient accepts an admission at short notice, but then cancels the admission, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the provider.
- 4.5.7 Urgent patients must be booked within the locally agreed maximum waiting time from the date of receipt. It is recognised that there will be occasional

exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Clearly defined booking protocols will be required to support specialties and booking staff.

- 4.5.8 Providers should have robust audit procedures in place to demonstrate compliance with the above.
- 4.5.9 To ensure the verbal booking process is auditable, the Trust should make and cancel a TCI date using the date of the second admission date offered and refused for this transaction.

4.6 INPATIENT AND DAYCASE ACTIVE WAITING LISTS

- 4.6.1 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to add the patient to the waiting list, i.e. the patient must be “fit, ready, and able” to come in.
- 4.6.2 To ensure consistency and the standardisation of reporting with commissioners and the DoH, all waiting lists are to be maintained in the PAS patient information system.
- 4.6.3 Details of patients must be entered on to the computer system (PAS) recording the date the decision was made to admit the patient or add the patient to the waiting list within two working days of the decision being made. Failure to do this will lead to incorrect assessment of waiting list times.
- 4.6.4 Where a decision to add to the waiting list depends on the outcome of diagnostic investigation, patients should not be added to an elective waiting list until the outcome of this investigation is known. There must be clear processes in place to ensure a decision is made in relation to the result of the investigation and the clinical patient pathway agreed.

4.7 SUSPENDED PATIENTS

- 4.7.1 At any time a consultant is likely to have a number of patients who are unsuitable for admission for clinical or personal reasons. These patients should be suspended from the active waiting list until they are ready for admission.
- 4.7.2 A period of suspension is defined as:
- A patient suspended from the active waiting list for medical reasons, or unavailable for admission for a specified period because of family commitments, holidays, or other reasons i.e. a patient may be suspended during any periods when they are unavailable for treatment for personal or medical reasons (but not for reasons such as the consultant being unavailable, beds being unavailable etc.).
 - A recommended maximum period not exceeding **three** months.
- 4.7.3 No patient should be suspended from the waiting list without a suspension end date.
- 4.7.4 Suspended patients should be reviewed one month prior to the end of their suspension period and a decision taken on their admission.
- 4.7.5 Every effort will be made to minimise the number of patients on the suspended waiting list, and the length of time patients are on the suspended waiting list.
- 4.7.6 Should there be any exceptions to the above, advice should be sought from the lead director or appropriate clinician.
- 4.7.7 Suspended patients will not count as waiting for statistical purposes. Any periods of suspension will be automatically subtracted from the patient's total time on the waiting list for central statistical returns.
- 4.7.8 No patient added to a waiting list should be immediately suspended. Patients should be recorded as suspended on the same day as the decision was taken that the patient was unfit or unavailable for admission/treatment.

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

4.8 PLANNED PATIENTS

- 4.8.1 Planned patients are those patients who are waiting to be admitted to hospital for a further stage in their course of treatment or surgical investigation within specific timescales.
- 4.8.2 These patients are not actively waiting for treatment, but for planned continuation of treatment. A patient is planned if there are clinical reasons that determine the patient must wait set periods of time between interventions. They will not be classified as being on a waiting list for statistical purposes.
- 4.8.3 Trusts must have systems and processes in place to identify high risk planned patients in line with clinical guidance.
- 4.8.4 Trusts should be able to demonstrate consistency in the way planned patients are treated and that patients are being treated in line with the clinical constraints. Planned patients should have a clearly identified month of treatment in which it can be shown that the patients are actually being treated.
- 4.8.5 Trusts must ensure that planned patients are not disadvantaged in the management of planned backlogs, with particular focus on high risk surveillance pathway patients.

4.9 PATIENTS LISTED FOR MORE THAN ONE PROCEDURE

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

- 4.9.2 Where different clinicians working together will perform more than one procedure at one time the patient should be added to the waiting list of the clinician for the priority procedure with additional clinician procedures noted.
- 4.9.3 Where a patient requires more than one procedure performed on separate occasions or bilateral procedures by different (or the same) clinician, the patient should be placed on the active waiting list for the first procedure and the planned waiting list for any subsequent procedures.

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

DNAs – Inpatient/Daycase

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

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

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

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

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

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

Is there a process in place for this the same as outpatients were a letter is sent to the patient and they phone in ?

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

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

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

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

4.10.2 CNAs – Patient Initiated Cancellations of inpatient/daycase admission

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

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

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

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

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

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

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

4.11. CNAs - HOSPITAL INITIATED CANCELLATIONS

- 4.11.1 No patient should have his or her admission cancelled. If Trusts cancel a patient's admission the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity.
- 4.11.2 The patient should be informed of the cancellation and the date of the new admission booked.
- 4.11.3 Trusts will make best efforts to ensure that a patient's admission is not cancelled a second time for non-clinical reasons.
- 4.11.4 Where patients are cancelled on the day of an admission/operation as a result of not being fit, they will be suspended, pending a clinical review of their condition. The patient should be fully informed of this process.
- 4.11.5 Hospital initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of admission a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

4.12 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

- 4.12.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between Trust sites or to independent sector (IS) providers.
- 4.12.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant and be managed in line with PAS technical guidance, (see also Reasonable Offers, ref. 4.5). Administrative speed and good communication are very important to ensure this process runs smoothly.

4.13 TECHNICAL GUIDANCE

4.13.1 See also Regional ISB Standards and Guidance

<https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Standards%20and%20Guidance.aspx> re acute activity definitions.

4.13.2 See also PAS technical guidance

<https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Technical%20Guidance.aspx> for recording;

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

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 5

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

DRAFT

5.1 INTRODUCTION

- 5.1.1 The following protocol is based on recommended good practice guidelines to assist staff with the effective management of the elective booking processes for elective Allied Health Professionals (AHP) services, including those patients whose referral is managed virtually.
- 5.1.2 Allied Health Professionals work with people of all age groups and conditions, and are trained in assessing, diagnosing, treating and rehabilitating people with health and social care needs. They work in a range of settings including hospital, community, education, housing, independent and voluntary sectors.
- 5.1.3 The administration and management of the AHP pathway from receipt of referral to appointment within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.
- 5.1.4 For the purposes of this section of the protocol, the generic term 'clinic' will be used to reflect AHP activity undertaken in hospital, community (schools, daycare settings, leisure and community centres) or domiciliary settings (people's own home or where they live e.g. residential or nursing homes) as AHPs provide patient care in a variety of care locations.
- 5.1.5 AHP services are administered on a wide range of information systems, with varying degrees of functionality able to support full IT implementation of the requirements of the IEAP. Trusts should ensure that the administrative management of patients is undertaken in line with the principles of the IEAP and that all efforts are made to ensure patient administration systems are made fit for purpose.
- 5.1.6 There will be dedicated booking offices within Trusts to receive, register and process all AHP referrals.
- 5.1.7 Fixed appointments should only be used in exceptional circumstances.

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

5.2 KEY PRINCIPLES

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

1. urgent and
2. routine.

No other clinical priorities should be used for AHP services.

- 5.2.2 Patients of equal clinical priority will be selected for booking in strict chronological order.
- 5.2.3 Patient appointments for new and review should be **partially booked**. Where fixed appointments are being issued, Trusts should ensure that the IEAP guidance is followed in the management of patients.
- 5.2.4 The regional target for a maximum AHP waiting time is outlined in the Health and Social Care Commissioning Plan and Indicators of Performance Direction (CPD), <https://www.health-ni.gov.uk/doh-management-and-structure> (see Ministerial Priorities).
- 5.2.5 Maximum waiting times for urgent patients should be agreed locally with AHP professionals and made explicit, through internal processes, to booking office staff. Booking staff should ensure that patients are appointed within the clinical timeframe indicated by the professional and capacity issues are quickly identified and escalated.
- 5.2.6 Patients should not be disadvantaged where a decision is made to assess their clinical need through virtual activity.

- 5.2.7 Trusts should ensure that clinical templates are constantly reviewed to meet changes in demand and new clinical practice.
- 5.2.8 Data collection in respect of referrals and waiting times should be accurate, timely, complete and subject to regular audit and validation.
- 5.2.9 Trusts should **not** use manual administration systems to record and report patients who have been booked.
- 5.2.10 Trusts should provide training programmes for staff which include all aspects of this IEAP. It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts.

5.3 NEW REFERRALS

- 5.3.1 All outpatient referrals (including those sent via Clinical Communication Gateway (CCG)) sent to Trusts will be registered within **one** working day of receipt. Referrer priority status must be recorded at registration.
- 5.3.2 Trusts will work towards a system whereby the location of all referrals (paper and electronic) not yet prioritised can be identified and tracked.
- 5.3.3 All referrals must be prioritised and clinical urgency must be clearly identified. Clinicians and management will be responsible for ensuring that cover is provided for referrals to be read and prioritised during any absence.
- 5.3.4 All referrals will be prioritised (including those prioritised via E Triage) within **three** working days of date of receipt of referral.
- 5.3.5 Following prioritisation, referrals must be actioned on PAS or the relevant electronic patient administration system and appropriate correspondence (including electronic), e.g. acknowledgement or appointment letter, issued to patients within **one** working day.

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

5.4 CALCULATION OF THE WAITING TIME

- 5.4.1 The starting point for the waiting time of an AHP new referral is the date the clinician's referral or self-referral is received by the booking office or, for internal referrals, when the referral is received by the booking office/department. All referrals, including emailed and electronically delivered referrals, will have the date the referral received into the organisation recorded either by date stamp or electronically.
- 5.4.2 In cases where referrals bypass the booking office, (e.g. sent directly to an allied health professional), the Trust must have a process in place to ensure that these are date stamped on receipt, immediately forwarded to the booking office/department and registered at the date on the date stamp.
- 5.4.3 The waiting time for each patient is calculated as the time period between the receipt of the referral and the date at the end of the applicable period for the waiting list return. If the patient has been suspended at all during this time, the period(s) of suspension will be automatically subtracted from the total waiting time.
- 5.4.4 The waiting time clock stops when the first definitive AHP treatment has commenced.

5.5 REASONABLE OFFERS

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

- 5.5.2 If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused.
- 5.5.3 This does not prevent patients being offered earlier appointment dates. If the patient is offered an appointment within a shorter notice period (i.e. less than three weeks' notice) and refuses it they will not have their waiting time reset.
- 5.5.4 If the patient accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the provider.
- 5.5.5 Urgent patients must be booked within the locally agreed maximum waiting time from the date of receipt. It is recognised that there will be occasional exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Clearly defined booking protocols will be required to support specialties and booking staff.
- 5.5.6 Providers should have robust audit procedures in place to demonstrate compliance with the above.
- 5.5.7 To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

5.6 REVIEW APPOINTMENTS

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

- 5.6.2 Patients must be recorded on PAS as requiring to be seen within a clinically indicated time. Trusts should actively monitor patients on the review list to ensure that they do not go past their indicative time of treatment.
- 5.6.3 Review patients who require an appointment within **six** weeks will be asked to agree the date and time of the appointment before leaving the department and PAS updated.
- 5.6.4 Patients requiring an appointment outside **six** weeks will be placed on a review waiting list, with the agreed clinically appropriate appointment date recorded, and be booked in line with implementation guidance for review pathway patients.
- 5.6.5 Virtual review appointments, e.g. telephone or video link, should be partially booked. If the patient cannot be contacted for their virtual review they should be sent a partial booking letter to arrange an appointment.

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

5.7.1 DNAs – New AHP Appointments

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

5.7.1(a) Patients who have been partially booked will **not** be offered a second appointment and should be removed from the waiting list.

The patient and referrer (and the patients GP, where they are not the referrer) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

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

- 5.7.1(c) Patients who DNA and are not discharged but offered a second appointment will have their waiting time clock reset to the date of the DNA.
- 5.7.1(d) *Where patients are discharged from the waiting list (ref. 5.7.1(a)) they should be advised to contact the Trust booking office within **four** weeks of the original appointment date if they consider that the appointment is still required. Where a patient makes contact within the **four** week deadline, and where the Trust considers that unforeseen or exceptional circumstances meant that the patient was unable to attend, the patient should be added to the waiting list at the date that they have made contact with the Trust. If a patient makes contact after the **four** week period they cannot be reinstated.*
- 5.7.1(e) If the patient DNAs the second appointment offered then the patient should **not** be offered another opportunity to be reinstated. The patient and referrer (and the patients GP, where they are not the referrer) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.
- 5.7.1(f) Where a patient DNAs a fixed new appointment (i.e. they have not had the opportunity to agree/confirm the date and time of the appointment) they should be offered another appointment.
- 5.7.1(g) If the patient DNAs this second appointment the above steps should be followed.
- 5.7.1(h) If a patient DNA's a virtual outpatient appointment this should follow the above protocol based on whether the appointment is partially booked or fixed. The Trust should ensure that the contact details of the patient are up to date and available.

5.7.2 DNAs – Review Appointments

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

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

- 5.7.2(c) Where the clinical decision is that a second appointment should **NOT** be offered, Trusts should contact patients advising that as they have failed to attend their appointment they will be discharged from the waiting list. The referrer (and the patient's GP, where they are not the referrer) should also be informed of this.
- 5.7.2(d) Patients being discharged from the list should be advised to contact the Trust booking office if they have any queries. Where unforeseen or exceptional circumstances meant that the patient was unable to attend, and the patient makes contact within **four** weeks of the original appointment date, a clinical decision may be made to offer a second appointment. Where this is the case, the patient should be added to the waiting list at the date they make contact with the Trust.
- 5.7.2(e) If the patient DNAs the second appointment offered then the patient should **NOT** be offered another opportunity to be reinstated. The patient and referrer will be informed that, as they have failed to attend their appointment, they will be discharged from the waiting list.
- 5.7.2(f) Where a patient DNAs a fixed review appointment where they have not had the opportunity to agree/ confirm the date and time of their appointment, they should be offered another appointment. If they DNA this second fixed appointment, the above should be followed.
- 5.7.2(g) If a patient DNA's a virtual outpatient review appointment this should follow the above protocol based on whether the appointment is partially booked or fixed. The Trust should ensure that the contact details of the patient are up to date and available.

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

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

- 5.7.3(a) The patient will be given a second opportunity to book an appointment (where this is still required), which should be within **six** weeks of the original appointment date.
- 5.7.3(b) Patients who CNA will have their waiting time clock reset to the date the Trust was informed of the cancellation.

- 5.7.3(c) If a second appointment is cancelled, the patient will **not** normally be given another appointment. Where a decision is taken not to offer a further appointment, Trusts should contact patients advising that they have been discharged from the waiting list. The referring professional (and the patient's GP, where they are not the referrer) should also be informed of this.
- 5.7.3(d) However, where unforeseen or exceptional circumstances mean that the patient had to cancel a second appointment, the Trust may exercise discretion to offer a third appointment. This should include seeking a clinical review of the patient's case where this is appropriate.
- 5.7.3(e) If a patient CNA's a virtual outpatient appointment this should follow the above protocol.
- 5.7.4 Trusts have a responsibility to ensure that children and adults at risk who DNA or CNA their outpatient, inpatient, diagnostic or AHP appointment are followed up by the most appropriate healthcare professional and a clear link to the referring clinician established.
- 5.8 CNAs – SERVICE INITIATED CANCELLATIONS**
- 5.8.1 No patient should have his or her appointment cancelled. If Trusts cancel a patient's appointment, including a virtual appointment, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity.
- 5.8.2 The patient should be informed of the cancellation and a new appointment partially booked.
- 5.8.3 Trusts will make best efforts to ensure that a patient's appointment is not cancelled a second time for non-clinical reasons.
- 5.8.4 Service initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

5.9 CLINIC OUTCOME MANAGEMENT

- 5.9.1 There are a number of locations within Trusts where patients present for their AHP consultation. This protocol applies to all AHP areas. It is the responsibility of the PAS/ IT system user managing the attendance to maintain data quality.
- 5.9.2 Changes in the patient's details must be updated on PAS and the medical records on the date of clinic.
- 5.9.3 When the consultation has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic.

5.10 CLINIC TEMPLATE CHANGES

- 5.10.1 Clinic templates should be agreed between the relevant AHP professional and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement (SBAs).
- 5.10.2 Templates will identify the number of slots available for new urgent and routine and review appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated for each appointment slot.
- 5.10.3 All requests for template and temporary clinic rule changes will only be accepted in writing. A minimum of six weeks' notice will be provided for clinic template changes.
- 5.10.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager.

5.11 TRANSFERS BETWEEN TRUSTS or to INDEPENDENT SECTOR

- 5.11.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between Trusts or to independent sector (IS) providers.
- 5.11.2 Transfers to alternative providers must always be with the consent of the patient and the receiving AHP professional, (see also Reasonable Offers, ref. 5.5). Administrative speed and good communication are very important to ensure this process runs smoothly.

5.12 TECHNICAL GUIDANCE

- 5.12.1 See also Public Health Agency;
<https://www.publichealth.hscni.net/publications/ahp-services-data-definitions-guidance-june-2015> re Guidance for monitoring the Ministerial AHP 13 week access target.
- 5.12.2 See also Regional ISB Standards and Guidance
<https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Standards%20and%20Guidance.aspx> re acute activity definitions.
- 5.12.3 See also PAS technical guidance
<https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Technical%20Guidance.aspx> for recording;
- ICATS waiting times and activity (including paper triage).
 - Patients treated (IP/DC) or seen (OP) by an independent sector provider.
 - Management of waiting times of patients who transfer between NHS sites (either within NI or the rest of the UK).
 - Patients who are to be treated as part of a waiting list initiative / additional in house activity.
 - Recording Consultant Virtual Outpatient Activity (June 2020).
 - AHP Virtual Consultation Guidance (to be issued).



Department of

**Health, Social Services
and Public Safety**

An Roinn

**Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí**

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**INTEGRATED ELECTIVE ACCESS PROTOCOL
30th April 2008**

DOCUMENT CONTROL			
INTEGRATED ELECTIVE ACCESS PROTOCOL			
Authors	Michelle Irvine – Programme Director, Elective Workstream Maria Wright – Associate Director, Outpatients Rosemary Hulatt – Associate Director, Diagnostics		
Issue Date 1st Draft	Wednesday 20 th February 2008		
Comments by	Close of Play - Friday 7 th March 2008		
2nd Draft	27 th March 08		
Final Protocol Date Approved	30 th April 08		
Issue Date	Friday 9 th May 2008		
Screened By	Service Delivery Unit, DHSSPSNI		
Approved By		Signature	
Distribution	Trust Chief Executives; Directors of Planning and Performance; Directors of Acute Care; DHSSPS		
Review Date	April 2009		

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ABBREVIATIONS

AHP	Allied Health Professional
BCC	Booking and Contact Centre (ICATS)
CNA	Could Not Attend (Admission or Appointment)
DHSSPSNI	Department of Health, Social Services and Public Safety
DNA	Did Not Attend (Admission or Appointment)
DTLs	Diagnostic Targeting Lists
ERMS	Electronic Referrals Management System
GP	General Practitioner
HIC	High Impact Changes
HROs	Hospital Registration Offices
ICATS	Integrated Clinical Assessment and Treatment Services
ICU	Intensive Care Unit
LOS	Length of Stay
PAS	Patient Administration System
PTLs	Primary Targeting Lists
SDU	Service Delivery Unit
TCI	To Come In (date for patients)

SECTION 1

CONTEXT

1.1 INTRODUCTION

- 1.1.1 This protocol has been developed to encompass the elective pathway within a hospital environment. The principles can be applied to primary and community settings, however it is recommended that guidance is developed which recognises the specific needs of the care pathway provided in these settings.
- 1.1.2 The length of time a patient needs to wait for elective treatment is an important quality issue and is a visible public indicator of the efficiency of the hospital services provided by the Trust. The successful management of patients who wait for outpatient assessments, diagnostic investigations and elective inpatient or day case treatment is the responsibility of a number of key individuals within the organisation. General Practitioners, commissioners, hospital medical staff, managers and clerical staff have an important role in ensuring access for patients in line with maximum waiting time guarantees, managing waiting lists effectively, treating patients and delivering a high quality, efficient and responsive service. Ensuring prompt timely and accurate communications with patients is a core responsibility of the hospital and the wider local health community.
- 1.1.3 The purpose of this protocol is to define those roles and responsibilities, to document how data should be collected, recorded and reported, and to establish a number of good practice guidelines to assist staff with the effective management of outpatient, diagnostic and inpatient waiting lists. It will be a step-by-step guide to staff, and act as a reference work, for the successful management of patients waiting for hospital treatment.
- 1.1.4 This protocol will be updated, as a minimum, on an annual basis to ensure that Trusts' policies and procedures remain up to date, and reflect best practice locally and nationally. Trusts will ensure a flexible approach to getting patients treated, which will deliver a quick response to the changing nature of waiting lists, and their successful management.
- 1.1.5 This protocol will be available to all staff via Trusts' Intranet.

- 1.1.6 The DHSSPSNI has set out a series of challenging targets for Trusts in Northern Ireland in the field of elective treatment management. Trusts will recognise the need to move the treatment agenda forward in the context of its shared responsibility for the delivery of these goals.
- 1.1.7 There is an imperative to identify capacity constraints that could threaten the delivery of these key access targets and speed up the planning and delivery of extra capacity, where it is needed, to address these constraints. The health community will need to develop a co-ordinated approach to capacity planning taking into account local capacity on a cross Trust basis and independent sector capacity on an on-going partnership basis.
- 1.1.8 In this context, this protocol has been prepared to provide clarity of purpose within Trusts with a view to merging seamlessly with the policies of other agencies in the wider health community as they emerge.
- 1.1.9 The intention is that this protocol will be further developed to consider all aspects of access to a range of quality healthcare at a date and time of the patients' choice.
- 1.1.10 This protocol has been prepared to clarify Trusts' medium and long-term objectives, set the context in which they will be delivered and establish the parameters within which staff at divisional, specialty and departmental levels will operate.
- 1.1.11 Delivery of this protocol will require a step change in the way Trusts function. Trusts will need to transform themselves and this can only be achieved through a change in the way its staff approach their work on a day-to-day basis. Through this protocol, Trusts will aspire to work with patients and staff to raise expectations basing them not on where we are but on where we need to be.
- 1.1.12 For the purposes of this protocol, the term inpatient refers to inpatient and day case elective treatment. The term 'PAS' refers to all patient

administration systems, whether in a hospital or community setting, or an electronic or manual system.

- 1.1.13 All staff involved in the administration of waiting lists will ensure that Trusts' policies and procedures with respect to data collection and entry are strictly adhered to. This is to ensure the accuracy and reliability of data held on PAS and the waiting times for treatment. All staff involved in the implementation of this protocol, clinical and clerical, will undertake initial training and regular annual updating. Trusts will provide appropriate information to staff so they can make informed decisions when implementing and monitoring this protocol. All staff involved in the administration of waiting lists will be expected to read and sign off this protocol.

1.2 UNDERPINNING PRINCIPLES

- 1.2.1 Patients will be treated on the basis of their clinical urgency with urgent patients seen and treated first. The definition of clinical urgency will be defined specifically by specialty / procedure / service.
- 1.2.2 Patients with the same clinical need will be treated in chronological order on grounds of fairness, and to minimise the waiting time for all patients.
- 1.2.3 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to admit, i.e. if there was a bed available tomorrow in which to admit a patient - they are fit, ready, and able to come in.
- 1.2.4 Trusts should design processes to ensure that inpatient care is the exception for the majority of elective procedures, not the norm. The principle is about moving care to the most appropriate setting, based on clinical judgement. This means moving day case surgery to outpatient care, and outpatient care to primary care or alternative clinical models where appropriate.

- 1.2.5 Change No 1 within the publication “10 High Impact Changes for Service Improvement and Delivery”¹ focuses on day surgery and the document provides Trusts with tools and resources to help implement this high impact change.
- 1.2.6 Trusts will introduce booking systems aimed at making hospital appointments more convenient for patients. Booking systems are chronologically based and will move Trusts onto a system of management and monitoring that is chronologically as opposed to statistically based.
- 1.2.7 As part of a plan for the implementation of booking, Trusts must ensure their elective admission selection system is managed on a chronological basis within clinical priority with immediate effect. The intention is to provide patients with certainty and choice enabling them to access services that are sensitive to their needs.
- 1.2.8 This will require changes in working practices. It will also require technological change to information systems to enable provision of quality information to support the booking process.
- 1.2.9 There is a need to balance the flow of patients from primary care through outpatients and on to booking schedules should they need elective admission. It follows that the level of activity in the Service and Budget Agreements and the level of provision of outpatient and inpatient capacity must be linked. If one changes, all should change.
- 1.2.10 This “bottom up” approach is based on the belief that services need to be built on firm clinical foundations. Trusts need a clinical vision built up specialty by specialty and department by department through debate and agreement between clinicians across the health community as to the best way to meet patient needs locally.
- 1.2.11 It is essential that patients who are considered vulnerable for whatever reason have their needs identified at the point of referral.

¹ “10 High Impact Changes for Service Improvement and Delivery” – September 2004, NHS Modernisation Agency, www.modern.nhs.uk/highimpactchanges

- 1.2.12 All relevant information must be recorded to ensure that when selecting a vulnerable patient for admission, their needs are identified early and appropriate arrangements made. This information should be recorded in detail in the episodic comment field of PAS relating to the listing. The patient master index comment field should not be used due to confidentiality issues.
- 1.2.13 Communication with this patient group will recognise their needs and, where appropriate, involve other agencies.
- 1.2.14 An operational process should be developed by Trusts to ensure that children and vulnerable adults who DNA or CNA their outpatient appointment are followed up by the most appropriate healthcare professional and a clear link to the referring clinician established.
- 1.2.15 In implementing this protocol the needs of ethnic groups and people with special requirements should be considered at all stages of the patient's pathway.

1.3 OWNERSHIP

- 1.3.1 Ownership is key to delivering quality of care. Trusts must ensure that all staff are conversant with the Departmental targets and standards and are comfortable with the local health communities' approach to their delivery.
- 1.3.2 These targets and standards must be seen to be core to the delivery of all aspects of care provision by all levels of staff within the Trust.
- 1.3.3 This is a major change agenda requiring significant commitment and investment at corporate and individual level. An Executive Director will take lead responsibility for ensuring all aspects of this Protocol are adhered to.

- 1.3.4 Trusts must be committed to training and developing staff and providing the supporting systems to ensure that together we can bring about the improvement in patient care.

1.4 REGIONAL TARGETS

- 1.4.1 The targets in respect of elective treatments are:

- A maximum waiting time of 13 weeks for inpatient and daycase admissions by March 2009
- A maximum waiting time of 9 weeks for a 1st outpatient appointment by March 2009
- A maximum waiting time of 9 weeks for a diagnostic test by March 2009
- A maximum waiting time of 13 weeks from referral to treatment by an Allied Health Professional (AHP) by March 2009
- By March 2009, sustain the target where 98% of patients diagnosed with cancer should begin treatment within a maximum of 31 days of the diagnosis
- By March 2009, 95% of patients with suspected cancer who have been referred urgently should begin their first definitive treatment within a maximum of 62 days

1.5 DELIVERY OF TARGETS

- 1.5.1 The waiting time targets are based on the “worst case” i.e. they reflect the minimum standards with which every Trust must comply.
- 1.5.2 The expectation is that these targets are factored into plans at Trust Board, divisional, specialty and departmental levels as part of the normal business

and strategic planning processes. Divisional, specialty and departmental managers will be expected to have produced implementation plans setting out the key steps they need to take to ensure the delivery of the Trust and Departmental protocol objectives within the area(s) of their responsibility. Trusts will manage implementation through a regular review of “local” divisional, specialty and departmental plans for the implementation of waiting and booking targets.

- 1.5.3 It is expected that Trusts will develop robust information systems to support the delivery of these targets. Daily management information should be available at both managerial and operational level so that staff responsible for selecting patients are working from up to date and accurate information. Future developments should also look towards a clinic management system which will highlight the inefficiencies within the outpatient setting.

1.6 CAPACITY

- 1.6.1 It is important for Trusts to understand their baseline capacity, the make-up of the current cohort of patients waiting and the likely changes in demand that will impact on their ability to treat patients and meet the Departmental Targets.

- 1.6.2 To manage at specialty and departmental level it is anticipated that managers will have, as a minimum, an overview of their core capacity including:

- Number of clinic and theatre sessions
- Session length
- Average procedure / slot time
- Average length of stay

- 1.6.3 It is expected that similar information will be available at consultant level. For inpatients this is at procedure level, and for outpatients and diagnostics at service level.

- 1.6.4 This information will enable Trusts to evaluate its waiting/booked lists in terms of theatre sessions (time in hours) and length of stay (time in bed days).
- 1.6.5 Each specialty should understand its elective bed requirements in terms of both inpatients and daycases, setting challenging daycase and LOS targets and agreeing plans to deliver them. In addition, systems must be developed to ensure assessment can be made of available capacity and flexible working arrangements developed accordingly.
- 1.6.6 Theatre sessions should be seen as corporate resources and used flexibly to ensure the delivery of waiting list and waiting time targets across consultants within the same specialty and specialties within the same Trust. This ties in with the Real Capacity Paper which also requires commissioners to demonstrate that they have used capacity flexibly across Trusts. The expectation is that divisions and/ or specialties will be able to demonstrate that they have optimised the use of existing capacity to maximise the treatment of patients within existing resources.
- 1.6.7 Trusts will treat patients on an equitable basis across specialties and managers will work together to ensure consistent waiting times for patients of the same clinical priority.
- 1.6.8 Trusts will set out to resource enough capacity to treat the number and anticipated casemix of patients agreed with commissioners. The Real Capacity Planning exercise will support this process locally.
- 1.6.9 Divisions/specialties will monitor referrals and additions to lists in terms of their impact on clinic, theatre time, bed requirements and other key resources e.g. ICU facilities, to ensure a balance of patients in the system and a balance between patients and resources.
- 1.6.10 When the balance in the system is disturbed to the extent that capacity is a constraint, divisional/specialty managers will be expected to produce plans

to expedite solutions and agree these through the accountability review process.

- 1.6.11 It is important for all services to understand their baseline capacity, the make-up of the cohort of patients waiting to be treated and the likely changes in demand that will impact on their ability to initiate treatment and meet the maximum waiting time guarantees for patients.
- 1.6.12 Trusts should ensure that robust prospective capacity planning arrangements are in place, with clear escalation procedures to facilitate capacity gaps to be identified and solutions found in a timely manner to support operational booking processes and delivery of the targets.
- 1.6.13 In summary, the intention is to link capacity to the Service and Budget Agreement i.e. to agree the plan, put in place the resources to achieve the plan, monitor the delivery of the plan and take corrective action in the event of divergence from the plan proactively. The existing arrangements whereby patients are added to waiting lists irrespective of whether Trusts have the capacity to treat them must change.

1.7 BOOKING PRINCIPLES

- 1.7.1 These booking principles have been developed to support all areas across the elective pathway where appointment systems are used.
- 1.7.2 Offering the patient choice of date and time is essential in agreeing and booking appointments with patients. Trusts should ensure booking systems enable patients to choose and agree hospital appointments that are convenient for them. This takes away the uncertainty of not knowing how long the wait will be as patients are advised of their expected wait. Advanced booking in this way also gives patients notice of the date so that they can make any necessary arrangements, such as child care or work arrangements.

- 1.7.3 Facilitating reasonable offers to patients should be seen within the context of robust booking systems being in place.
- 1.7.4 Booking development work within Trusts should be consistent with regional and local targets, which provide a framework for progress towards ensuring successful and consistent booking processes across the health community in Northern Ireland.
- 1.7.5 All booking processes should be underpinned with the relevant local policies and procedures to provide clarity to operational staff of the day to day requirements and escalation route, for example: management of patients who cancel / DNA their appointment, process for re-booking patients, and monitoring of clinical leave and absence.
- 1.7.6 Trusts should ensure booking processes are continually reviewed and updated as required to reflect local and regional requirements at an operational level.
- 1.7.7 The definition of a booked appointment is:
- a) The patient is given the choice of when to attend.
 - b) The patient is advised of the total waiting time during the consultation between themselves and the healthcare provider / practitioner or in correspondence from them.
 - c) The patient is able to choose and confirm their appointment within the timeframe relevant to the clinical urgency of their appointment
 - d) The range of dates available to a patient may reduce if they need to be seen quickly, e.g. urgent referrals or within 2 weeks if cancer is suspected.
 - e) The patient may choose to agree a date outside the range of dates offered or defer their decision until later

1.7.8 Booking Process

1.7.9 There are 3 main patient appointment types to be booked. Booking systems for these appointments should be designed around an agreed patient pathway and accepted clinical practice. They are:

- a) New Urgent patients (including suspected cancer)
- b) New Routine patients
- c) Review patients

1.7.10 Clinic templates should be constructed to ensure that sufficient capacity is carved out to meet the local and maximum waiting time guarantees for new patients, and the clinical requirements of follow-up patients.

1.7.11 Principles for booking Cancer Pathway patients

- a) All suspected cancer referrals should be booked in line with the agreed clinical pathway requirement for the patient and a maximum of 14 days from the receipt of referral
- b) Dedicated registration functions for red flag and suspected cancer referrals should be in place within centralised HROs
- c) Clinical teams must ensure triage is undertaken daily, irrespective of leave, in order to initiate booking patients
- d) Patients will be contacted by telephone twice (morning and afternoon)
- e) If telephone contact cannot be made, a fixed appointment will be issued to the patient within a maximum of 3 days of receipt of referral
- f) Systems should be established to ensure the Patient Tracker / MDT Co-ordinator is notified of the suspected cancer patient referral, to allow them to commence prospective tracking of the patient

1.7.12 Principles for booking Urgent Pathway patients

- a) Local agreements should be in place with consultants to determine the timeframe within which urgent patients should be booked, and made explicit to booking teams

- b) Referrals will be received, registered within one working day and forwarded to consultants for prioritisation
- c) If clinical priority is not received from consultants within 72 hours, processes should be in place to initiate booking of urgent patients according to the GP's classification of urgency
- d) Patients will be issued with a letter inviting them to contact the Trust to agree and confirm their appointment in line with the urgent booking process.
- e) In exceptional cases, some patients will require to be appointed to the next available slot. A robust process for telephone booking these patients should be developed which should be clearly auditable.

1.7.13 Principles for booking Routine Pathway patients

- a) Patients should be booked to ensure appointment within the maximum waiting time guarantees for routine appointments
- b) Referrals will be received, registered within one working day at HRO's and forwarded to consultants for prioritisation
- c) Patients will receive an acknowledgement from the Trust indicating their expected length of wait and information on the booking process they will follow
- d) Approximately eight weeks prior to appointment, Trusts should calculate prospective slot capacity and immediately implement escalation policy where capacity gaps are identified
- e) Patients should be selected for booking in chronological order from the PTL
- f) Six weeks prior to appointment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment

1.7.14 Principles for Booking Review Patients

- a) Patients who need to be reviewed within 6 weeks will agree their appointment before they leave the clinic

- b) Patients who require a review appointment more than 6 weeks in advance will be added to and managed on a review waiting list
- c) Patients will be added to the review waiting list with an indicative date of treatment and selected for booking according to this date
- d) Six weeks prior to the indicative date of treatment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment within a clinically agreed window either side of the indicative date of treatment

1.7.15 It is recognised that some groups of patients may require booking processes that have additional steps in the pathway. These should be designed around the principles outlined to ensure choice and certainty as well as reflecting the individual requirements necessary to support their particular patient journey. Examples of this include:

- a) midwives contacting patients directly by telephone to arrange their appointment
- b) clinical genetics services where family appointments are required
- c) mental health or vulnerable children's services where patients may need additional reminders or more than one professional contacted if patients fail to make an appointment.

SECTION 2

GUIDANCE FOR MANAGEMENT OF ICATS SERVICES

2.1 INTRODUCTION

- 2.1.1 The administration and management of ICATS referrals and ICATS requests for diagnostics must be consistent, easily understood, patient focused, and responsive to clinical decision-making.
- 2.1.2 ICATS services are managed in accordance with the Data Definitions and Guidance Document for Monitoring of ICATS Services Sept 2007 (**Appendix 1**).
- 2.1.3 The level of functionality available on the Electronic Referral Management System to support the administration of patients in an ICATS setting is developmental. Achievement of the standards outlined will be where functionality permits.
- 2.1.4 Referrals will be managed through a centralised registration process in the nominated Hospital Registration Offices (HRO's) within Trusts to receive, register and process all ICATS referrals. The Trust should ensure that a robust process is in place to ensure that referrals received outside the HRO are date stamped, forwarded to the HRO and registered onto ERMS according to the date received by the Trust.
- 2.1.5 All new patients should be able to book their appointment in line with the guidance outlined in Booking Principles Section 1.7 The expectation is that follow up patients should also be offered an opportunity to choose the date and time of their appointment.

2.2 KEY PRINCIPLES

- 2.2.1 Where ICATS is in place for a specialty, all referrals should be registered and scanned onto Electronic Referral Management System (ERMS) within 24 hours of receipt.
- 2.2.2 Each ICATS must have a triage rota to ensure that every referral is triaged and the appropriate next step is confirmed, according to the clinically agreed

rules, within three working days of receipt in any Hospital Registration Office (HRO). Triage rotas must take multi-site working into account. A designated officer in ICATS should oversee the triage arrangements.

- 2.2.3 The outcome of the triage will be confirmed by letters to the GP and patient within a further two working days of triage (five working days in total from receipt).
- 2.2.4 ICATS clinical staff will be aware of all exclusions that prevent patients from being assessed or treated within the ICATS setting.
- 2.2.5 Patients of equal clinical priority will be selected for booking in chronological order in order to meet the maximum waiting time guarantee for patients and local access standards.
- 2.2.6 All patients deemed appropriate will be offered an ICATS appointment within six weeks from the triage date.
- 2.2.7 Data collection should be accurate, timely, complete and subject to regular audit and validation.
- 2.2.8 Staff should be supported by appropriate training programmes.

2.3 CALCULATION OF THE WAITING TIME

- 2.3.1 The waiting time clock for ICATS starts after the triage decision has been taken that an appointment in ICATS clinic is the appropriate next step.
- 2.3.2 The ICATS clock stops when the patient attends for first appointment or when the patient has been discharged from ICATS.
- 2.3.3 Patients who cancel an appointment will have their waiting time clock reset to the date the hospital was informed of the cancellation. Patients who refuse a reasonable offer of an appointment will also have their waiting time clock reset to the date the reasonable offer was refused. To ensure the

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

- 2.3.4 Patients who fail to attend their appointment without giving prior notice (DNA) will have their waiting time clock reset to the date of the DNA.
- 2.3.4 No patient should have his or her appointment cancelled. If the ICATS service cancels a patient's appointment, the patient's waiting time clock will not be reset and the patient should be offered another appointment, ideally at the time of the cancellation, and which is within six weeks of the original appointment date.

2.4 NEW REFERRALS

- 2.4.1 All ICATS referrals will be registered and scanned onto ERMS within 24 hours of receipt. All referrals forwarded for ICATS triage must be triaged or assessed to make a clear decision on the next step of a referral within three working days of the referral being logged by the HRO onto ERMS.
- 2.4.2 Within five working days of the referral being recorded onto ERMS, the GP and patient must be issued with written confirmation of the next stage of the patient's treatment.
- 2.4.3 Where there is insufficient information for the professional to make a decision, they have the option to either return the referral to the referrer requesting the necessary information or contact the referrer in the first instance to access the necessary information. If this cannot be gained, the referral should be returned to the referrer requesting the necessary information and a new referral may be initiated.
- 2.4.4 Those patients identified for outpatients and diagnostic services following triage will be managed in line with the relevant sections of this IEAP.

Flowcharts illustrating the Triage Outcomes Process can be found in **Appendix 2.**

2.5 BOOKING

- 2.5.1 All patients requiring an appointment in an ICATS will have the opportunity to agree the date and time of their appointment, in line with the booking principles outlined in Section 1.7.
- 2.5.2 If a patient requests an appointment beyond the six week ICATS standard the patient will be discharged and told to revisit their GP when they are ready to be seen at the ICATS clinic. This will ensure that all patients waiting for an ICATS appointment are fit and ready to be seen. It is accepted that local discretion may be required where short periods of time are involved, for example, if patients are requesting dates up to a week over their breach date. Trusts should ensure that reasonableness is complied with to facilitate recalculation of the patient's waiting time and to facilitate booking the patient into the date they requested.
- 2.5.3 Trusts must ensure that all communication to patients is clear, easily understood and complies with all relevant legislation.

2.6 REASONABLE OFFERS

- 2.6.1 All patients must be offered reasonable notice. A reasonable offer is defined as an offer of appointment, irrespective of provider, that gives the patient a minimum of three weeks' notice and two appointments. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date of the second appointment date declined.
- 2.6.2 If the patient is offered an appointment within a shorter notice period and it is refused, the waiting time cannot be recalculated.

2.6.3 If the patient however accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date the service was notified of the cancellation, as the patient has entered into an agreement with the Trust.

2.6.4 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above. The Implementation Procedure on Reasonableness can be found in **Appendix 3**.

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

2.7.1 If a patient DNAs their first ICATS appointment the following process must be implemented.

- Where a patient has had an opportunity to agree the date and time of their appointment, they will not normally be offered a second appointment. These patients will be referred back to the care of their referring clinician.
- Under exceptional circumstances a clinician may decide that a patient should be offered a second appointment. The second appointment must be booked.

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

- The patient will be given a second opportunity to book an appointment, which should be within six weeks of the original appointment date.
- If a second appointment is cancelled, the patient will not normally be offered a third opportunity and will be referred back to their referring clinician.

- 2.7.3 If a patient has been referred back to their referring clinician and the referrer still wishes a patient to be seen in ICATS, a new referral is required.
- 2.7.4 The Implementation Procedure for the Management of Patients who DNA or Cancel can be found in **Appendix 4**.

2.8 MAXIMUM WAITING TIME GUARANTEE

- 2.8.1 If a patient requests an appointment date that is beyond the maximum waiting time guarantee, the patient will be discharged and advised to revisit their GP when they are ready to be seen. This will ensure that all patients waiting for an appointment are fit and ready to be seen. It is accepted that local discretion may be required where short periods of time are involved, for example, if patients are requesting dates up to a week over their breach date. Trusts should ensure that reasonableness is complied to facilitate re-calculation of the patient's waiting time, and to facilitate booking the patient into the date they requested.

2.9 COMPLIANCE WITH TRUST LEAVE PROTOCOL

- 2.9.1 It is essential that leave/absence of ICATS practitioners is organised in line with Trusts' notification of leave protocol. It is also necessary for Trusts to have robust policies and procedures that minimise the cancellation/reduction of ICATS clinics.
- 2.9.2 The protocol should require a minimum of six weeks' notification of intended leave. A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

2.10 CLINIC OUTCOME MANAGEMENT

- 2.10.1 There are a number of locations within Trusts where patients present for their ICATS consultation. This protocol applies to all ICATS locations. It is the responsibility of the ERMS user managing the attendance to maintain data quality.
- 2.10.2 Changes in the patient's details must be updated on ERMS and the medical records on the date of clinic.
- 2.10.3 When the assessment has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on ERMS.

2.11 REVIEW APPOINTMENTS

- 2.11.1 All review appointments must be made within the time frame specified by the ICATS practitioner. If a review appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the ICATS practitioner.
- 2.11.2 As previously stated, the Booking Centres will be responsible for partially booking all new appointments. Booking Centres will also book review appointments that are required to be more than 6 weeks in the future. ICATS administration staff will make bookings directly with the patient at the clinic for any further appointments needing to occur within 6 weeks.

2.12 TEMPLATE CHANGES

- 2.12.1 Templates should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement.

- 2.12.2 Templates will identify the number of slots available for new and follow up appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated to each appointment slot.
- 2.12.3 All requests for template and temporary clinic rule changes will only be accepted in writing. A minimum of six weeks notice will be provided for clinic template changes.
- 2.12.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager. The Implementation Procedure for management of Clinic Template Changes can be found in **Appendix 5**.

2.13 VALIDATION

- 2.13.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. Trusts should ensure that all relevant data fields are completed in ERMS. This should be undertaken as a minimum on a monthly basis and ideally on a weekly basis as waiting times reduce.
- 2.13.2 The data validation process will apply to both new and follow up appointments. The Implementation Procedure for data validation can be found in **Appendix 6**.

SECTION 3

GUIDANCE FOR MANAGEMENT OF OUTPATIENT SERVICES

3.1 INTRODUCTION

- 3.1.1 The following protocol is based on nationally recommended good practice guidelines to assist staff with the effective management of outpatient services.
- 3.1.2 The administration and management of the outpatient pathway from receipt of referral to appointment within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.
- 3.1.3 There will be dedicated Hospital Registration Offices (HROs) within Trusts to receive, register and process all outpatient referrals. The HROs will be required to register and scan referrals (where appropriate) onto the Electronic Referrals Management System (ERMS) and PAS.
- 3.1.4 There will be dedicated booking functions within Trusts and all new and review outpatients should have the opportunity to book their appointment. The booking process for non-routine groups of outpatients or those with additional service needs should be designed to identify and incorporate the specific pathway requirements of these patients.

3.2 CALCULATION OF THE WAITING TIME

- 3.2.1 The starting point for the waiting time of an outpatient new referral is the date the clinician's referral letter is received by Trusts. All referral letters, including faxed, emailed and electronically delivered referrals, will be date stamped on the date received into the organisation.
- 3.2.2 In cases where referrals bypass the dedicated HRO's, (e.g. sent directly to a consultant), the Trust must have a process in place to ensure that these are date stamped on receipt, immediately forwarded to the HRO and registered at the date on the date stamp.
- 3.2.2 Patients who cancel an appointment will have their waiting time clock reset to the date the hospital was informed of the cancellation. Patients who

refuse a reasonable offer of an appointment will also have their waiting time clock reset to the date the reasonable offer was refused. To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

- 3.2.3 Patients who fail to attend their appointment without giving prior notice (DNA) will have their waiting time clock reset to the date of the DNA.

3.3 KEY PRINCIPLES

- 3.3.1 Referrals into Trusts should be pooled where possible within specialties. Referrals to a specific consultant by a GP should only be accepted where there are specific clinical requirements or stated patient preference. As a minimum, all un-named referrals should be pooled.
- 3.3.2 All referrals, appointments and waiting lists should be managed according to clinical priorities. Priorities must be identified for each patient on the waiting list, allocated according to urgency of the treatment. Trusts will manage patients in 2 streams, i.e. urgent and routine. Templates should be constructed to ensure enough capacity is available to treat each stream within agreed maximum waiting time guarantees. The Implementation Procedure for Template Redesign can be found in **Appendix 7**.
- 3.3.3 The regional target for a maximum OP waiting time is outlined in Section 1.4. Maximum waiting times for urgent patients should be agreed locally with clinicians.
- 3.3.4 Maximum waiting times for urgent patients should be agreed locally with clinicians, and made explicit to staff booking these patients to ensure that they are appointed within the clinical timeframe indicated by the consultant and capacity issues quickly identified and escalated.

- 3.3.5 Patients of equal clinical priority will be selected for booking in strict chronological order. Trusts must ensure that Department waiting and booking targets and standards are met.
- 3.3.6 Data collection should be accurate, timely, complete and subject to regular audit and validation.
- 3.3.7 Trusts should provide training programmes for staff which include all aspects of this IEAP and its Implementation Procedures. It is expected that training will be cascaded at and by each clinical, managerial or administrative tier within Trusts, providing the opportunity where required, for staff to work through operational scenarios.
- 3.3.8 Trusts will work towards providing a single point of contact for all patients with respect to outpatient appointment services. It is recognised that there may be services which require alternative processes.

3.4 NEW REFERRALS

- 3.4.1 All outpatient referrals sent to Trusts will be received at the dedicated HRO's and registered within one working day of receipt. GP priority status must be recorded at registration.
- 3.4.2 Trusts will work towards a system whereby the location of all letters can be tracked at all times through the referral and appointment system, and that letters sent to be prioritised and which are not returned can be identified.
- 3.4.3 All referrals must be prioritised and clinical urgency must be clearly identified. Clinicians will be responsible for ensuring that cover is provided for referrals to be read and prioritised during their absence. A designated officer should oversee this and a protocol will be required for each department.
- 3.4.5 All outpatient referrals letters will be prioritised and returned to the HRO within 3 working days. It will be the responsibility of the health records

manager or departmental manager to monitor this performance indicator. Monitoring will take place by consultant on a monthly basis. Following prioritisation, referrals must be actioned on PAS and appropriate correspondence issued to patients within 1 working day.

- 3.4.6 Where clinics take place, or referrals can be reviewed less frequently than weekly, a process must be put in place and agreed with clinicians whereby GP prioritisation is accepted in order to proceed with booking urgent patients.
- 3.4.7 Inappropriate and inadequate referrals should be returned to the referral source. A minimum referral criteria dataset has been agreed and is outlined in **Appendix 8**
- 3.4.8 An Effective Use of Resources Policy is in place for some services and Trusts should ensure that this is adhered to. The policy is included for reference in **Appendix 9**.

3.5 URGENT AND ROUTINE APPOINTMENTS

- 3.5.1 All consultant led outpatient appointments where the patient attends the Trust should be booked. The key requirements are that the patient is directly involved in negotiating the appointment date and time, and that no appointment is made more than six weeks into the future.
- 3.5.2 All routine patients must be booked within the maximum waiting time guarantee. Urgent patients must be booked within the maximum wait agreed locally with clinicians, from the date of receipt. It is recognised that there will be occasional exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Trusts should ensure that when accommodating these patients, the appointment process is robust and clinical governance requirements met.
- 3.5.3 Acknowledgment letters will be sent to routine patients within five days of receipt of the referral. The estimated length of wait, along with information on

how the patient will be booked, should be included on the acknowledgement letter.

3.5.4 A minimum of three weeks' notice should be provided for all routine patients. This does not prevent patients being offered earlier appointment dates. Patients refusing short notice appointments (i.e. less than three weeks' notice) will not have their waiting time reset, in line with guidance on reasonable offers.

3.5.5 Trusts must ensure that all communication to patients is clear, easily understood and complies with all relevant legislation.

3.6 BOOKING

3.6.1 All new and review consultant led outpatient clinics should be able to book their appointment. This will entail patients having an opportunity to contact the hospital and agree a convenient date and time for their appointment. The use of the Patient Choice field on PAS is mandatory. The only fields that should be used are 'Y' to indicate that the appointment has been booked or 'N' to indicate that an appointment has not been booked. No other available field should be used as compliance with booking requirements will be monitored via the use of the Patient Choice field. For non-ISOFT and manual administration systems, Trusts should ensure that they are able to record and report patients who have been booked.

3.7 REASONABLE OFFERS

3.7.1 For patients who have been able to book their appointment, a reasonable offer is defined as an offer of appointment, irrespective of provider, that gives the patient a minimum of three weeks' notice and two appointments. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused.

3.7.2 If the patient is offered an appointment within a shorter notice period and it is refused, the waiting time cannot be recalculated.

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

3.7.4 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above. The Implementation Procedure on Reasonableness can be found in **Appendix 3**.

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

3.8.1 If a patient DNAs their outpatient appointment, the following process must be implemented.

- Where a patient has had an opportunity to agree the date and time of their appointment, they will not normally be offered a second appointment. These patients will be referred back to the care of their referring clinician.
- Under exceptional circumstances a clinician may decide that a patient should be offered a second appointment. The second appointment must be booked.

3.8.2 There may be instances for review patients where the clinician may wish to review notes prior to any action to remove a patient because of DNA or failure to respond to partial booking invitation letters. Trusts should ensure that robust and locally agreed rules and processes are in place so that booking clerks are clear about how to administer these patients.

3.8.3 In a transition period where fixed appointments are still being issued, patients should have two opportunities to attend.

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

- The patient will be given a second opportunity to book an appointment, which should be within six weeks of the original appointment date.
- If a second appointment is cancelled, the patient will not normally be offered a third opportunity and will be referred back to their referring clinician.

3.8.5 Following discharge, patients will be added to the waiting list at the written request of the referring GP and within a four week period from the date of discharge. Patients should be added to the waiting list at the date the written request is received.

3.8.6 The Implementation Procedure on DNAs and Cancellations can be found in **Appendix 4.**

3.9 MAXIMUM WAITING TIME GUARANTEE

3.9.1 If a patient requests an appointment date that is beyond the maximum waiting time guarantee, the patient will be discharged and advised to revisit their GP when they are ready to be seen in the Outpatient Clinic. This will ensure that all patients waiting for an outpatient appointment are fit and ready to be seen. It is accepted that local discretion may be required where short periods of time are involved, for example, if patients are requesting dates up to a week over their breach date. Trusts should ensure that reasonableness is complied to facilitate re-calculation of the patient's waiting time, and to facilitate booking the patient into the date they requested.

3.10 COMPLIANCE WITH LEAVE PROTOCOL

3.10.1 Capacity lost due to cancelled or reduced clinics at short notice has negative consequences for patients and on the Trust's ability to successfully

implement booking processes. Clinic cancellation and rebooking of appointments is an extremely inefficient way to use such valuable resources.

- 3.10.2 It is essential that planned medical and other clinical leave or absence is organised in line with an agreed Trust Human Resources (HR) protocol. Thus it is necessary for Trusts to have robust local HR policies and procedures in place that minimise the cancellation/reduction of outpatient clinics and the work associated with the rebooking of appointments. There should be clear medical and clinical agreement and commitment to this HR policy. Where cancelling and rebooking is unavoidable the procedures used must be equitable, efficient, comply with clinical governance principles and ensure that maximum waiting times for patients are not compromised.
- 3.10.3 The protocol should require a minimum of six weeks' notification of intended leave, in line with locally agreed HR policies.
- 3.10.4 A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit. The Implementation Procedure for Compliance with Leave Protocol can be found in **Appendix 10**.

3.11 CLINIC OUTCOME MANAGEMENT

- 3.11.1 There are a number of locations within Trusts where patients present for their outpatient consultation. This protocol applies to all outpatient areas. It is the responsibility of the PAS user managing the attendance to maintain data quality.
- 3.11.2 All patients will have their attendance registered on PAS upon arrival in the clinic. The patient must verify their demographic details on every visit. The verified information must be cross-checked on PAS and the medical records.
- 3.11.3 Changes in the patient's details must be updated on PAS and the medical records on the date of clinic.

- 3.11.4 When the consultation has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic. The implementation procedure for the Management of Clinic Outcomes can be found in **Appendix 11**.

3.12 REVIEW APPOINTMENTS

- 3.12.1 All review appointments must be made within the time frame specified by the clinician. If a review appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the consultant. Trusts should actively monitor patients on the review list to ensure that they do not go past their indicative month of treatment and take the necessary action to ensure capacity is available for this cohort.
- 3.12.2 Review patients who require an appointment within six weeks will negotiate the date and time of the appointment before leaving the department and PAS updated. Patients requiring an appointment outside six weeks will be placed on a review waiting list, with the indicative appointment date recorded, and be booked in line with implementation guidance for review pathway patients.

3.13 CLINIC TEMPLATE CHANGES

- 3.13.1 Clinic templates should be agreed between the consultant and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement and ensure that there is sufficient capacity allocated to enable each appointment type to be booked in line with clinical requirements and maximum waiting time guarantees for patients.

- 3.13.2 Templates will identify the number of slots available for new urgent, new routine and follow up appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated for each appointment slot.
- 3.13.3 All requests for template and temporary clinic rule changes will only be accepted in writing. A minimum of six weeks notice will be provided for clinic template changes.
- 3.13.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager. The Implementation Procedure for the management of Clinic Template Changes can be found in **Appendix 5**.

3.14 VALIDATION

- 3.14.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a weekly basis and continually reviewed as waiting times reduce. This is essential to ensure PTLs are accurate and robust at all times. The Implementation Guidance for Data Validation can be found in **Appendix 6**.
- 3.14.2 As booking processes are implemented and waiting times reduce, there is no longer the need to validate patients by letter.
- 3.14.3 For patients in specialties that are not yet booked, they will be contacted to establish whether they will still require their appointment.

3.15 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

- 3.15.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between hospitals or to Independent Sector Providers. Transfers should not be a feature of an effective scheduled system.

3.15.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant. Administrative speed and good communication are very important to ensure this process runs smoothly. The Implementation Procedure and Technical Guidance for Handling Outpatient Transfers can be found in **Appendix 15a**.

SECTION 4

PROTOCOL GUIDANCE FOR MANAGEMENT OF DIAGNOSTIC SERVICES

4.1 INTRODUCTION

- 4.1.1 The following protocol is based on nationally recommended good practice guidelines to assist staff with the effective management of diagnostic waiting lists. Where possible, the principles of good practice outlined in the Outpatient and Elective Admissions Section of this document should be adopted in order to ensure consistent standards and processes for patients as they move along the pathway of investigations, assessment and treatment. This section aims to recognise areas where differences may be encountered due to the nature of specific diagnostic services.
- 4.1.2 The administration and management of requests for diagnostics, waiting lists and appointments within and across Trust should be consistent, easily understood, patient focused and responsive to clinical decision making.
- 4.1.3 There will be a centralised registration process within Trusts to receive, register and process all diagnostic referrals. It is expected that this will be in a single location, where possible.
- 4.1.4 The Trust should work towards introducing choice of the date and time of tests to all patients. The Booking Principles outlined in Section 1 of this document should be considered in the development of this strategy.

4.2 CALCULATION OF THE WAITING TIME

- 4.2.1 The starting point for the waiting time of a request for a diagnostic test is the date the clinician's request is received into the department, in line with the guidance on Completing Diagnostic Waiting Times Collection (Definitions Document), September 2007. This can be found in **Appendix 14**. All referral letters and requests, including faxed, emailed and electronically delivered referrals, will be date stamped on the date received.
- 4.2.2 Patients who cancel an appointment will have their waiting time clock reset to the date the service was informed of the cancellation.

4.2.3 Patients who refuse a reasonable offer of an appointment will also have their waiting time clock reset to the date the reasonable offer was refused. To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

4.2.4 Patients who fail to attend their appointment without giving prior notice (DNA) will have their waiting time clock reset to the date of the DNA.

4.3 KEY PRINCIPLES

4.3.1 Trusts must have in place arrangements for pooling all referrals unless there is specific clinical information which determines that the patient should be seen by a particular consultant with sub-specialty interest.

4.3.2 All diagnostic requests, appointments and waiting lists should be managed according to clinical priority. A clinical priority must be identified for each patient on a waiting list, and patients managed in 2 streams, i.e. urgent and routine. Session or clinic templates should be constructed to ensure enough capacity is available to treat each stream within the maximum waiting time guarantees outlined in Section 1.4. Maximum waiting times for urgent patients should be agreed locally with clinicians.

4.3.3 Data collection should be accurate, timely, complete and subject to regular audit and validation.

4.3.4 Staff should be supported by appropriate training programmes.

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

4.4 NEW DIAGNOSTIC REQUESTS

- 4.4.1 All diagnostic requests sent to Trusts will be received at a single location within the specialty Department. Trusts should explore the setting of one centralised diagnostic registration centre.
- 4.4.2 All requests will be registered on PAS / relevant IT system within one working day of receipt. Only authorised staff will have the ability to add, change or remove information in the outpatient module of PAS or other diagnostic system.
- 4.4.3 Trusts will work towards a system whereby the location of all letters can be tracked at all times through the referral and appointment system and that letters sent for prioritisation and not returned can be identified. Trusts should consider the introduction of clinical tracking systems similar to that used in patient chart tracking.
- 4.4.4 All requests must be prioritised and clinical urgency must be clearly identified. Clinicians will be responsible for ensuring that cover is provided for requests to be read and prioritised during their absence. A designated officer should oversee this and a protocol will be required for each department.
- 4.4.5 All requests will be prioritised and returned to the central registration point within 3 working days. It will be the responsibility of the health records manager or departmental manager to monitor this performance indicator. Monitoring on a consultant level will take place by consultant on a monthly basis. Following prioritisation, requests must be actioned on PAS / IT system and appropriate correspondence issued to patients within 1 working day.
- 4.4.6 Where clinics take place, or requests can be reviewed less frequently than weekly, a process must be put in place and agreed with clinicians whereby the GP's priority is accepted in order to proceed with booking urgent patients.

- 4.4.7 Inappropriate and inadequate requests should be returned to the referral source. Minimum referral criteria is being developed to ensure the referral process is robust.

4.5 URGENT AND ROUTINE APPOINTMENTS

- 4.5.1 All requests must be booked within the maximum waiting time guarantee. The key requirement is that the patient is directly involved in negotiating the date and time of the appointment and that no appointment is made more than six weeks in advance.
- 4.5.2 Urgent requests must be booked within locally agreed maximum waits from the date of receipt. It is recognised that there will be exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Trusts should ensure that when accommodating these patients, the appointment process is robust and clinical governance requirements met.
- 4.5.3 All routine patients must be booked within the maximum waiting time guarantee. Acknowledgement letters will be issued to routine patients within 5 working days of receipt of request. The estimated wait, along with information on how the patients will be booked should be included on the acknowledgement letter.
- 4.5.4 A minimum of three weeks notice should be provided for all routine patients. This does not prevent patients being offered earlier appointment dates. Patients who refuse short notice appointments (i.e. less than three weeks notice) will not have their waiting time reset in line with guidance on reasonable offers.
- 4.5.5 Trusts must ensure that all communication to patients is clear, easily understood and complies with all relevant legislation.

4.6 CHRONOLOGICAL MANAGEMENT

- 4.6.1 Patients of equal clinical priority will be selected for appointment in chronological order and Trusts must ensure that regional standards and targets in relation to waiting times and booking requirements are met. The process of selecting patients for diagnostic investigations is a complex activity. It entails balancing the needs and priorities of the patient and the Trust against the available resources.
- 4.6.2 It is expected that Trusts will use two prioritisation categories; urgent and routine.

4.7 BOOKING METHODS

- 4.7.1 Booking will enable patients to have an opportunity to contact the service and agree a convenient time for their appointment. As outlined in paragraph 4.1.4, booking strategies should be developed in line with these Booking Principles. In the interim period, while fixed appointments are being issued, Trusts should ensure that the regional guidance is followed in the management of patients.

4.8 REASONABLE OFFERS

- 4.8.1 For patients who have been able to book their appointment, a reasonable offer is defined as an offer of appointment, irrespective of provider, that gives the patient a minimum of three weeks' notice and two appointments. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused. To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

- 4.8.2 If the patient is offered an appointment within a shorter notice period and it is refused, the waiting time cannot be recalculated.
- 4.8.3 If the patient however accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the Trust.
- 4.8.4 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above. The Implementation Procedure on Reasonableness can be found in **Appendix 3**.

4.9 PATIENT CANCELLATIONS (CNAS) AND DID NOT ATTENDS (DNAS)

- 4.9.1 If a patient DNAs their diagnostic test, the following process must be implemented.
- Where a patient has had an opportunity to agree the date and time of their appointment, they will not normally be offered a second appointment. These patients will be referred back to the care of their referring clinician.
 - Under exceptional circumstances a clinician may decide that a patient should be offered a second appointment. The second appointment must be booked.
- 4.9.2 There may be instances for follow-up patients where the clinician may wish to review notes prior to any action to remove a patient because of DNA or failure to respond to booking invitation letters. Trusts should ensure that robust and locally agreed rules and processes are in place so that booking clerks are clear about how to administer these patients.
- 4.9.3 In a transition period where fixed appointments are still being issued, patients should have two opportunities to attend.

4.9.4 If a patient cancels their appointment, the following process must be implemented.

- The patient will be given a second opportunity to book an appointment, which should be within six weeks of the original appointment date.
- If a second appointment is cancelled, the patient will not normally be offered a third opportunity and will be referred back to their referring clinician.

4.9.5 Following discharge, patients will be added to the waiting list at the written request of the referring GP and within a four week period from the date of discharge. Patients should be added to the waiting list at the date the written request is received.

4.10 TRANSFERS BETWEEN HOSPITALS

4.10.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between hospitals. Transfers should not be a feature of an effective scheduled system.

4.10.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant. Administrative speed and good communication are very important to ensure this process runs smoothly.

4.11 COMPLIANCE WITH TRUST LEAVE PROTOCOL

4.11.1 One of the major issues regarding the operation of healthcare services is the capacity lost due to cancelled or reduced clinics at short notice. This has negative consequences for patients and on the ability to successfully implement booking requirements. Clinic or session cancellation and rebooking of appointments is an extremely inefficient way to use such valuable resources.

- 4.11.2 It is therefore essential that leave/absence is organised in line with the Trust's Human Resources leave protocol. It is necessary for Trusts to have robust policies and procedures that minimise the cancellation/reduction of diagnostic sessions and the work associated with the rebooking of appointments. Where cancelling and rebooking is unavoidable the procedures used must be equitable and comply with clinical governance principles.
- 4.11.3 The local absence/leave protocol should require a minimum of six weeks' notification of intended leave, in line with locally agreed policies.
- 4.11.4 A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

4.12 SESSION OUTCOME MANAGEMENT

- 4.12.1 There are a number of locations within Trusts where patients present for their diagnostic tests. This protocol applies to all diagnostic services. It is the responsibility of the PAS / relevant system user administrating the clinic to maintain data quality.
- 4.12.2 All patients will have their attendance registered on PAS / IT system upon arrival at the clinic. The patient must verify their demographic details on every visit. The verified information must be cross-checked on PAS / IT system and the medical record.
- 4.12.3 Changes in the patient's details must be updated on PAS / IT system and the medical record on the date of clinic.
- 4.12.4 When the test has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic.

4.13.1 DIAGNOSTIC TEST OUTCOME

- 4.13.1 The outcome of the diagnostic test must be available to the referrer without undue delay. A standard for the reporting turnaround time of tests will be introduced during 2008 and Trusts will be expected to monitor and report compliance to the standard.

4.14 FOLLOW UP APPOINTMENTS

- 4.14.1 All follow up appointments must be made within the time frame specified by the clinician. If a follow up appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the clinician.
- 4.14.2 Where follow up appointments are not booked, patients who require a review within six weeks will negotiate the date and time of this appointment before leaving the department and PAS / IT system updated. Patients requiring an appointment outside six weeks will have their appointment managed through a 'hold and treat' system. They will be managed on a review waiting list, with an indicative date of treatment and sent a letter confirming their appointment date six weeks in advance.

4.15 TEMPLATE CHANGES

- 4.15.1 Session templates should be agreed with the healthcare professional and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement.
- 4.15.2 Templates will identify the number of slots available for new urgent, new routine, planned and follow up appointments; specify the time each session is scheduled to start and finish; and identify the length of time allocated for each appointment slot.

4.15.3 All requests for template and temporary session rule changes will only be accepted in writing. A minimum of six weeks notice will be provided for session template changes.

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

4.16 VALIDATION

4.16.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a monthly basis and ideally on a weekly basis as waiting times reduce. This is essential to ensure PTLs are accurate and robust at all times.

4.16.2 As booking processes are implemented and waiting times reduce, there is no longer the need to validate patients by letter.

4.16.3 For patients in specialties which still issue fixed appointments, they will be contacted to establish whether they require their appointment.

4.16.4 Until follow-up and planned appointments are booked, the validation process will apply to follow up appointments.

4.17 PLANNED PATIENTS AND DIAGNOSTICS TESTS CLASSIFIED AS DAY CASES

4.17.1 Trusts should ensure that the relevant standards in the Elective Admissions section of this document are adhered to.

4.18 PLANNED PATIENTS

- 4.18.1 Planned patients are those who are waiting to be recalled to hospital for a further stage in their course of treatment or investigation within specific timescales. This is usually part of a planned sequence of clinical care determined on clinical criteria.
- 4.18.2 These patients are not actively waiting for treatment to be initiated, only for planned continuation of treatment. A patient's care is considered as planned if there are clinical reasons that determine the patient must wait set periods of time between interventions. They will not be classified as being on a waiting list for statistical purposes.
- 4.18.3 Trusts should be able to demonstrate consistency in the way planned patients are treated and that patients are being treated in line with the clinical constraints. Planned patients must have a clearly identified month of treatment in which it can be shown that the patients are actually being treated.

4.19 HOSPITAL INITIATED CANCELLATIONS

- 4.19.1 No patient should have his or her admission cancelled. If Trusts cancel a patient's admission, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity, which should must be within the maximum waiting time guarantee.
- 4.19.2 Trusts should aim to have processes in place to have the new proposed admission date arranged before that patient is informed of the cancellation.
- 4.19.3 The patient should be informed in writing of the reason for the cancellation and the date of the new admission. The correspondence should include an explanation and an apology on behalf of the Trust.
- 4.19.4 Trusts will make best efforts to ensure that a patient's admission is not cancelled a second time for non-clinical reasons.

- 4.19.5 Where patients are cancelled on the day of a test as a result of not being fit, they will be suspended, pending a clinical review of their condition. The patient should be fully informed of this process.
- 4.19.6 Hospital initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment as a result of hospital initiated reasons, i.e. equipment failure, a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

4.20 PATIENTS LISTED FOR MORE THAN ONE DIAGNOSTIC TEST

- 4.20.1 Where more than one diagnostic test is required to assist with clinical decision making, the first test should be added to the waiting list with additional tests noted.
- 4.20.2 Where different clinicians are working together will perform more than one test at one time the patient should be added to the waiting list of the clinician for the priority test with additional clinicians noted, subject to local protocols.
- 4.20.3 Where a patient requires more than one test carried out on separate occasions by different (or the same) clinician, the patient should be placed on the active waiting list for the first test and on the planned waiting list for any subsequent tests.
- 4.20.4 Where a patient is being managed in one Trust but has to attend another for another type of diagnostic test, monitoring arrangements must be in place between the relevant Trusts to ensure that the patient pathway runs smoothly.

SECTION 5

GUIDANCE FOR MANAGEMENT OF ALLIED HEALTH PROFESSIONAL (AHP) SERVICES

5.1 INTRODUCTION

- 5.1.1 Allied Health Professionals work with all age groups and conditions, and are trained in assessing, diagnosing, treating and rehabilitating people with health and social care needs. They work in a range of settings including hospital, community, education, housing, independent and voluntary sectors. This guidance provides an administrative framework to support the management of patients waiting for AHP services.
- 5.1.2 Although it is written primarily for services provided in Trusts, it is recognised that there are a number of AHPs who provide services for children with physical and learning disabilities within special schools and with special educational needs within mainstream schools. Operational practices in these settings should be in line with the principles of the IEAP and provide consistency and equity for patients. Trusts should collaborate with colleagues within the Department of Education and the relevant schools to harmonise practices and ensure that children are able to access services equitably and within the maximum waiting time guarantees. A robust monitoring process will be required.
- 5.1.3 For the purposes of this section of the protocol, the generic term 'clinic' will be used to reflect AHP activity undertaken in hospital, community or domiciliary settings as it is recognised that AHPs provide patient care in a variety of care locations.

5.2 KEY PRINCIPLES

- 5.2.1 Trusts should ensure that there is a systematic approach to modernising AHP services which will help to improve access to services and quality of care for patients. This section should be read within the overall context of both the IEAP and the specific section governing the management of hospital outpatient services.

- 5.2.2 When looking at the experience of the patient it is important to consider the whole of their journey, with both the care and administrative pathways designed to support the patient's needs at each stage. The wait to receive outpatient therapy is likely to be one of many they experience in different parts of the system. It is the responsibility of all those involved to ensure that the patient wastes as little time as possible waiting and is seen by the right person as quickly as possible.
- 5.2.3 Booking will enable patients to have an opportunity to contact the hospital and agree a convenient time for their appointment. As outlined in paragraph 4.1.4, booking strategies should be developed in line with these Booking Principles. In the interim period, while fixed appointments are being issued, Trusts should ensure that the regional guidance is followed in the management of patients.

5.3 CALCULATION OF THE WAITING TIME

- 5.3.1 The waiting time clock for an AHP referral commences on the date the referral letter is received by the AHP service within the Trust. All referral letters, including faxed, emailed and electronically received referrals, will be date stamped on the date received.
- 5.3.2 The waiting time clock stops when the first definitive AHP treatment has commenced or when a decision is made that treatment is not required. Further information on definitions and sample patient pathways is contained in the Data Definitions and Guidance Document for AHP Waiting Times and can be found in **Appendix 12**.
- 5.3.3 As booking systems are introduced, patients should be made a reasonable offer, where clinically possible. Patients who refuse a reasonable offer of treatment, or fail to attend an AHP appointment, will have their waiting time clock re-set to the date the service was informed of the cancellation (CNAs) or the date the patient failed to attend (DNAs).

5.4 NEW REFERRALS

- 5.4.1 All AHP referrals will be registered on the relevant information system within 1 working day of receipt.
- 5.4.2 Trusts should work towards a system whereby all AHP referrals sent to the Trust are received at a dedicated registration function (s). Trusts should ensure that adequate systems are in place to deal with multiple referrals for the same patient regarding the same condition from a number of sources.
- 5.4.3 All referrals must be triaged or assessed to make a clear decision on the next step of a referral and clinical urgency (urgent or routine) clearly identified and recorded. All referrals will be prioritised and returned to the registration point with 3 working days.
- 5.4.4 Trusts must ensure that protocols are in place to prevent unnecessary delay from date stamping / logging of referrals to forwarding to the AHP department responsible for referral triage and/or initiation of treatment. It will be the responsibility of the relevant manager to monitor this performance indicator.
- 5.4.5 A robust system should be in place to ensure that cover is provided for referrals to be read and prioritised during practitioners' absence. A designated officer should oversee this and a protocol will be required for each service.
- 5.4.6 Where referrals can be reviewed less frequently than weekly, a process must be put in place and agreed with AHPs whereby the referrer's prioritisation is accepted in order to proceed with booking patients.
- 5.4.7 Following prioritisation, referrals must be updated on the relevant information system and appropriate correspondence issued to patients within 1 working day. Where there is insufficient information for the AHP to make a decision, they should contact the originating referrer in the first instance to access the

necessary information. If this cannot be gained, the referral should be returned to the referral source.

- 5.4.8 Trusts will work towards a system whereby the location of all letters can be tracked at all times through the referral and appointment system, and that letters sent to be prioritised and letters which are not returned can be identified.
- 5.4.9 If at the referral stage the patient / client is identified as being clinically or socially unfit to receive the necessary service the referral should not be accepted (not added to a waiting list) and returned to the originating referrer with a request that they re-refer the patient / client when they are clinically or socially fit to be treated.

5.5 URGENT AND ROUTINE APPOINTMENTS

- 5.5.1 All routine patients should be appointed within the maximum waiting time guarantee. Urgent patients must be booked within locally agreed maximum waits from the date of receipt. Local booking process should be based upon the principles outlined in Section 1.7.
- 5.5.2 For routine waiting list patients, an acknowledgement letter will be sent to patients within 5 working days of receipt of the referral, which should provide information to patients on their anticipated length of wait and details of the booking process.
- 5.5.3 A minimum of three weeks' notice should be provided for all routine patients. This does not prevent patients being offered an earlier appointment. Patients refusing short notice appointments (i.e. less than three weeks notice) will not have their waiting time clock reset, in line with guidance on reasonable offers.
- 5.5.4 Trusts must ensure that all communication to patients is clear, easily understood and complies with all relevant legislation.

5.6 CHRONOLOGICAL MANAGEMENT

- 5.6.1 Patients, within each clinical priority category, should be selected for booking in chronological order, i.e. based on the date the referral was received. Trusts should ensure that local administrative systems have the capability and functionality to effectively operate a referral management and booking system that is chronologically based.

5.7 CAPACITY PLANNING AND ESCALATION

- 5.7.1 It is important for AHP services to understand their baseline capacity, the make-up of the cohort of patients waiting to be treated and the likely changes in demand that will impact on their ability to initiate treatment and meet the maximum waiting time guarantees for patients.
- 5.7.2 Trusts should ensure that robust prospective capacity planning arrangements are in place, with clear escalation procedures to facilitate capacity gaps to be identified and solutions found in a timely manner to support operational booking processes and delivery of the targets.

5.8 REASONABLE OFFERS

- 5.8.1 As booking systems are introduced, patients should be offered reasonable notice, where clinically possible. A reasonable offer is defined as an offer of appointment, irrespective of provider, that gives the patient a minimum of three weeks notice and two appointments. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused. To ensure a verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.
- 5.8.2 If the patient is offered an appointment within a shorter notice period and it is refused, the waiting time cannot be recalculated.

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

5.8.3 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above.

5.9 AHP SERVICE INITIATED CANCELLATIONS

5.9.1 No patient should have his or her appointment cancelled. If Trusts cancel a patient's appointment, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable appointment date, ideally at the time of cancellation, and no more than 6 weeks in advance. The Trust must ensure that the new appointment date is within the maximum waiting time guarantee.

5.9.2 The patient should be informed of the reason for the cancellation and the date of the new appointment. This should include an explanation and an apology on behalf of the Trust.

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

5.9.4 AHP service initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment as a result of AHP service initiated reasons, i.e. equipment failure, staff sickness, a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

5.10 MAXIMUM WAITING TIME GUARANTEE

- 5.10.1 If a patient requests an appointment date that is beyond the maximum waiting time guarantee, the patient will be discharged and advised to revisit their referrer when they are ready to be seen. This will ensure that all patients waiting for an AHP appointment / treatment are fit and ready to be seen.
- 5.10.2 There will undoubtedly be occasions and instances where local discretion is required and sensitivity should be applied when short periods of time are involved; for example, if patients are requesting dates up to a week over their breach date. Trusts should ensure that reasonableness is complied with to facilitate re-calculation of the patient's waiting time, and to facilitate booking the patient into the date they requested.

5.11 COMPLIANCE WITH LEAVE PROTOCOL

- 5.11.1 Capacity lost due to cancelled or reduced clinics or visits at short notice has negative consequences for patients and on the Trust's ability to successfully implement robust booking processes. Clinic cancellation and rebooking of appointments is an extremely inefficient way to use such valuable resources.
- 5.11.2 It is therefore essential that AHP practitioners and other clinical planned leave or absence is organised in line with an agreed Trust Human Resources (HR) protocol. Thus it is necessary for Trusts to have robust local HR policies and procedures in place that minimise the cancellation/reduction of AHP clinics and the work associated with rebooking patient appointments. There should be clear practitioner agreement and commitment to this HR policy. Where cancelling and rebooking is unavoidable the procedures used must be equitable, efficient and comply with clinical governance principles.
- 5.11.3 The protocol should require a minimum of six weeks' notification of planned leave, in line with locally agreed HR policies.

- 5.11.4 A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

5.12 CLINIC OUTCOME MANAGEMENT

- 5.12.1 All patients will have their attendance recorded or registered on the relevant information system upon arrival for their appointment. The patient must verify their demographic details on every visit. The verified information must be cross-checked on information system and the patient records. Any changes must be recorded and updated in the patient record on the date of the clinic.
- 5.12.2 When the assessment/treatment has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic.

5.13 REVIEW APPOINTMENTS

- 5.13.1 All review appointments must be made within the time frame specified by the practitioner. If a review appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the practitioner. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the practitioner.
- 5.13.2 Review patients who require an appointment within six weeks will negotiate the date and time of the appointment before leaving the service and PAS / information system updated. Patients requiring an appointment outside six weeks should be managed on a review waiting list, with the indicative date recorded when appointment is required and booked in line with the booking principles outlined.

- 5.13.3 If domiciliary review appointment is required within 6 weeks, the appointment date should be agreed with the patient and confirmed in writing by the booking office. Where a domiciliary review appointment is required outside 6 weeks, the patient should be managed on a review waiting list, within the indicative date recorded, and booking in line with the booking principles outlined.

5.14 CLINIC TEMPLATE MANAGEMENT

- 5.14.1 Clinic templates should be agreed between the practitioner and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement.
- 5.14.2 Templates will identify the number of slots available for new urgent, new routine and follow up appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated for each appointment slot.
- 5.14.3 All requests for template and temporary clinic rule changes will only be accepted in writing to the relevant service manager. A minimum of six weeks notice will be provided for clinic template changes.
- 5.14.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager.

5.15 ROBUSTNESS OF DATA / VALIDATION

- 5.15.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a weekly basis and continually reviewed as waiting times reduce. This is essential to ensure Primary Targeting Lists are accurate and robust at all times.

- 5.15.2 As booking processes are implemented and waiting times reduce, there is no longer the need to validate patients by letter.
- 5.15.3 For patients in AHP services that are not yet booked, they will be contacted to establish whether they will still require their appointment.

**SECTION 6 PROTOCOL GUIDANCE FOR MANAGEMENT
OF ELECTIVE ADMISSIONS**

6.1 INTRODUCTION

- 6.1.1 The following protocol is based on nationally recommended good practice guidelines to assist staff with the effective management of elective waiting lists.
- 6.1.2 The administration and management of elective admissions within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.

6.2 COMPUTER SYSTEMS

- 6.2.1 To ensure consistency and the standardisation of reporting with Commissioners and the Department, all waiting lists are to be maintained in the PAS system.
- 6.2.2 Details of patients must be entered on to the computer system within two working days of the decision to admit being made. Failure to do this will lead to incorrect assessment of waiting list size when the daily / weekly downloads are taken.
- 6.2.3 As a minimum 3 digit OPCS codes should be included when adding a patient to a waiting list. Trusts should work towards expanding this to 4 digit codes.

6.3 CALCULATION OF THE WAITING TIME

- 6.3.1 The starting point for the waiting time of an inpatient is the date the consultant agrees with the patient that a procedure will be pursued as an active treatment or diagnostic intervention, and that the patient is medically fit to undergo such a procedure.
- 6.3.2 The waiting time for each inpatient on the elective admission list is calculated as the time period between the original decision to admit date and the date

at the end of the applicable period for the waiting list return. If the patient has been suspended at all during this time, the period(s) of suspension will be automatically subtracted from the total waiting time.

- 6.3.3 Patients who refuse a reasonable offer of treatment, or fail to attend an offer of admission, will have their waiting time reset to the date the hospital was informed of the cancellation (CNAs) or the date the patient failed to attend (DNAs). Any periods of suspension are subtracted from the patients overall waiting time.

6.4 STRUCTURE OF WAITING LISTS

- 6.4.1 To aid both the clinical and administrative management of the waiting list, lists should be sub-divided into a limited number of smaller lists, differentiating between active waiting lists, planned lists and suspended patients.
- 6.4.2 Priorities must be identified for each patient on the active waiting list, allocated according to urgency of the treatment. The current priorities are urgent and routine.

6.5 INPATIENT AND DAY CASE ACTIVE WAITING LISTS

- 6.5.1 Inpatient care should be the exception in the majority of elective procedures. Trusts should move away from initially asking “is this patient suitable for day case treatment?” towards a default position where they ask “what is the justification for admitting this patient?” The Trust’s systems, processes and physical space should be redesigned and organized on this basis.
- 6.5.2 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to admit, i.e. if there was a bed available tomorrow in which to admit a patient they are fit, ready, and able to come in.

- 6.5.3 All decisions to admit will be recorded on PAS within two working days of the decision to admit being taken.
- 6.5.4 Robust booking and scheduling systems will be developed to support patients having a say in the date and time of their admission. Further guidance will be provided on this.
- 6.5.5 Where a decision to admit depends on the outcome of diagnostic investigation, patients should not be added to an elective waiting list until the outcome of this investigation is known. There must be clear processes in place to ensure the result of the investigation is timely and in accordance with the clinical urgency required to admit the patient.
- 6.5.6 The statements above apply to all decisions to admit, irrespective of the decision route, i.e. direct access patients or decisions to directly list patients without outpatient consultation.

6.6 COMPLIANCE WITH TRUST HR LEAVE PROTOCOL

- 6.6.1 Trusts should have in place a robust protocol for the notification and management of medical and clinical leave and other absence. This protocol should include a proforma for completion by or on behalf of the consultant with a clear process for notifying the theatre scheduler of leave / absence.
- 6.6.2 The protocol should require a minimum of six weeks' notification of intended leave, in line with locally agreed consultant's contracts.
- 6.6.3 A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

6.7 TO COME IN (TCI) OFFERS OF TREATMENT

- 6.7.1 The patient should be advised of their expected waiting time during the consultation between themselves and the health care provider/practitioner and confirmed in writing.
- 6.7.2 Patients should be made reasonable offers to come in on the basis of clinical priority. Within clinical priority groups offers should then be made on the basis of the patient's chronological wait.
- 6.7.3 All patients must be offered reasonable notice. A reasonable offer is defined as an offer of admission, irrespective of provider, that gives the patient a minimum of three weeks' notice and two TCI dates. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date of the refused admission.
- 6.7.4 If the patient is offered an admission within a shorter notice period and it is refused, the waiting time cannot be recalculated.
- 6.7.5 If the patient however accepts an admission at short notice, but then cancels the admission, the waiting time can be recalculated from the date of that admission as the patient has entered into an agreement with the Trust.
- 6.7.6 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above.

6.8 SUSPENDED PATIENTS

- 6.8.1 A period of suspension is defined as:
- A patient suspended from the active waiting list for medical reasons, or unavailable for admission for a specified period because of family commitments, holidays, or other reasons i.e. a patient may be suspended during any periods when they are unavailable for treatment for social or

medical reasons (but not for reasons such as the consultant being unavailable, beds being unavailable etc).

- A maximum period not exceeding 3 months.
- 6.8.2 At any time a consultant is likely to have a number of patients who are unsuitable for admission for clinical or social reasons. These patients should be suspended from the active waiting list until they are ready for admission. All patients who require a period of suspension will have a personal treatment plan agreed by the consultant with relevant healthcare professionals. One month prior to the end of the suspension period, these plans should be reviewed and actions taken to review patients where required.
- 6.8.3 Every effort will be made to minimise the number of patients on the suspended waiting list, and the length of time patients are on the suspended waiting list.
- 6.8.4 Should there be any exceptions to the above, advice should be sought from the lead director or appropriate clinician.
- 6.8.5 Suspended patients will not count as waiting for statistical purposes. Any periods of suspension will be automatically subtracted from the patient's total time on the waiting list for central statistical returns.
- 6.8.6 No patient added to a waiting list should be immediately suspended. Patients should be recorded as suspended on the same day as the decision was taken that the patient was unfit or unavailable for surgery.
- 6.8.7 No patient should be suspended from the waiting list without a review date. All review dates must be 1st of the month to allow sufficient time for the patient to be treated in-month to avoid breaching waiting times targets.
- 6.8.8 No more than 5% of patients should be suspended from the waiting list at any time. This indicator should be regularly monitored.

- 6.8.9 Trusts should ensure that due regard is given to the guidance on reasonableness in their management of suspended patients.

6.9 PLANNED PATIENTS

- 6.9.1 Planned patients are those who are waiting to be recalled to hospital for a further stage in their course of treatment or surgical investigation within specific timescales. This is usually part of a planned sequence of clinical care determined on clinical criteria (e.g. check cystoscopy).
- 6.9.2 These patients are not actively waiting for treatment, but for planned continuation of treatment. A patient is planned if there are clinical reasons that determine the patient must wait set periods of time between interventions. They will not be classified as being on a waiting list for statistical purposes.
- 6.9.3 Trusts should be able to demonstrate consistency in the way planned patients are treated and that patients are being treated in line with the clinical constraints. Planned patients should have a clearly identified month of treatment in which it can be shown that the patients are actually being treated.
- 6.9.4 Ideally, children should be kept under outpatient review and only listed when they reach an age when they are ready for surgery. However, where a child has been added to a list with explicit clinical instructions that they cannot have surgery until they reach the optimum age, this patient can be classed as planned. The Implementation Procedure for Planned Patients can be found in **Appendix 13**.

6.10 CANCELLATIONS AND DNA'S

6.10.1 Patient Initiated Cancellations

Patients who cancel a reasonable offer will be given a second opportunity to book an admission, which should be within six weeks of the original admission date. If a second admission offer is cancelled, the patient will not normally be offered a third opportunity and will be referred back to their referring clinician.

6.10.2 Patients who DNA

If a patient DNAs their first admission date, the following process must be implemented:

- Where a patient has had an opportunity to agree the date and time of their admission, they will not normally be offered a second admission date.
- Under exceptional circumstances a clinician may decide that a patient should be offered a second admission. The second admission date must be agreed with the patient.

6.10.3 In a period of transition where fixed TCIs are still being issued, patients should have two opportunities to attend.

6.10.4 Following discharge patients will be added to the waiting list at the written request of the referring GP and within a four week period from date of discharge. Patients should be added to the waiting list at the date of the written request is received.

6.10.5 It is acknowledged that there may be exceptional circumstances for those patients identified as being 'at risk' (children, vulnerable adults).

6.10.6 No patient should have his or her operation cancelled prior to admission. If Trusts cancel a patient's admission/operation in advance of the anticipated TCI date, the waiting time clock (based on the original date to admit) will not be reset and the patient will be offered an alternative reasonable guaranteed future date within a maximum of 28 days.

- 6.10.7 Trusts should aim to have processes in place to have the new proposed admission date arranged before the patient is informed of the cancellation.
- 6.10.8 The patient should be informed in writing of the reason for the cancellation and the date of the new admission. The correspondence should include an explanation and an apology on behalf of the Trust.
- 6.10.9 Trusts will make best efforts to ensure that a patient's operation is not cancelled a second time for non clinical reasons.
- 6.10.10 Where patients are cancelled on the day of surgery as a result of not being fit for surgery / high anaesthetic risk, they will be suspended, pending a clinical review of their condition either by the consultant in outpatients or by their GP. The patient should be fully informed of this process.
- 6.10.11 Hospital-initiated cancellations will be recorded and reported to the relevant department on a monthly basis.

6.11 PERSONAL TREATMENT PLAN

- 6.11.1 A personal treatment plan must be put in place when a confirmed TCI date has been cancelled by the hospital, a patient has been suspended or is simply a potential breach. The plan should:
- Be agreed with the patient
 - Be recorded in the patient's notes
 - Be monitored by the appropriate person responsible for ensuring that the treatment plan is delivered.
- 6.11.2 The listing clinician will be responsible for implementing the personal treatment plan.

6.12 CHRONOLOGICAL MANAGEMENT

- 6.12.1 The process of selecting patients for admission and subsequent treatment is a complex activity. It entails balancing the needs and priorities of the patient and the Trust against the available resources of theatre time and staffed beds.
- 6.12.2 The Booking Principles outlined in Section 1.7 should underpin the development of booking systems to ensure a system of management and monitoring that is chronologically as opposed to statistically based.
- 6.12.3 It is expected that Trusts will work towards reducing the number of prioritisation categories to urgent and routine.

6.13 PRE-OPERATIVE ASSESSMENT

- 6.13.1 All patients undergoing an elective procedure (including endoscopy procedures) must undergo a pre-operative assessment. This can be provided using a variety of methods including telephone, postal or face to face assessment. Please refer to the Design and Deliver Guide 2007 for further reference.
- 6.13.2 Pre operative assessment will include an anaesthetic assessment. It will be the responsibility of the pre-operative assessment team, in accordance with protocols developed by surgeons and anaesthetists, to authorise fitness for surgery.
- 6.13.3 If a patient is unfit for their operation, their date will be cancelled and decision taken as to the appropriate next action.
- 6.13.4 Only those patients that are deemed fit for surgery may be offered a firm TCI date.
- 6.13.5 Pre-operative services should be supported by a robust booking system.

6.14 PATIENTS WHO DNE THEIR PRE OPERATIVE ASSESSMENT

6.14.1 Please refer to the guidance outlined in the Outpatient section.

6.15 VALIDATION OF WAITING LISTS

6.15.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a monthly basis, and ideally on a weekly basis as waiting times reduce. This is essential to ensure the efficiency of the elective pathway at all times.

6.15.2 As booking processes are implemented and waiting times reduce, there will no longer be the need to validate patients by letter. For patients in specialties that are not yet booked, they will be contacted to establish whether they will still require their admission.

6.15.3 Involvement of clinicians in the validation process is essential to ensure that waiting lists are robust from a clinical perspective. Trusts should ensure an ongoing process of clinical validation and audit is in place.

6.16 PATIENTS LISTED FOR MORE THAN ONE PROCEDURE

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

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

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

6.17 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

- 6.17.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between hospitals or to Independent Sector Providers. Transfers should not be a feature of an effective scheduled system.
- 6.17.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant. Administrative speed and good communication are very important to ensure this process runs smoothly. The Implementation Procedure and Technical Guidance for Handling Inpatient Transfers can be found in **Appendix 15b**.

INTEGRATED ELECTIVE ACCESS PROTOCOL

DRAFT

June 2020

Integrated Elective Access Protocol

Protocol Summary -

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

Version	2.0 This guidance replaces the Integrated Elective Access Protocol, 30 th April 2008.
Status	Draft for approval
Date	30 June 2020

Integrated Elective Access Protocol**Version**

Version	Date of issue	Summary of change	Author
1.0	25 August 2006	New Regional Guidance: Integrated Elective Access Protocol	M Irvine M Wright S Greenwood
2.0	30 April 2008	Protocol refresh to encompass guidance on all aspects of the elective care pathway	M. Irvine, M. Wright, R. Hullat
3.0		Update and relaunch IEAP to provide updated regional guidance on administration of patients on elective care pathways.	L. Mc Laughlin, Regional IEAP Review Group.

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Integrated Elective Access Protocol**Document control**

The current and approved version of this document can be found on the Department of Health website <https://www.health-ni.gov.uk> and on the Health and Social Care Board and Trusts intranet sites.

Document:	Integrated Elective Access Protocol 3.0
Department:	Department of Health
Purpose:	To advise and inform patients and clinical, administrative and managerial staff of the approved processes for managing patients access to outpatient, diagnostic, elective and elective Allied Health Professional (AHP) services.
For use by:	All clinical, administrative and managerial staff who are responsible for managing referrals, appointments and elective admissions.
This document is compliant with:	Northern Ireland Health and Social Care (NI HSCC) and Department of Health (DOH) Information Standards and Guidance and Systems Technical Guidance. https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Home.aspx
Screened by:	
Issue date:	
Approval by:	
Approval date:	
Distribution:	Trust Chief Executives, Directors of Planning and Performance, Directors of Acute Care, Department of Health.
Review date:	1 April 2021

Monitoring compliance with protocol

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

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Abbreviations

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

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 1

CONTEXT

DRAFT

1.1 INTRODUCTION

- 1.1.1 This protocol has been developed to define the roles and responsibilities of all those involved in the elective care pathway and to outline good practice to assist staff with the effective management of outpatient appointments, diagnostic, elective admissions and allied health professional (AHP) bookings, including cancer pathways and waiting list management.
- 1.1.2 The length of time a patient needs to wait for elective treatment is an important quality issue and is a visible public indicator of the efficiency of the hospital and AHP services provided by the Trust. The successful management of patients who wait for outpatient assessments, diagnostic investigations, elective inpatient or daycase treatment and AHP services is the responsibility of a number of key individuals within the organisation. General Practitioners (GPs), commissioners, hospital medical staff, allied health professionals, managers and clerical staff have an important role in ensuring access for patients in line with maximum waiting time targets as defined in the Department of Health (DOH) Commissioning Plan Direction (CPD) and good clinical practice, managing waiting lists effectively, treating patients and delivering a high quality, efficient and responsive service. Ensuring prompt timely and accurate communication with patients is a core responsibility of the hospital and the wider local health community.
- 1.1.3 The purpose of this protocol is to outline the approved processes for managing referrals to outpatient clinics, diagnostic procedures, elective procedures and operations and AHP booking procedures, through to discharge, to allow consistent and fair care and treatment for all patients.
- 1.1.4 The overall aim of the protocol is to ensure patients are treated in a timely and effective manner, specifically to:
- Ensure that patients receive treatment according to their clinical priority, with routine patients and those with the same clinical priority treated in chronological order, thereby minimising the time a patient spends on the waiting list and improving the quality of the patient experience.

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

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

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

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

1.2 METHODOLOGY

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

- 1.2.2 In this context, this protocol has been prepared to provide clarity of purpose within Trusts with a view to merging seamlessly with the policies of other agencies in the wider health community as they emerge.
- 1.2.3 This protocol has been prepared to clarify Trusts' medium and long-term objectives, set the context in which they will be delivered and establish the parameters within which staff at divisional, specialty and departmental levels will operate.
- 1.2.4 For the purposes of this protocol, the term;
- outpatient refers to a patient who has a clinical consultation. This may be face to face or virtual,
 - elective admissions refer to inpatient and daycase admissions,
 - inpatient refers to inpatient and daycase elective treatment,
 - diagnostic refers to patients who attend for a scan / test or investigation,
 - AHP refers to allied health professionals who work with people to help them protect and improve their health and well-being. There are thirteen professions recognised as allied health professions in Northern Ireland (NI),
 - partial booking refers to the process whereby a patient has an opportunity to agree the date and time of their appointment,
 - fixed booking refers to processes where the patient's appointment is made by the Trust booking office and the patient does not have the opportunity to agree/confirm the date and time of their appointment,
 - virtual appointment refers to any appointment that does not involve the physical presence of a patient at a clinic, (see also 1.5 Virtual Activity).
 - PAS refers to all electronic patient administration systems, including PARIS, whether in a hospital or community setting and those used in diagnostic departments such as NIPACS and systems used for other diagnostics / physiological investigations.

- 1.2.5 Trusts must maintain robust information systems to support the delivery of patient care through their clinical pathway. Robust data quality is essential to ensure accurate and reliable data is held, to support the production of timely operational and management information and to facilitate clinical and clerical training. All patient information should be recorded and held on an electronic system (PAS). Manual patient information systems should not be maintained.
- 1.2.6 All staff involved in the administration of waiting lists will ensure that Trusts' policies and procedures with respect to data collection and entry are strictly adhered to. This is to ensure the accuracy and reliability of data held on electronic hospital/patient administration systems and the waiting times for treatment.
- 1.2.7 Trusts should provide training programmes for staff which include all aspects of this Integrated Elective Access Protocol (IEAP). It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts. Trusts will provide appropriate information to staff so they can make informed decisions when delivering and monitoring this protocol. All staff involved in the administration of waiting lists will be expected to read and sign off this protocol.
- 1.2.8 This protocol will be available to all staff via Trusts' Intranet.

1.3 UNDERPINNING PRINCIPLES

- 1.3.1 Patients will be treated on the basis of their clinical urgency with urgent patients seen and treated first. The definition of clinical urgency will be defined and agreed at specialty / procedure / service level.
- 1.3.2 Patients with the same clinical need will be treated in chronological order on grounds of fairness, and to minimise the waiting time for all patients.

- 1.3.3 As part of a plan for the implementation of booking, Trusts must ensure their elective admission selection system is managed on a chronological basis within clinical priority.
- 1.3.4 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to add the patient to the waiting list, i.e. the patient must be “fit, ready, and able” to come in (TCI).
- 1.3.5 Trusts should design processes to ensure that inpatient care is the exception for the majority of elective procedures and that daycase is promoted. The principle is about moving care to the most appropriate setting, based on clinical judgement. This means moving daycase surgery to outpatient care and outpatient care to primary care or alternative clinical models where appropriate.
- 1.3.6 Referrals into Trusts should be pooled where possible as the norm within specialties.
- 1.3.7 Trusts will maintain and promote electronic booking systems aimed at making hospital appointments more convenient for patients. Trusts should move away from fixed appointments to partially booked appointments.
- 1.3.8 Trusts should also promote direct access services where patients are directly referred from primary and community care to the direct access service for both assessment and treatment. Direct access arrangements must be supported by clearly agreed clinical pathways and referral guidance, jointly developed by primary and secondary care.
- 1.3.9 For the purposes of booking/arranging appointments, all patient information should be recorded and held on an electronic system. Trusts should not use manual administration systems to record and report patient's information.
- 1.3.10 In all aspects of the booking processes, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language**. It is essential that patients who are considered at risk for whatever reason have their needs identified

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

Have we anything in place for 1.3.10

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

1.3.12 Trusts must ensure that the needs of ethnic groups and people with special requirements should be considered at all stages of the patient's pathway.

1.4 BOOKING PRINCIPLES

1.4.1 These booking principles will support all areas across the elective and AHP pathways where appointment systems are used.

1.4.2 Offering the patient choice of date and time where possible is essential in agreeing and booking appointments with patients through partial booking systems. Trusts should ensure booking systems enable patients to choose and agree hospital appointments that are convenient for them.

1.4.3 Facilitating reasonable offers to patients should be seen within the context of robust booking systems being in place.

1.4.4 All booking principles should be underpinned with the relevant local policies to provide clarity to operational staff.

1.4.5 Trusts should ensure booking processes are continually reviewed and updated as required to reflect local and regional requirements at an operational level.

1.4.6 The definition of a booked appointment is:

- a) The patient is given the choice of when to attend or have a virtual appointment.
- b) The patient is able to choose and confirm their appointment within the timeframe relevant to the clinical urgency of their appointment.
- c) The range of dates available to a patient may reduce if they need to be seen quickly, e.g. urgent referrals or within two weeks if cancer is suspected.
- d) The patient may choose to agree a date outside the range of dates offered or defer their decision until later.

1.4.7 Principles for booking Cancer Pathway patients:

- a) All suspected cancer referrals should be booked in line with the agreed clinical pathway requirement for the patient and a maximum of 14 days from the receipt of referral.
- b) Dedicated registration functions for red flag (suspect cancer) referrals should be in place within centralised booking teams.
- c) Clinical teams must ensure triage, where required, is undertaken daily, irrespective of leave, in order to initiate booking patients.
- d) Patients will be contacted by telephone twice (morning and afternoon).
- e) If telephone contact cannot be made, a fixed appointment will be issued to the patient within a maximum of three days of receipt of referral.
- f) Systems should be established to ensure the Patient Tracker / Multidisciplinary Team (MDT) Co-coordinator is notified of the suspected cancer patient referral, to allow them to commence prospective tracking of the patient.

1.4.8 Principles for booking Urgent Pathway patients:

- a) Maximum waiting times for urgent patients should be agreed locally with clinicians and/or service managers and made explicit, through internal processes, to booking office staff.
- b) Referrals will be received, registered within one working day and forwarded to consultants for prioritisation.

- c) If clinical priority is not received from consultants within 72 hours, processes should be in place to initiate booking of urgent patients according to the referrers's classification of urgency.
- d) Patients will be issued with a letter inviting them to contact the Trust to agree and confirm their appointment in line with the urgent booking process.
- e) In exceptional cases, some patients will require to be appointed to the next available slot. A robust process for telephone booking these patients should be developed which should be clearly auditable.

1.4.9 Principles for booking Routine Pathway patients:

- a) Patients should be booked to ensure appointment (including virtual appointment) is within the maximum waiting time guarantees for routine appointments.
- b) Referrals will be received, registered within one working day at booking teams and forwarded to consultants for prioritisation.
- c) Approximately eight weeks prior to appointment, Trusts should calculate prospective slot capacity and immediately implement escalation policy where capacity gaps are identified.
Rotas are not normally available 8 weeks out (annual leave/study leave notification period is 6 weeks. What escalation policy is being followed and where are the capacity gaps being escalated to? If this is an already known and accepted capacity gap, eg, through discussions with HSCB, vacant posts, do we always have to escalate?
- d) Patients should be selected for booking in chronological order from the Primary Targeting List (PTL).
- e) Six weeks prior to appointment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment.

1.4.10 Principles for Booking Review Patients;

- a) Patients who need to be reviewed within 6 weeks will agree their appointment (including virtual appointment) before they leave the clinic, where possible.

- b) Patients who require a review appointment more than 6 weeks in advance will be added to and managed on a review waiting list.
- c) Patients will be added to the review waiting list with a clearly indicated date of treatment and selected for booking according to this date.
- d) Six weeks prior to the indicative date of treatment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment within a clinically agreed window either side of the indicative date of treatment.

1.4.11 It is recognised that some groups of patients may require booking processes that have additional steps in the pathway. These should be designed around the principles outlined to ensure choice and certainty as well as reflecting the individual requirements necessary to support their particular patient journey.

Is there any provision to change date required if patient does not accept reasonable offer?

1.5 VIRTUAL ACTIVITY

1.5.1 Virtual Activity relates to any planned contact by the Trust with a patient (or their proxy) for healthcare delivery purposes i.e. clinical consultation, advice, review and treatment planning. It may be in the form of a telephone contact, video link, telemedicine or telecommunication, e.g. email.

1.5.2 The contact is in lieu of a face-to-face contact of a patient/client, i.e. a face-to-face contact would have been necessary if the telephone/video link/etc. had not taken place.

1.5.3 The call/contact should be prearranged with the patient and /or their proxy. Patients should not be disadvantaged where a decision is made to assess their clinical need through the use of virtual clinics.

Not all patient contact is pre-arranged, there has been a number of virtual clinics following validation when contact is made with the patient at the point of validation and a decision/treatment plan agreed.

- 1.5.4 The contact must be auditable with a written note detailing the date and substance of the contact is made following the consultation and retained in the patient's records.

1.6 COMPLIANCE WITH LEAVE PROTOCOL

- 1.6.1 It is essential that planned medical and other clinical staff leave or absence is organised in line with an agreed Trust Human Resources (HR) protocol. Thus it is necessary for Trusts to have robust local HR policies and procedures in place that minimise the cancellation/reduction of outpatient clinics and the work associated with the rebooking of appointments.
- 1.6.2 There should be clear medical and clinical agreement and commitment to this HR policy. Where cancelling and rebooking is unavoidable the procedures used must be equitable, efficient, comply with clinical governance principles and ensure that maximum waiting times for patients are not compromised.
- 1.6.3 The protocol should require a minimum of six weeks' notification of intended leave, in line with locally agreed HR policies, in order to facilitate Trusts booking teams to manage appointment processes six weeks in advance.
- 1.6.4 The booking team should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

1.7 VALIDATION

- 1.7.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a monthly basis. This is essential to ensure the efficiency of the elective pathway at all times. In addition, Trusts should ensure that waiting lists are regularly validated to ensure that only those patients who want or still require a procedure are on the waiting list.

- 1.7.2 Involvement of clinicians in the validation process is essential to ensure that waiting lists are robust from a clinical perspective. Trusts should ensure an ongoing process of clinical validation and audit is in place.

Have we anything set up for the ongoing clinical validation

DRAFT

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 2

**GUIDANCE FOR MANAGEMENT OF OUTPATIENT
SERVICES**

DRAFT

2.1 INTRODUCTION

- 2.1.1 The following protocol is based on recommended good practice guidelines to assist staff with the effective management of outpatient services, including those patients whose referral is managed virtually.
- 2.1.2 The administration and management of the outpatient pathway from receipt of referral to appointment within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.
- 2.1.3 There will be dedicated booking offices within Trusts to receive, register and process all outpatient referrals.
- 2.1.4 Fixed appointments should only be used in exceptional circumstances.
- 2.1.5 In all aspects of the outpatient booking process, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language**. Local booking policies should be developed accordingly.

Is there anything we need to have n place here?

2.2 KEY PRINCIPLES

- 2.2.1 Referrals into Trusts should be pooled where possible within specialties.
- 2.2.2 All new referrals, appointments and outpatient waiting lists should be managed according to clinical priorities. Priorities must be identified for each patient on the waiting list and allocated according to urgency of the treatment. Trusts will manage patients in three priorities, i.e.
 1. Red flag (suspect cancer),
 2. urgent and
 3. routine.

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

There are currently only 2 priority categories on PAS for referrals – urgent and routine. Red flags are identified by reason for referral code. Is this an opportunity to update PAS with a priority category for red flag? Yes that would make sense

- 2.2.3 Patients of equal clinical priority will be selected for booking in strict chronological order.
- 2.2.4 Patient appointments for new and review should be **partially booked**.
In the case of red flag appointments and 14 day target, it is not always possible to partial book appointments. The principles in section 1 are applied, ie the 2 attempts at telephone contacts and 1 fixed appointment.
- 2.2.5 The regional target for a maximum outpatient waiting time is outlined in the Health and Social Care Commissioning Plan and Indicators of Performance Direction (CPD), <https://www.health-ni.gov.uk/doh-management-and-structure> (see Ministerial Priorities).
- 2.2.6 Maximum waiting times for urgent patients should be agreed locally with clinicians and made explicit, through internal processes, to booking office staff. Booking staff should ensure that patients are appointed within the clinical timeframe indicated by the consultant and capacity issues are quickly identified and escalated.
- 2.2.7 Patients should not be disadvantaged where a decision is made to assess their clinical need through virtual activity.
- 2.2.8 Trusts should ensure that clinical templates are constantly reviewed to meet changes in demand and new clinical practice.
- 2.2.9 Data collection in respect of referrals and waiting times should be accurate, timely, complete and subject to regular audit and validation.
- 2.2.10 Trusts will work towards providing a single point of contact for all patients with respect to outpatient appointment services. It is recognised that there may be services which require alternative processes.

- 2.2.11 Trusts should **not** use manual administration systems to record and report patients who have been booked.
- 2.2.12 Trusts should provide training programmes for staff which include all aspects of IEAP. It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts.

2.3 NEW REFERRALS

- 2.3.1 All outpatient referrals (including those sent via Clinical Communication Gateway (CCG)) sent to Trusts will be registered within **one** working day of receipt. Referrer priority status must be recorded at registration.
- 2.3.2 Trusts will work towards a system whereby the location of all referrals (paper and electronic) not yet prioritised can be identified and tracked.
- 2.3.3 All referrals must be prioritised and clinical urgency must be clearly identified. Clinicians and management will be responsible for ensuring that cover is provided for referrals to be read and prioritised during any absence.
- 2.3.4 All referrals will be prioritised (including those prioritised via E-Triage) within **a maximum of three** working days of date of receipt of referral. Note; Red flag referrals require **daily** triage.
- 2.3.5 Following prioritisation, referrals must be actioned on PAS and appropriate correspondence (including electronic), e.g. acknowledgement or appointment letter, issued to patients within **one** working day.
- 2.3.6 Inappropriate and inadequate referrals should be returned to the referral source immediately and the referral closed and managed in line with the PAS technical guidance.

2.4 CALCULATION OF THE WAITING TIME – STARTING TIME

2.4.1 The starting point for the waiting time of an outpatient new referral is the date the referral is received by the booking office/department.

2.4.2 In exceptional cases where referrals bypass the booking office (e.g. sent directly to a consultant) the Trust must have a process in place to ensure that these are date stamped on receipt, immediately forwarded to the booking office and registered at the date on the date stamp.

2.5 REASONABLE OFFERS

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

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

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

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

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

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

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

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

2.6 REVIEW APPOINTMENTS

- 2.6.1 All review appointments must be made within the time frame specified by the clinician. If a review appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the clinician.
- 2.6.2 Patients must be recorded on PAS as requiring to be seen within a clinically indicated time. Trusts should actively monitor patients on the review list to ensure that they do not go past their indicative time of treatment.
- 2.6.3 Review patients who require an appointment within six weeks will be asked to agree the date and time of the appointment before leaving the department and PAS updated.
- 2.6.4 Patients requiring an appointment outside six weeks will be placed on a review waiting list, with the agreed clinically appropriate appointment date recorded, and be booked in line with implementation guidance for review pathway patients.
- 2.6.5 Virtual review appointments, e.g. telephone or video link, should be partially booked. If the patient cannot be contacted for their virtual review they should be sent a partial booking letter to arrange an appointment.

Not all patient contact is pre-arranged, there has been a number of virtual clinics following validation when contact is made with the patient at the point of validation and a decision/treatment plan agreed.

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

2.7.1 DNAs – New Outpatient

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

- 2.7.1(a) Patients who have been partially booked will **not** be offered a second appointment and should be removed from the waiting list. The patient and referring clinician (and the patient's GP, where they are not the referring clinician) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.
- 2.7.1(b) Under exceptional circumstances a clinician may decide that a patient who DNAs a first appointment should not be removed from the waiting list and should be offered a second appointment. Trusts should put in place local agreements with clinicians, regarding those referrals (e.g. red flag) or specialties where patients may be at risk (e.g. paediatrics or adults at risk) where a second appointment should always be offered.
- 2.7.1(c) Patients who DNA and are not discharged but offered a second appointment will have their waiting time clock reset to the date of the DNA.
- 2.7.1(d) *Where patients are discharged from the waiting list (ref. 2.7.1(a)) they should be advised to contact the Trust booking office within **four** weeks of the original appointment date if they consider that the appointment is still required. Where a patient makes contact within the **four** week deadline, and where the Trust considers that unforeseen or exceptional circumstances meant that the patient was unable to attend, the patient should be added to the waiting list at the date that they have made contact with the Trust. If a patient makes contact after the **four** week period they cannot be reinstated.*

- 2.7.1(e) If the patient DNAs the second appointment offered then the patient should **not** be offered another opportunity to be reinstated. The patient and referring clinician (and the patient's GP, where they are not the referring clinician) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.
- 2.7.1(f) Where a patient DNAs a fixed new appointment (i.e. they have not had the opportunity to agree/confirm the date and time of the appointment) they should be offered another appointment.
- 2.7.1(g) If the patient DNAs this second fixed appointment they will be removed from the waiting list and the steps in 2.7.1(d) should be followed.
- 2.7.1(h) If a patient DNA's a virtual outpatient appointment this should follow the above protocol based on whether the appointment is partially booked or fixed. The Trust should ensure that the contact details of the patient are up to date and available.

2.7.2 DNAs – Review Outpatient

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

- 2.7.2(a) Where a patient has been partially booked and does not attend, a clinical decision should be taken as to whether a second appointment should be offered or whether the patient can be discharged.
- 2.7.2(b) Where the clinical decision is that a second appointment should be offered, this should be partially booked.
- 2.7.2(c) Where the clinical decision is that a second appointment should **not** be offered, Trusts should contact patients advising that as they have failed to attend their appointment they have been discharged from the waiting list. The referring clinician (and the patient's GP, where they are not the referring clinician) should also be informed of this.
- 2.7.2(d) *Patients being discharged from the list should be advised to contact the Trust booking office if they have any queries. Where unforeseen or exceptional circumstances meant that the patient was unable to attend, and the patient makes contact within **four** weeks*

of the original appointment date, a clinical decision may be made to offer a second appointment. Where this is the case, the patient should be added to the review waiting list with a revised clinically indicated date at the date they make contact with the Trust.

- 2.7.2(e) If the patient DNAs the second review appointment which has been partially booked then the patient should **not** be offered another opportunity to be reinstated. The patient and referrer will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.
- 2.7.2(f) Where a patient DNAs a fixed review appointment where they have not had the opportunity to agree/ confirm the date and time of their appointment, they should be offered another appointment. If they DNA this second fixed appointment, the above should be followed.
- 2.7.2(g) If a patient DNA's a virtual outpatient review appointment this should follow the above protocol based on whether the appointment is partially booked or fixed. The Trust should ensure that the contact details of the patient are up to date and available.
- 2.7.2(h) There may be instances for review patients where the clinician may wish to review notes prior to any action to remove a patient because of a DNA or failure to respond to a partial booking letter. Trusts should ensure that there are locally agreed processes in place to administer these patients.

Is there any provision to change date required if patient does not accept reasonable offer/DNA or the consultant changes plan following review of notes?

2.7.3 CNAs – Patient Initiated Cancellations of Outpatient Appointments

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

- 2.7.3(a) The patient will be given a second opportunity to book an appointment (where this is still required), which should be within **six** weeks of the original appointment date.
- 2.7.3(b) Patients who CNA will have their waiting time clock reset to the date the Trust was informed of the cancellation.

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

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

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

2.8 CNAs – HOSPITAL INITIATED CANCELLATIONS

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

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

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

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

2.9 CLINIC OUTCOME MANAGEMENT

- 2.9.1 Changes in the patient's details must be updated on PAS and the medical records on the date of the clinic.
- 2.9.2 When the consultation has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic.

2.10 CLINIC TEMPLATE CHANGES

- 2.10.1 Clinic templates should be agreed between the consultant and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement (SBAs).
- 2.10.2 Templates will identify the number of slots available for red flag, urgent, and routine and review appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated for each appointment slot.
- 2.10.3 All requests for template and temporary clinic rule changes will only be accepted in writing. A minimum of **six** weeks' notice will be provided for clinic template changes.
- 2.10.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager.

2.11 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

- 2.11.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between hospitals or to independent sector (IS) providers.
- 2.11.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant and be managed in line with PAS technical guidance, (see also Reasonable Offers, ref. 2.5). Administrative speed and good communication are very important to ensure this process runs smoothly.

2.12 OPEN REGISTRATIONS

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

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

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

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

2.13 TIME CRITICAL CONDITIONS

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

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

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

- 2.13.4 If the patient refuses the first appointment they should be offered a second appointment during the same telephone call. This second appointment should be offered on a date which is within **14** days of the date the initial appointment was offered and refused. In order to capture the correct waiting time the first appointment will have to be scheduled and then cancelled on the day of the offer and the patient choice field updated in line with the technical guidance. This will then reset the patient's waiting time to the date the initial appointment was refused.
- 2.13.5 If the patient cancels **two** agreed appointment dates the relevant clinical team should be advised before a decision is taken to discharge. Where a decision is taken to discharge the patient, the patient's GP should be informed.
- 2.13.6 If the patient has agreed an appointment but then DNAs the relevant clinical team should be advised before a decision is taken to discharge. Where a decision is taken to discharge the patient, the patient's GP should be informed.
- 2.13.7 Where the patient DNAs a fixed appointment they should be offered another appointment.
- 2.13.8 If the patient DNAs this second fixed appointment the relevant clinical team should be advised before a decision is taken to discharge. Where a decision is taken to discharge the patient, the patient's GP should be informed.
- 2.13.9 With regard to 2.13.4 to 2.13.8 above, it is the responsibility of each individual Trust to agree the discharge arrangements with the clinical team.
- 2.13.10 If the patient is not available for up to **six** weeks following receipt of referral, the original referral should be discharged a second new referral should be opened with the same information as the original referral and with a new date equal to the date the patient has advised that they will be available and the patient monitored from this date.

2.14 TECHNICAL GUIDANCE

2.14.1 See also Regional ISB Standards and Guidance

<https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Standards%20and%20Guidance.aspx> re;

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

2.14.2 See also PAS technical guidance

<https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Technical%20Guidance.aspx> for recording;

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

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 3

**GUIDANCE FOR MANAGEMENT OF DIAGNOSTIC
SERVICES**

DRAFT

3.1 INTRODUCTION

- 3.1.1 A diagnostic procedure may be performed by a range of medical and clinical professionals across many different modalities, including, diagnostic imaging, cardiac imaging and physiological measurement services. These may have differing operational protocols, pathways and information systems but the principles of the IEAP should be applied across all diagnostic services.
- 3.1.2 The principles of good practice outlined in the Outpatient and Elective Admissions sections of this document should be adopted in order to ensure consistent standards and processes for patients as they move along the pathway of investigations, assessment and treatment. This section aims to recognise areas where differences may be encountered due to the nature of specific diagnostic services.
- 3.1.3 The administration and management of requests for diagnostics, waiting lists and appointments within and across Trust should be consistent, easily understood, patient focused and responsive to clinical decision making.
- 3.1.4 It is recognised that diagnostic services are administered on a wide range of information systems, with varying degrees of functionality able to support full information technology (IT) implementation of the requirements of the IEAP. Trusts should ensure that the administrative management of patients is undertaken in line with the principles of the IEAP and that all efforts are made to ensure patient administration systems are made fit for purpose.
- 3.1.5 In all aspects of the diagnostic booking process, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language as well as associated legislative requirements such as Ionising Radiation (Medical Exposure) Regulations**. Local booking policies should be developed accordingly.

3.2 KEY PRINCIPLES

- 3.2.1 Referrals into Trusts should be pooled as the norm where possible.
- 3.2.2 All diagnostic requests, appointments and waiting lists should be managed according to clinical priority. Priorities must be identified for each patient on a waiting list and allocated according to urgency of the diagnostic procedure. Trusts will manage patients in four priorities, i.e.
1. Red flag (suspect cancer),
 2. urgent,
 3. routine and
 4. planned.
- No other clinical priority categories should be used for diagnostic services.
- 3.2.3 Patients of equal clinical priority will be selected for booking in strict chronological order.
- 3.2.4 Trusts should work towards an appointment system where patient appointments are **partially booked** (where applicable). Where fixed appointments are being issued, Trusts should ensure that the regional IEAP guidance is followed in the management of patients.
- 3.2.5 The regional target for a maximum diagnostic waiting time is outlined in the Health and Social Care Commissioning Plan and Indicators of Performance Direction (CPD), <https://www.health-ni.gov.uk/doh-management-and-structure> (see Ministerial Priorities).
- 3.2.6 Maximum waiting times for urgent patients should be agreed locally with clinicians and/or service managers and made explicit, through internal processes, to booking office staff. Booking staff should ensure that patients are appointed within the clinical timeframe indicated and capacity issues are quickly identified and escalated.
- 3.2.7 The outcome of the diagnostic test must be available to the referrer without undue delay and within the relevant DoH targets / standards.

- 3.2.8 Trusts should ensure that specific diagnostic tests or planned patients which are classified as daycases adhere to the relevant standards in the Elective Admissions section of this document.
- 3.2.9 Trusts should ensure that clinical templates are constantly reviewed to meet changes in demand and new clinical practice.
- 3.2.10 Data collection in respect of referrals and waiting times should be accurate, timely, complete and subject to regular audit and validation.
- 3.2.11 Trusts will work towards providing a single point of contact for all patients with respect to diagnostic appointment services. It is recognised that there will be services which require alternative processes.
- 3.2.12 Trusts should **not** use manual administration systems to record and report patients who have been booked.
- 3.2.13 Trusts should provide training programmes for staff which include all aspects of this IEAP. It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts.

3.3 NEW DIAGNOSTIC REQUESTS

- 3.3.1 All diagnostic requests will be registered on the IT system within **one** working day of receipt. Referrer priority status must be recorded at registration.
- 3.3.2 Trust diagnostic services must have mechanisms in place to track all referrals (paper and electronic) at all times.
- 3.3.3 All requests must be prioritised and clinical urgency must be clearly identified. Clinicians and management will be responsible for ensuring that cover is provided for referrals to be read and prioritised during any absence.

- 3.3.4 All referrals will be prioritised (including those prioritised via E Triage) within **three** working days of date of receipt of referral.
- 3.3.5 Following prioritisation, requests must be actioned on the IT system and appropriate correspondence (including electronic) issued to patients within **one** working day.
- 3.3.6 Inappropriate and inadequate requests should be returned to the referral source and the referral closed and managed in line with the PAS/relevant technical guidance, where appropriate.

3.4 CALCULATION OF THE WAITING TIME – STARTING TIME

- 3.4.1 The starting point for the waiting time of a request for a diagnostic investigation or procedure is the date the request is received into the department.
- 3.4.2 All referral letters and requests, emailed and electronically delivered referrals, will have the date received into the department recorded either by date stamp or electronically.

3.5 REASONABLE OFFERS

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

The IT Systems currently being used for the management of the majority of diagnostics do not facilitate partial booking, however, the fixed appointment letters do ask patients to confirm and are issued with 3 weeks' notice where appropriate. The diagnostic booking teams follow this up with telephone calls to patients to confirm attendances.

- 3.5.2 If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused.
- 3.5.3 This does not prevent patients being offered earlier appointment dates. If the patient is offered an appointment within a shorter notice period (i.e. less than three weeks' notice) and refuses it they will not have their waiting time reset.
- 3.5.4 If the patient accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the provider.
- 3.5.5 Providers should have robust audit procedures in place to demonstrate compliance with the above.
- 3.5.6 To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.
- 3.5.7 Urgent patients must be booked within the locally agreed maximum waiting time from the date of receipt. It is recognised that there will be occasional exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Clearly defined booking protocols will be required to support specialties and booking staff.

3.6 FOLLOW UP APPOINTMENTS

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

- 3.6.2 Patients must be recorded on the IT system as requiring to be seen within a clinically indicated time. Trusts should actively monitor follow up patients on the review list to ensure that they do not go past their indicative time of treatment.
- 3.6.3 Follow up patients who require an appointment within six weeks will be asked to agree the date and time of the appointment before leaving the department and the IT system updated.
- 3.6.4 Follow up patients requiring an appointment outside six weeks will be placed on a review waiting list, with the agreed clinically appropriate appointment date recorded, and be booked in line with management guidance for follow up pathway patients.

3.7 PLANNED PATIENTS

- 3.7.1 Planned patients are those who are waiting to be recalled to hospital for a further stage in their course of treatment or investigation within specific timescales. This is usually part of a planned sequence of clinical care determined on clinical criteria.
- 3.7.2 These patients are not actively waiting for treatment to be initiated, only for planned continuation of treatment. A patient's care is considered as planned if there are clinical reasons that determine the patient must wait set periods of time between interventions. They will not be classified as being on a waiting list for statistical purposes.
- 3.7.3 Trusts should be able to demonstrate consistency in the way planned patients are treated and that patients are being treated in line with the clinical constraints. Planned patients must have a clearly identified month of treatment in which it can be shown that the patients are actually being treated.
- 3.7.4 Trusts must ensure that planned patients are not disadvantaged in the management of planned backlogs.

3.8 PATIENTS LISTED FOR MORE THAN ONE DIAGNOSTIC TEST

- 3.8.1 Where more than one diagnostic test is required to assist with clinical decision making, the first test should be added to the waiting list with additional tests noted.
- 3.8.2 Where different clinicians working together perform more than one test at one time, the patient should be added to the waiting list of the clinician for the priority test (with additional clinicians noted) subject to local protocols.
- 3.8.3 Where a patient requires more than one test carried out on separate occasions the patient should be placed on the active waiting list for the first test and on the planned waiting list for any subsequent tests.
- 3.8.4 Where a patient is being managed in one Trust but has to attend another for another type of diagnostic test, monitoring arrangements must be in place between the relevant Trusts to ensure that the patient pathway runs smoothly.

There would be concern that a patient is only added to one waiting list, eg, a patient could require a number of different diagnostic tests to reach diagnosis and treatment plan, with varying waiting times for these tests, eg, a patient could be referred for a CT examination but also be added to the waiting list for an endoscopy procedure. A patient on cancer pathway could require PET and CT – these are different radiology modalities with different waiting lists. Cardiac patients could be listed for different examinations, eg, echo, stress test etc with varying waiting times.

The concern would be the risk that the patient would be closed off the system after the initial investigation or before all tests completed if only added to one waiting list.

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

- 3.9.1 DNAs – Diagnostic Appointment

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

- 3.9.1(a) Patients who have been partially booked will **not** be offered a second appointment and should be removed from the waiting list. The patient and referring clinician (and the patient's GP, where they are not the referring clinician) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.
- 3.9.1(b) Under exceptional circumstances a clinician may decide that a patient who DNAs a first appointment should not be removed from the waiting list and should be offered a second appointment. Trusts should put in place local agreements with clinicians, regarding those referrals (e.g. red flag) or specialties where patients may be at risk (e.g. paediatrics or adults at risk) where a second appointment should be offered.
- 3.9.1(c) Patients who DNA and are not discharged but offered a second appointment will have their waiting time clock reset to the date of the DNA.
- 3.9.1(d) *Where patients are discharged from the waiting list (ref. 3.7.1(a) above) they should be advised to contact the Trust booking office within **four** weeks of the original appointment date if they consider that the appointment is still required. Where a patient makes contact within the **four** week deadline, and where the Trust considers that unforeseen or exceptional circumstances meant that the patient was unable to attend, the patient should be added to the waiting list at the date that they have made contact with the Trust. If a patient makes contact after the **four** week period they cannot be reinstated.*
- 3.9.1(e) If the patient DNAs the second appointment offered then the patient should **not** be offered another opportunity to be reinstated. The patient and referring clinician (and the patient's GP, where they are not the referring clinician) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

- 3.9.1(f) Where a patient DNAs a fixed diagnostic appointment (i.e. they have not had the opportunity to agree/confirm the date and time of the appointment) they should be offered another appointment.
- 3.9.1(g) If the patient DNAs this second fixed diagnostic appointment they will be removed from the waiting list and the above steps in 3.7.1(d) should be followed.

3.9.2 DNAs – Follow up Diagnostic Appointment

If a patient DNAs their follow up diagnostic appointment the following process must be followed:

- 3.9.2(a) Where a patient has been partially booked and does not attend, a clinical decision should be taken as to whether a second appointment should be offered or whether the patient can be discharged.
- 3.9.2(b) Where the clinical decision is that a second appointment should be offered, this should be partially booked.
- 3.9.2(c) Where the clinical decision is that a second appointment should **not** be offered, Trusts should contact patients advising that as they have failed to attend they have been discharged from the waiting list. The referring clinician (and the patients GP, where they are not the referring clinician) should also be informed of this.
- 3.9.2(d) *Patients being discharged from the list should be advised to contact the Trust booking office if they have any queries. Where unforeseen or exceptional circumstances meant that the patient was unable to attend, and the patient makes contact within **four** weeks of the original appointment date, a clinical decision may be made to offer a second appointment. Where this is the case, the patient should be added to the review waiting list with a revised clinically indicated date at the date they make contact with the Trust.*
- 3.9.2(e) If the patient DNAs the second follow up appointment which has been partially booked then the patient should **not** be offered another opportunity to be reinstated. The patient and referrer will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

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

3.9.2(g) There may be instances for follow up patients where the clinician may wish to review notes prior to any action to remove a patient because of a DNA or failure to respond to a partial booking letter. Trusts should ensure that there are locally agreed processes in place to administer these patients.

3.9.3 CNAs – Patient Initiated Cancellations of Diagnostic Appointment

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

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

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

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

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

3.10 CNAs - HOSPITAL INITIATED CANCELLATIONS

- 3.10.1 No patient should have his or her appointment cancelled. If Trusts cancel a patient's appointment, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity.
- 3.10.2 The patient should be informed of the cancellation and the date of the new appointment.
- 3.10.3 Trusts will make best efforts to ensure that a patient's appointment is not cancelled a second time for non-clinical reasons.
- 3.10.4 Hospital initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

3.11 SESSION OUTCOME MANAGEMENT

- 3.11.1 Changes in the patient's details must be updated on the IT system and the medical record on the date of the session.
- 3.11.2 When the test has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of session.

3.12 SESSION TEMPLATE CHANGES

- 3.12.1 Session templates should be agreed with the healthcare professional and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement (SBAs).
- 3.12.2 Templates will identify the number of slots available for new red flag, new urgent, new routine, planned and follow up appointments; specify the time each session is scheduled to start and finish; and identify the length of time allocated for each appointment slot.

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

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

3.13 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

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

3.13.2 Transfers to alternative providers must always be with the consent of the patient and the receiving clinician and be managed in line with PAS technical guidance (see also Reasonable Offers, ref. 3.5). Administrative speed and good communication are very important to ensure this process runs smoothly.

3.14 TECHNICAL GUIDANCE

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

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

- Diagnostic waiting time and report turnaround time.
- Patients treated (IP/DC) or seen (OP) by an independent sector provider.
- Rapid angina assessment clinic (RAAC).
- Management of waiting times of patients who transfer between NHS sites (either within NI or the rest of the UK).

- Patients who are to be treated as part of a waiting list initiative / additional in house activity.

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INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 4

**GUIDANCE FOR MANAGEMENT OF ELECTIVE
ADMISSIONS**

DRAFT

4.1 INTRODUCTION

- 4.1.1 The following protocol is based on recommended good practice guidelines to assist staff with the effective management of elective inpatient and daycase admissions.
- 4.1.2 The administration and management of elective admissions within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.
- 4.1.3 In all aspects of the elective admissions booking process, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language**. Local booking policies should be developed accordingly.

Have we anything in place for this?

4.2 KEY PRINCIPLES

- 4.2.1 To aid both the clinical and administrative management of the waiting list, lists should be sub-divided and managed appropriately. Trusts will manage patients on one of three waiting lists, i.e.
1. active,
 2. planned and
 3. suspended.
- 4.2.2 All elective inpatient and daycase waiting lists should be managed according to clinical priorities. Priorities must be identified for each patient on the waiting list and allocated according to urgency of the treatment. Trusts will manage patients in four priorities, i.e.
1. Red flag (suspect cancer),
 2. urgent,
 3. routine and
 4. planned.
- No other clinical priority categories should be used for inpatient and daycase services.

There are currently only 2 priority categories on PAS for referrals – urgent and routine. Red flags are identified by reason for referral code. Is this an opportunity to update PAS with a priority category for red flag? Yes this would make sense

- 4.2.3 Patients of equal clinical priority will be selected for booking in strict chronological order, taking into account planned patients expected date of admission.
- 4.2.4 The regional targets for a maximum inpatient and daycase waiting times are outlined in the Health and Social Care Commissioning Plan and Indicators of Performance Direction (CPD), <https://www.health-ni.gov.uk/doh-management-and-structure> (see Ministerial Priorities).
- 4.2.5 Maximum waiting times for urgent patients should be agreed locally with clinicians and made explicit, through internal processes, to booking office staff. Booking staff should ensure that patients are appointed within the clinical timeframe indicated by the consultant and capacity issues are quickly identified and escalated.
- 4.2.6 Trusts should ensure that clinical templates are constantly reviewed to meet changes in demand and new clinical practice.
Is this relevant to elective? Consultants normally select cases based on clinical priority etc.
- 4.2.7 Data collection in respect of referrals and waiting times should be accurate, timely, complete and subject to regular audit and validation.
- 4.2.8 Trusts should **not** use manual administration systems to record and report patients who have been booked.
- 4.2.9 Trusts should provide training programmes for staff which include all aspects of IEAP. It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts.

4.3 PRE-ASSESSMENT

- 4.3.1 All patients undergoing an elective procedure (including endoscopy procedures) must undergo a pre-assessment. This can be provided using a variety of methods including telephone, video link, postal or face to face assessment.
- 4.3.2 Pre-assessment may include an anesthetic assessment or guidance on how to comply with pre-procedure requirements such as bowel preparation. It will be the responsibility of the pre- assessment team, in accordance with protocols developed by the relevant clinical teams, to authorise fitness for an elective procedure.
- 4.3.3 Only those patients that are deemed fit for their procedure may be offered a TCI date.
- 4.3.4 If a patient is assessed as being unfit for their procedure, their To Come In (TCI) date may be cancelled and decision taken as to the appropriate next action.
- 4.3.5 Pre-assessment services should be supported by a robust booking system.

4.4 CALCULATION OF THE WAITING TIME

- 4.4.1 The starting point for the waiting time of an inpatient/daycase admission is the date the appropriate clinician agrees that a procedure will be pursued as an active treatment or diagnostic intervention, and that the patient is clinically and socially fit to undergo such a procedure.
- 4.4.2 The waiting time for each patient on the elective admission list is calculated as the time period between the original decision to admit date and the date at the end of the applicable period for the waiting list return. If the patient has been suspended at all during this time, the period(s) of suspension will be automatically subtracted from the total waiting time.

4.5 REASONABLE OFFERS - TO COME IN (TCI) OFFERS OF TREATMENT

- 4.5.1 The patient should be advised of their expected waiting time during the consultation between themselves and the health care provider/practitioner.
- 4.5.2 All patients must be offered reasonable notice. Patients should be made reasonable offers to come in (TCI) on the basis of clinical priority. Within clinical priority groups offers should then be made on the basis of the patient's chronological wait.
- 4.5.3 A reasonable offer is defined as:
- an offer of admission, irrespective of provider or location, that gives the patient a minimum of three weeks' notice and a choice of two TCI dates, and
 - at least one of the offers must be within N. I., except for any regional specialties where there are no alternative providers within NI.

The majority of elective procedures are fixed appointments, based on when consultants are available for theatre sessions, availability of ICU capacity if required, volume of predicted in-patient beds etc. This is a complex booking process which can be difficult to adapt with partial booking.
Does there need to be a guidance for fixed elective offers?

- 4.5.4 If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the admission was refused.
- 4.5.5 This does not prevent patients being offered earlier appointment dates. If the patient is offered an admission within a shorter notice period (i.e. less than three weeks' notice) and refuses it they will not have their waiting time reset.
- 4.5.6 If the patient accepts an admission at short notice, but then cancels the admission, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the provider.
- 4.5.7 Urgent patients must be booked within the locally agreed maximum waiting time from the date of receipt. It is recognised that there will be occasional

exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Clearly defined booking protocols will be required to support specialties and booking staff.

- 4.5.8 Providers should have robust audit procedures in place to demonstrate compliance with the above.
- 4.5.9 To ensure the verbal booking process is auditable, the Trust should make and cancel a TCI date using the date of the second admission date offered and refused for this transaction.

4.6 INPATIENT AND DAYCASE ACTIVE WAITING LISTS

- 4.6.1 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to add the patient to the waiting list, i.e. the patient must be “fit, ready, and able” to come in.
- 4.6.2 To ensure consistency and the standardisation of reporting with commissioners and the DoH, all waiting lists are to be maintained in the PAS patient information system.
- 4.6.3 Details of patients must be entered on to the computer system (PAS) recording the date the decision was made to admit the patient or add the patient to the waiting list within two working days of the decision being made. Failure to do this will lead to incorrect assessment of waiting list times.
- 4.6.4 Where a decision to add to the waiting list depends on the outcome of diagnostic investigation, patients should not be added to an elective waiting list until the outcome of this investigation is known. There must be clear processes in place to ensure a decision is made in relation to the result of the investigation and the clinical patient pathway agreed.

4.7 SUSPENDED PATIENTS

- 4.7.1 At any time a consultant is likely to have a number of patients who are unsuitable for admission for clinical or personal reasons. These patients should be suspended from the active waiting list until they are ready for admission.
- 4.7.2 A period of suspension is defined as:
- A patient suspended from the active waiting list for medical reasons, or unavailable for admission for a specified period because of family commitments, holidays, or other reasons i.e. a patient may be suspended during any periods when they are unavailable for treatment for personal or medical reasons (but not for reasons such as the consultant being unavailable, beds being unavailable etc.).
 - A recommended maximum period not exceeding **three** months.
- 4.7.3 No patient should be suspended from the waiting list without a suspension end date.
- 4.7.4 Suspended patients should be reviewed one month prior to the end of their suspension period and a decision taken on their admission.
- 4.7.5 Every effort will be made to minimise the number of patients on the suspended waiting list, and the length of time patients are on the suspended waiting list.
- 4.7.6 Should there be any exceptions to the above, advice should be sought from the lead director or appropriate clinician.
- 4.7.7 Suspended patients will not count as waiting for statistical purposes. Any periods of suspension will be automatically subtracted from the patient's total time on the waiting list for central statistical returns.
- 4.7.8 No patient added to a waiting list should be immediately suspended. Patients should be recorded as suspended on the same day as the decision was taken that the patient was unfit or unavailable for admission/treatment.

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

4.8 PLANNED PATIENTS

- 4.8.1 Planned patients are those patients who are waiting to be admitted to hospital for a further stage in their course of treatment or surgical investigation within specific timescales.
- 4.8.2 These patients are not actively waiting for treatment, but for planned continuation of treatment. A patient is planned if there are clinical reasons that determine the patient must wait set periods of time between interventions. They will not be classified as being on a waiting list for statistical purposes.
- 4.8.3 Trusts must have systems and processes in place to identify high risk planned patients in line with clinical guidance.
- 4.8.4 Trusts should be able to demonstrate consistency in the way planned patients are treated and that patients are being treated in line with the clinical constraints. Planned patients should have a clearly identified month of treatment in which it can be shown that the patients are actually being treated.
- 4.8.5 Trusts must ensure that planned patients are not disadvantaged in the management of planned backlogs, with particular focus on high risk surveillance pathway patients.

4.9 PATIENTS LISTED FOR MORE THAN ONE PROCEDURE

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

- 4.9.2 Where different clinicians working together will perform more than one procedure at one time the patient should be added to the waiting list of the clinician for the priority procedure with additional clinician procedures noted.
- 4.9.3 Where a patient requires more than one procedure performed on separate occasions or bilateral procedures by different (or the same) clinician, the patient should be placed on the active waiting list for the first procedure and the planned waiting list for any subsequent procedures.

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

DNAs – Inpatient/Daycase

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

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

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

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

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

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

Is there a process in place for this the same as outpatients were a letter is sent to the patient and they phone in ?

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

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

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

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

4.10.2 CNAs – Patient Initiated Cancellations of inpatient/daycase admission

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

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

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

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

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

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

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

4.11. CNAs - HOSPITAL INITIATED CANCELLATIONS

- 4.11.1 No patient should have his or her admission cancelled. If Trusts cancel a patient's admission the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity.
- 4.11.2 The patient should be informed of the cancellation and the date of the new admission booked.
- 4.11.3 Trusts will make best efforts to ensure that a patient's admission is not cancelled a second time for non-clinical reasons.
- 4.11.4 Where patients are cancelled on the day of an admission/operation as a result of not being fit, they will be suspended, pending a clinical review of their condition. The patient should be fully informed of this process.
- 4.11.5 Hospital initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of admission a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

4.12 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

- 4.12.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between Trust sites or to independent sector (IS) providers.
- 4.12.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant and be managed in line with PAS technical guidance, (see also Reasonable Offers, ref. 4.5). Administrative speed and good communication are very important to ensure this process runs smoothly.

4.13 TECHNICAL GUIDANCE

4.13.1 See also Regional ISB Standards and Guidance

<https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Standards%20and%20Guidance.aspx> re acute activity definitions.

4.13.2 See also PAS technical guidance

<https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Technical%20Guidance.aspx> for recording;

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

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 5

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

DRAFT

5.1 INTRODUCTION

- 5.1.1 The following protocol is based on recommended good practice guidelines to assist staff with the effective management of the elective booking processes for elective Allied Health Professionals (AHP) services, including those patients whose referral is managed virtually.
- 5.1.2 Allied Health Professionals work with people of all age groups and conditions, and are trained in assessing, diagnosing, treating and rehabilitating people with health and social care needs. They work in a range of settings including hospital, community, education, housing, independent and voluntary sectors.
- 5.1.3 The administration and management of the AHP pathway from receipt of referral to appointment within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.
- 5.1.4 For the purposes of this section of the protocol, the generic term 'clinic' will be used to reflect AHP activity undertaken in hospital, community (schools, daycare settings, leisure and community centres) or domiciliary settings (people's own home or where they live e.g. residential or nursing homes) as AHPs provide patient care in a variety of care locations.
- 5.1.5 AHP services are administered on a wide range of information systems, with varying degrees of functionality able to support full IT implementation of the requirements of the IEAP. Trusts should ensure that the administrative management of patients is undertaken in line with the principles of the IEAP and that all efforts are made to ensure patient administration systems are made fit for purpose.
- 5.1.6 There will be dedicated booking offices within Trusts to receive, register and process all AHP referrals.
- 5.1.7 Fixed appointments should only be used in exceptional circumstances.

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

5.2 KEY PRINCIPLES

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

1. urgent and
2. routine.

No other clinical priorities should be used for AHP services.

- 5.2.2 Patients of equal clinical priority will be selected for booking in strict chronological order.
- 5.2.3 Patient appointments for new and review should be **partially booked**. Where fixed appointments are being issued, Trusts should ensure that the IEAP guidance is followed in the management of patients.
- 5.2.4 The regional target for a maximum AHP waiting time is outlined in the Health and Social Care Commissioning Plan and Indicators of Performance Direction (CPD), <https://www.health-ni.gov.uk/doh-management-and-structure> (see Ministerial Priorities).
- 5.2.5 Maximum waiting times for urgent patients should be agreed locally with AHP professionals and made explicit, through internal processes, to booking office staff. Booking staff should ensure that patients are appointed within the clinical timeframe indicated by the professional and capacity issues are quickly identified and escalated.
- 5.2.6 Patients should not be disadvantaged where a decision is made to assess their clinical need through virtual activity.

- 5.2.7 Trusts should ensure that clinical templates are constantly reviewed to meet changes in demand and new clinical practice.
- 5.2.8 Data collection in respect of referrals and waiting times should be accurate, timely, complete and subject to regular audit and validation.
- 5.2.9 Trusts should **not** use manual administration systems to record and report patients who have been booked.
- 5.2.10 Trusts should provide training programmes for staff which include all aspects of this IEAP. It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts.

5.3 NEW REFERRALS

- 5.3.1 All outpatient referrals (including those sent via Clinical Communication Gateway (CCG)) sent to Trusts will be registered within **one** working day of receipt. Referrer priority status must be recorded at registration.
- 5.3.2 Trusts will work towards a system whereby the location of all referrals (paper and electronic) not yet prioritised can be identified and tracked.
- 5.3.3 All referrals must be prioritised and clinical urgency must be clearly identified. Clinicians and management will be responsible for ensuring that cover is provided for referrals to be read and prioritised during any absence.
- 5.3.4 All referrals will be prioritised (including those prioritised via E Triage) within **three** working days of date of receipt of referral.
- 5.3.5 Following prioritisation, referrals must be actioned on PAS or the relevant electronic patient administration system and appropriate correspondence (including electronic), e.g. acknowledgement or appointment letter, issued to patients within **one** working day.

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

5.4 CALCULATION OF THE WAITING TIME

- 5.4.1 The starting point for the waiting time of an AHP new referral is the date the clinician's referral or self-referral is received by the booking office or, for internal referrals, when the referral is received by the booking office/department. All referrals, including emailed and electronically delivered referrals, will have the date the referral received into the organisation recorded either by date stamp or electronically.
- 5.4.2 In cases where referrals bypass the booking office, (e.g. sent directly to an allied health professional), the Trust must have a process in place to ensure that these are date stamped on receipt, immediately forwarded to the booking office/department and registered at the date on the date stamp.
- 5.4.3 The waiting time for each patient is calculated as the time period between the receipt of the referral and the date at the end of the applicable period for the waiting list return. If the patient has been suspended at all during this time, the period(s) of suspension will be automatically subtracted from the total waiting time.
- 5.4.4 The waiting time clock stops when the first definitive AHP treatment has commenced.

5.5 REASONABLE OFFERS

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

- 5.5.2 If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused.
- 5.5.3 This does not prevent patients being offered earlier appointment dates. If the patient is offered an appointment within a shorter notice period (i.e. less than three weeks' notice) and refuses it they will not have their waiting time reset.
- 5.5.4 If the patient accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the provider.
- 5.5.5 Urgent patients must be booked within the locally agreed maximum waiting time from the date of receipt. It is recognised that there will be occasional exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Clearly defined booking protocols will be required to support specialties and booking staff.
- 5.5.6 Providers should have robust audit procedures in place to demonstrate compliance with the above.
- 5.5.7 To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

5.6 REVIEW APPOINTMENTS

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

- 5.6.2 Patients must be recorded on PAS as requiring to be seen within a clinically indicated time. Trusts should actively monitor patients on the review list to ensure that they do not go past their indicative time of treatment.
- 5.6.3 Review patients who require an appointment within **six** weeks will be asked to agree the date and time of the appointment before leaving the department and PAS updated.
- 5.6.4 Patients requiring an appointment outside **six** weeks will be placed on a review waiting list, with the agreed clinically appropriate appointment date recorded, and be booked in line with implementation guidance for review pathway patients.
- 5.6.5 Virtual review appointments, e.g. telephone or video link, should be partially booked. If the patient cannot be contacted for their virtual review they should be sent a partial booking letter to arrange an appointment.

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

5.7.1 DNAs – New AHP Appointments

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

5.7.1(a) Patients who have been partially booked will **not** be offered a second appointment and should be removed from the waiting list.

The patient and referrer (and the patients GP, where they are not the referrer) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

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

- 5.7.1(c) Patients who DNA and are not discharged but offered a second appointment will have their waiting time clock reset to the date of the DNA.
- 5.7.1(d) *Where patients are discharged from the waiting list (ref. 5.7.1(a)) they should be advised to contact the Trust booking office within **four** weeks of the original appointment date if they consider that the appointment is still required. Where a patient makes contact within the **four** week deadline, and where the Trust considers that unforeseen or exceptional circumstances meant that the patient was unable to attend, the patient should be added to the waiting list at the date that they have made contact with the Trust. If a patient makes contact after the **four** week period they cannot be reinstated.*
- 5.7.1(e) If the patient DNAs the second appointment offered then the patient should **not** be offered another opportunity to be reinstated. The patient and referrer (and the patients GP, where they are not the referrer) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.
- 5.7.1(f) Where a patient DNAs a fixed new appointment (i.e. they have not had the opportunity to agree/confirm the date and time of the appointment) they should be offered another appointment.
- 5.7.1(g) If the patient DNAs this second appointment the above steps should be followed.
- 5.7.1(h) If a patient DNA's a virtual outpatient appointment this should follow the above protocol based on whether the appointment is partially booked or fixed. The Trust should ensure that the contact details of the patient are up to date and available.

5.7.2 DNAs – Review Appointments

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

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

- 5.7.2(c) Where the clinical decision is that a second appointment should **NOT** be offered, Trusts should contact patients advising that as they have failed to attend their appointment they will be discharged from the waiting list. The referrer (and the patient's GP, where they are not the referrer) should also be informed of this.
- 5.7.2(d) Patients being discharged from the list should be advised to contact the Trust booking office if they have any queries. Where unforeseen or exceptional circumstances meant that the patient was unable to attend, and the patient makes contact within **four** weeks of the original appointment date, a clinical decision may be made to offer a second appointment. Where this is the case, the patient should be added to the waiting list at the date they make contact with the Trust.
- 5.7.2(e) If the patient DNAs the second appointment offered then the patient should **NOT** be offered another opportunity to be reinstated. The patient and referrer will be informed that, as they have failed to attend their appointment, they will be discharged from the waiting list.
- 5.7.2(f) Where a patient DNAs a fixed review appointment where they have not had the opportunity to agree/ confirm the date and time of their appointment, they should be offered another appointment. If they DNA this second fixed appointment, the above should be followed.
- 5.7.2(g) If a patient DNA's a virtual outpatient review appointment this should follow the above protocol based on whether the appointment is partially booked or fixed. The Trust should ensure that the contact details of the patient are up to date and available.

5.7.3 CNAs – Patient initiated cancellations (new and review)

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

- 5.7.3(a) The patient will be given a second opportunity to book an appointment (where this is still required), which should be within **six** weeks of the original appointment date.
- 5.7.3(b) Patients who CNA will have their waiting time clock reset to the date the Trust was informed of the cancellation.

- 5.7.3(c) If a second appointment is cancelled, the patient will **not** normally be given another appointment. Where a decision is taken not to offer a further appointment, Trusts should contact patients advising that they have been discharged from the waiting list. The referring professional (and the patient's GP, where they are not the referrer) should also be informed of this.
- 5.7.3(d) However, where unforeseen or exceptional circumstances mean that the patient had to cancel a second appointment, the Trust may exercise discretion to offer a third appointment. This should include seeking a clinical review of the patient's case where this is appropriate.
- 5.7.3(e) If a patient CNA's a virtual outpatient appointment this should follow the above protocol.
- 5.7.4 Trusts have a responsibility to ensure that children and adults at risk who DNA or CNA their outpatient, inpatient, diagnostic or AHP appointment are followed up by the most appropriate healthcare professional and a clear link to the referring clinician established.
- 5.8 CNAs – SERVICE INITIATED CANCELLATIONS**
- 5.8.1 No patient should have his or her appointment cancelled. If Trusts cancel a patient's appointment, including a virtual appointment, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity.
- 5.8.2 The patient should be informed of the cancellation and a new appointment partially booked.
- 5.8.3 Trusts will make best efforts to ensure that a patient's appointment is not cancelled a second time for non-clinical reasons.
- 5.8.4 Service initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

5.9 CLINIC OUTCOME MANAGEMENT

- 5.9.1 There are a number of locations within Trusts where patients present for their AHP consultation. This protocol applies to all AHP areas. It is the responsibility of the PAS/ IT system user managing the attendance to maintain data quality.
- 5.9.2 Changes in the patient's details must be updated on PAS and the medical records on the date of clinic.
- 5.9.3 When the consultation has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic.

5.10 CLINIC TEMPLATE CHANGES

- 5.10.1 Clinic templates should be agreed between the relevant AHP professional and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement (SBAs).
- 5.10.2 Templates will identify the number of slots available for new urgent and routine and review appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated for each appointment slot.
- 5.10.3 All requests for template and temporary clinic rule changes will only be accepted in writing. A minimum of six weeks' notice will be provided for clinic template changes.
- 5.10.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager.

5.11 TRANSFERS BETWEEN TRUSTS or to INDEPENDENT SECTOR

- 5.11.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between Trusts or to independent sector (IS) providers.
- 5.11.2 Transfers to alternative providers must always be with the consent of the patient and the receiving AHP professional, (see also Reasonable Offers, ref. 5.5). Administrative speed and good communication are very important to ensure this process runs smoothly.

5.12 TECHNICAL GUIDANCE

- 5.12.1 See also Public Health Agency;
<https://www.publichealth.hscni.net/publications/ahp-services-data-definitions-guidance-june-2015> re Guidance for monitoring the Ministerial AHP 13 week access target.
- 5.12.2 See also Regional ISB Standards and Guidance
<https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Standards%20and%20Guidance.aspx> re acute activity definitions.
- 5.12.3 See also PAS technical guidance
<https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Technical%20Guidance.aspx> for recording;
- ICATS waiting times and activity (including paper triage).
 - Patients treated (IP/DC) or seen (OP) by an independent sector provider.
 - Management of waiting times of patients who transfer between NHS sites (either within NI or the rest of the UK).
 - Patients who are to be treated as part of a waiting list initiative / additional in house activity.
 - Recording Consultant Virtual Outpatient Activity (June 2020).
 - AHP Virtual Consultation Guidance (to be issued).

Administrative & Clerical Standard Operating Procedure

No:

TITLE	Procedures for Referral & Booking Centre	
S.O.P.		
Version Number	1.0	Supersedes:
Author	Katherine Robinson, Helen Forde, Marie Loughran/Leeanne Browne	
Page Count	11	
Date of implementation	1.1.10	
Date of Review	1.1.12	
Approved by	A&C Implementation Group	

Standard Operating Procedure (S.O.P) Referral and Booking Centre Procedures

Introduction

This SOP outlines the procedures followed by the Referral and Booking Centre from initial receipt of referral letters to booking the appointment.

It also highlights the procedures which need to be followed should a clinic need to be cancelled or reduced.

Implementation

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

Referral Letters

There are 3 deliveries of post to the post room each day

Morning
Lunchtime
Afternoon

Post room staff open the post and sort.

Electronic Referrals

There are referrals now coming from some GP practices electronically. These are currently opened in the post room and printed. Red flag referrals are redirected to the Mandeville Unit/DHH. This project is in initial stages.

New Referrals

Date stamp the letter with the current date.

The post is then sorted out into the relevant teams and left in the appropriate trays in the RBC. Each team within the Booking Centre has responsibility for booking certain specialties.

If there are any discrepancies or queries with hospital numbers these referral letters should be placed in the registration tray in the RBC for registering on PAS. Hospital numbers should always be written in Red on the top right hand corner of the referral.

Triaged Referrals

Referrals received back following triage should be sorted into team specialties and put in appropriate trays for Add to Waiting List in RBC, **with the exception of Urology letters which are handed to directly to that team.**

ORE'ing

Priority is given to ORE'ing the referral letters – all members of the team ORE and the supervisor will monitor the flow. Referral letters should be ore'd within 24 hrs. The function set required is DWA – ORE.

You are required to ORE in site related to referral e.g, STH address has to be ORE'd in STH site. Relevant hospital number related to site is also required. All referrals are to be ORE'd to GP Specification, i.e. Urgent – GPU, priority type 2.

Creating an Episode

The function on PAS to be used when creating an episode is ORE. You will need to know which consultant code/speciality code to use – each team has a table of instructions which contains information relating to the codes and any special instructions, eg optician. You will need to check this each time you create an episode until you become familiar with the consultant's requirements.

When you have recorded the patient on PAS you then need to send the referral letters up to the consultant for triage (grading of the letter into routine / urgent).

For most specialities in Daisy Hill Hospital (DHH), South Tyrone Hospital (STH) and Armagh Community Hospital (ACH) referral letters are scanned and e-mailed to relevant secretaries for triage. In CAH referral letters are sent by post or delivered by hand.

Letters returned from Triage

When the letter is returned from the consultant they are ready to be added to the Waiting List. Each team is responsible for their own specialities. Check if:

- Priority has been changed, eg from urgent to routine
- The patient has been assigned to a named consultant in same speciality – previously an unnamed referral

Changes like this will mean you have to go into PAS and amend the OP REG using the function RBA which will allow you to make the amendments and also add to W/L) ensuring the correct hospital number.

To add to the Waiting List if there are no amendments to the OP REG – use the function OWL select your OP REG and then get the Waiting List code from the table of instructions and add in. Also add in additional details to the Procedure Field such as Bowels, Gastro, x-ray needed.

During this updating of PAS you must check to ensure that the date of the OP REG is the same as the date stamp on the letter and the same as the date on list on PAS.

For Dermatology ICATS and Urology ICATS the original episode needs discharged on PAS – function OD with reason code CICT. Referral is then re-ored using relevant ICATS specification.

Selecting from Waiting List

Each month there is a “big select”. Before you do your “big select” you will need to:

- Check the front of the Select file for guidance/clinic instructions
- Check the back of the file to see what instructions are recorded on the calendar – if clinics are to be cancelled or reduced check PAS to make sure that this has been done
- Phone the consultant’s secretary to double check all holidays/reduced clinics are correct, and that there are no changes to the information
- Check that the cancelled clinic details are recorded on the cancelled clinic spreadsheet

To determine how many slots you have for NR (New Routine) patients use the function CBK and look at each individual clinic and see how many NR slots there are for the time period you are working on and this will let you know the number of patients you can send for.

The same procedure above applies for NU (New Urgent) and R (review) patients.

You’re now ready to select your patients so using SWO select the appropriate number of patients and on PAS record in the comment field:

- PB1,
- the date it was sent (today’s date) and
- the code of the clinic that the patient is to be booked to, and the consultant or clinician code if appropriate eg Ortho Icats and Paeds staff grade clinics.
- the month they have to be booked into.

Patients must be selected in chronological order – your SWO screen and your PTL will guide you with this.

Only one person per speciality will work on the selection at a time to avoid duplication.

When you have completed your select you must then record the patient details etc on the **SELECT SHEET** You should also remove all the referral letters that you’ve selected and keep them with this list at the front of the select file.

In two weeks’ time when you’re checking to see who needs to have a PB2 sent you can use this check together with SWO to ensure that all patients have been actioned. You may also check function EPI to see if patients have responded to their PB1 letter.

When sending out the PB2 letters remember to update the comment field with your appropriate PB2 code, today’s date, the clinic code/consultant code if appropriate to be booked into, and also the month the patient is to be seen in.

PB1 letter sent – if no response within 14 days from the date in the comment field the PB2 letter is sent. PB2 letter is sent – if no response within 7 days from the date in the comment field the patient is discharged and a letter sent to the patient and the GP.

Discharging a Patient

Before you can discharge a patient on PAS you must do a check on their address – phone their GP to confirm address. If this is different from what is recorded on PAS then you must get in contact with the patient to offer them an appointment – this is usually done by telephoning the patient. If no contact can be made by telephone then the PB1 will be re-issued to the correct address.

If the address is correct then you can discharge the patient, issue a letter to the patient and to the GP, and forward the referral letter to the consultant. There are however exceptions where you need to email the secretary details of the non-responders and forward the referral letter.

Children – you cannot discharge a child (child = under 17 years and 364 days old). Fill in “Under 18’s O/P Discharge” form and forward to the consultant with the referral letter. They must inform you of the follow up action, eg discharge, send for again.

Primary Target Lists (PTL’s)

Every Monday you will get a new PTL (can be requested more frequently if required). When you get your PTL you will need to:

Look for any blanks (ie patient episodes where the W/L code is not entered)

Are there any episodes where a PB2 is now required

Are there any PB2’s that now need to be closed

Check, using CBK and SWO, if there is capacity in any of your clinics

Check, using CBK and SWO, if there is a shortfall in any of your clinics

Diary

Each team has a diary which is used as a checking mechanism. The diary is date stamped with the following headings and also includes the codes of the clinics that are held on that day:

Completed Clinic

PB1

PB2

PBG

Example

Today's date is Tuesday 19th April – the diary entry will look like this:

Completed Clinic	26/04/11	(this is one week in advance)
PB1	31/05/11	(this is 6 weeks in advance)
PB2	05/04/11	(this is 2 weeks previously)
PBG	29/03/11	(this is 3 weeks previously)

Completed Clinic

Today is the 19th April, so you want to check the clinics held on the 26th April to make sure they are all fully booked. The clinic codes are all on this page for reference.

PB1

Today you want to send out your PB1 letters for the clinics that are 6 weeks away – so you will be checking the clinics on the 31st May to check their capacity and then selecting your patients to send. The clinic codes are all on this page for reference.

PB2

Today you want to check who needs a PB2 letter sent – so you want to check the clinics that are held on a Friday that have had a PB1 sent on the 05/04/11 and that haven't responded, as they now require the PB2 letter. Use both the list at the front of the select file and also the function SWO.

PBDG

Today you want to check who has received a PB2 letter on the 29/03/11 and who have not responded – use the list at the front of the select file and also the function SWO. These patients now need discharged on PAS (except if they are a child).

Booking an appointment

When a patient phones up to make their appointment having received their letters you use function BWL.

You have to remember here:

- Breach Codes – being aware of target dates i.e. 9/17/21/26/41 weeks
- Letter codes – remember to use the relevant letter codes depending on the clinic, this gives information to patients what to expect at the clinic.
- Letter options i.e. U6/DB/VA

You may also have to use function RBA if the patient has come of an unnamed list, the consultant will have to be changed from unnamed to named. You have to ensure that when using RBA that you use the correct hospital number for the appointment.

Resetting

If a patient has an appointment for the 2nd July and phones up on the 23rd June to cancel the appointment then the date that they are reset on the PTL will be 23/6/09 – in other words PAS will always take the reset from the date the appointment was cancelled, not the date of the clinic. Their new date will be calculated to 23/6/09 by the PTL. Do not ever change the date on list for New Patients EXCEPT SFA following NRPB – no response to Partial Booking.

Cancelling a clinic

You may only cancel a clinic if you are in receipt of an e-mail containing a cancel clinic proforma from the consultant or their secretary giving the details of the clinic to be cancelled and confirming that you should now proceed and cancel same.

If the clinic is to be within 6 weeks then clearance is required from the heads of service before any action can be taken.

If the clinic is 6 weeks or beyond then clearance is not required and relevant action can be taken.

Some clinics are set up on PAS to build well into the future (on screen) while others are set up to build a few weeks into the future (not on screen).

Do a CBK, enter in clinic code and check if this date is built on PAS. At this stage make a note of the number of NU, NR, RF, REV slots on the clinic as you will need to record this information on a spreadsheet*.

Built on PAS

Function Set = ODM and Function = CCL (cancelled clinic)

Enter in clinic code and date of clinic to be cancelled.

If there are patients booked onto this clinic a Rebook List will be automatically produced. It is best practice to phone the patients on the Rebook List and cancel the appointment, giving them a new appointment if possible.

If you do not have capacity to rebook the patients into the correct month then this should be escalated to your supervisor/referral and booking centre manager.

- Now go to the cancelled clinic *spreadsheet and fill in the clinic details including the number of slots cancelled by category.
- Record the cancelled clinic details on the calendar at the back of the Select File.
- Record the cancelled clinic details in the diary.
- File the e-mail in the cancelled clinics team folder.

Not Yet Built on PAS

If the date of the clinic you have to cancel is not built on PAS then you need to:

- Record the information on the calendar at the back of the Select File
- Record the information in the diary
- File the e-mail in the cancelled clinic team folder

Reducing a Clinic

You may only reduce a clinic if you are in receipt of an e-mail containing a proforma to reduce the relevant clinic from the consultant or their secretary giving the details of the clinic to be reduced and confirming that you should now proceed and reduce same.

If the clinic is to be within 6 weeks then clearance is required from the heads of service before any action can be taken.

If the clinic is 6 weeks or beyond then clearance is not required and relevant action can be taken.

CBK – get details of the timeslots as you need to record the reduced clinic details on the cancelled clinic spreadsheet.

Some clinics are manned by one doctor while other clinics are manned by several doctors, some occur once a week, and some once a day. Therefore you need to know your clinic set up so when you get confirmation that a clinic is to be reduced you need to check:

Follow relevant instructions per consultant template.

- How many doctors are at this clinic?
- How many patients would need cancelled?
- What types of appointments should be cancelled – eg NR or Rev?

To reduce the clinic use the function TBO – this will allow you to view the clinic and see what the timeslots are and how they are set up, eg every 10 minutes, with 2 NR and 1 Rev at each timeslot.

Example of a clinic set up (using only NR and Rev as the categories)

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

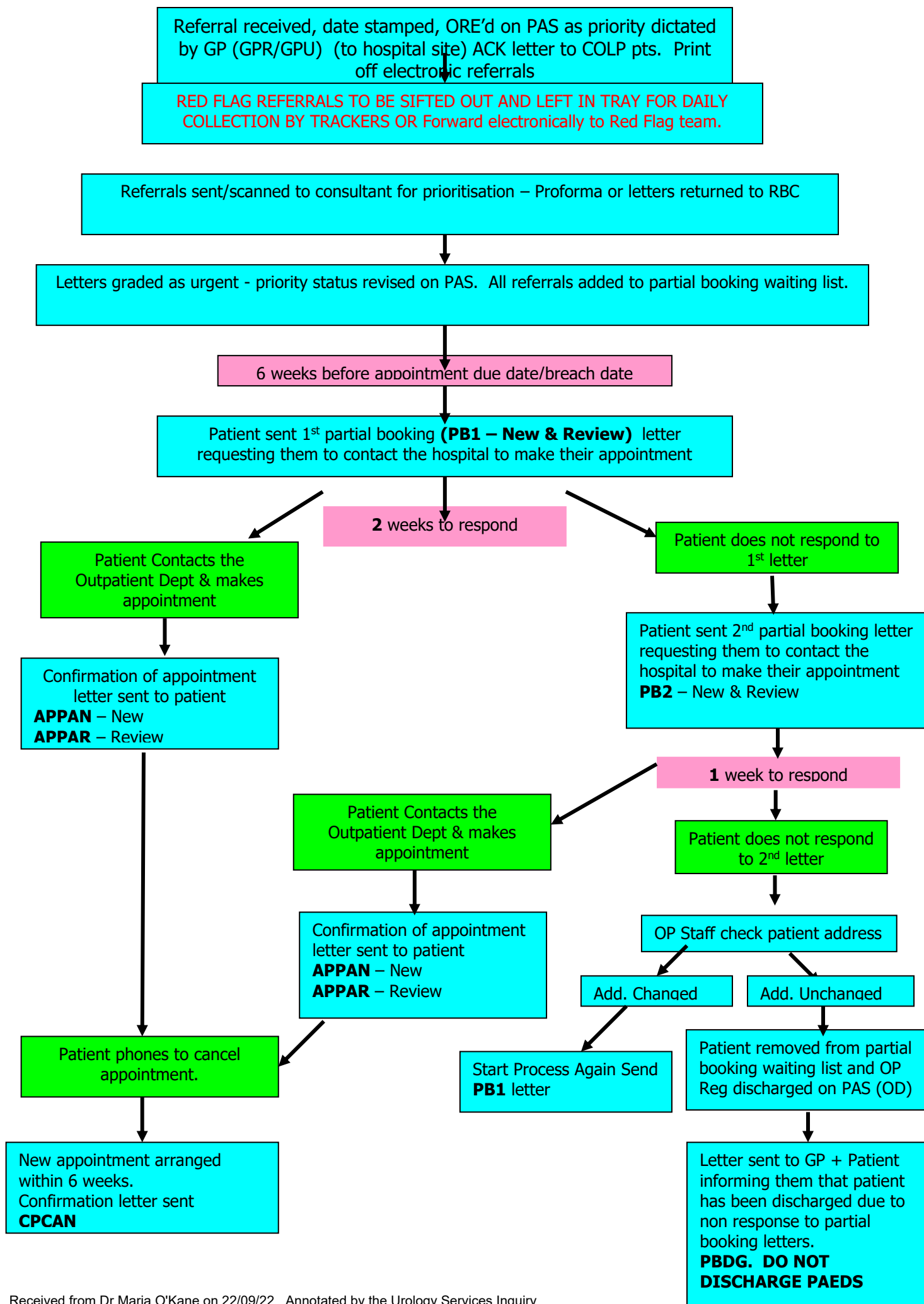
If you were asked to reduce this clinic by 4 NR and 3 R as there will be one doctor on leave from the clinic then you need to make sure that the reductions

you make still ensure patient flow, ie you don't have all the reductions at the start of the clinic, leaving the 2 remaining doctors with no patients at 9 am. The reductions should be spread throughout the clinic. It's also important to consider the category of the patient, ie a doctor can generally see a review patient in a shorter time than a new patient.
Function set required is ODM – MS

Remember not to take away new patients from the start of an afternoon clinic to allow for ambulance patients.

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

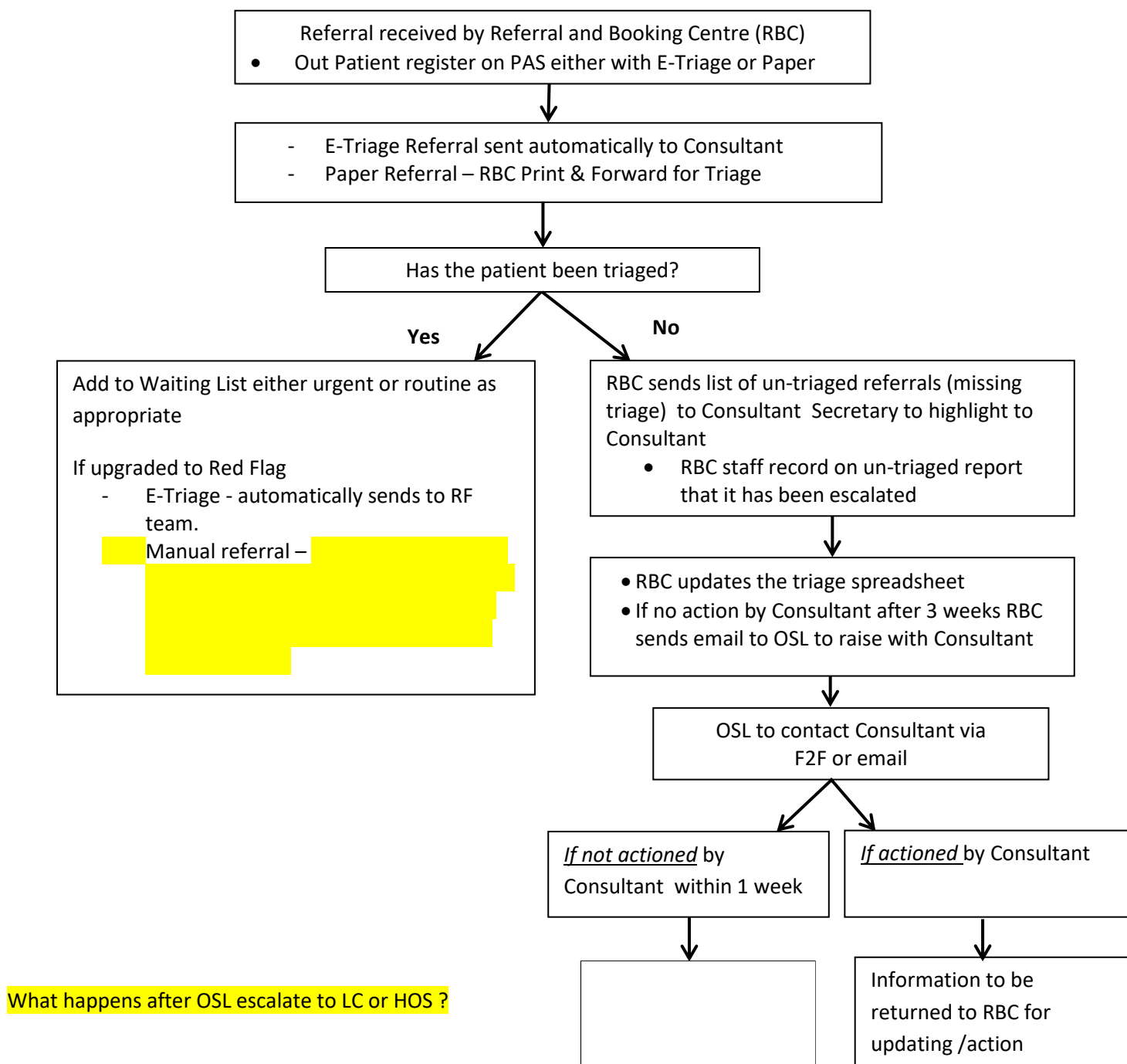
PARTIAL BOOKING ROUTINE APPOINTMENTS – RBC



- Red Flag referrals should be returned from Triage within 24hrs
- Urgent referrals should be returned from Triage within 72hrs
- Routine referrals should be returned from Triage within week.

PURPOSE OF TRIAGE

- Consultant triage is to confirm that the speciality is appropriate and the clinical urgency is appropriate.
- It also serves a purpose to direct the referral to an appropriate service within the speciality (e.g. to vascular surgeons etc.)
- It allows the Consultant to request any investigations which the patient will require prior to outpatient attendance
- The Consultant can return referrals with advice and no outpatient attendance where appropriate.



What happens after OSL escalate to LC or HOS ?

Please Note: This process will incur a minimum of 7 weeks in total if referral is un-triaged within the target times which means that if the referral is upgraded to Red Flag it is in excess of 14 day Red Flag turnaround.

It is the responsibility of the Consultant to ensure Triage is done within the appropriate timescales detailed above



Memorandum

To:	All Trust Urology Team Members
c.c.	Melanie McClements, Interim Director Acute Services; Mr Mark Haynes, AMD Surgery and Elective Care
From:	Dr Maria O'Kane, Medical Director
Date:	7 th December 2020
Subject:	Identification of Variation of Diagnoses / Prescribed Treatments

Dear Colleagues,

I would like to extend my thanks and appreciation to each of you regarding exemplary commitment to delivery of high quality services through what has been the most challenging of years for Health and Social Care Services. Without doubt the previous weeks have been significantly difficult for members of the Urology team in particular following the Ministerial announcement regarding the public inquiry regarding the practice of a former colleague, Mr O'Brien.

As part of the Trust response to ensuring patient safety each of you may be reviewing patients who were previously under the care of Mr O'Brien. As with all routine patient reviews any appointment may result in changes in prescribed treatment or may revise diagnoses based on new evidence or changes in the patient's condition.

Although this is part of routine practice I would ask that you identify **any patient previously under the care of Mr O'Brien** whom you have reviewed since his departure from the Trust on the 17th July 2010 and identify any:

- Inappropriate or incomplete investigations carried out / to be carried out
- Prescribing of treatments that are inconsistent with evidence based practice
- Any diagnoses that may be insecure
- Any clinical management approaches that appear unreasonable
- Any unexplained delays with any aspect of care (reviews, prescribing, diagnostics etc)

- An patient that may have suffered harm as a result of any of the above

I ask that as well as taking appropriate clinical follow up actions regarding any of the above that you pass the details of the same to Martina Corrigan, Head of Service to ensure we can use this information to direct our patient safety reviews moving forward.

We have developed a template to help capture this information (attached).

Finally I would like to again extend my appreciation for the work you are conducting under the most difficult of circumstances, as a Trust we recognise the vital contribution of each team member to ensure our services remain of the highest quality.

Yours sincerely

Personal information redacted by USI

DR MARIA O'KANE
MEDICAL DIRECTOR

UROLOGY PATIENT REVIEW FORM

This form is to be completed for each patient previously under the care of Mr O'Brien reviewed by the Southern Trust Urology team since Mr O'Brien's departure on 17th July 2020. This form is to be retained in the patient notes and copied to Martina Corrigan, Head of Service.

Patient Details

Appointment Details

Presenting Condition	
Summary of Appointment	

While under Mr O'Briens care please answer the following to the best of your knowledge

Question	Y/N	Details
Where appropriate investigations carried out?		
Was the prescribed treatment appropriate at the time / is it appropriate now?		
Was the diagnosis secure?		
What the clinical management approach taken reasonable?		
Was there unexplained delays with any aspect of care (reviews, prescribing, diagnostics etc)		
Did the patient suffer harm as a result?		

Clinical Professional Reviewing Care

Name	
Title	
Date of Appointment	

Urology Oversight Group Minutes

Tuesday 8th December 2020, 4:00pm

Via Zoom

	Item	Actions
1	In Attendance Stephen Wallace Melanie McClements Martina Corrigan Dr Maria O’Kane Dr Damian Gormley Jane McKimm Siobhan Hynds Mr Mark Haynes Patricia Kingsnorth	
2	Apologies Vivienne Toal Ronan Carroll	
3	Weekly DoH Update Melanie updated on the meeting. Main update was to suggest that the SJR methodology would be a potentially viable vehicle going forward. Public Inquiry isn’t likely to commence until March 2021. DOH meetings will now be two weekly. Prof Krishna to quality assure work to date. Second victim discussion regarding supports required.	
Management of Patient Reviews		
4	Private Practice Martina updated on another case identified via GP practice. DLS have identified that AOB has still been liaising with DLS regarding medico-legal cases. Further information on this has been sought.	DLS to update on AOB work
5	Update on Radiology and MDM Review No update this meeting, to follow next week	Update next meeting
6	IPT for Review Process Martina reviewed IPT with the HSCB and costed at 2.3 million for 15 months. Costs in year to be met with 200k urology funding. Further funding required for 2021/22 via IPT process.	To be discussed at HSCB meeting
7	Additional Subject Matter Expertise Group reviewed the role description and agreed content.	
8	Royal College of Surgeons Engagement Group reviewed the terms of reference, broadly agreed content. Sampling strategy to be agreed. Group felt 5 years may be appropriate.	
9	Bicalutamide Patient Review No further update	
10	Engagement of ISP to undertake waiting list work Martina and Mark to speak to Patrick Keane to agree if he will be willing to engage beyond December.	Martina / Mark to discuss with






11	Information Telephone Line Martina stated that the information line has been quiet this week. Martina referenced a recent communication from a patient who received a letter from an unknown source regarding the care provided by AOB asking to contact the information line, this was not issued by the SHSCT. Group discussed producing a holding letter to patients regarding those patients who will not be part of the review going forward. Group agreed holding letters should be issued.	Holding letter to patients to be issued
Professional Governance		
12	GMC Discussions Maria updated on the meeting with the GMC ELA. AOB will be going to interim orders on 15 th December 2020.	
13	Litigation / DLS Update Next meeting – update covered in item 4	
14	Grievance Process Next meeting	
15	Professional Alert Letter Next meeting	
16	Administration Review Update Next meeting	
Serious Adverse Incident Reviews		
17	Update on Current SAIs Communications are ongoing, a letter has been drafted to AOB via Tughans to invite AOB to take part. Summary position is expected on Friday. Maria asked that for responses are to be submitted by set deadlines.	Patricia to write to AOB on SAI Chair behalf
18	Initial SAI Recommendations Recommendations are in progress, update to be provided at a future meeting	SJR model to be discussed with the HSCB
19	Structured Judgement Review Process Next meeting	
20	Family Liaison Role Liaison role closes on Friday this week.	
Communications		
21	Media / Assembly Questions No update this week	
Any Other Business		
22	Coronial Processes Next meeting	
23	Letter to Staff re AOB Patient Reviews Letter agreed	
24	Declaration re CURE	
25	Securing Records for Public Inquiry	
Date of Next Meeting		
26	Via Zoom – 15th December 2020	




Incident Oversight Group

Tuesday 15th December 2020, 4:00pm

Via Zoom

AGENDA

1	Apologies	
2	Minutes	 MINUTES - Incident Group 08.12.2020.doc
3	Team Working - Maxine Williamson	
4	Private Practice <ul style="list-style-type: none"> - Private Practice Audit - Private Practice Patients transferred to HSC 	
5	Update on Radiology and MDM Review	
6	IPT for Review Process	 Urology Inquiry IPT - draft 8 15.12.2020.c
7	Additional Subject Matter Expertise <ul style="list-style-type: none"> - British Association of Urological Surgeons - British Association of Urological Nurses 	
8	Royal College of Surgeons Engagement	 Terms of Reference CLINICAL RECORD RI
9	Bicalutamide Patient Review	 Clinical And Social Care Audit Registrati
10	Engagement of ISP to undertake waiting list work	
11	Telephone Support Service / Patient Triage Update	
Professional Governance		
12	GMC Discussions	
13	Litigation / DLS Update	
14	Grievance Process	
15	Professional Alert Letter	
16	Administration Review Update	
Serious Adverse Incident (SAI) Reviews		
17	Update on Current SAI Progress	
18	Initial SAI Recommendations	 Action plan Personal referral.docx
19	Structured Judgement Review Process	
20	Family Liaison Role	
Communications		
21	Media / Assembly Questions	
Any Other Business		
22	Coronial Processes	

23	Letter to Staff re AOB Patient Reviews	  WIT-56273 07.12.2020 - Memo - UROLOGY PATIENT Identification of Varia REVIEW FORM v1.do
24	Declaration re CURE	 DECLARATION OF INTERESTS FORM.do
25	Securing Records for Public Inquiry	
Date of Next Meeting		
23	Via Zoom – 22 nd December 2020	

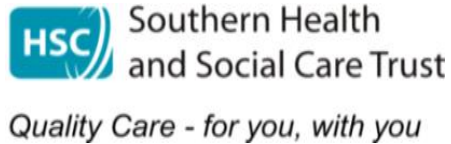
Urology Oversight Group Minutes

Tuesday 8th December 2020, 4:00pm

Via Zoom

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Strictly Confidential

Staffing Support Requirement for Serious Adverse Incident /Inquiry - Urology

3 December 2020

1.0 Introduction

There have been significant clinical concerns raised in relation to Consultant A which require immediate and coordinated actions to ensure patient safety is maintained. Comprehensive plans need to be put into place to undertake the following:

- Review of professional governance arrangements
- Liaison with professional bodies
- Review of patient safety and clinical governance arrangements
- Commencement of operational support activities including
 - Offering additional clinical activity
 - Provide complaints resolution
 - Media queries, Assembly Questions responses
 - Managing the volume of patients who require to be reviewed
 - Patient Support (Psychology / Telephone Support / Liaison)
 - Staff Support
 - Claim handling / medico-legal requests

This proposal identifies the staffing requirements and costs required to support the Serious Adverse Incident (SAI) Investigation/Inquiry for Urology in the Southern Trust.

This proposal will require revision as demands change over time.

2.0 Needs Assessment

A comprehensive review of patients who have been under the care of Consultant A will be required and this may likely number from high hundreds to thousands of patients.

Following discussions with the Head of Service the following clinics have initially been proposed and have been estimated in the first instance to continue for one year.

Clinics will commence in December 2020 and continue throughout 2021. A putative timetable has been included. We will require that consultants have access to records, have reviewed the contents and results and are familiar with each patient's care prior to face to face review where required. Each set of patient records will require 10-30 minutes to review depending on complexity. In addition, each of the patients reviewed will require 45 minute consultant urologist appointments to include time for administration/ dictation in addition to 15 mins preparation time on average. That is 8 patients require 8hrs Direct Clinical Contact (DCC) Programmed Activity (PA). 800 patients require 800 hours of Direct Clinical and so on. (Each consultant DCC PA is 4hrs).

The purpose of the clinical review is to ascertain if the:

1. diagnosis is secure
2. patient was appropriately investigated
3. Investigations, results and communications were requested in a timely fashion
4. Investigations, results and communications were responded to/ processed in a timely fashion
5. Patient was prescribed / is receiving appropriate treatment
6. Overall approach taken is reasonable
7. Patient has, is or likely to suffer harm as a result of the approach taken.

In addition, it will be expected that where there are concerns in relation to patient safety or inappropriate management that these will be identified and a treatment plan developed by the assessing consultant and shared with the urology team for ongoing oversight or with the patient's GP.

Table 2-1 Suggested timetable

Day	Clinic Session	Number of Patients
Monday	AM	8
Monday	PM	8
Tuesday	AM	8
Tuesday	PM	8
To be confirmed	AM	8
To be confirmed	PM	8
Total no of patients per week		48

3.0 Staffing Levels Identified

3.1 Information Line – First Point of Contact

An information line will be established for patients to contact the Trust to speak with a member of staff regarding any concerns they may have and will operate on Monday to Friday from 10am until 3pm. A call handler will receive the call and complete an agreed Proforma (appendix 1) with all of the patient's details and advise that a colleague will be in contact with them. The PAS handler will take the information received and collate any information included on PAS/ECR and this will be examined in detail by the Admin/Information Handler. The following staff have been identified as a requirement for this phase. It must be noted that the WTE is an estimate and will be adjusted dependent on the volume of calls received. Costs are included in Appendix 1.

Table 3-1 – Information Line Initial Staffing Requirements

Title	Band	WTE
Call Handlers	4	2
Admin Support for identifying notes/ looking up NIECR etc	4	2
Admin/Information Handler	5	1

3.2 Clinic Requirements

To date a clinical process audit has been carried out in relation to aspects of the Consultant's work over a period of 17 months.

In addition to this 236 urology oncology patients are being rapidly and comprehensively reviewed in the private sector. [\(Patients returned with management plan are included in Table 3.2/Table 3.4\)](#)

A further 26 urology oncology patients have been offered appointments or reviewed in relation to their current prescription of Bicalutamide.

Given the emerging patterns of concerns from these reviews and Multi-Disciplinary Meetings (MDMS) which have resulted in 9 patients' care meeting the standard for SAI based on this work to date, it is considered that a comprehensive clinical review of the other patients is required. The Royal College of Surgeons has advised that this includes 5 years of clinical activity in the first instance.

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The numbers and clinical prioritisation will be identified collectively by the Head of Service, Independent Consultant and the Clinical Nurse Specialist either face to face or via virtual clinics. The volume of patients is 2327 for 18 months in the first instance and the number of DCC PA has been identified as **. The staffing required to operate these clinics is detailed below. This work will be additionality and should not disrupt usual current urology services. It must be noted that again this is an estimate and will be dependent on the volume of patients involved. .

Clinic Requirements Staffing – 6 sessions as detailed in Section 2. Costs are included in Appendix 1.

Table 3-2 – Clinic Staffing Requirements

Title	Band	WTE
Outpatient Manager	7	0.7
Medical Secretarial Support	4	0.5
Booking clerk	3	0.7
Audio Typist	2	0.7
Medical Records	2	0.7
Nursing staff	5	0.7
Nurse Clinical Specialist	7	0.7
Health Care Assistant	3	0.7
Receptionist	2	0.7
Consultant		DCC
Pharmacist	8a	0.7
Psychology Band 8B and above		1 present per clinic
Domestic Support	2	0.7

3.3 Procedure Requirements

If the outcome of the patient review by the Independent consultant urologist is that the patient requires further investigation, this will be arranged through phlebotomy, radiology, day procedure, and pathology / cytology staff. The provision will be dictated by clinical demand. The following staffing levels have been identified as below for each 1 day sessions. Costs are included in Appendix 1.

Table 3-3 – Procedure Staffing Requirements

Title	Band	WTE
Secretary	4	
Reception	2	
Nurses	5	0.64

Title	Band	WTE
Health Care Assistant	3	0.22
Sterile Services	3	0.22
Consultant - locum		2 PAs
Anaesthetic cover		1 PA
Domestic Support	2	0.22

3.4 Multi-Disciplinary Weekly Meetings Requirements

In order to monitor and review the number of patients contacting the following multi-disciplinary team has been identified as a requirement. Costs are included in Appendix 1.

Table 3-4 --Staffing Requirements for Multi-Disciplinary Meetings (weekly)

Title	Band	WTE
Cancer Tracker	4	0.4
Nurse Clinical Specialist	7	0.1
Consultant Urologist x 2		2 PAS
Consultant Oncologist		1 PA
Consultant Radiologist		1 PA
Consultant Pathologist		1 PA

3.5 Serious Adverse Incident Requirements

Work has commenced on 9 SAI's and the following staff have been identified as a requirement to support the SAI and the Head of Service to enable investigative work to take place and to enable current provision to continue. Costs are included in Appendix 1.

Table 3-5 -Additional staffing and Services required to support SAI

Title	Band	WTE
Head of Service (Acute) – SAI backfill	8b	1
Chair of Panel	N/A	sessional
Band 5 admin support	5	1
Governance Nurse/ Officer	7	2
Admin support to the panel	3	1
Psychology support	Inspire	sessional
Family Liaison SLA	7	1

3.6 Inquiry Requirements

Costs are included in Appendix 1.

Table 3-6 - Additional staffing and Services required to Support Inquiry

Title	Band	WTE
Head of Service Backfill	8b	1
Clinical Nurse Specialist	7	1
Admin Support for HOS	4	1
Admin Support to respond and collate requests for information for inquiry team	5	2
Health records staff to prepare notes for Inquiry Team	2	4
Urology Experts – WL Initiative Funding £138 per hour	Consultant	Sessional
Media queries, Assembly Questions responses	8a (uplift from Band 7's)	2
Admin Support for media queries/Assembly questions	4	1

3.7 Professional and Clinical Governance Requirements to Support the SAI/ Inquiry

Investigations involving senior medical staff are resource intensive due to the many concerns about patient safety, professional behaviours, demands on comprehensive information and communications with multiple agencies. In particular this case has highlighted the need for clinical and professional governance processes across clinical areas within the Trust, to develop these systems and to embed and learning from the SAIs and Inquiry. This work should be rigorous and robust and develop systems fit for the future.

This strand will have responsibility for undertaking activities to ensure embedding of learning, improvement and communication of Trust response to the Urology incidents. This includes providing assurance that improvement efforts are benchmarked outside the Trust from both a service development and national policy perspective [and the acquired learning process and may include:-](#)

- Revision of Appraisal and Revalidation processes
- Quality Assurance of information processes in relation to Appraisal and Revalidation
- Development of systems and processes that marry professional and clinical governance
- Embedding and providing assurance regarding learning, improvement and communication
- Provide support on Trust communications regarding incident response
- Support triangulation of clinical and social care governance and professional governance information to improve assurance mechanisms
- Support the benchmarking of Trust service developments against regional and national perspectives
- Support liaison and communications with PHA / HSCB and Department of Health on matters relating to the urology incidents

-
- Support for corporate complaints department

Costs are included in Appendix 1.

Table 3-7 - Professional Governance, Learning and Assurance

Title	Band	WTE
AD Professional Governance, Learning and Assurance	8c	1
Project Lead	7	1
Administrative Support	4	1

Table 3-8 – Claims Management / Medico – Legal Requests (DLS 20%)

It is anticipated that the number of medico-legal requests for patient records and the number of legal claims will significantly increase as a result of the patient reviews and SAs. This will require support for claims handling, responses to subject access requests and redaction of records.

Title	Band	WTE
Head of Litigation (uplift from band 7)	8a (uplift from band 7)	1
Specialist Claims Handler	7	1
Claims Administrative Support	4	1
Medico – Legal Admin Support	3	1
Service admin support – redaction	4	1
Support Health Professional for redaction – Clinical Nurse Specialist	7	1
2 x Solicitor Consultants (DLS)	sessional	

4.0 Identified Risks

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

Risk Identified	Mitigation Measure
	documentation as soon as possible • Liaise with Human Resources
• Securing Funding	• Liaise with PHA and HSCB regarding additional funding required to support the SAI/Inquiry.
• Volume of calls received by the information line will exceed expectations leading to further complaints	• Monitoring of call volumes • Extending the operational hours to receive calls • Increasing the number of call handlers
• Number of clinics is insufficient to cope with the demand for review appointments	• Monitoring the number of review appointments required • Monitoring clinics and virtual clinics • Increasing the number of virtual clinics
• Current Service Provision will be impacted by the additional clinics being taken forward and Waiting Lists will continue to grow.	• Current provision continues • Utilise independent resources • Provide evening/weekend clinics
• Red flag appointments will not be seen within the required timeframe	• Monitor all current referrals and red flag appointments
• Reputation of Trust	• Provide a response within an agreed timeframe

5.0 Monitoring

Monitoring and reporting will continue throughout the investigation period and will be provided on a weekly basis. Meetings are scheduled on a weekly basis.

TERMS OF REFERENCE FOR CLINICAL RECORDS REVIEW

Review of Urology clinical records at Southern Health and Social Care Trust
under the Invited Review Mechanism.

Background

The review team will consider the standard of care provided to patients in a sample of clinical records provided by Southern Health and Social Care Trust for patients that had been under the care of Mr O'Brien, Consultant Urologist.

Review

The review will involve:

- A clinical record review of up to 100 cases from period January 2015 – December 2015 of put forward by the Southern Health and Social Care Trust

Terms of Reference

In conducting the review, the review team will consider the standard of care demonstrated in the clinical records provided by the Southern Health and Social Care Trust including with specific reference to:

- Assessment including history taking, examination and diagnosis;
- Investigations and imaging undertaken;
- Treatment including clinical decision-making, case-selection, operation or procedures;
- Communication with the patient, their family and the GP, and patient consent;
- Team working including communication with other members of the care team, MDT discussions and working with colleagues;
- Follow-up action on the patient care (for example, ordering diagnosis/onward referral to other specialties (oncology etc).
- Actions taken as a result of Multidisciplinary Meeting recommendations
- Administration in connection to the patients episode

Conclusions and recommendations

The review team will, where appropriate:

- Form conclusions as to the standard of care provided and whether there is a basis for concern in light of the findings of the review.

- May make recommendations for the consideration to the Medical Director of Southern Health and Social Care Trust as to courses of action which may be taken to address any specific areas of concern which have been identified or otherwise improve patient care.

The above terms of reference were agreed by the College, the healthcare organisation and the review team on [date].

Audit Title: Audit of Prescribing of anti-androgen medicine 'Bicalutamide'			
Directorate: Acute Services <input checked="" type="checkbox"/> Children & Young People <input type="checkbox"/> Older Persons & Primary Care <input type="checkbox"/> Mental Health & Disability <input type="checkbox"/> Corporate request <input type="checkbox"/>			
Division:			
Auditor's name: Mr Mark Haynes		Audit Supervisor's Name : Not Applicable	
Contact details: (email) Personal Information redacted by the USI			
Is this a: National audit <input type="checkbox"/> Regional audit <input type="checkbox"/> Trust audit <input checked="" type="checkbox"/> International audit <input type="checkbox"/>			
Proposed audit commencement date 27 th October 2020		Proposed audit completion date .../.../....	
Audit Aims			
To ensure that the anti-androgen medicine 'Bicalutamide' has been prescribed as licensed and in line with NICE guideline NG131 Prostate Cancer: Diagnosis and Management			
Audit Objectives			
<ul style="list-style-type: none"> To ensure that where Bicalutamide is prescribed only where indicated and as per licensed usage To ensure that where Bicalutamide is prescribed this is prescribed in the correct therapeutic dosages To ensure that patients prescribed Bicalutamide is appropriately reviewed as part of the patients ongoing care To ensure that any deviations from prescribing guidance is based on sound evidence based clinical rationale 			
Audit Standards			
The following audit standards obtained from NICE guideline [NG131] Prostate cancer: diagnosis and management Published date: 09 May 2019.			
Audit Criteria	Target	Exceptions	Source of Evidence
Bicalutamide prescribed as per indicated conditions in NICE NG131	100%	Clinical rationale for deviation from guidance	NICE guideline NG131 Prostate Cancer: Diagnosis and Management
Therapeutic doses of anti-androgen monotherapy with bicalutamide are prescribed at recommended dose (150 mg).	100%	Discussions with patient / Clinical rationale	NICE guideline NG131 Prostate Cancer: Diagnosis and Management
Audit Methodology			
The following audit methodology will be followed: <ul style="list-style-type: none"> HSCB to provide information on primary care prescriptions of the medication Bicalutamide Southern Health and Social Care Trust patients to be identified and a consultant led review of prescribing to take place to identify prescribing of Bicalutamide that is outside of that prescribed in NICE guideline NG131 Prostate Cancer: Diagnosis and Management 			
Rationale for the audit (please tick all that apply)			
Topic is included in the Directorate's clinical audit work-plan		<input type="checkbox"/> Compliance with standards & guidelines <input checked="" type="checkbox"/>	

National Healthcare Quality Improvement Partnership (HQIP) audit	<input type="checkbox"/>	Regional RQIA/GAIN audit	<input type="checkbox"/>												
Other national / international audit	<input type="checkbox"/>	Trust based audit topic important to team/division	<input checked="" type="checkbox"/>												
Clinical risk	<input checked="" type="checkbox"/>	Recommendation from national / regional report	<input type="checkbox"/>												
Serious Adverse Incident or Adverse Incident review	<input checked="" type="checkbox"/>	Clinician / personal interest	<input type="checkbox"/>												
Incident reporting	<input type="checkbox"/>	Educational audit	<input type="checkbox"/>												
Other – please specify															
Level 1 <input type="checkbox"/>	Level 2 <input checked="" type="checkbox"/>	Level 3 <input type="checkbox"/>	Level 4 <input type="checkbox"/>												
Has this audit been approved based on the priority level? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>															
Level 1 - Approval required by Associate Medical Director or Clinical Director or Directorate Governance Forum Level 2 - Approval required by Associate Medical Director or Clinical Director or Directorate Governance Forum Level 3 – Approval required by Supervising Consultant Level 4 – Approval required by Supervising Consultant Please be advised that the audit cannot proceed without approval as above.															
Please Note: The Information Team have advised they will not release data to the requestor unless the clinical audit has been approved as above. The clinical audit team will also advise contact with Information Governance for any advice required.															
The clinical audit team can be contacted via: Email: Personal Information redacted by the USI Tel: <table style="width: 100%; margin-top: 5px;"> <tr> <td style="width: 33%;">Raymond Haffey</td> <td style="width: 33%;">Personal Information redacted by the USI</td> <td style="width: 33%;">Mary Markey</td> <td style="width: 33%;">Personal Information redacted by the USI</td> </tr> <tr> <td>Terri Harte</td> <td>Personal Information redacted by the USI</td> <td>Roisin Feely</td> <td>Personal Information redacted by the USI</td> </tr> <tr> <td>Sandra McLoughlin</td> <td>Personal Information redacted by the USI</td> <td>Philip Sullivan</td> <td>Personal Information redacted by the USI</td> </tr> </table>				Raymond Haffey	Personal Information redacted by the USI	Mary Markey	Personal Information redacted by the USI	Terri Harte	Personal Information redacted by the USI	Roisin Feely	Personal Information redacted by the USI	Sandra McLoughlin	Personal Information redacted by the USI	Philip Sullivan	Personal Information redacted by the USI
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<i>In submitting this audit registration form, I agree to share the audit findings, recommendations and audit summary template with: the Audit Supervisor, appropriate Divisional/Directorate Committee and the Trust's Clinical audit team</i>															
Please submit your audit registration form to: Personal Information redacted by the USI															







Priority levels for clinical audit






Level	Audit type - projects identified through	
Level 1 audits, "external must dos" (where the service is applicable to SHSCT)	<ul style="list-style-type: none"> National audits (NHS England Quality Accounts List (HQIP), including the National Confidential Enquiry into Patient Outcomes and Deaths (NCEPOD) / Other Confidential Inquires 	1
Level 2 audits, other national audits and 'internal must dos'	<ul style="list-style-type: none"> National audits not contained within the HQIP list, or other clinical audits arising from: Clinical risk Serious untoward incident / internal reviews National Institute of Clinical Excellence Standards & Guidelines Complaints Re-audit Regional audits initiated by RQIA / GAIN 	2
Level 3 audits, 'divisional priorities'	<ul style="list-style-type: none"> Local topics important to the division 	3
Level 4 audits	<ul style="list-style-type: none"> Clinician / personal interest Educational audits 	4

Action Plan Urology

 Personal
Information

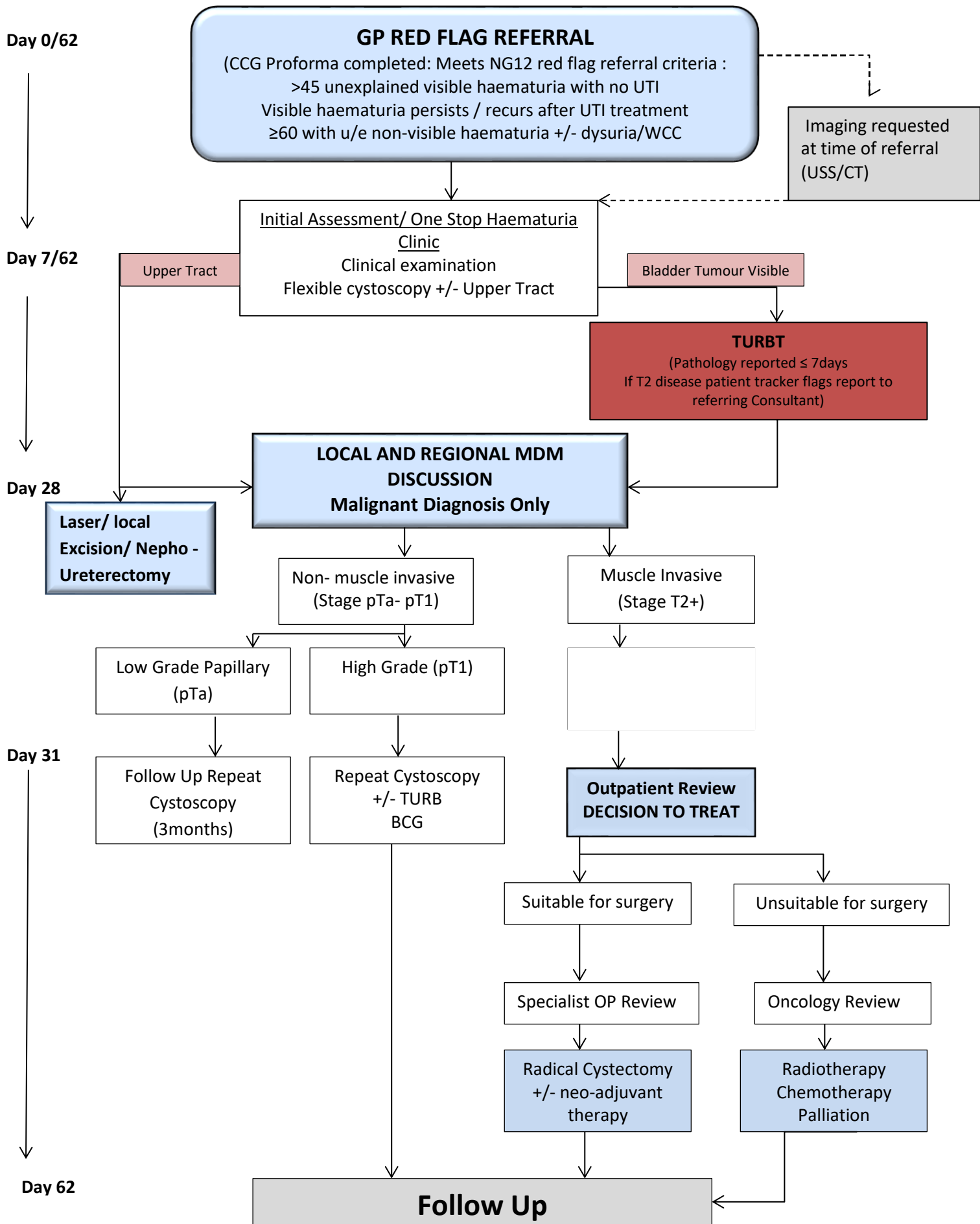
Reference number	Recommendations	Designated responsible person	Action required	Date for completion / timescale	Date recommendation completed with evidence
1	HSCB should link with the electronic Clinical Communication Gateway (CCG) implementation group to ensure it is updated to include NICE/NICaN clinical referral criteria. These fields should be mandatory.	HSCB	See recommendation 5		
2	HSCB should consider GP's providing them with assurances that the NICE guidance has been implemented within GP practices	HSCB			
3	HSCB should review the implementation of NICE NG12 and the processes surrounding occasions when there is failure to implement NICE guidance, to the detriment of patients.	HSCB			
4	GPs should be encouraged to use the electronic CCG referral system which should be adapted to allow a triaging service to be performed to NICE NG12 and NICaN standards. This will also mean systems should be designed that ensure electronic referral reliably produces correct triaging e.g. use of mandatory entry fields.	HSCB			

5	<p>TRUST</p> <p>Work should begin in communicating with local GPs, perhaps by a senior clinician in Urology, to formulate decision aids which simplify the process of Red-flag, Urgent or Routine referral. The triage system works best when the initial GP referral is usually correct and the secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence the norm.</p>	AD surgical/ AMD Primary Care	The urology service hold the view that to enable the referral process to be efficient and effective, the CCG form requires to have mandatory fields which require it to be completed prior to referral from Primary Care.		<p>NiCan pathway.</p> <p> Bladder Cancer Pathway March 2020.</p> <p> Revised Prostate Diagnostic Pathway C</p> <p> Female Lower Urinary Tract Sympto</p> <p> Female Urinary Tract Infection.docx</p> <p> Male Lower Urinary Tract Symptoms.docx</p> <p> male urinary tract infections.docx</p>
6	The Trust should re-examine or re-assure itself that it is feasible for the Consultant of the Week (CoW) to perform both triage of non-red flag referrals and the duties of the CoW.	AD Surgery/ AMD Surgery	Time needs to be made available in consultant job plans to undertake the task of triaging referral letters. Discussions are ongoing with MD and AD	Jan 2021	

7	The Trust will develop written policy and guidance for clinicians on the expectations and requirements of the triage process. This guidance will outline the systems and processes required to ensure that all referrals are triaged in an appropriate and timely manner.	AD surgery	Currently the IEAP protocol is followed The current regional protocol is being updated.	Jan 2021	 Integrated Elective Access Protocol - Apr  Integrated Elective Access Protocol Draft  FW IEAP referral.msg  Booking Centre SOP manual.doc  TRIAGE PROCESS 2. Imca.docx
8	The current Informal Default Triage (IDT) process should be abandoned. If replaced, this must be with an escalation process that performs within the triage guidance and does not allow Red-flag patients to wait on a routine waiting list.	AD Surgery		Nov 2020	
9	Monthly audit reports by Service and Consultant will be provided to Assistant Directors on compliance with triage. These audits should be incorporated into Annual Consultant Appraisal programmes. Persistent issues with triage must be escalated as set out in recommendation 10.	AD surgery	Reports will be sent to AD and AMD/ CD	Nov 2020	
10	The Trust must set in place a robust system within its medical management hierarchy for highlighting	MD			

	and dealing with 'difficult colleagues' and 'difficult issues', ensuring that patient safety problems uncovered anywhere in the organisation can make their way upwards to the Medical Director's and Chief Executive's tables. This needs to be open and transparent with patient safety issues taking precedence over seniority, reputation and influence.				
11	Consultant 1 needs to review his chosen 'advanced' method and degree of triage, to align it more completely with that of his Consultant colleagues, thus ensuring all patients are triaged in a timely manner.	MD			
12	Consultant 1 needs to review and rationalise, along with his other duties, his Consultant obligation to triage GP referrals promptly and in a fashion that meets the agreed time targets, as agreed in guidance which he himself set out and signed off. As he does this, he should work with the Trust to aid compliance with recommendation 6.	MD			

NICaN SUSPECT BLADDER CANCER REFERRAL AND DIAGNOSTIC PATHWAY



NICA SUSPECT PROSTATE CANCER DIAGNOSTIC PATHWAY

GP RED FLAG REFERRAL

Initial Assessment

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

ECOG <2 or CCI <5

PSA <20 and
ECOG ≥2 or
CCI ≥5

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

DRE normal
And
PSAD (US/ DRE) <0.1

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

MRI prostate

MRI PSAD <0.15
And
MRI No
Abnormality

MDM DISCUSSION
Malignant Diagnosis Only

PSA monitoring

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

Prostate biopsy (TP or TRUS) + targeted biopsies of MRI abnormality

(Consider prostate volume as part of the initial assessment of a patient with a raised PSA and before MRI)

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

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

Watchful Waiting /
Symptomatic management

(Refer to NICA Watch and Wait Pathway)

Guidance Notes

To help men decide whether to have a prostate biopsy, discuss with them their prostate-specific antigen (PSA) level, digital rectal examination (DRE) findings (including an estimate of prostate size) and comorbidities, together with their risk factors.

Prostate volume should form part of the discussion with a man about whether further investigation (eg MRI +/- biopsy) or monitoring.

Give men and their partners or carers information, support and adequate time to decide whether or not they wish to undergo prostate biopsy.

Female Lower Urinary Tract Symptoms

History;

- Storage symptoms – Frequency, Urgency, Nocturia, Incontinence
- Voiding symptoms – Hesitancy, Poor flow, Straining, Stop-start void.
- Assessment of Fluid intake

Examination;

- Abdomen
 - Palpable bladder?
- External Genitalia/Pelvic Examination
 - Atrophic Vaginitis
 - Pelvic Organ Prolapse

Investigations;

- Urine Dipstick
 - Glucose
 - Nitrite and Leukocytes
 - Haem
- Blood test
 - Renal profile
 - Glucose (found on Dipstick)
- USS Urinary tract
 - Hydronephrosis?
 - Residual Volume?
 - Pelvic organs?

Primary Care management;

- Lifestyle advice
 - Reduce Caffeine
 - Timing of fluid intake
- Palpable Bladder
 - refer to Urology
- Atrophic Vaginitis
 - Consider oestrogens therapy
- Pelvic Organ Prolapse
 - Refer to Gynae
- Leukocytes
 - manage infection as per Guidelines.
- If Renal Impairment
 - see Nephrology Guidelines

- Ultrasound Urinary tract
 - Hydronephrosis - refer to Urology
 - Residual Volume >150ml – refer to Urology
- Incontinent, residual volume <150ml, storage symptoms
 - If incontinent consider Anticholinergic treatment
 - Symptom review after 3/12 treatment

If urinary incontinent,

- If mainly stress incontinent, refer to community
- Consider anticholinergice treatment – and reassessment after three months

- Others – patients who do not fit into the above two categories
 - Refer to Urology
 - Treat with topical oestrogens.
 - Hydronephrosis → Refer Urology
 - Residual Volume ≥ 300ml → Refer Urology
 - Residual volume 150ml – 300ml → Refer community continence team

Referral;

- Abnormal findings as above
- No symptomatic improvement after 3/12 of medical treatment refer to Urology

Female Urinary Tract Infection**History;**

- First, recurrent or persistent UTI
- Symptoms suggestive of sepsis
- Cystitis (lower UTI) or pyelonephritis (upper UTI)?

Examination;

- Sepsis - Temperature? Heart Rate? Respiratory Rate? Blood Pressure?
- Abdomen – Is the bladder palpable?
- External Genitalia - consider the possibility of
 - Atrophic Vaginitis
 - Urethral pathology
- Pelvic Examination - consider the possibility of
 - Pelvic Mass
 - Cervix
 - Pelvic Organ Prolapse

Investigations;

- MSU for all patients suspected of having UTI.
- USS Urinary tract for recurrent or persistent UTI
 - Hydronephrosis? Residual Volume? Pelvic Organs?

Primary Care treatment;

- UTI with Sepsis
 - Refer to secondary care for admission
- Simple, Single Lower UTI
 - Antibiotics as per microbiology guidelines.
 - Repeat MSU 2/52 post treatment.
- Recurrent Lower UTI
 - 7 day course antibiotics as per microbiology guidance followed by 3 month course of low dose antibiotics.
 - Repeat MSU after 1/12 of treatment.
- Upper UTI no sepsis
 - 14 day course antibiotics as per microbiology guidance

Referral to Urology;

- Abnormal findings as above
- UTI with Sepsis
 - Refer to secondary care for admission
- Upper UTI no sepsis
 - Refer to Urology 'Hot clinic'
- Recurrent Lower UTI
 - Further UTI while on low dose antibiotics.
 - 3rd UTI within 12 months of first presentation.

Male Lower Urinary Tract Symptoms

History

Storage symptoms – Frequency, Urgency, Nocturia

Voiding symptoms – Hesitancy, poor flow, straining, intermittent stream

Incontinence

Comorbidities – constipation, review of relevant medication

Consider IPSS record and frequency / volume chart.

Examination

External genitalia specifically foreskin and meatus

Abdomen specifically to exclude a palpable bladder

DRE

Investigation

Urine Dipstick test for glucose, haem and nitrites/leucocytes

MSU if indicated

Blood tests – renal function, (glucose if indicated by dipstick test)

- PSA if 40+yrs, abnormal DRE, concern re prostate cancer

Ultrasound Urinary Tract specifically pre and post void bladder volumes and prostate volume

Refer if:

urinary incontinence

suspect urological cancer – raised PSA, abnormal DRE

palpable post void bladder

bothersome phimosis, meatal stenosis

haematuria (see Red Flag guidelines)

recurrent or persisting UTI

Hydronephrosis or bladder residual more than 200mls

Renal impairment if suspected if relating to lower urinary tract dysfunction

Primary care management

Lifestyle advice : - Timing / content of fluid intake (eg evening time fluids and caffeine)

- Co-morbidity issues (eg constipation)

Medication : Initial 3 month prescription (and continue if symptomatic improvement)

- Alpha blocker
- Consider 5-Alpha reductase inhibitor if prostate more than 30cc volume or PSA more than 1.4ng/ml (these medications can be given in combination)
- Consider anticholinergic medication if frequency / urge symptoms continue after trial of alpha blocker medication.

Refer if :

Initial concerns met

Lack of response to initial management plan

Male Urinary Tract Infection

History;

- Red Flag symptoms? – See Red Flag Guidance
- Lower UTI or Upper UTI?
- 'Normal' lower Urinary tract symptoms?

Examination;

- Sepsis Response – Temperature? Heart Rate? Respiratory Rate? Blood Pressure?
- Abdomen – Is the bladder palpable?
 - Palpable bladder → Refer Urology
- External Genitalia – Foreskin, Glans / Meatus
 - Phimosis, Meatal stenosis → Refer Urology
- Digital Rectal Examination – Prostate
 - Malignant feeling prostate → Refer (see red flag guidance)
 - Tender Prostate without sepsis → Refer Urology 'Hot' clinic

Investigations;

- MSU – All patients suspected of having UTI.
- Blood – Renal profile and glucose.
- USS Urinary tract – Hydronephrosis? Residual Volume?
 - Hydronephrosis >> Refer Urology
 - Residual Volume \geq 300ml >> Refer Urology
 - Residual volume 150ml – 300ml ??

Primary Care treatment;

- UTI with Sepsis;
- Lower UTI;
 - 7 day course antibiotics as per microbiology guidelines.
 - Repeat MSU 2/52 post treatment.
- Upper UTI no sepsis;
 - 14 day course antibiotics as per microbiology guidance.

Referral;

- Abnormal findings as above
- UTI with Sepsis;
 - Refer acutely to on-call team
- Upper UTI no sepsis;
 - Refer to Urology 'Hot clinic'
- Lower UTI;
 - Refer to Urology.

INTEGRATED ELECTIVE ACCESS PROTOCOL

DRAFT

June 2020

Integrated Elective Access Protocol

Protocol Summary -

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

Version	2.0 This guidance replaces the Integrated Elective Access Protocol, 30 th April 2008.
Status	Draft for approval
Date	30 June 2020

Integrated Elective Access Protocol**Version**

Version	Date of issue	Summary of change	Author
1.0	25 August 2006	New Regional Guidance: Integrated Elective Access Protocol	M Irvine M Wright S Greenwood
2.0	30 April 2008	Protocol refresh to encompass guidance on all aspects of the elective care pathway	M. Irvine, M. Wright, R. Hullat
3.0		Update and relaunch IEAP to provide updated regional guidance on administration of patients on elective care pathways.	L. Mc Laughlin, Regional IEAP Review Group.

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Integrated Elective Access Protocol**Document control**

The current and approved version of this document can be found on the Department of Health website <https://www.health-ni.gov.uk> and on the Health and Social Care Board and Trusts intranet sites.

Document:	Integrated Elective Access Protocol 3.0
Department:	Department of Health
Purpose:	To advise and inform patients and clinical, administrative and managerial staff of the approved processes for managing patients access to outpatient, diagnostic, elective and elective Allied Health Professional (AHP) services.
For use by:	All clinical, administrative and managerial staff who are responsible for managing referrals, appointments and elective admissions.
This document is compliant with:	Northern Ireland Health and Social Care (NI HSCC) and Department of Health (DOH) Information Standards and Guidance and Systems Technical Guidance. https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Home.aspx
Screened by:	
Issue date:	
Approval by:	
Approval date:	
Distribution:	Trust Chief Executives, Directors of Planning and Performance, Directors of Acute Care, Department of Health.
Review date:	1 April 2021

Monitoring compliance with protocol

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

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Abbreviations

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

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 1

CONTEXT

DRAFT

1.1 INTRODUCTION

- 1.1.1 This protocol has been developed to define the roles and responsibilities of all those involved in the elective care pathway and to outline good practice to assist staff with the effective management of outpatient appointments, diagnostic, elective admissions and allied health professional (AHP) bookings, including cancer pathways and waiting list management.
- 1.1.2 The length of time a patient needs to wait for elective treatment is an important quality issue and is a visible public indicator of the efficiency of the hospital and AHP services provided by the Trust. The successful management of patients who wait for outpatient assessments, diagnostic investigations, elective inpatient or daycase treatment and AHP services is the responsibility of a number of key individuals within the organisation. General Practitioners (GPs), commissioners, hospital medical staff, allied health professionals, managers and clerical staff have an important role in ensuring access for patients in line with maximum waiting time targets as defined in the Department of Health (DOH) Commissioning Plan Direction (CPD) and good clinical practice, managing waiting lists effectively, treating patients and delivering a high quality, efficient and responsive service. Ensuring prompt timely and accurate communication with patients is a core responsibility of the hospital and the wider local health community.
- 1.1.3 The purpose of this protocol is to outline the approved processes for managing referrals to outpatient clinics, diagnostic procedures, elective procedures and operations and AHP booking procedures, through to discharge, to allow consistent and fair care and treatment for all patients.
- 1.1.4 The overall aim of the protocol is to ensure patients are treated in a timely and effective manner, specifically to:
- Ensure that patients receive treatment according to their clinical priority, with routine patients and those with the same clinical priority treated in chronological order, thereby minimising the time a patient spends on the waiting list and improving the quality of the patient experience.

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

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

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

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

1.2 METHODOLOGY

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

- 1.2.2 In this context, this protocol has been prepared to provide clarity of purpose within Trusts with a view to merging seamlessly with the policies of other agencies in the wider health community as they emerge.
- 1.2.3 This protocol has been prepared to clarify Trusts' medium and long-term objectives, set the context in which they will be delivered and establish the parameters within which staff at divisional, specialty and departmental levels will operate.
- 1.2.4 For the purposes of this protocol, the term;
- outpatient refers to a patient who has a clinical consultation. This may be face to face or virtual,
 - elective admissions refer to inpatient and daycase admissions,
 - inpatient refers to inpatient and daycase elective treatment,
 - diagnostic refers to patients who attend for a scan / test or investigation,
 - AHP refers to allied health professionals who work with people to help them protect and improve their health and well-being. There are thirteen professions recognised as allied health professions in Northern Ireland (NI),
 - partial booking refers to the process whereby a patient has an opportunity to agree the date and time of their appointment,
 - fixed booking refers to processes where the patient's appointment is made by the Trust booking office and the patient does not have the opportunity to agree/confirm the date and time of their appointment,
 - virtual appointment refers to any appointment that does not involve the physical presence of a patient at a clinic, (see also 1.5 Virtual Activity).
 - PAS refers to all electronic patient administration systems, including PARIS, whether in a hospital or community setting and those used in diagnostic departments such as NIPACS and systems used for other diagnostics / physiological investigations.

- 1.2.5 Trusts must maintain robust information systems to support the delivery of patient care through their clinical pathway. Robust data quality is essential to ensure accurate and reliable data is held, to support the production of timely operational and management information and to facilitate clinical and clerical training. All patient information should be recorded and held on an electronic system (PAS). Manual patient information systems should not be maintained.
- 1.2.6 All staff involved in the administration of waiting lists will ensure that Trusts' policies and procedures with respect to data collection and entry are strictly adhered to. This is to ensure the accuracy and reliability of data held on electronic hospital/patient administration systems and the waiting times for treatment.
- 1.2.7 Trusts should provide training programmes for staff which include all aspects of this Integrated Elective Access Protocol (IEAP). It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts. Trusts will provide appropriate information to staff so they can make informed decisions when delivering and monitoring this protocol. All staff involved in the administration of waiting lists will be expected to read and sign off this protocol.
- 1.2.8 This protocol will be available to all staff via Trusts' Intranet.

1.3 UNDERPINNING PRINCIPLES

- 1.3.1 Patients will be treated on the basis of their clinical urgency with urgent patients seen and treated first. The definition of clinical urgency will be defined and agreed at specialty / procedure / service level.
- 1.3.2 Patients with the same clinical need will be treated in chronological order on grounds of fairness, and to minimise the waiting time for all patients.

- 1.3.3 As part of a plan for the implementation of booking, Trusts must ensure their elective admission selection system is managed on a chronological basis within clinical priority.
- 1.3.4 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to add the patient to the waiting list, i.e. the patient must be “fit, ready, and able” to come in (TCI).
- 1.3.5 Trusts should design processes to ensure that inpatient care is the exception for the majority of elective procedures and that daycase is promoted. The principle is about moving care to the most appropriate setting, based on clinical judgement. This means moving daycase surgery to outpatient care and outpatient care to primary care or alternative clinical models where appropriate.
- 1.3.6 Referrals into Trusts should be pooled where possible as the norm within specialties.
- 1.3.7 Trusts will maintain and promote electronic booking systems aimed at making hospital appointments more convenient for patients. Trusts should move away from fixed appointments to partially booked appointments.
- 1.3.8 Trusts should also promote direct access services where patients are directly referred from primary and community care to the direct access service for both assessment and treatment. Direct access arrangements must be supported by clearly agreed clinical pathways and referral guidance, jointly developed by primary and secondary care.
- 1.3.9 For the purposes of booking/arranging appointments, all patient information should be recorded and held on an electronic system. Trusts should not use manual administration systems to record and report patient's information.
- 1.3.10 In all aspects of the booking processes, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language**. It is essential that patients who are considered at risk for whatever reason have their needs identified

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

Have we anything in place for 1.3.10

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

1.3.12 Trusts must ensure that the needs of ethnic groups and people with special requirements should be considered at all stages of the patient's pathway.

1.4 BOOKING PRINCIPLES

1.4.1 These booking principles will support all areas across the elective and AHP pathways where appointment systems are used.

1.4.2 Offering the patient choice of date and time where possible is essential in agreeing and booking appointments with patients through partial booking systems. Trusts should ensure booking systems enable patients to choose and agree hospital appointments that are convenient for them.

1.4.3 Facilitating reasonable offers to patients should be seen within the context of robust booking systems being in place.

1.4.4 All booking principles should be underpinned with the relevant local policies to provide clarity to operational staff.

1.4.5 Trusts should ensure booking processes are continually reviewed and updated as required to reflect local and regional requirements at an operational level.

1.4.6 The definition of a booked appointment is:

- a) The patient is given the choice of when to attend or have a virtual appointment.
- b) The patient is able to choose and confirm their appointment within the timeframe relevant to the clinical urgency of their appointment.
- c) The range of dates available to a patient may reduce if they need to be seen quickly, e.g. urgent referrals or within two weeks if cancer is suspected.
- d) The patient may choose to agree a date outside the range of dates offered or defer their decision until later.

1.4.7 Principles for booking Cancer Pathway patients:

- a) All suspected cancer referrals should be booked in line with the agreed clinical pathway requirement for the patient and a maximum of 14 days from the receipt of referral.
- b) Dedicated registration functions for red flag (suspect cancer) referrals should be in place within centralised booking teams.
- c) Clinical teams must ensure triage, where required, is undertaken daily, irrespective of leave, in order to initiate booking patients.
- d) Patients will be contacted by telephone twice (morning and afternoon).
- e) If telephone contact cannot be made, a fixed appointment will be issued to the patient within a maximum of three days of receipt of referral.
- f) Systems should be established to ensure the Patient Tracker / Multidisciplinary Team (MDT) Co-coordinator is notified of the suspected cancer patient referral, to allow them to commence prospective tracking of the patient.

1.4.8 Principles for booking Urgent Pathway patients:

- a) Maximum waiting times for urgent patients should be agreed locally with clinicians and/or service managers and made explicit, through internal processes, to booking office staff.
- b) Referrals will be received, registered within one working day and forwarded to consultants for prioritisation.

- c) If clinical priority is not received from consultants within 72 hours, processes should be in place to initiate booking of urgent patients according to the referrers's classification of urgency.
- d) Patients will be issued with a letter inviting them to contact the Trust to agree and confirm their appointment in line with the urgent booking process.
- e) In exceptional cases, some patients will require to be appointed to the next available slot. A robust process for telephone booking these patients should be developed which should be clearly auditable.

1.4.9 Principles for booking Routine Pathway patients:

- a) Patients should be booked to ensure appointment (including virtual appointment) is within the maximum waiting time guarantees for routine appointments.
- b) Referrals will be received, registered within one working day at booking teams and forwarded to consultants for prioritisation.
- c) Approximately eight weeks prior to appointment, Trusts should calculate prospective slot capacity and immediately implement escalation policy where capacity gaps are identified.
Rotas are not normally available 8 weeks out (annual leave/study leave notification period is 6 weeks. What escalation policy is being followed and where are the capacity gaps being escalated to? If this is an already known and accepted capacity gap, eg, through discussions with HSCB, vacant posts, do we always have to escalate?
- d) Patients should be selected for booking in chronological order from the Primary Targeting List (PTL).
- e) Six weeks prior to appointment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment.

1.4.10 Principles for Booking Review Patients;

- a) Patients who need to be reviewed within 6 weeks will agree their appointment (including virtual appointment) before they leave the clinic, where possible.

- b) Patients who require a review appointment more than 6 weeks in advance will be added to and managed on a review waiting list.
- c) Patients will be added to the review waiting list with a clearly indicated date of treatment and selected for booking according to this date.
- d) Six weeks prior to the indicative date of treatment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment within a clinically agreed window either side of the indicative date of treatment.

1.4.11 It is recognised that some groups of patients may require booking processes that have additional steps in the pathway. These should be designed around the principles outlined to ensure choice and certainty as well as reflecting the individual requirements necessary to support their particular patient journey.

Is there any provision to change date required if patient does not accept reasonable offer?

1.5 VIRTUAL ACTIVITY

- 1.5.1 Virtual Activity relates to any planned contact by the Trust with a patient (or their proxy) for healthcare delivery purposes i.e. clinical consultation, advice, review and treatment planning. It may be in the form of a telephone contact, video link, telemedicine or telecommunication, e.g. email.
- 1.5.2 The contact is in lieu of a face-to-face contact of a patient/client, i.e. a face-to-face contact would have been necessary if the telephone/video link/etc. had not taken place.
- 1.5.3 The call/contact should be prearranged with the patient and /or their proxy. Patients should not be disadvantaged where a decision is made to assess their clinical need through the use of virtual clinics.

Not all patient contact is pre-arranged, there has been a number of virtual clinics following validation when contact is made with the patient at the point of validation and a decision/treatment plan agreed.

- 1.5.4 The contact must be auditable with a written note detailing the date and substance of the contact is made following the consultation and retained in the patient's records.

1.6 COMPLIANCE WITH LEAVE PROTOCOL

- 1.6.1 It is essential that planned medical and other clinical staff leave or absence is organised in line with an agreed Trust Human Resources (HR) protocol. Thus it is necessary for Trusts to have robust local HR policies and procedures in place that minimise the cancellation/reduction of outpatient clinics and the work associated with the rebooking of appointments.
- 1.6.2 There should be clear medical and clinical agreement and commitment to this HR policy. Where cancelling and rebooking is unavoidable the procedures used must be equitable, efficient, comply with clinical governance principles and ensure that maximum waiting times for patients are not compromised.
- 1.6.3 The protocol should require a minimum of six weeks' notification of intended leave, in line with locally agreed HR policies, in order to facilitate Trusts booking teams to manage appointment processes six weeks in advance.
- 1.6.4 The booking team should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

1.7 VALIDATION

- 1.7.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a monthly basis. This is essential to ensure the efficiency of the elective pathway at all times. In addition, Trusts should ensure that waiting lists are regularly validated to ensure that only those patients who want or still require a procedure are on the waiting list.

- 1.7.2 Involvement of clinicians in the validation process is essential to ensure that waiting lists are robust from a clinical perspective. Trusts should ensure an ongoing process of clinical validation and audit is in place.

Have we anything set up for the ongoing clinical validation

DRAFT

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 2

**GUIDANCE FOR MANAGEMENT OF OUTPATIENT
SERVICES**

DRAFT

2.1 INTRODUCTION

- 2.1.1 The following protocol is based on recommended good practice guidelines to assist staff with the effective management of outpatient services, including those patients whose referral is managed virtually.
- 2.1.2 The administration and management of the outpatient pathway from receipt of referral to appointment within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.
- 2.1.3 There will be dedicated booking offices within Trusts to receive, register and process all outpatient referrals.
- 2.1.4 Fixed appointments should only be used in exceptional circumstances.
- 2.1.5 In all aspects of the outpatient booking process, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language**. Local booking policies should be developed accordingly.

Is there anything we need to have n place here?

2.2 KEY PRINCIPLES

- 2.2.1 Referrals into Trusts should be pooled where possible within specialties.
- 2.2.2 All new referrals, appointments and outpatient waiting lists should be managed according to clinical priorities. Priorities must be identified for each patient on the waiting list and allocated according to urgency of the treatment. Trusts will manage patients in three priorities, i.e.
 1. Red flag (suspect cancer),
 2. urgent and
 3. routine.

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

There are currently only 2 priority categories on PAS for referrals – urgent and routine. Red flags are identified by reason for referral code. Is this an opportunity to update PAS with a priority category for red flag? Yes that would make sense

- 2.2.3 Patients of equal clinical priority will be selected for booking in strict chronological order.
- 2.2.4 Patient appointments for new and review should be **partially booked**.
In the case of red flag appointments and 14 day target, it is not always possible to partial book appointments. The principles in section 1 are applied, ie the 2 attempts at telephone contacts and 1 fixed appointment.
- 2.2.5 The regional target for a maximum outpatient waiting time is outlined in the Health and Social Care Commissioning Plan and Indicators of Performance Direction (CPD), <https://www.health-ni.gov.uk/doh-management-and-structure> (see Ministerial Priorities).
- 2.2.6 Maximum waiting times for urgent patients should be agreed locally with clinicians and made explicit, through internal processes, to booking office staff. Booking staff should ensure that patients are appointed within the clinical timeframe indicated by the consultant and capacity issues are quickly identified and escalated.
- 2.2.7 Patients should not be disadvantaged where a decision is made to assess their clinical need through virtual activity.
- 2.2.8 Trusts should ensure that clinical templates are constantly reviewed to meet changes in demand and new clinical practice.
- 2.2.9 Data collection in respect of referrals and waiting times should be accurate, timely, complete and subject to regular audit and validation.
- 2.2.10 Trusts will work towards providing a single point of contact for all patients with respect to outpatient appointment services. It is recognised that there may be services which require alternative processes.

- 2.2.11 Trusts should **not** use manual administration systems to record and report patients who have been booked.
- 2.2.12 Trusts should provide training programmes for staff which include all aspects of IEAP. It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts.

2.3 NEW REFERRALS

- 2.3.1 All outpatient referrals (including those sent via Clinical Communication Gateway (CCG)) sent to Trusts will be registered within **one** working day of receipt. Referrer priority status must be recorded at registration.
- 2.3.2 Trusts will work towards a system whereby the location of all referrals (paper and electronic) not yet prioritised can be identified and tracked.
- 2.3.3 All referrals must be prioritised and clinical urgency must be clearly identified. Clinicians and management will be responsible for ensuring that cover is provided for referrals to be read and prioritised during any absence.
- 2.3.4 All referrals will be prioritised (including those prioritised via E-Triage) within **a maximum of three** working days of date of receipt of referral. Note; Red flag referrals require **daily** triage.
- 2.3.5 Following prioritisation, referrals must be actioned on PAS and appropriate correspondence (including electronic), e.g. acknowledgement or appointment letter, issued to patients within **one** working day.
- 2.3.6 Inappropriate and inadequate referrals should be returned to the referral source immediately and the referral closed and managed in line with the PAS technical guidance.

2.4 CALCULATION OF THE WAITING TIME – STARTING TIME

2.4.1 The starting point for the waiting time of an outpatient new referral is the date the referral is received by the booking office/department.

2.4.2 In exceptional cases where referrals bypass the booking office (e.g. sent directly to a consultant) the Trust must have a process in place to ensure that these are date stamped on receipt, immediately forwarded to the booking office and registered at the date on the date stamp.

2.5 REASONABLE OFFERS

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

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

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

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

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

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

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

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

2.6 REVIEW APPOINTMENTS

- 2.6.1 All review appointments must be made within the time frame specified by the clinician. If a review appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the clinician.
- 2.6.2 Patients must be recorded on PAS as requiring to be seen within a clinically indicated time. Trusts should actively monitor patients on the review list to ensure that they do not go past their indicative time of treatment.
- 2.6.3 Review patients who require an appointment within six weeks will be asked to agree the date and time of the appointment before leaving the department and PAS updated.
- 2.6.4 Patients requiring an appointment outside six weeks will be placed on a review waiting list, with the agreed clinically appropriate appointment date recorded, and be booked in line with implementation guidance for review pathway patients.
- 2.6.5 Virtual review appointments, e.g. telephone or video link, should be partially booked. If the patient cannot be contacted for their virtual review they should be sent a partial booking letter to arrange an appointment.

Not all patient contact is pre-arranged, there has been a number of virtual clinics following validation when contact is made with the patient at the point of validation and a decision/treatment plan agreed.

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

2.7.1 DNAs – New Outpatient

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

- 2.7.1(a) Patients who have been partially booked will **not** be offered a second appointment and should be removed from the waiting list. The patient and referring clinician (and the patient's GP, where they are not the referring clinician) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.
- 2.7.1(b) Under exceptional circumstances a clinician may decide that a patient who DNAs a first appointment should not be removed from the waiting list and should be offered a second appointment. Trusts should put in place local agreements with clinicians, regarding those referrals (e.g. red flag) or specialties where patients may be at risk (e.g. paediatrics or adults at risk) where a second appointment should always be offered.
- 2.7.1(c) Patients who DNA and are not discharged but offered a second appointment will have their waiting time clock reset to the date of the DNA.
- 2.7.1(d) *Where patients are discharged from the waiting list (ref. 2.7.1(a)) they should be advised to contact the Trust booking office within **four** weeks of the original appointment date if they consider that the appointment is still required. Where a patient makes contact within the **four** week deadline, and where the Trust considers that unforeseen or exceptional circumstances meant that the patient was unable to attend, the patient should be added to the waiting list at the date that they have made contact with the Trust. If a patient makes contact after the **four** week period they cannot be reinstated.*

- 2.7.1(e) If the patient DNAs the second appointment offered then the patient should **not** be offered another opportunity to be reinstated. The patient and referring clinician (and the patient's GP, where they are not the referring clinician) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.
- 2.7.1(f) Where a patient DNAs a fixed new appointment (i.e. they have not had the opportunity to agree/confirm the date and time of the appointment) they should be offered another appointment.
- 2.7.1(g) If the patient DNAs this second fixed appointment they will be removed from the waiting list and the steps in 2.7.1(d) should be followed.
- 2.7.1(h) If a patient DNA's a virtual outpatient appointment this should follow the above protocol based on whether the appointment is partially booked or fixed. The Trust should ensure that the contact details of the patient are up to date and available.

2.7.2 DNAs – Review Outpatient

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

- 2.7.2(a) Where a patient has been partially booked and does not attend, a clinical decision should be taken as to whether a second appointment should be offered or whether the patient can be discharged.
- 2.7.2(b) Where the clinical decision is that a second appointment should be offered, this should be partially booked.
- 2.7.2(c) Where the clinical decision is that a second appointment should **not** be offered, Trusts should contact patients advising that as they have failed to attend their appointment they have been discharged from the waiting list. The referring clinician (and the patient's GP, where they are not the referring clinician) should also be informed of this.
- 2.7.2(d) *Patients being discharged from the list should be advised to contact the Trust booking office if they have any queries. Where unforeseen or exceptional circumstances meant that the patient was unable to attend, and the patient makes contact within **four** weeks*

of the original appointment date, a clinical decision may be made to offer a second appointment. Where this is the case, the patient should be added to the review waiting list with a revised clinically indicated date at the date they make contact with the Trust.

- 2.7.2(e) If the patient DNAs the second review appointment which has been partially booked then the patient should **not** be offered another opportunity to be reinstated. The patient and referrer will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.
- 2.7.2(f) Where a patient DNAs a fixed review appointment where they have not had the opportunity to agree/ confirm the date and time of their appointment, they should be offered another appointment. If they DNA this second fixed appointment, the above should be followed.
- 2.7.2(g) If a patient DNA's a virtual outpatient review appointment this should follow the above protocol based on whether the appointment is partially booked or fixed. The Trust should ensure that the contact details of the patient are up to date and available.
- 2.7.2(h) There may be instances for review patients where the clinician may wish to review notes prior to any action to remove a patient because of a DNA or failure to respond to a partial booking letter. Trusts should ensure that there are locally agreed processes in place to administer these patients.

Is there any provision to change date required if patient does not accept reasonable offer/DNA or the consultant changes plan following review of notes?

2.7.3 CNAs – Patient Initiated Cancellations of Outpatient Appointments

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

- 2.7.3(a) The patient will be given a second opportunity to book an appointment (where this is still required), which should be within **six** weeks of the original appointment date.
- 2.7.3(b) Patients who CNA will have their waiting time clock reset to the date the Trust was informed of the cancellation.

- 2.7.3(c) If a second appointment is cancelled, the patient will **not** normally be given another appointment. Where a decision is taken not to offer a further appointment, Trusts should contact patients advising that they have been discharged from the waiting list. The referring clinician (and the GP, where they are not the referring clinician) should also be informed of this.
- 2.7.3(d) However, where unforeseen or exceptional circumstances mean that the patient had to cancel a second appointment, the Trust may exercise discretion to offer a third appointment. This should include seeking a clinical review of the patient's case where this is appropriate.
- 2.7.3(e) If a patient CNA's a virtual outpatient appointment this should follow the above protocol.

2.8 CNAs – HOSPITAL INITIATED CANCELLATIONS

- 2.8.1 No patient should have his or her appointment cancelled. If Trusts cancel a patient's appointment, including a virtual appointment, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity.
- 2.8.2 The patient should be informed of the cancellation and a new appointment partially booked.
- 2.8.3 Trusts will make best efforts to ensure that a patient's appointment is not cancelled a second time for non-clinical reasons.
- 2.8.4 Hospital initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

2.9 CLINIC OUTCOME MANAGEMENT

- 2.9.1 Changes in the patient's details must be updated on PAS and the medical records on the date of the clinic.
- 2.9.2 When the consultation has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic.

2.10 CLINIC TEMPLATE CHANGES

- 2.10.1 Clinic templates should be agreed between the consultant and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement (SBAs).
- 2.10.2 Templates will identify the number of slots available for red flag, urgent, and routine and review appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated for each appointment slot.
- 2.10.3 All requests for template and temporary clinic rule changes will only be accepted in writing. A minimum of **six** weeks' notice will be provided for clinic template changes.
- 2.10.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager.

2.11 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

- 2.11.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between hospitals or to independent sector (IS) providers.
- 2.11.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant and be managed in line with PAS technical guidance, (see also Reasonable Offers, ref. 2.5). Administrative speed and good communication are very important to ensure this process runs smoothly.

2.12 OPEN REGISTRATIONS

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

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

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

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

2.13 TIME CRITICAL CONDITIONS

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

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

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

- 2.13.4 If the patient refuses the first appointment they should be offered a second appointment during the same telephone call. This second appointment should be offered on a date which is within **14** days of the date the initial appointment was offered and refused. In order to capture the correct waiting time the first appointment will have to be scheduled and then cancelled on the day of the offer and the patient choice field updated in line with the technical guidance. This will then reset the patient's waiting time to the date the initial appointment was refused.
- 2.13.5 If the patient cancels **two** agreed appointment dates the relevant clinical team should be advised before a decision is taken to discharge. Where a decision is taken to discharge the patient, the patient's GP should be informed.
- 2.13.6 If the patient has agreed an appointment but then DNAs the relevant clinical team should be advised before a decision is taken to discharge. Where a decision is taken to discharge the patient, the patient's GP should be informed.
- 2.13.7 Where the patient DNAs a fixed appointment they should be offered another appointment.
- 2.13.8 If the patient DNAs this second fixed appointment the relevant clinical team should be advised before a decision is taken to discharge. Where a decision is taken to discharge the patient, the patient's GP should be informed.
- 2.13.9 With regard to 2.13.4 to 2.13.8 above, it is the responsibility of each individual Trust to agree the discharge arrangements with the clinical team.
- 2.13.10 If the patient is not available for up to **six** weeks following receipt of referral, the original referral should be discharged a second new referral should be opened with the same information as the original referral and with a new date equal to the date the patient has advised that they will be available and the patient monitored from this date.

2.14 TECHNICAL GUIDANCE

2.14.1 See also Regional ISB Standards and Guidance

<https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Standards%20and%20Guidance.aspx> re;

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

2.14.2 See also PAS technical guidance

<https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Technical%20Guidance.aspx> for recording;

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

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 3

**GUIDANCE FOR MANAGEMENT OF DIAGNOSTIC
SERVICES**

DRAFT

3.1 INTRODUCTION

- 3.1.1 A diagnostic procedure may be performed by a range of medical and clinical professionals across many different modalities, including, diagnostic imaging, cardiac imaging and physiological measurement services. These may have differing operational protocols, pathways and information systems but the principles of the IEAP should be applied across all diagnostic services.
- 3.1.2 The principles of good practice outlined in the Outpatient and Elective Admissions sections of this document should be adopted in order to ensure consistent standards and processes for patients as they move along the pathway of investigations, assessment and treatment. This section aims to recognise areas where differences may be encountered due to the nature of specific diagnostic services.
- 3.1.3 The administration and management of requests for diagnostics, waiting lists and appointments within and across Trust should be consistent, easily understood, patient focused and responsive to clinical decision making.
- 3.1.4 It is recognised that diagnostic services are administered on a wide range of information systems, with varying degrees of functionality able to support full information technology (IT) implementation of the requirements of the IEAP. Trusts should ensure that the administrative management of patients is undertaken in line with the principles of the IEAP and that all efforts are made to ensure patient administration systems are made fit for purpose.
- 3.1.5 In all aspects of the diagnostic booking process, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language as well as associated legislative requirements such as Ionising Radiation (Medical Exposure) Regulations**. Local booking policies should be developed accordingly.

3.2 KEY PRINCIPLES

- 3.2.1 Referrals into Trusts should be pooled as the norm where possible.
- 3.2.2 All diagnostic requests, appointments and waiting lists should be managed according to clinical priority. Priorities must be identified for each patient on a waiting list and allocated according to urgency of the diagnostic procedure. Trusts will manage patients in four priorities, i.e.
1. Red flag (suspect cancer),
 2. urgent,
 3. routine and
 4. planned.
- No other clinical priority categories should be used for diagnostic services.
- 3.2.3 Patients of equal clinical priority will be selected for booking in strict chronological order.
- 3.2.4 Trusts should work towards an appointment system where patient appointments are **partially booked** (where applicable). Where fixed appointments are being issued, Trusts should ensure that the regional IEAP guidance is followed in the management of patients.
- 3.2.5 The regional target for a maximum diagnostic waiting time is outlined in the Health and Social Care Commissioning Plan and Indicators of Performance Direction (CPD), <https://www.health-ni.gov.uk/doh-management-and-structure> (see Ministerial Priorities).
- 3.2.6 Maximum waiting times for urgent patients should be agreed locally with clinicians and/or service managers and made explicit, through internal processes, to booking office staff. Booking staff should ensure that patients are appointed within the clinical timeframe indicated and capacity issues are quickly identified and escalated.
- 3.2.7 The outcome of the diagnostic test must be available to the referrer without undue delay and within the relevant DoH targets / standards.

- 3.2.8 Trusts should ensure that specific diagnostic tests or planned patients which are classified as daycases adhere to the relevant standards in the Elective Admissions section of this document.
- 3.2.9 Trusts should ensure that clinical templates are constantly reviewed to meet changes in demand and new clinical practice.
- 3.2.10 Data collection in respect of referrals and waiting times should be accurate, timely, complete and subject to regular audit and validation.
- 3.2.11 Trusts will work towards providing a single point of contact for all patients with respect to diagnostic appointment services. It is recognised that there will be services which require alternative processes.
- 3.2.12 Trusts should **not** use manual administration systems to record and report patients who have been booked.
- 3.2.13 Trusts should provide training programmes for staff which include all aspects of this IEAP. It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts.

3.3 NEW DIAGNOSTIC REQUESTS

- 3.3.1 All diagnostic requests will be registered on the IT system within **one** working day of receipt. Referrer priority status must be recorded at registration.
- 3.3.2 Trust diagnostic services must have mechanisms in place to track all referrals (paper and electronic) at all times.
- 3.3.3 All requests must be prioritised and clinical urgency must be clearly identified. Clinicians and management will be responsible for ensuring that cover is provided for referrals to be read and prioritised during any absence.

- 3.3.4 All referrals will be prioritised (including those prioritised via E Triage) within **three** working days of date of receipt of referral.
- 3.3.5 Following prioritisation, requests must be actioned on the IT system and appropriate correspondence (including electronic) issued to patients within **one** working day.
- 3.3.6 Inappropriate and inadequate requests should be returned to the referral source and the referral closed and managed in line with the PAS/relevant technical guidance, where appropriate.

3.4 CALCULATION OF THE WAITING TIME – STARTING TIME

- 3.4.1 The starting point for the waiting time of a request for a diagnostic investigation or procedure is the date the request is received into the department.
- 3.4.2 All referral letters and requests, emailed and electronically delivered referrals, will have the date received into the department recorded either by date stamp or electronically.

3.5 REASONABLE OFFERS

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

The IT Systems currently being used for the management of the majority of diagnostics do not facilitate partial booking, however, the fixed appointment letters do ask patients to confirm and are issued with 3 weeks' notice where appropriate. The diagnostic booking teams follow this up with telephone calls to patients to confirm attendances.

- 3.5.2 If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused.
- 3.5.3 This does not prevent patients being offered earlier appointment dates. If the patient is offered an appointment within a shorter notice period (i.e. less than three weeks' notice) and refuses it they will not have their waiting time reset.
- 3.5.4 If the patient accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the provider.
- 3.5.5 Providers should have robust audit procedures in place to demonstrate compliance with the above.
- 3.5.6 To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.
- 3.5.7 Urgent patients must be booked within the locally agreed maximum waiting time from the date of receipt. It is recognised that there will be occasional exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Clearly defined booking protocols will be required to support specialties and booking staff.

3.6 FOLLOW UP APPOINTMENTS

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

- 3.6.2 Patients must be recorded on the IT system as requiring to be seen within a clinically indicated time. Trusts should actively monitor follow up patients on the review list to ensure that they do not go past their indicative time of treatment.
- 3.6.3 Follow up patients who require an appointment within six weeks will be asked to agree the date and time of the appointment before leaving the department and the IT system updated.
- 3.6.4 Follow up patients requiring an appointment outside six weeks will be placed on a review waiting list, with the agreed clinically appropriate appointment date recorded, and be booked in line with management guidance for follow up pathway patients.

3.7 PLANNED PATIENTS

- 3.7.1 Planned patients are those who are waiting to be recalled to hospital for a further stage in their course of treatment or investigation within specific timescales. This is usually part of a planned sequence of clinical care determined on clinical criteria.
- 3.7.2 These patients are not actively waiting for treatment to be initiated, only for planned continuation of treatment. A patient's care is considered as planned if there are clinical reasons that determine the patient must wait set periods of time between interventions. They will not be classified as being on a waiting list for statistical purposes.
- 3.7.3 Trusts should be able to demonstrate consistency in the way planned patients are treated and that patients are being treated in line with the clinical constraints. Planned patients must have a clearly identified month of treatment in which it can be shown that the patients are actually being treated.
- 3.7.4 Trusts must ensure that planned patients are not disadvantaged in the management of planned backlogs.

3.8 PATIENTS LISTED FOR MORE THAN ONE DIAGNOSTIC TEST

- 3.8.1 Where more than one diagnostic test is required to assist with clinical decision making, the first test should be added to the waiting list with additional tests noted.
- 3.8.2 Where different clinicians working together perform more than one test at one time, the patient should be added to the waiting list of the clinician for the priority test (with additional clinicians noted) subject to local protocols.
- 3.8.3 Where a patient requires more than one test carried out on separate occasions the patient should be placed on the active waiting list for the first test and on the planned waiting list for any subsequent tests.
- 3.8.4 Where a patient is being managed in one Trust but has to attend another for another type of diagnostic test, monitoring arrangements must be in place between the relevant Trusts to ensure that the patient pathway runs smoothly.

There would be concern that a patient is only added to one waiting list, eg, a patient could require a number of different diagnostic tests to reach diagnosis and treatment plan, with varying waiting times for these tests, eg, a patient could be referred for a CT examination but also be added to the waiting list for an endoscopy procedure. A patient on cancer pathway could require PET and CT – these are different radiology modalities with different waiting lists. Cardiac patients could be listed for different examinations, eg, echo, stress test etc with varying waiting times.

The concern would be the risk that the patient would be closed off the system after the initial investigation or before all tests completed if only added to one waiting list.

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

- 3.9.1 DNAs – Diagnostic Appointment

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

- 3.9.1(a) Patients who have been partially booked will **not** be offered a second appointment and should be removed from the waiting list. The patient and referring clinician (and the patient's GP, where they are not the referring clinician) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.
- 3.9.1(b) Under exceptional circumstances a clinician may decide that a patient who DNAs a first appointment should not be removed from the waiting list and should be offered a second appointment. Trusts should put in place local agreements with clinicians, regarding those referrals (e.g. red flag) or specialties where patients may be at risk (e.g. paediatrics or adults at risk) where a second appointment should be offered.
- 3.9.1(c) Patients who DNA and are not discharged but offered a second appointment will have their waiting time clock reset to the date of the DNA.
- 3.9.1(d) *Where patients are discharged from the waiting list (ref. 3.7.1(a) above) they should be advised to contact the Trust booking office within **four** weeks of the original appointment date if they consider that the appointment is still required. Where a patient makes contact within the **four** week deadline, and where the Trust considers that unforeseen or exceptional circumstances meant that the patient was unable to attend, the patient should be added to the waiting list at the date that they have made contact with the Trust. If a patient makes contact after the **four** week period they cannot be reinstated.*
- 3.9.1(e) If the patient DNAs the second appointment offered then the patient should **not** be offered another opportunity to be reinstated. The patient and referring clinician (and the patient's GP, where they are not the referring clinician) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

- 3.9.1(f) Where a patient DNAs a fixed diagnostic appointment (i.e. they have not had the opportunity to agree/confirm the date and time of the appointment) they should be offered another appointment.
- 3.9.1(g) If the patient DNAs this second fixed diagnostic appointment they will be removed from the waiting list and the above steps in 3.7.1(d) should be followed.

3.9.2 DNAs – Follow up Diagnostic Appointment

If a patient DNAs their follow up diagnostic appointment the following process must be followed:

- 3.9.2(a) Where a patient has been partially booked and does not attend, a clinical decision should be taken as to whether a second appointment should be offered or whether the patient can be discharged.
- 3.9.2(b) Where the clinical decision is that a second appointment should be offered, this should be partially booked.
- 3.9.2(c) Where the clinical decision is that a second appointment should **not** be offered, Trusts should contact patients advising that as they have failed to attend they have been discharged from the waiting list. The referring clinician (and the patients GP, where they are not the referring clinician) should also be informed of this.
- 3.9.2(d) *Patients being discharged from the list should be advised to contact the Trust booking office if they have any queries. Where unforeseen or exceptional circumstances meant that the patient was unable to attend, and the patient makes contact within **four** weeks of the original appointment date, a clinical decision may be made to offer a second appointment. Where this is the case, the patient should be added to the review waiting list with a revised clinically indicated date at the date they make contact with the Trust.*
- 3.9.2(e) If the patient DNAs the second follow up appointment which has been partially booked then the patient should **not** be offered another opportunity to be reinstated. The patient and referrer will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

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

3.9.2(g) There may be instances for follow up patients where the clinician may wish to review notes prior to any action to remove a patient because of a DNA or failure to respond to a partial booking letter. Trusts should ensure that there are locally agreed processes in place to administer these patients.

3.9.3 CNAs – Patient Initiated Cancellations of Diagnostic Appointment

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

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

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

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

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

3.10 **CNAs - HOSPITAL INITIATED CANCELLATIONS**

- 3.10.1 No patient should have his or her appointment cancelled. If Trusts cancel a patient's appointment, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity.
- 3.10.2 The patient should be informed of the cancellation and the date of the new appointment.
- 3.10.3 Trusts will make best efforts to ensure that a patient's appointment is not cancelled a second time for non-clinical reasons.
- 3.10.4 Hospital initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

3.11 SESSION OUTCOME MANAGEMENT

- 3.11.1 Changes in the patient's details must be updated on the IT system and the medical record on the date of the session.
- 3.11.2 When the test has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of session.

3.12 SESSION TEMPLATE CHANGES

- 3.12.1 Session templates should be agreed with the healthcare professional and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement (SBAs).
- 3.12.2 Templates will identify the number of slots available for new red flag, new urgent, new routine, planned and follow up appointments; specify the time each session is scheduled to start and finish; and identify the length of time allocated for each appointment slot.

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

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

3.13 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

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

3.13.2 Transfers to alternative providers must always be with the consent of the patient and the receiving clinician and be managed in line with PAS technical guidance (see also Reasonable Offers, ref. 3.5). Administrative speed and good communication are very important to ensure this process runs smoothly.

3.14 TECHNICAL GUIDANCE

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

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

- Diagnostic waiting time and report turnaround time.
- Patients treated (IP/DC) or seen (OP) by an independent sector provider.
- Rapid angina assessment clinic (RAAC).
- Management of waiting times of patients who transfer between NHS sites (either within NI or the rest of the UK).

- Patients who are to be treated as part of a waiting list initiative / additional in house activity.

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INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 4

**GUIDANCE FOR MANAGEMENT OF ELECTIVE
ADMISSIONS**

DRAFT

4.1 INTRODUCTION

- 4.1.1 The following protocol is based on recommended good practice guidelines to assist staff with the effective management of elective inpatient and daycase admissions.
- 4.1.2 The administration and management of elective admissions within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.
- 4.1.3 In all aspects of the elective admissions booking process, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language**. Local booking policies should be developed accordingly.

Have we anything in place for this?

4.2 KEY PRINCIPLES

- 4.2.1 To aid both the clinical and administrative management of the waiting list, lists should be sub-divided and managed appropriately. Trusts will manage patients on one of three waiting lists, i.e.
1. active,
 2. planned and
 3. suspended.
- 4.2.2 All elective inpatient and daycase waiting lists should be managed according to clinical priorities. Priorities must be identified for each patient on the waiting list and allocated according to urgency of the treatment. Trusts will manage patients in four priorities, i.e.
1. Red flag (suspect cancer),
 2. urgent,
 3. routine and
 4. planned.
- No other clinical priority categories should be used for inpatient and daycase services.

There are currently only 2 priority categories on PAS for referrals – urgent and routine. Red flags are identified by reason for referral code. Is this an opportunity to update PAS with a priority category for red flag? Yes this would make sense

- 4.2.3 Patients of equal clinical priority will be selected for booking in strict chronological order, taking into account planned patients expected date of admission.
- 4.2.4 The regional targets for a maximum inpatient and daycase waiting times are outlined in the Health and Social Care Commissioning Plan and Indicators of Performance Direction (CPD), <https://www.health-ni.gov.uk/doh-management-and-structure> (see Ministerial Priorities).
- 4.2.5 Maximum waiting times for urgent patients should be agreed locally with clinicians and made explicit, through internal processes, to booking office staff. Booking staff should ensure that patients are appointed within the clinical timeframe indicated by the consultant and capacity issues are quickly identified and escalated.
- 4.2.6 Trusts should ensure that clinical templates are constantly reviewed to meet changes in demand and new clinical practice.
Is this relevant to elective? Consultants normally select cases based on clinical priority etc.
- 4.2.7 Data collection in respect of referrals and waiting times should be accurate, timely, complete and subject to regular audit and validation.
- 4.2.8 Trusts should **not** use manual administration systems to record and report patients who have been booked.
- 4.2.9 Trusts should provide training programmes for staff which include all aspects of IEAP. It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts.

4.3 PRE-ASSESSMENT

- 4.3.1 All patients undergoing an elective procedure (including endoscopy procedures) must undergo a pre-assessment. This can be provided using a variety of methods including telephone, video link, postal or face to face assessment.
- 4.3.2 Pre-assessment may include an anesthetic assessment or guidance on how to comply with pre-procedure requirements such as bowel preparation. It will be the responsibility of the pre- assessment team, in accordance with protocols developed by the relevant clinical teams, to authorise fitness for an elective procedure.
- 4.3.3 Only those patients that are deemed fit for their procedure may be offered a TCI date.
- 4.3.4 If a patient is assessed as being unfit for their procedure, their To Come In (TCI) date may be cancelled and decision taken as to the appropriate next action.
- 4.3.5 Pre-assessment services should be supported by a robust booking system.

4.4 CALCULATION OF THE WAITING TIME

- 4.4.1 The starting point for the waiting time of an inpatient/daycase admission is the date the appropriate clinician agrees that a procedure will be pursued as an active treatment or diagnostic intervention, and that the patient is clinically and socially fit to undergo such a procedure.
- 4.4.2 The waiting time for each patient on the elective admission list is calculated as the time period between the original decision to admit date and the date at the end of the applicable period for the waiting list return. If the patient has been suspended at all during this time, the period(s) of suspension will be automatically subtracted from the total waiting time.

4.5 REASONABLE OFFERS - TO COME IN (TCI) OFFERS OF TREATMENT

- 4.5.1 The patient should be advised of their expected waiting time during the consultation between themselves and the health care provider/practitioner.
- 4.5.2 All patients must be offered reasonable notice. Patients should be made reasonable offers to come in (TCI) on the basis of clinical priority. Within clinical priority groups offers should then be made on the basis of the patient's chronological wait.
- 4.5.3 A reasonable offer is defined as:
- an offer of admission, irrespective of provider or location, that gives the patient a minimum of three weeks' notice and a choice of two TCI dates, and
 - at least one of the offers must be within N. I., except for any regional specialties where there are no alternative providers within NI.

The majority of elective procedures are fixed appointments, based on when consultants are available for theatre sessions, availability of ICU capacity if required, volume of predicted in-patient beds etc. This is a complex booking process which can be difficult to adapt with partial booking.
Does there need to be a guidance for fixed elective offers?

- 4.5.4 If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the admission was refused.
- 4.5.5 This does not prevent patients being offered earlier appointment dates. If the patient is offered an admission within a shorter notice period (i.e. less than three weeks' notice) and refuses it they will not have their waiting time reset.
- 4.5.6 If the patient accepts an admission at short notice, but then cancels the admission, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the provider.
- 4.5.7 Urgent patients must be booked within the locally agreed maximum waiting time from the date of receipt. It is recognised that there will be occasional

exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Clearly defined booking protocols will be required to support specialties and booking staff.

- 4.5.8 Providers should have robust audit procedures in place to demonstrate compliance with the above.
- 4.5.9 To ensure the verbal booking process is auditable, the Trust should make and cancel a TCI date using the date of the second admission date offered and refused for this transaction.

4.6 INPATIENT AND DAYCASE ACTIVE WAITING LISTS

- 4.6.1 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to add the patient to the waiting list, i.e. the patient must be “fit, ready, and able” to come in.
- 4.6.2 To ensure consistency and the standardisation of reporting with commissioners and the DoH, all waiting lists are to be maintained in the PAS patient information system.
- 4.6.3 Details of patients must be entered on to the computer system (PAS) recording the date the decision was made to admit the patient or add the patient to the waiting list within two working days of the decision being made. Failure to do this will lead to incorrect assessment of waiting list times.
- 4.6.4 Where a decision to add to the waiting list depends on the outcome of diagnostic investigation, patients should not be added to an elective waiting list until the outcome of this investigation is known. There must be clear processes in place to ensure a decision is made in relation to the result of the investigation and the clinical patient pathway agreed.

4.7 SUSPENDED PATIENTS

- 4.7.1 At any time a consultant is likely to have a number of patients who are unsuitable for admission for clinical or personal reasons. These patients should be suspended from the active waiting list until they are ready for admission.
- 4.7.2 A period of suspension is defined as:
- A patient suspended from the active waiting list for medical reasons, or unavailable for admission for a specified period because of family commitments, holidays, or other reasons i.e. a patient may be suspended during any periods when they are unavailable for treatment for personal or medical reasons (but not for reasons such as the consultant being unavailable, beds being unavailable etc.).
 - A recommended maximum period not exceeding **three** months.
- 4.7.3 No patient should be suspended from the waiting list without a suspension end date.
- 4.7.4 Suspended patients should be reviewed one month prior to the end of their suspension period and a decision taken on their admission.
- 4.7.5 Every effort will be made to minimise the number of patients on the suspended waiting list, and the length of time patients are on the suspended waiting list.
- 4.7.6 Should there be any exceptions to the above, advice should be sought from the lead director or appropriate clinician.
- 4.7.7 Suspended patients will not count as waiting for statistical purposes. Any periods of suspension will be automatically subtracted from the patient's total time on the waiting list for central statistical returns.
- 4.7.8 No patient added to a waiting list should be immediately suspended. Patients should be recorded as suspended on the same day as the decision was taken that the patient was unfit or unavailable for admission/treatment.

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

4.8 PLANNED PATIENTS

- 4.8.1 Planned patients are those patients who are waiting to be admitted to hospital for a further stage in their course of treatment or surgical investigation within specific timescales.
- 4.8.2 These patients are not actively waiting for treatment, but for planned continuation of treatment. A patient is planned if there are clinical reasons that determine the patient must wait set periods of time between interventions. They will not be classified as being on a waiting list for statistical purposes.
- 4.8.3 Trusts must have systems and processes in place to identify high risk planned patients in line with clinical guidance.
- 4.8.4 Trusts should be able to demonstrate consistency in the way planned patients are treated and that patients are being treated in line with the clinical constraints. Planned patients should have a clearly identified month of treatment in which it can be shown that the patients are actually being treated.
- 4.8.5 Trusts must ensure that planned patients are not disadvantaged in the management of planned backlogs, with particular focus on high risk surveillance pathway patients.

4.9 PATIENTS LISTED FOR MORE THAN ONE PROCEDURE

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

- 4.9.2 Where different clinicians working together will perform more than one procedure at one time the patient should be added to the waiting list of the clinician for the priority procedure with additional clinician procedures noted.
- 4.9.3 Where a patient requires more than one procedure performed on separate occasions or bilateral procedures by different (or the same) clinician, the patient should be placed on the active waiting list for the first procedure and the planned waiting list for any subsequent procedures.

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

DNAs – Inpatient/Daycase

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

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

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

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

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

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

Is there a process in place for this the same as outpatients were a letter is sent to the patient and they phone in ?

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

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

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

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

4.10.2 CNAs – Patient Initiated Cancellations of inpatient/daycase admission

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

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

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

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

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

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

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

4.11. CNAs - HOSPITAL INITIATED CANCELLATIONS

- 4.11.1 No patient should have his or her admission cancelled. If Trusts cancel a patient's admission the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity.
- 4.11.2 The patient should be informed of the cancellation and the date of the new admission booked.
- 4.11.3 Trusts will make best efforts to ensure that a patient's admission is not cancelled a second time for non-clinical reasons.
- 4.11.4 Where patients are cancelled on the day of an admission/operation as a result of not being fit, they will be suspended, pending a clinical review of their condition. The patient should be fully informed of this process.
- 4.11.5 Hospital initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of admission a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

4.12 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

- 4.12.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between Trust sites or to independent sector (IS) providers.
- 4.12.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant and be managed in line with PAS technical guidance, (see also Reasonable Offers, ref. 4.5). Administrative speed and good communication are very important to ensure this process runs smoothly.

4.13 TECHNICAL GUIDANCE

4.13.1 See also Regional ISB Standards and Guidance

<https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Standards%20and%20Guidance.aspx> re acute activity definitions.

4.13.2 See also PAS technical guidance

<https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Technical%20Guidance.aspx> for recording;

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

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 5

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

DRAFT

5.1 INTRODUCTION

- 5.1.1 The following protocol is based on recommended good practice guidelines to assist staff with the effective management of the elective booking processes for elective Allied Health Professionals (AHP) services, including those patients whose referral is managed virtually.
- 5.1.2 Allied Health Professionals work with people of all age groups and conditions, and are trained in assessing, diagnosing, treating and rehabilitating people with health and social care needs. They work in a range of settings including hospital, community, education, housing, independent and voluntary sectors.
- 5.1.3 The administration and management of the AHP pathway from receipt of referral to appointment within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.
- 5.1.4 For the purposes of this section of the protocol, the generic term 'clinic' will be used to reflect AHP activity undertaken in hospital, community (schools, daycare settings, leisure and community centres) or domiciliary settings (people's own home or where they live e.g. residential or nursing homes) as AHPs provide patient care in a variety of care locations.
- 5.1.5 AHP services are administered on a wide range of information systems, with varying degrees of functionality able to support full IT implementation of the requirements of the IEAP. Trusts should ensure that the administrative management of patients is undertaken in line with the principles of the IEAP and that all efforts are made to ensure patient administration systems are made fit for purpose.
- 5.1.6 There will be dedicated booking offices within Trusts to receive, register and process all AHP referrals.
- 5.1.7 Fixed appointments should only be used in exceptional circumstances.

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

5.2 KEY PRINCIPLES

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

1. urgent and
2. routine.

No other clinical priorities should be used for AHP services.

- 5.2.2 Patients of equal clinical priority will be selected for booking in strict chronological order.
- 5.2.3 Patient appointments for new and review should be **partially booked**. Where fixed appointments are being issued, Trusts should ensure that the IEAP guidance is followed in the management of patients.
- 5.2.4 The regional target for a maximum AHP waiting time is outlined in the Health and Social Care Commissioning Plan and Indicators of Performance Direction (CPD), <https://www.health-ni.gov.uk/doh-management-and-structure> (see Ministerial Priorities).
- 5.2.5 Maximum waiting times for urgent patients should be agreed locally with AHP professionals and made explicit, through internal processes, to booking office staff. Booking staff should ensure that patients are appointed within the clinical timeframe indicated by the professional and capacity issues are quickly identified and escalated.
- 5.2.6 Patients should not be disadvantaged where a decision is made to assess their clinical need through virtual activity.

- 5.2.7 Trusts should ensure that clinical templates are constantly reviewed to meet changes in demand and new clinical practice.
- 5.2.8 Data collection in respect of referrals and waiting times should be accurate, timely, complete and subject to regular audit and validation.
- 5.2.9 Trusts should **not** use manual administration systems to record and report patients who have been booked.
- 5.2.10 Trusts should provide training programmes for staff which include all aspects of this IEAP. It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts.

5.3 NEW REFERRALS

- 5.3.1 All outpatient referrals (including those sent via Clinical Communication Gateway (CCG)) sent to Trusts will be registered within **one** working day of receipt. Referrer priority status must be recorded at registration.
- 5.3.2 Trusts will work towards a system whereby the location of all referrals (paper and electronic) not yet prioritised can be identified and tracked.
- 5.3.3 All referrals must be prioritised and clinical urgency must be clearly identified. Clinicians and management will be responsible for ensuring that cover is provided for referrals to be read and prioritised during any absence.
- 5.3.4 All referrals will be prioritised (including those prioritised via E Triage) within **three** working days of date of receipt of referral.
- 5.3.5 Following prioritisation, referrals must be actioned on PAS or the relevant electronic patient administration system and appropriate correspondence (including electronic), e.g. acknowledgement or appointment letter, issued to patients within **one** working day.

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

5.4 CALCULATION OF THE WAITING TIME

- 5.4.1 The starting point for the waiting time of an AHP new referral is the date the clinician's referral or self-referral is received by the booking office or, for internal referrals, when the referral is received by the booking office/department. All referrals, including emailed and electronically delivered referrals, will have the date the referral received into the organisation recorded either by date stamp or electronically.
- 5.4.2 In cases where referrals bypass the booking office, (e.g. sent directly to an allied health professional), the Trust must have a process in place to ensure that these are date stamped on receipt, immediately forwarded to the booking office/department and registered at the date on the date stamp.
- 5.4.3 The waiting time for each patient is calculated as the time period between the receipt of the referral and the date at the end of the applicable period for the waiting list return. If the patient has been suspended at all during this time, the period(s) of suspension will be automatically subtracted from the total waiting time.
- 5.4.4 The waiting time clock stops when the first definitive AHP treatment has commenced.

5.5 REASONABLE OFFERS

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

- 5.5.2 If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused.
- 5.5.3 This does not prevent patients being offered earlier appointment dates. If the patient is offered an appointment within a shorter notice period (i.e. less than three weeks' notice) and refuses it they will not have their waiting time reset.
- 5.5.4 If the patient accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the provider.
- 5.5.5 Urgent patients must be booked within the locally agreed maximum waiting time from the date of receipt. It is recognised that there will be occasional exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Clearly defined booking protocols will be required to support specialties and booking staff.
- 5.5.6 Providers should have robust audit procedures in place to demonstrate compliance with the above.
- 5.5.7 To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

5.6 REVIEW APPOINTMENTS

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

- 5.6.2 Patients must be recorded on PAS as requiring to be seen within a clinically indicated time. Trusts should actively monitor patients on the review list to ensure that they do not go past their indicative time of treatment.
- 5.6.3 Review patients who require an appointment within **six** weeks will be asked to agree the date and time of the appointment before leaving the department and PAS updated.
- 5.6.4 Patients requiring an appointment outside **six** weeks will be placed on a review waiting list, with the agreed clinically appropriate appointment date recorded, and be booked in line with implementation guidance for review pathway patients.
- 5.6.5 Virtual review appointments, e.g. telephone or video link, should be partially booked. If the patient cannot be contacted for their virtual review they should be sent a partial booking letter to arrange an appointment.

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

5.7.1 DNAs – New AHP Appointments

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

5.7.1(a) Patients who have been partially booked will **not** be offered a second appointment and should be removed from the waiting list.

The patient and referrer (and the patients GP, where they are not the referrer) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

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

- 5.7.1(c) Patients who DNA and are not discharged but offered a second appointment will have their waiting time clock reset to the date of the DNA.
- 5.7.1(d) *Where patients are discharged from the waiting list (ref. 5.7.1(a)) they should be advised to contact the Trust booking office within **four** weeks of the original appointment date if they consider that the appointment is still required. Where a patient makes contact within the **four** week deadline, and where the Trust considers that unforeseen or exceptional circumstances meant that the patient was unable to attend, the patient should be added to the waiting list at the date that they have made contact with the Trust. If a patient makes contact after the **four** week period they cannot be reinstated.*
- 5.7.1(e) If the patient DNAs the second appointment offered then the patient should **not** be offered another opportunity to be reinstated. The patient and referrer (and the patients GP, where they are not the referrer) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.
- 5.7.1(f) Where a patient DNAs a fixed new appointment (i.e. they have not had the opportunity to agree/confirm the date and time of the appointment) they should be offered another appointment.
- 5.7.1(g) If the patient DNAs this second appointment the above steps should be followed.
- 5.7.1(h) If a patient DNA's a virtual outpatient appointment this should follow the above protocol based on whether the appointment is partially booked or fixed. The Trust should ensure that the contact details of the patient are up to date and available.

5.7.2 DNAs – Review Appointments

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

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

- 5.7.2(c) Where the clinical decision is that a second appointment should **NOT** be offered, Trusts should contact patients advising that as they have failed to attend their appointment they will be discharged from the waiting list. The referrer (and the patient's GP, where they are not the referrer) should also be informed of this.
- 5.7.2(d) Patients being discharged from the list should be advised to contact the Trust booking office if they have any queries. Where unforeseen or exceptional circumstances meant that the patient was unable to attend, and the patient makes contact within **four** weeks of the original appointment date, a clinical decision may be made to offer a second appointment. Where this is the case, the patient should be added to the waiting list at the date they make contact with the Trust.
- 5.7.2(e) If the patient DNAs the second appointment offered then the patient should **NOT** be offered another opportunity to be reinstated. The patient and referrer will be informed that, as they have failed to attend their appointment, they will be discharged from the waiting list.
- 5.7.2(f) Where a patient DNAs a fixed review appointment where they have not had the opportunity to agree/ confirm the date and time of their appointment, they should be offered another appointment. If they DNA this second fixed appointment, the above should be followed.
- 5.7.2(g) If a patient DNA's a virtual outpatient review appointment this should follow the above protocol based on whether the appointment is partially booked or fixed. The Trust should ensure that the contact details of the patient are up to date and available.

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

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

- 5.7.3(a) The patient will be given a second opportunity to book an appointment (where this is still required), which should be within **six** weeks of the original appointment date.
- 5.7.3(b) Patients who CNA will have their waiting time clock reset to the date the Trust was informed of the cancellation.

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

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

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

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

5.8 CNAs – SERVICE INITIATED CANCELLATIONS

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

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

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

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

5.9 CLINIC OUTCOME MANAGEMENT

- 5.9.1 There are a number of locations within Trusts where patients present for their AHP consultation. This protocol applies to all AHP areas. It is the responsibility of the PAS/ IT system user managing the attendance to maintain data quality.
- 5.9.2 Changes in the patient's details must be updated on PAS and the medical records on the date of clinic.
- 5.9.3 When the consultation has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic.

5.10 CLINIC TEMPLATE CHANGES

- 5.10.1 Clinic templates should be agreed between the relevant AHP professional and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement (SBAs).
- 5.10.2 Templates will identify the number of slots available for new urgent and routine and review appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated for each appointment slot.
- 5.10.3 All requests for template and temporary clinic rule changes will only be accepted in writing. A minimum of **six** weeks' notice will be provided for clinic template changes.
- 5.10.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager.

5.11 TRANSFERS BETWEEN TRUSTS or to INDEPENDENT SECTOR

- 5.11.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between Trusts or to independent sector (IS) providers.
- 5.11.2 Transfers to alternative providers must always be with the consent of the patient and the receiving AHP professional, (see also Reasonable Offers, ref. 5.5). Administrative speed and good communication are very important to ensure this process runs smoothly.

5.12 TECHNICAL GUIDANCE

- 5.12.1 See also Public Health Agency;
<https://www.publichealth.hscni.net/publications/ahp-services-data-definitions-guidance-june-2015> re Guidance for monitoring the Ministerial AHP 13 week access target.
- 5.12.2 See also Regional ISB Standards and Guidance
<https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Standards%20and%20Guidance.aspx> re acute activity definitions.
- 5.12.3 See also PAS technical guidance
<https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Technical%20Guidance.aspx> for recording;
- ICATS waiting times and activity (including paper triage).
 - Patients treated (IP/DC) or seen (OP) by an independent sector provider.
 - Management of waiting times of patients who transfer between NHS sites (either within NI or the rest of the UK).
 - Patients who are to be treated as part of a waiting list initiative / additional in house activity.
 - Recording Consultant Virtual Outpatient Activity (June 2020).
 - AHP Virtual Consultation Guidance (to be issued).

INTEGRATED ELECTIVE ACCESS PROTOCOL

DRAFT

June 2020

Integrated Elective Access Protocol

Protocol Summary -

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

Version	2.0 This guidance replaces the Integrated Elective Access Protocol, 30 th April 2008.
Status	Draft for approval
Date	30 June 2020

Integrated Elective Access Protocol**Version**

Version	Date of issue	Summary of change	Author
1.0	25 August 2006	New Regional Guidance: Integrated Elective Access Protocol	M Irvine M Wright S Greenwood
2.0	30 April 2008	Protocol refresh to encompass guidance on all aspects of the elective care pathway	M. Irvine, M. Wright, R. Hullat
3.0		Update and relaunch IEAP to provide updated regional guidance on administration of patients on elective care pathways.	L. Mc Laughlin, Regional IEAP Review Group.

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Integrated Elective Access Protocol**Document control**

The current and approved version of this document can be found on the Department of Health website <https://www.health-ni.gov.uk> and on the Health and Social Care Board and Trusts intranet sites.

Document:	Integrated Elective Access Protocol 3.0
Department:	Department of Health
Purpose:	To advise and inform patients and clinical, administrative and managerial staff of the approved processes for managing patients access to outpatient, diagnostic, elective and elective Allied Health Professional (AHP) services.
For use by:	All clinical, administrative and managerial staff who are responsible for managing referrals, appointments and elective admissions.
This document is compliant with:	Northern Ireland Health and Social Care (NI HSCC) and Department of Health (DOH) Information Standards and Guidance and Systems Technical Guidance. https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Home.aspx
Screened by:	
Issue date:	
Approval by:	
Approval date:	
Distribution:	Trust Chief Executives, Directors of Planning and Performance, Directors of Acute Care, Department of Health.
Review date:	1 April 2021

Monitoring compliance with protocol

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

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Abbreviations

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

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 1

CONTEXT

DRAFT

1.1 INTRODUCTION

- 1.1.1 This protocol has been developed to define the roles and responsibilities of all those involved in the elective care pathway and to outline good practice to assist staff with the effective management of outpatient appointments, diagnostic, elective admissions and allied health professional (AHP) bookings, including cancer pathways and waiting list management.
- 1.1.2 The length of time a patient needs to wait for elective treatment is an important quality issue and is a visible public indicator of the efficiency of the hospital and AHP services provided by the Trust. The successful management of patients who wait for outpatient assessments, diagnostic investigations, elective inpatient or daycase treatment and AHP services is the responsibility of a number of key individuals within the organisation. General Practitioners (GPs), commissioners, hospital medical staff, allied health professionals, managers and clerical staff have an important role in ensuring access for patients in line with maximum waiting time targets as defined in the Department of Health (DOH) Commissioning Plan Direction (CPD) and good clinical practice, managing waiting lists effectively, treating patients and delivering a high quality, efficient and responsive service. Ensuring prompt timely and accurate communication with patients is a core responsibility of the hospital and the wider local health community.
- 1.1.3 The purpose of this protocol is to outline the approved processes for managing referrals to outpatient clinics, diagnostic procedures, elective procedures and operations and AHP booking procedures, through to discharge, to allow consistent and fair care and treatment for all patients.
- 1.1.4 The overall aim of the protocol is to ensure patients are treated in a timely and effective manner, specifically to:
- Ensure that patients receive treatment according to their clinical priority, with routine patients and those with the same clinical priority treated in chronological order, thereby minimising the time a patient spends on the waiting list and improving the quality of the patient experience.

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

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

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

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

1.2 METHODOLOGY

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

- 1.2.2 In this context, this protocol has been prepared to provide clarity of purpose within Trusts with a view to merging seamlessly with the policies of other agencies in the wider health community as they emerge.
- 1.2.3 This protocol has been prepared to clarify Trusts' medium and long-term objectives, set the context in which they will be delivered and establish the parameters within which staff at divisional, specialty and departmental levels will operate.
- 1.2.4 For the purposes of this protocol, the term;
- outpatient refers to a patient who has a clinical consultation. This may be face to face or virtual,
 - elective admissions refer to inpatient and daycase admissions,
 - inpatient refers to inpatient and daycase elective treatment,
 - diagnostic refers to patients who attend for a scan / test or investigation,
 - AHP refers to allied health professionals who work with people to help them protect and improve their health and well-being. There are thirteen professions recognised as allied health professions in Northern Ireland (NI),
 - partial booking refers to the process whereby a patient has an opportunity to agree the date and time of their appointment,
 - fixed booking refers to processes where the patient's appointment is made by the Trust booking office and the patient does not have the opportunity to agree/confirm the date and time of their appointment,
 - virtual appointment refers to any appointment that does not involve the physical presence of a patient at a clinic, (see also 1.5 Virtual Activity).
 - PAS refers to all electronic patient administration systems, including PARIS, whether in a hospital or community setting and those used in diagnostic departments such as NIPACS and systems used for other diagnostics / physiological investigations.

- 1.2.5 Trusts must maintain robust information systems to support the delivery of patient care through their clinical pathway. Robust data quality is essential to ensure accurate and reliable data is held, to support the production of timely operational and management information and to facilitate clinical and clerical training. All patient information should be recorded and held on an electronic system (PAS). Manual patient information systems should not be maintained.
- 1.2.6 All staff involved in the administration of waiting lists will ensure that Trusts' policies and procedures with respect to data collection and entry are strictly adhered to. This is to ensure the accuracy and reliability of data held on electronic hospital/patient administration systems and the waiting times for treatment.
- 1.2.7 Trusts should provide training programmes for staff which include all aspects of this Integrated Elective Access Protocol (IEAP). It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts. Trusts will provide appropriate information to staff so they can make informed decisions when delivering and monitoring this protocol. All staff involved in the administration of waiting lists will be expected to read and sign off this protocol.
- 1.2.8 This protocol will be available to all staff via Trusts' Intranet.

1.3 UNDERPINNING PRINCIPLES

- 1.3.1 Patients will be treated on the basis of their clinical urgency with urgent patients seen and treated first. The definition of clinical urgency will be defined and agreed at specialty / procedure / service level.
- 1.3.2 Patients with the same clinical need will be treated in chronological order on grounds of fairness, and to minimise the waiting time for all patients.

- 1.3.3 As part of a plan for the implementation of booking, Trusts must ensure their elective admission selection system is managed on a chronological basis within clinical priority.
- 1.3.4 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to add the patient to the waiting list, i.e. the patient must be “fit, ready, and able” to come in (TCI).
- 1.3.5 Trusts should design processes to ensure that inpatient care is the exception for the majority of elective procedures and that daycase is promoted. The principle is about moving care to the most appropriate setting, based on clinical judgement. This means moving daycase surgery to outpatient care and outpatient care to primary care or alternative clinical models where appropriate.
- 1.3.6 Referrals into Trusts should be pooled where possible as the norm within specialties.
- 1.3.7 Trusts will maintain and promote electronic booking systems aimed at making hospital appointments more convenient for patients. Trusts should move away from fixed appointments to partially booked appointments.
- 1.3.8 Trusts should also promote direct access services where patients are directly referred from primary and community care to the direct access service for both assessment and treatment. Direct access arrangements must be supported by clearly agreed clinical pathways and referral guidance, jointly developed by primary and secondary care.
- 1.3.9 For the purposes of booking/arranging appointments, all patient information should be recorded and held on an electronic system. Trusts should not use manual administration systems to record and report patient's information.
- 1.3.10 In all aspects of the booking processes, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language**. It is essential that patients who are considered at risk for whatever reason have their needs identified

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

Have we anything in place for 1.3.10

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

1.3.12 Trusts must ensure that the needs of ethnic groups and people with special requirements should be considered at all stages of the patient's pathway.

1.4 BOOKING PRINCIPLES

1.4.1 These booking principles will support all areas across the elective and AHP pathways where appointment systems are used.

1.4.2 Offering the patient choice of date and time where possible is essential in agreeing and booking appointments with patients through partial booking systems. Trusts should ensure booking systems enable patients to choose and agree hospital appointments that are convenient for them.

1.4.3 Facilitating reasonable offers to patients should be seen within the context of robust booking systems being in place.

1.4.4 All booking principles should be underpinned with the relevant local policies to provide clarity to operational staff.

1.4.5 Trusts should ensure booking processes are continually reviewed and updated as required to reflect local and regional requirements at an operational level.

1.4.6 The definition of a booked appointment is:

- a) The patient is given the choice of when to attend or have a virtual appointment.
- b) The patient is able to choose and confirm their appointment within the timeframe relevant to the clinical urgency of their appointment.
- c) The range of dates available to a patient may reduce if they need to be seen quickly, e.g. urgent referrals or within two weeks if cancer is suspected.
- d) The patient may choose to agree a date outside the range of dates offered or defer their decision until later.

1.4.7 Principles for booking Cancer Pathway patients:

- a) All suspected cancer referrals should be booked in line with the agreed clinical pathway requirement for the patient and a maximum of 14 days from the receipt of referral.
- b) Dedicated registration functions for red flag (suspect cancer) referrals should be in place within centralised booking teams.
- c) Clinical teams must ensure triage, where required, is undertaken daily, irrespective of leave, in order to initiate booking patients.
- d) Patients will be contacted by telephone twice (morning and afternoon).
- e) If telephone contact cannot be made, a fixed appointment will be issued to the patient within a maximum of three days of receipt of referral.
- f) Systems should be established to ensure the Patient Tracker / Multidisciplinary Team (MDT) Co-coordinator is notified of the suspected cancer patient referral, to allow them to commence prospective tracking of the patient.

1.4.8 Principles for booking Urgent Pathway patients:

- a) Maximum waiting times for urgent patients should be agreed locally with clinicians and/or service managers and made explicit, through internal processes, to booking office staff.
- b) Referrals will be received, registered within one working day and forwarded to consultants for prioritisation.

- c) If clinical priority is not received from consultants within 72 hours, processes should be in place to initiate booking of urgent patients according to the referrers's classification of urgency.
- d) Patients will be issued with a letter inviting them to contact the Trust to agree and confirm their appointment in line with the urgent booking process.
- e) In exceptional cases, some patients will require to be appointed to the next available slot. A robust process for telephone booking these patients should be developed which should be clearly auditable.

1.4.9 Principles for booking Routine Pathway patients:

- a) Patients should be booked to ensure appointment (including virtual appointment) is within the maximum waiting time guarantees for routine appointments.
- b) Referrals will be received, registered within one working day at booking teams and forwarded to consultants for prioritisation.
- c) Approximately eight weeks prior to appointment, Trusts should calculate prospective slot capacity and immediately implement escalation policy where capacity gaps are identified.
Rotas are not normally available 8 weeks out (annual leave/study leave notification period is 6 weeks. What escalation policy is being followed and where are the capacity gaps being escalated to? If this is an already known and accepted capacity gap, eg, through discussions with HSCB, vacant posts, do we always have to escalate?
- d) Patients should be selected for booking in chronological order from the Primary Targeting List (PTL).
- e) Six weeks prior to appointment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment.

1.4.10 Principles for Booking Review Patients;

- a) Patients who need to be reviewed within 6 weeks will agree their appointment (including virtual appointment) before they leave the clinic, where possible.

- b) Patients who require a review appointment more than 6 weeks in advance will be added to and managed on a review waiting list.
- c) Patients will be added to the review waiting list with a clearly indicated date of treatment and selected for booking according to this date.
- d) Six weeks prior to the indicative date of treatment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment within a clinically agreed window either side of the indicative date of treatment.

1.4.11 It is recognised that some groups of patients may require booking processes that have additional steps in the pathway. These should be designed around the principles outlined to ensure choice and certainty as well as reflecting the individual requirements necessary to support their particular patient journey.

Is there any provision to change date required if patient does not accept reasonable offer?

1.5 VIRTUAL ACTIVITY

1.5.1 Virtual Activity relates to any planned contact by the Trust with a patient (or their proxy) for healthcare delivery purposes i.e. clinical consultation, advice, review and treatment planning. It may be in the form of a telephone contact, video link, telemedicine or telecommunication, e.g. email.

1.5.2 The contact is in lieu of a face-to-face contact of a patient/client, i.e. a face-to-face contact would have been necessary if the telephone/video link/etc. had not taken place.

1.5.3 The call/contact should be prearranged with the patient and /or their proxy. Patients should not be disadvantaged where a decision is made to assess their clinical need through the use of virtual clinics.

Not all patient contact is pre-arranged, there has been a number of virtual clinics following validation when contact is made with the patient at the point of validation and a decision/treatment plan agreed.

- 1.5.4 The contact must be auditable with a written note detailing the date and substance of the contact is made following the consultation and retained in the patient's records.

1.6 COMPLIANCE WITH LEAVE PROTOCOL

- 1.6.1 It is essential that planned medical and other clinical staff leave or absence is organised in line with an agreed Trust Human Resources (HR) protocol. Thus it is necessary for Trusts to have robust local HR policies and procedures in place that minimise the cancellation/reduction of outpatient clinics and the work associated with the rebooking of appointments.
- 1.6.2 There should be clear medical and clinical agreement and commitment to this HR policy. Where cancelling and rebooking is unavoidable the procedures used must be equitable, efficient, comply with clinical governance principles and ensure that maximum waiting times for patients are not compromised.
- 1.6.3 The protocol should require a minimum of six weeks' notification of intended leave, in line with locally agreed HR policies, in order to facilitate Trusts booking teams to manage appointment processes six weeks in advance.
- 1.6.4 The booking team should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

1.7 VALIDATION

- 1.7.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a monthly basis. This is essential to ensure the efficiency of the elective pathway at all times. In addition, Trusts should ensure that waiting lists are regularly validated to ensure that only those patients who want or still require a procedure are on the waiting list.

- 1.7.2 Involvement of clinicians in the validation process is essential to ensure that waiting lists are robust from a clinical perspective. Trusts should ensure an ongoing process of clinical validation and audit is in place.

Have we anything set up for the ongoing clinical validation

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INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 2

**GUIDANCE FOR MANAGEMENT OF OUTPATIENT
SERVICES**

DRAFT

2.1 INTRODUCTION

- 2.1.1 The following protocol is based on recommended good practice guidelines to assist staff with the effective management of outpatient services, including those patients whose referral is managed virtually.
- 2.1.2 The administration and management of the outpatient pathway from receipt of referral to appointment within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.
- 2.1.3 There will be dedicated booking offices within Trusts to receive, register and process all outpatient referrals.
- 2.1.4 Fixed appointments should only be used in exceptional circumstances.
- 2.1.5 In all aspects of the outpatient booking process, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language**. Local booking policies should be developed accordingly.

Is there anything we need to have n place here?

2.2 KEY PRINCIPLES

- 2.2.1 Referrals into Trusts should be pooled where possible within specialties.
- 2.2.2 All new referrals, appointments and outpatient waiting lists should be managed according to clinical priorities. Priorities must be identified for each patient on the waiting list and allocated according to urgency of the treatment. Trusts will manage patients in three priorities, i.e.
1. Red flag (suspect cancer),
 2. urgent and
 3. routine.

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

There are currently only 2 priority categories on PAS for referrals – urgent and routine. Red flags are identified by reason for referral code. Is this an opportunity to update PAS with a priority category for red flag? Yes that would make sense

- 2.2.3 Patients of equal clinical priority will be selected for booking in strict chronological order.
- 2.2.4 Patient appointments for new and review should be **partially booked**.
In the case of red flag appointments and 14 day target, it is not always possible to partial book appointments. The principles in section 1 are applied, ie the 2 attempts at telephone contacts and 1 fixed appointment.
- 2.2.5 The regional target for a maximum outpatient waiting time is outlined in the Health and Social Care Commissioning Plan and Indicators of Performance Direction (CPD), <https://www.health-ni.gov.uk/doh-management-and-structure> (see Ministerial Priorities).
- 2.2.6 Maximum waiting times for urgent patients should be agreed locally with clinicians and made explicit, through internal processes, to booking office staff. Booking staff should ensure that patients are appointed within the clinical timeframe indicated by the consultant and capacity issues are quickly identified and escalated.
- 2.2.7 Patients should not be disadvantaged where a decision is made to assess their clinical need through virtual activity.
- 2.2.8 Trusts should ensure that clinical templates are constantly reviewed to meet changes in demand and new clinical practice.
- 2.2.9 Data collection in respect of referrals and waiting times should be accurate, timely, complete and subject to regular audit and validation.
- 2.2.10 Trusts will work towards providing a single point of contact for all patients with respect to outpatient appointment services. It is recognised that there may be services which require alternative processes.

- 2.2.11 Trusts should **not** use manual administration systems to record and report patients who have been booked.
- 2.2.12 Trusts should provide training programmes for staff which include all aspects of IEAP. It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts.

2.3 NEW REFERRALS

- 2.3.1 All outpatient referrals (including those sent via Clinical Communication Gateway (CCG)) sent to Trusts will be registered within **one** working day of receipt. Referrer priority status must be recorded at registration.
- 2.3.2 Trusts will work towards a system whereby the location of all referrals (paper and electronic) not yet prioritised can be identified and tracked.
- 2.3.3 All referrals must be prioritised and clinical urgency must be clearly identified. Clinicians and management will be responsible for ensuring that cover is provided for referrals to be read and prioritised during any absence.
- 2.3.4 All referrals will be prioritised (including those prioritised via E-Triage) within **a maximum of three** working days of date of receipt of referral. Note; Red flag referrals require **daily** triage.
- 2.3.5 Following prioritisation, referrals must be actioned on PAS and appropriate correspondence (including electronic), e.g. acknowledgement or appointment letter, issued to patients within **one** working day.
- 2.3.6 Inappropriate and inadequate referrals should be returned to the referral source immediately and the referral closed and managed in line with the PAS technical guidance.

2.4 CALCULATION OF THE WAITING TIME – STARTING TIME

2.4.1 The starting point for the waiting time of an outpatient new referral is the date the referral is received by the booking office/department.

2.4.2 In exceptional cases where referrals bypass the booking office (e.g. sent directly to a consultant) the Trust must have a process in place to ensure that these are date stamped on receipt, immediately forwarded to the booking office and registered at the date on the date stamp.

2.5 REASONABLE OFFERS

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

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

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

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

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

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

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

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

2.6 REVIEW APPOINTMENTS

- 2.6.1 All review appointments must be made within the time frame specified by the clinician. If a review appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the clinician.
- 2.6.2 Patients must be recorded on PAS as requiring to be seen within a clinically indicated time. Trusts should actively monitor patients on the review list to ensure that they do not go past their indicative time of treatment.
- 2.6.3 Review patients who require an appointment within six weeks will be asked to agree the date and time of the appointment before leaving the department and PAS updated.
- 2.6.4 Patients requiring an appointment outside six weeks will be placed on a review waiting list, with the agreed clinically appropriate appointment date recorded, and be booked in line with implementation guidance for review pathway patients.
- 2.6.5 Virtual review appointments, e.g. telephone or video link, should be partially booked. If the patient cannot be contacted for their virtual review they should be sent a partial booking letter to arrange an appointment.

Not all patient contact is pre-arranged, there has been a number of virtual clinics following validation when contact is made with the patient at the point of validation and a decision/treatment plan agreed.

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

2.7.1 DNAs – New Outpatient

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

- 2.7.1(a) Patients who have been partially booked will **not** be offered a second appointment and should be removed from the waiting list. The patient and referring clinician (and the patient's GP, where they are not the referring clinician) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.
- 2.7.1(b) Under exceptional circumstances a clinician may decide that a patient who DNAs a first appointment should not be removed from the waiting list and should be offered a second appointment. Trusts should put in place local agreements with clinicians, regarding those referrals (e.g. red flag) or specialties where patients may be at risk (e.g. paediatrics or adults at risk) where a second appointment should always be offered.
- 2.7.1(c) Patients who DNA and are not discharged but offered a second appointment will have their waiting time clock reset to the date of the DNA.
- 2.7.1(d) *Where patients are discharged from the waiting list (ref. 2.7.1(a)) they should be advised to contact the Trust booking office within **four** weeks of the original appointment date if they consider that the appointment is still required. Where a patient makes contact within the **four** week deadline, and where the Trust considers that unforeseen or exceptional circumstances meant that the patient was unable to attend, the patient should be added to the waiting list at the date that they have made contact with the Trust. If a patient makes contact after the **four** week period they cannot be reinstated.*

- 2.7.1(e) If the patient DNAs the second appointment offered then the patient should **not** be offered another opportunity to be reinstated. The patient and referring clinician (and the patient's GP, where they are not the referring clinician) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.
- 2.7.1(f) Where a patient DNAs a fixed new appointment (i.e. they have not had the opportunity to agree/confirm the date and time of the appointment) they should be offered another appointment.
- 2.7.1(g) If the patient DNAs this second fixed appointment they will be removed from the waiting list and the steps in 2.7.1(d) should be followed.
- 2.7.1(h) If a patient DNA's a virtual outpatient appointment this should follow the above protocol based on whether the appointment is partially booked or fixed. The Trust should ensure that the contact details of the patient are up to date and available.

2.7.2 DNAs – Review Outpatient

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

- 2.7.2(a) Where a patient has been partially booked and does not attend, a clinical decision should be taken as to whether a second appointment should be offered or whether the patient can be discharged.
- 2.7.2(b) Where the clinical decision is that a second appointment should be offered, this should be partially booked.
- 2.7.2(c) Where the clinical decision is that a second appointment should **not** be offered, Trusts should contact patients advising that as they have failed to attend their appointment they have been discharged from the waiting list. The referring clinician (and the patient's GP, where they are not the referring clinician) should also be informed of this.
- 2.7.2(d) *Patients being discharged from the list should be advised to contact the Trust booking office if they have any queries. Where unforeseen or exceptional circumstances meant that the patient was unable to attend, and the patient makes contact within **four** weeks*

of the original appointment date, a clinical decision may be made to offer a second appointment. Where this is the case, the patient should be added to the review waiting list with a revised clinically indicated date at the date they make contact with the Trust.

- 2.7.2(e) If the patient DNAs the second review appointment which has been partially booked then the patient should **not** be offered another opportunity to be reinstated. The patient and referrer will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.
- 2.7.2(f) Where a patient DNAs a fixed review appointment where they have not had the opportunity to agree/ confirm the date and time of their appointment, they should be offered another appointment. If they DNA this second fixed appointment, the above should be followed.
- 2.7.2(g) If a patient DNA's a virtual outpatient review appointment this should follow the above protocol based on whether the appointment is partially booked or fixed. The Trust should ensure that the contact details of the patient are up to date and available.
- 2.7.2(h) There may be instances for review patients where the clinician may wish to review notes prior to any action to remove a patient because of a DNA or failure to respond to a partial booking letter. Trusts should ensure that there are locally agreed processes in place to administer these patients.

Is there any provision to change date required if patient does not accept reasonable offer/DNA or the consultant changes plan following review of notes?

2.7.3 CNAs – Patient Initiated Cancellations of Outpatient Appointments

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

- 2.7.3(a) The patient will be given a second opportunity to book an appointment (where this is still required), which should be within **six** weeks of the original appointment date.
- 2.7.3(b) Patients who CNA will have their waiting time clock reset to the date the Trust was informed of the cancellation.

- 2.7.3(c) If a second appointment is cancelled, the patient will **not** normally be given another appointment. Where a decision is taken not to offer a further appointment, Trusts should contact patients advising that they have been discharged from the waiting list. The referring clinician (and the GP, where they are not the referring clinician) should also be informed of this.
- 2.7.3(d) However, where unforeseen or exceptional circumstances mean that the patient had to cancel a second appointment, the Trust may exercise discretion to offer a third appointment. This should include seeking a clinical review of the patient's case where this is appropriate.
- 2.7.3(e) If a patient CNA's a virtual outpatient appointment this should follow the above protocol.

2.8 CNAs – HOSPITAL INITIATED CANCELLATIONS

- 2.8.1 No patient should have his or her appointment cancelled. If Trusts cancel a patient's appointment, including a virtual appointment, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity.
- 2.8.2 The patient should be informed of the cancellation and a new appointment partially booked.
- 2.8.3 Trusts will make best efforts to ensure that a patient's appointment is not cancelled a second time for non-clinical reasons.
- 2.8.4 Hospital initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

2.9 CLINIC OUTCOME MANAGEMENT

- 2.9.1 Changes in the patient's details must be updated on PAS and the medical records on the date of the clinic.
- 2.9.2 When the consultation has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic.

2.10 CLINIC TEMPLATE CHANGES

- 2.10.1 Clinic templates should be agreed between the consultant and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement (SBAs).
- 2.10.2 Templates will identify the number of slots available for red flag, urgent, and routine and review appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated for each appointment slot.
- 2.10.3 All requests for template and temporary clinic rule changes will only be accepted in writing. A minimum of **six** weeks' notice will be provided for clinic template changes.
- 2.10.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager.

2.11 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

- 2.11.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between hospitals or to independent sector (IS) providers.
- 2.11.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant and be managed in line with PAS technical guidance, (see also Reasonable Offers, ref. 2.5). Administrative speed and good communication are very important to ensure this process runs smoothly.

2.12 OPEN REGISTRATIONS

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

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

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

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

2.13 TIME CRITICAL CONDITIONS

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

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

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

- 2.13.4 If the patient refuses the first appointment they should be offered a second appointment during the same telephone call. This second appointment should be offered on a date which is within **14** days of the date the initial appointment was offered and refused. In order to capture the correct waiting time the first appointment will have to be scheduled and then cancelled on the day of the offer and the patient choice field updated in line with the technical guidance. This will then reset the patient's waiting time to the date the initial appointment was refused.
- 2.13.5 If the patient cancels **two** agreed appointment dates the relevant clinical team should be advised before a decision is taken to discharge. Where a decision is taken to discharge the patient, the patient's GP should be informed.
- 2.13.6 If the patient has agreed an appointment but then DNAs the relevant clinical team should be advised before a decision is taken to discharge. Where a decision is taken to discharge the patient, the patient's GP should be informed.
- 2.13.7 Where the patient DNAs a fixed appointment they should be offered another appointment.
- 2.13.8 If the patient DNAs this second fixed appointment the relevant clinical team should be advised before a decision is taken to discharge. Where a decision is taken to discharge the patient, the patient's GP should be informed.
- 2.13.9 With regard to 2.13.4 to 2.13.8 above, it is the responsibility of each individual Trust to agree the discharge arrangements with the clinical team.
- 2.13.10 If the patient is not available for up to **six** weeks following receipt of referral, the original referral should be discharged a second new referral should be opened with the same information as the original referral and with a new date equal to the date the patient has advised that they will be available and the patient monitored from this date.

2.14 TECHNICAL GUIDANCE

2.14.1 See also Regional ISB Standards and Guidance

<https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Standards%20and%20Guidance.aspx> re;

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

2.14.2 See also PAS technical guidance

<https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Technical%20Guidance.aspx> for recording;

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

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 3

**GUIDANCE FOR MANAGEMENT OF DIAGNOSTIC
SERVICES**

DRAFT

3.1 INTRODUCTION

- 3.1.1 A diagnostic procedure may be performed by a range of medical and clinical professionals across many different modalities, including, diagnostic imaging, cardiac imaging and physiological measurement services. These may have differing operational protocols, pathways and information systems but the principles of the IEAP should be applied across all diagnostic services.
- 3.1.2 The principles of good practice outlined in the Outpatient and Elective Admissions sections of this document should be adopted in order to ensure consistent standards and processes for patients as they move along the pathway of investigations, assessment and treatment. This section aims to recognise areas where differences may be encountered due to the nature of specific diagnostic services.
- 3.1.3 The administration and management of requests for diagnostics, waiting lists and appointments within and across Trust should be consistent, easily understood, patient focused and responsive to clinical decision making.
- 3.1.4 It is recognised that diagnostic services are administered on a wide range of information systems, with varying degrees of functionality able to support full information technology (IT) implementation of the requirements of the IEAP. Trusts should ensure that the administrative management of patients is undertaken in line with the principles of the IEAP and that all efforts are made to ensure patient administration systems are made fit for purpose.
- 3.1.5 In all aspects of the diagnostic booking process, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language as well as associated legislative requirements such as Ionising Radiation (Medical Exposure) Regulations**. Local booking policies should be developed accordingly.

3.2 KEY PRINCIPLES

- 3.2.1 Referrals into Trusts should be pooled as the norm where possible.
- 3.2.2 All diagnostic requests, appointments and waiting lists should be managed according to clinical priority. Priorities must be identified for each patient on a waiting list and allocated according to urgency of the diagnostic procedure. Trusts will manage patients in four priorities, i.e.
1. Red flag (suspect cancer),
 2. urgent,
 3. routine and
 4. planned.
- No other clinical priority categories should be used for diagnostic services.
- 3.2.3 Patients of equal clinical priority will be selected for booking in strict chronological order.
- 3.2.4 Trusts should work towards an appointment system where patient appointments are **partially booked** (where applicable). Where fixed appointments are being issued, Trusts should ensure that the regional IEAP guidance is followed in the management of patients.
- 3.2.5 The regional target for a maximum diagnostic waiting time is outlined in the Health and Social Care Commissioning Plan and Indicators of Performance Direction (CPD), <https://www.health-ni.gov.uk/doh-management-and-structure> (see Ministerial Priorities).
- 3.2.6 Maximum waiting times for urgent patients should be agreed locally with clinicians and/or service managers and made explicit, through internal processes, to booking office staff. Booking staff should ensure that patients are appointed within the clinical timeframe indicated and capacity issues are quickly identified and escalated.
- 3.2.7 The outcome of the diagnostic test must be available to the referrer without undue delay and within the relevant DoH targets / standards.

- 3.2.8 Trusts should ensure that specific diagnostic tests or planned patients which are classified as daycases adhere to the relevant standards in the Elective Admissions section of this document.
- 3.2.9 Trusts should ensure that clinical templates are constantly reviewed to meet changes in demand and new clinical practice.
- 3.2.10 Data collection in respect of referrals and waiting times should be accurate, timely, complete and subject to regular audit and validation.
- 3.2.11 Trusts will work towards providing a single point of contact for all patients with respect to diagnostic appointment services. It is recognised that there will be services which require alternative processes.
- 3.2.12 Trusts should **not** use manual administration systems to record and report patients who have been booked.
- 3.2.13 Trusts should provide training programmes for staff which include all aspects of this IEAP. It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts.

3.3 NEW DIAGNOSTIC REQUESTS

- 3.3.1 All diagnostic requests will be registered on the IT system within **one** working day of receipt. Referrer priority status must be recorded at registration.
- 3.3.2 Trust diagnostic services must have mechanisms in place to track all referrals (paper and electronic) at all times.
- 3.3.3 All requests must be prioritised and clinical urgency must be clearly identified. Clinicians and management will be responsible for ensuring that cover is provided for referrals to be read and prioritised during any absence.

- 3.3.4 All referrals will be prioritised (including those prioritised via E Triage) within **three** working days of date of receipt of referral.
- 3.3.5 Following prioritisation, requests must be actioned on the IT system and appropriate correspondence (including electronic) issued to patients within **one** working day.
- 3.3.6 Inappropriate and inadequate requests should be returned to the referral source and the referral closed and managed in line with the PAS/relevant technical guidance, where appropriate.

3.4 CALCULATION OF THE WAITING TIME – STARTING TIME

- 3.4.1 The starting point for the waiting time of a request for a diagnostic investigation or procedure is the date the request is received into the department.
- 3.4.2 All referral letters and requests, emailed and electronically delivered referrals, will have the date received into the department recorded either by date stamp or electronically.

3.5 REASONABLE OFFERS

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

The IT Systems currently being used for the management of the majority of diagnostics do not facilitate partial booking, however, the fixed appointment letters do ask patients to confirm and are issued with 3 weeks' notice where appropriate. The diagnostic booking teams follow this up with telephone calls to patients to confirm attendances.

- 3.5.2 If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused.
- 3.5.3 This does not prevent patients being offered earlier appointment dates. If the patient is offered an appointment within a shorter notice period (i.e. less than three weeks' notice) and refuses it they will not have their waiting time reset.
- 3.5.4 If the patient accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the provider.
- 3.5.5 Providers should have robust audit procedures in place to demonstrate compliance with the above.
- 3.5.6 To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.
- 3.5.7 Urgent patients must be booked within the locally agreed maximum waiting time from the date of receipt. It is recognised that there will be occasional exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Clearly defined booking protocols will be required to support specialties and booking staff.

3.6 FOLLOW UP APPOINTMENTS

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

- 3.6.2 Patients must be recorded on the IT system as requiring to be seen within a clinically indicated time. Trusts should actively monitor follow up patients on the review list to ensure that they do not go past their indicative time of treatment.
- 3.6.3 Follow up patients who require an appointment within six weeks will be asked to agree the date and time of the appointment before leaving the department and the IT system updated.
- 3.6.4 Follow up patients requiring an appointment outside six weeks will be placed on a review waiting list, with the agreed clinically appropriate appointment date recorded, and be booked in line with management guidance for follow up pathway patients.

3.7 PLANNED PATIENTS

- 3.7.1 Planned patients are those who are waiting to be recalled to hospital for a further stage in their course of treatment or investigation within specific timescales. This is usually part of a planned sequence of clinical care determined on clinical criteria.
- 3.7.2 These patients are not actively waiting for treatment to be initiated, only for planned continuation of treatment. A patient's care is considered as planned if there are clinical reasons that determine the patient must wait set periods of time between interventions. They will not be classified as being on a waiting list for statistical purposes.
- 3.7.3 Trusts should be able to demonstrate consistency in the way planned patients are treated and that patients are being treated in line with the clinical constraints. Planned patients must have a clearly identified month of treatment in which it can be shown that the patients are actually being treated.
- 3.7.4 Trusts must ensure that planned patients are not disadvantaged in the management of planned backlogs.

3.8 PATIENTS LISTED FOR MORE THAN ONE DIAGNOSTIC TEST

- 3.8.1 Where more than one diagnostic test is required to assist with clinical decision making, the first test should be added to the waiting list with additional tests noted.
- 3.8.2 Where different clinicians working together perform more than one test at one time, the patient should be added to the waiting list of the clinician for the priority test (with additional clinicians noted) subject to local protocols.
- 3.8.3 Where a patient requires more than one test carried out on separate occasions the patient should be placed on the active waiting list for the first test and on the planned waiting list for any subsequent tests.
- 3.8.4 Where a patient is being managed in one Trust but has to attend another for another type of diagnostic test, monitoring arrangements must be in place between the relevant Trusts to ensure that the patient pathway runs smoothly.

There would be concern that a patient is only added to one waiting list, eg, a patient could require a number of different diagnostic tests to reach diagnosis and treatment plan, with varying waiting times for these tests, eg, a patient could be referred for a CT examination but also be added to the waiting list for an endoscopy procedure. A patient on cancer pathway could require PET and CT – these are different radiology modalities with different waiting lists. Cardiac patients could be listed for different examinations, eg, echo, stress test etc with varying waiting times.

The concern would be the risk that the patient would be closed off the system after the initial investigation or before all tests completed if only added to one waiting list.

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

- 3.9.1 DNAs – Diagnostic Appointment

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

- 3.9.1(a) Patients who have been partially booked will **not** be offered a second appointment and should be removed from the waiting list. The patient and referring clinician (and the patient's GP, where they are not the referring clinician) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.
- 3.9.1(b) Under exceptional circumstances a clinician may decide that a patient who DNAs a first appointment should not be removed from the waiting list and should be offered a second appointment. Trusts should put in place local agreements with clinicians, regarding those referrals (e.g. red flag) or specialties where patients may be at risk (e.g. paediatrics or adults at risk) where a second appointment should be offered.
- 3.9.1(c) Patients who DNA and are not discharged but offered a second appointment will have their waiting time clock reset to the date of the DNA.
- 3.9.1(d) *Where patients are discharged from the waiting list (ref. 3.7.1(a) above) they should be advised to contact the Trust booking office within **four** weeks of the original appointment date if they consider that the appointment is still required. Where a patient makes contact within the **four** week deadline, and where the Trust considers that unforeseen or exceptional circumstances meant that the patient was unable to attend, the patient should be added to the waiting list at the date that they have made contact with the Trust. If a patient makes contact after the **four** week period they cannot be reinstated.*
- 3.9.1(e) If the patient DNAs the second appointment offered then the patient should **not** be offered another opportunity to be reinstated. The patient and referring clinician (and the patient's GP, where they are not the referring clinician) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

- 3.9.1(f) Where a patient DNAs a fixed diagnostic appointment (i.e. they have not had the opportunity to agree/confirm the date and time of the appointment) they should be offered another appointment.
- 3.9.1(g) If the patient DNAs this second fixed diagnostic appointment they will be removed from the waiting list and the above steps in 3.7.1(d) should be followed.

3.9.2 DNAs – Follow up Diagnostic Appointment

If a patient DNAs their follow up diagnostic appointment the following process must be followed:

- 3.9.2(a) Where a patient has been partially booked and does not attend, a clinical decision should be taken as to whether a second appointment should be offered or whether the patient can be discharged.
- 3.9.2(b) Where the clinical decision is that a second appointment should be offered, this should be partially booked.
- 3.9.2(c) Where the clinical decision is that a second appointment should **not** be offered, Trusts should contact patients advising that as they have failed to attend they have been discharged from the waiting list. The referring clinician (and the patients GP, where they are not the referring clinician) should also be informed of this.
- 3.9.2(d) *Patients being discharged from the list should be advised to contact the Trust booking office if they have any queries. Where unforeseen or exceptional circumstances meant that the patient was unable to attend, and the patient makes contact within **four** weeks of the original appointment date, a clinical decision may be made to offer a second appointment. Where this is the case, the patient should be added to the review waiting list with a revised clinically indicated date at the date they make contact with the Trust.*
- 3.9.2(e) If the patient DNAs the second follow up appointment which has been partially booked then the patient should **not** be offered another opportunity to be reinstated. The patient and referrer will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

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

3.9.2(g) There may be instances for follow up patients where the clinician may wish to review notes prior to any action to remove a patient because of a DNA or failure to respond to a partial booking letter. Trusts should ensure that there are locally agreed processes in place to administer these patients.

3.9.3 CNAs – Patient Initiated Cancellations of Diagnostic Appointment

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

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

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

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

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

3.10 CNAs - HOSPITAL INITIATED CANCELLATIONS

- 3.10.1 No patient should have his or her appointment cancelled. If Trusts cancel a patient's appointment, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity.
- 3.10.2 The patient should be informed of the cancellation and the date of the new appointment.
- 3.10.3 Trusts will make best efforts to ensure that a patient's appointment is not cancelled a second time for non-clinical reasons.
- 3.10.4 Hospital initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

3.11 SESSION OUTCOME MANAGEMENT

- 3.11.1 Changes in the patient's details must be updated on the IT system and the medical record on the date of the session.
- 3.11.2 When the test has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of session.

3.12 SESSION TEMPLATE CHANGES

- 3.12.1 Session templates should be agreed with the healthcare professional and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement (SBAs).
- 3.12.2 Templates will identify the number of slots available for new red flag, new urgent, new routine, planned and follow up appointments; specify the time each session is scheduled to start and finish; and identify the length of time allocated for each appointment slot.

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

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

3.13 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

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

3.13.2 Transfers to alternative providers must always be with the consent of the patient and the receiving clinician and be managed in line with PAS technical guidance (see also Reasonable Offers, ref. 3.5). Administrative speed and good communication are very important to ensure this process runs smoothly.

3.14 TECHNICAL GUIDANCE

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

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

- Diagnostic waiting time and report turnaround time.
- Patients treated (IP/DC) or seen (OP) by an independent sector provider.
- Rapid angina assessment clinic (RAAC).
- Management of waiting times of patients who transfer between NHS sites (either within NI or the rest of the UK).

- Patients who are to be treated as part of a waiting list initiative / additional in house activity.

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INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 4

**GUIDANCE FOR MANAGEMENT OF ELECTIVE
ADMISSIONS**

DRAFT

4.1 INTRODUCTION

- 4.1.1 The following protocol is based on recommended good practice guidelines to assist staff with the effective management of elective inpatient and daycase admissions.
- 4.1.2 The administration and management of elective admissions within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.
- 4.1.3 In all aspects of the elective admissions booking process, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language**. Local booking policies should be developed accordingly.

Have we anything in place for this?

4.2 KEY PRINCIPLES

- 4.2.1 To aid both the clinical and administrative management of the waiting list, lists should be sub-divided and managed appropriately. Trusts will manage patients on one of three waiting lists, i.e.
1. active,
 2. planned and
 3. suspended.
- 4.2.2 All elective inpatient and daycase waiting lists should be managed according to clinical priorities. Priorities must be identified for each patient on the waiting list and allocated according to urgency of the treatment. Trusts will manage patients in four priorities, i.e.
1. Red flag (suspect cancer),
 2. urgent,
 3. routine and
 4. planned.
- No other clinical priority categories should be used for inpatient and daycase services.

There are currently only 2 priority categories on PAS for referrals – urgent and routine. Red flags are identified by reason for referral code. Is this an opportunity to update PAS with a priority category for red flag? Yes this would make sense

- 4.2.3 Patients of equal clinical priority will be selected for booking in strict chronological order, taking into account planned patients expected date of admission.
- 4.2.4 The regional targets for a maximum inpatient and daycase waiting times are outlined in the Health and Social Care Commissioning Plan and Indicators of Performance Direction (CPD), <https://www.health-ni.gov.uk/doh-management-and-structure> (see Ministerial Priorities).
- 4.2.5 Maximum waiting times for urgent patients should be agreed locally with clinicians and made explicit, through internal processes, to booking office staff. Booking staff should ensure that patients are appointed within the clinical timeframe indicated by the consultant and capacity issues are quickly identified and escalated.
- 4.2.6 Trusts should ensure that clinical templates are constantly reviewed to meet changes in demand and new clinical practice.
Is this relevant to elective? Consultants normally select cases based on clinical priority etc.
- 4.2.7 Data collection in respect of referrals and waiting times should be accurate, timely, complete and subject to regular audit and validation.
- 4.2.8 Trusts should **not** use manual administration systems to record and report patients who have been booked.
- 4.2.9 Trusts should provide training programmes for staff which include all aspects of IEAP. It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts.

4.3 PRE-ASSESSMENT

- 4.3.1 All patients undergoing an elective procedure (including endoscopy procedures) must undergo a pre-assessment. This can be provided using a variety of methods including telephone, video link, postal or face to face assessment.
- 4.3.2 Pre-assessment may include an anesthetic assessment or guidance on how to comply with pre-procedure requirements such as bowel preparation. It will be the responsibility of the pre- assessment team, in accordance with protocols developed by the relevant clinical teams, to authorise fitness for an elective procedure.
- 4.3.3 Only those patients that are deemed fit for their procedure may be offered a TCI date.
- 4.3.4 If a patient is assessed as being unfit for their procedure, their To Come In (TCI) date may be cancelled and decision taken as to the appropriate next action.
- 4.3.5 Pre-assessment services should be supported by a robust booking system.

4.4 CALCULATION OF THE WAITING TIME

- 4.4.1 The starting point for the waiting time of an inpatient/daycase admission is the date the appropriate clinician agrees that a procedure will be pursued as an active treatment or diagnostic intervention, and that the patient is clinically and socially fit to undergo such a procedure.
- 4.4.2 The waiting time for each patient on the elective admission list is calculated as the time period between the original decision to admit date and the date at the end of the applicable period for the waiting list return. If the patient has been suspended at all during this time, the period(s) of suspension will be automatically subtracted from the total waiting time.

4.5 REASONABLE OFFERS - TO COME IN (TCI) OFFERS OF TREATMENT

- 4.5.1 The patient should be advised of their expected waiting time during the consultation between themselves and the health care provider/practitioner.
- 4.5.2 All patients must be offered reasonable notice. Patients should be made reasonable offers to come in (TCI) on the basis of clinical priority. Within clinical priority groups offers should then be made on the basis of the patient's chronological wait.
- 4.5.3 A reasonable offer is defined as:
- an offer of admission, irrespective of provider or location, that gives the patient a minimum of three weeks' notice and a choice of two TCI dates, and
 - at least one of the offers must be within N. I., except for any regional specialties where there are no alternative providers within NI.
- The majority of elective procedures are fixed appointments, based on when consultants are available for theatre sessions, availability of ICU capacity if required, volume of predicted in-patient beds etc. This is a complex booking process which can be difficult to adapt with partial booking.
- Does there need to be a guidance for fixed elective offers?
- 4.5.4 If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the admission was refused.
- 4.5.5 This does not prevent patients being offered earlier appointment dates. If the patient is offered an admission within a shorter notice period (i.e. less than three weeks' notice) and refuses it they will not have their waiting time reset.
- 4.5.6 If the patient accepts an admission at short notice, but then cancels the admission, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the provider.
- 4.5.7 Urgent patients must be booked within the locally agreed maximum waiting time from the date of receipt. It is recognised that there will be occasional

exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Clearly defined booking protocols will be required to support specialties and booking staff.

- 4.5.8 Providers should have robust audit procedures in place to demonstrate compliance with the above.
- 4.5.9 To ensure the verbal booking process is auditable, the Trust should make and cancel a TCI date using the date of the second admission date offered and refused for this transaction.

4.6 INPATIENT AND DAYCASE ACTIVE WAITING LISTS

- 4.6.1 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to add the patient to the waiting list, i.e. the patient must be “fit, ready, and able” to come in.
- 4.6.2 To ensure consistency and the standardisation of reporting with commissioners and the DoH, all waiting lists are to be maintained in the PAS patient information system.
- 4.6.3 Details of patients must be entered on to the computer system (PAS) recording the date the decision was made to admit the patient or add the patient to the waiting list within two working days of the decision being made. Failure to do this will lead to incorrect assessment of waiting list times.
- 4.6.4 Where a decision to add to the waiting list depends on the outcome of diagnostic investigation, patients should not be added to an elective waiting list until the outcome of this investigation is known. There must be clear processes in place to ensure a decision is made in relation to the result of the investigation and the clinical patient pathway agreed.

4.7 SUSPENDED PATIENTS

- 4.7.1 At any time a consultant is likely to have a number of patients who are unsuitable for admission for clinical or personal reasons. These patients should be suspended from the active waiting list until they are ready for admission.
- 4.7.2 A period of suspension is defined as:
- A patient suspended from the active waiting list for medical reasons, or unavailable for admission for a specified period because of family commitments, holidays, or other reasons i.e. a patient may be suspended during any periods when they are unavailable for treatment for personal or medical reasons (but not for reasons such as the consultant being unavailable, beds being unavailable etc.).
 - A recommended maximum period not exceeding **three** months.
- 4.7.3 No patient should be suspended from the waiting list without a suspension end date.
- 4.7.4 Suspended patients should be reviewed one month prior to the end of their suspension period and a decision taken on their admission.
- 4.7.5 Every effort will be made to minimise the number of patients on the suspended waiting list, and the length of time patients are on the suspended waiting list.
- 4.7.6 Should there be any exceptions to the above, advice should be sought from the lead director or appropriate clinician.
- 4.7.7 Suspended patients will not count as waiting for statistical purposes. Any periods of suspension will be automatically subtracted from the patient's total time on the waiting list for central statistical returns.
- 4.7.8 No patient added to a waiting list should be immediately suspended. Patients should be recorded as suspended on the same day as the decision was taken that the patient was unfit or unavailable for admission/treatment.

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

4.8 PLANNED PATIENTS

- 4.8.1 Planned patients are those patients who are waiting to be admitted to hospital for a further stage in their course of treatment or surgical investigation within specific timescales.
- 4.8.2 These patients are not actively waiting for treatment, but for planned continuation of treatment. A patient is planned if there are clinical reasons that determine the patient must wait set periods of time between interventions. They will not be classified as being on a waiting list for statistical purposes.
- 4.8.3 Trusts must have systems and processes in place to identify high risk planned patients in line with clinical guidance.
- 4.8.4 Trusts should be able to demonstrate consistency in the way planned patients are treated and that patients are being treated in line with the clinical constraints. Planned patients should have a clearly identified month of treatment in which it can be shown that the patients are actually being treated.
- 4.8.5 Trusts must ensure that planned patients are not disadvantaged in the management of planned backlogs, with particular focus on high risk surveillance pathway patients.

4.9 PATIENTS LISTED FOR MORE THAN ONE PROCEDURE

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

- 4.9.2 Where different clinicians working together will perform more than one procedure at one time the patient should be added to the waiting list of the clinician for the priority procedure with additional clinician procedures noted.
- 4.9.3 Where a patient requires more than one procedure performed on separate occasions or bilateral procedures by different (or the same) clinician, the patient should be placed on the active waiting list for the first procedure and the planned waiting list for any subsequent procedures.

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

DNAs – Inpatient/Daycase

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

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

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

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

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

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

Is there a process in place for this the same as outpatients were a letter is sent to the patient and they phone in ?

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

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

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

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

4.10.2 CNAs – Patient Initiated Cancellations of inpatient/daycase admission

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

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

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

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

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

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

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

4.11. CNAs - HOSPITAL INITIATED CANCELLATIONS

- 4.11.1 No patient should have his or her admission cancelled. If Trusts cancel a patient's admission the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity.
- 4.11.2 The patient should be informed of the cancellation and the date of the new admission booked.
- 4.11.3 Trusts will make best efforts to ensure that a patient's admission is not cancelled a second time for non-clinical reasons.
- 4.11.4 Where patients are cancelled on the day of an admission/operation as a result of not being fit, they will be suspended, pending a clinical review of their condition. The patient should be fully informed of this process.
- 4.11.5 Hospital initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of admission a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

4.12 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

- 4.12.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between Trust sites or to independent sector (IS) providers.
- 4.12.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant and be managed in line with PAS technical guidance, (see also Reasonable Offers, ref. 4.5). Administrative speed and good communication are very important to ensure this process runs smoothly.

4.13 TECHNICAL GUIDANCE

4.13.1 See also Regional ISB Standards and Guidance

<https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Standards%20and%20Guidance.aspx> re acute activity definitions.

4.13.2 See also PAS technical guidance

<https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Technical%20Guidance.aspx> for recording;

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

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 5

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

DRAFT

5.1 INTRODUCTION

- 5.1.1 The following protocol is based on recommended good practice guidelines to assist staff with the effective management of the elective booking processes for elective Allied Health Professionals (AHP) services, including those patients whose referral is managed virtually.
- 5.1.2 Allied Health Professionals work with people of all age groups and conditions, and are trained in assessing, diagnosing, treating and rehabilitating people with health and social care needs. They work in a range of settings including hospital, community, education, housing, independent and voluntary sectors.
- 5.1.3 The administration and management of the AHP pathway from receipt of referral to appointment within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.
- 5.1.4 For the purposes of this section of the protocol, the generic term 'clinic' will be used to reflect AHP activity undertaken in hospital, community (schools, daycare settings, leisure and community centres) or domiciliary settings (people's own home or where they live e.g. residential or nursing homes) as AHPs provide patient care in a variety of care locations.
- 5.1.5 AHP services are administered on a wide range of information systems, with varying degrees of functionality able to support full IT implementation of the requirements of the IEAP. Trusts should ensure that the administrative management of patients is undertaken in line with the principles of the IEAP and that all efforts are made to ensure patient administration systems are made fit for purpose.
- 5.1.6 There will be dedicated booking offices within Trusts to receive, register and process all AHP referrals.
- 5.1.7 Fixed appointments should only be used in exceptional circumstances.

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

5.2 KEY PRINCIPLES

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

1. urgent and
2. routine.

No other clinical priorities should be used for AHP services.

- 5.2.2 Patients of equal clinical priority will be selected for booking in strict chronological order.
- 5.2.3 Patient appointments for new and review should be **partially booked**. Where fixed appointments are being issued, Trusts should ensure that the IEAP guidance is followed in the management of patients.
- 5.2.4 The regional target for a maximum AHP waiting time is outlined in the Health and Social Care Commissioning Plan and Indicators of Performance Direction (CPD), <https://www.health-ni.gov.uk/doh-management-and-structure> (see Ministerial Priorities).
- 5.2.5 Maximum waiting times for urgent patients should be agreed locally with AHP professionals and made explicit, through internal processes, to booking office staff. Booking staff should ensure that patients are appointed within the clinical timeframe indicated by the professional and capacity issues are quickly identified and escalated.
- 5.2.6 Patients should not be disadvantaged where a decision is made to assess their clinical need through virtual activity.

- 5.2.7 Trusts should ensure that clinical templates are constantly reviewed to meet changes in demand and new clinical practice.
- 5.2.8 Data collection in respect of referrals and waiting times should be accurate, timely, complete and subject to regular audit and validation.
- 5.2.9 Trusts should **not** use manual administration systems to record and report patients who have been booked.
- 5.2.10 Trusts should provide training programmes for staff which include all aspects of this IEAP. It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts.

5.3 NEW REFERRALS

- 5.3.1 All outpatient referrals (including those sent via Clinical Communication Gateway (CCG)) sent to Trusts will be registered within **one** working day of receipt. Referrer priority status must be recorded at registration.
- 5.3.2 Trusts will work towards a system whereby the location of all referrals (paper and electronic) not yet prioritised can be identified and tracked.
- 5.3.3 All referrals must be prioritised and clinical urgency must be clearly identified. Clinicians and management will be responsible for ensuring that cover is provided for referrals to be read and prioritised during any absence.
- 5.3.4 All referrals will be prioritised (including those prioritised via E Triage) within **three** working days of date of receipt of referral.
- 5.3.5 Following prioritisation, referrals must be actioned on PAS or the relevant electronic patient administration system and appropriate correspondence (including electronic), e.g. acknowledgement or appointment letter, issued to patients within **one** working day.

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

5.4 CALCULATION OF THE WAITING TIME

- 5.4.1 The starting point for the waiting time of an AHP new referral is the date the clinician's referral or self-referral is received by the booking office or, for internal referrals, when the referral is received by the booking office/department. All referrals, including emailed and electronically delivered referrals, will have the date the referral received into the organisation recorded either by date stamp or electronically.
- 5.4.2 In cases where referrals bypass the booking office, (e.g. sent directly to an allied health professional), the Trust must have a process in place to ensure that these are date stamped on receipt, immediately forwarded to the booking office/department and registered at the date on the date stamp.
- 5.4.3 The waiting time for each patient is calculated as the time period between the receipt of the referral and the date at the end of the applicable period for the waiting list return. If the patient has been suspended at all during this time, the period(s) of suspension will be automatically subtracted from the total waiting time.
- 5.4.4 The waiting time clock stops when the first definitive AHP treatment has commenced.

5.5 REASONABLE OFFERS

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

- 5.5.2 If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused.
- 5.5.3 This does not prevent patients being offered earlier appointment dates. If the patient is offered an appointment within a shorter notice period (i.e. less than three weeks' notice) and refuses it they will not have their waiting time reset.
- 5.5.4 If the patient accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the provider.
- 5.5.5 Urgent patients must be booked within the locally agreed maximum waiting time from the date of receipt. It is recognised that there will be occasional exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Clearly defined booking protocols will be required to support specialties and booking staff.
- 5.5.6 Providers should have robust audit procedures in place to demonstrate compliance with the above.
- 5.5.7 To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

5.6 REVIEW APPOINTMENTS

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

- 5.6.2 Patients must be recorded on PAS as requiring to be seen within a clinically indicated time. Trusts should actively monitor patients on the review list to ensure that they do not go past their indicative time of treatment.
- 5.6.3 Review patients who require an appointment within **six** weeks will be asked to agree the date and time of the appointment before leaving the department and PAS updated.
- 5.6.4 Patients requiring an appointment outside **six** weeks will be placed on a review waiting list, with the agreed clinically appropriate appointment date recorded, and be booked in line with implementation guidance for review pathway patients.
- 5.6.5 Virtual review appointments, e.g. telephone or video link, should be partially booked. If the patient cannot be contacted for their virtual review they should be sent a partial booking letter to arrange an appointment.

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

5.7.1 DNAs – New AHP Appointments

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

5.7.1(a) Patients who have been partially booked will **not** be offered a second appointment and should be removed from the waiting list.

The patient and referrer (and the patients GP, where they are not the referrer) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

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

- 5.7.1(c) Patients who DNA and are not discharged but offered a second appointment will have their waiting time clock reset to the date of the DNA.
- 5.7.1(d) *Where patients are discharged from the waiting list (ref. 5.7.1(a)) they should be advised to contact the Trust booking office within **four** weeks of the original appointment date if they consider that the appointment is still required. Where a patient makes contact within the **four** week deadline, and where the Trust considers that unforeseen or exceptional circumstances meant that the patient was unable to attend, the patient should be added to the waiting list at the date that they have made contact with the Trust. If a patient makes contact after the **four** week period they cannot be reinstated.*
- 5.7.1(e) If the patient DNAs the second appointment offered then the patient should **not** be offered another opportunity to be reinstated. The patient and referrer (and the patients GP, where they are not the referrer) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.
- 5.7.1(f) Where a patient DNAs a fixed new appointment (i.e. they have not had the opportunity to agree/confirm the date and time of the appointment) they should be offered another appointment.
- 5.7.1(g) If the patient DNAs this second appointment the above steps should be followed.
- 5.7.1(h) If a patient DNA's a virtual outpatient appointment this should follow the above protocol based on whether the appointment is partially booked or fixed. The Trust should ensure that the contact details of the patient are up to date and available.

5.7.2 DNAs – Review Appointments

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

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

- 5.7.2(c) Where the clinical decision is that a second appointment should **NOT** be offered, Trusts should contact patients advising that as they have failed to attend their appointment they will be discharged from the waiting list. The referrer (and the patient's GP, where they are not the referrer) should also be informed of this.
- 5.7.2(d) Patients being discharged from the list should be advised to contact the Trust booking office if they have any queries. Where unforeseen or exceptional circumstances meant that the patient was unable to attend, and the patient makes contact within **four** weeks of the original appointment date, a clinical decision may be made to offer a second appointment. Where this is the case, the patient should be added to the waiting list at the date they make contact with the Trust.
- 5.7.2(e) If the patient DNAs the second appointment offered then the patient should **NOT** be offered another opportunity to be reinstated. The patient and referrer will be informed that, as they have failed to attend their appointment, they will be discharged from the waiting list.
- 5.7.2(f) Where a patient DNAs a fixed review appointment where they have not had the opportunity to agree/ confirm the date and time of their appointment, they should be offered another appointment. If they DNA this second fixed appointment, the above should be followed.
- 5.7.2(g) If a patient DNA's a virtual outpatient review appointment this should follow the above protocol based on whether the appointment is partially booked or fixed. The Trust should ensure that the contact details of the patient are up to date and available.

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

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

- 5.7.3(a) The patient will be given a second opportunity to book an appointment (where this is still required), which should be within **six** weeks of the original appointment date.
- 5.7.3(b) Patients who CNA will have their waiting time clock reset to the date the Trust was informed of the cancellation.

- 5.7.3(c) If a second appointment is cancelled, the patient will **not** normally be given another appointment. Where a decision is taken not to offer a further appointment, Trusts should contact patients advising that they have been discharged from the waiting list. The referring professional (and the patient's GP, where they are not the referrer) should also be informed of this.
- 5.7.3(d) However, where unforeseen or exceptional circumstances mean that the patient had to cancel a second appointment, the Trust may exercise discretion to offer a third appointment. This should include seeking a clinical review of the patient's case where this is appropriate.
- 5.7.3(e) If a patient CNA's a virtual outpatient appointment this should follow the above protocol.
- 5.7.4 Trusts have a responsibility to ensure that children and adults at risk who DNA or CNA their outpatient, inpatient, diagnostic or AHP appointment are followed up by the most appropriate healthcare professional and a clear link to the referring clinician established.
- 5.8 CNAs – SERVICE INITIATED CANCELLATIONS**
- 5.8.1 No patient should have his or her appointment cancelled. If Trusts cancel a patient's appointment, including a virtual appointment, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity.
- 5.8.2 The patient should be informed of the cancellation and a new appointment partially booked.
- 5.8.3 Trusts will make best efforts to ensure that a patient's appointment is not cancelled a second time for non-clinical reasons.
- 5.8.4 Service initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

5.9 CLINIC OUTCOME MANAGEMENT

- 5.9.1 There are a number of locations within Trusts where patients present for their AHP consultation. This protocol applies to all AHP areas. It is the responsibility of the PAS/ IT system user managing the attendance to maintain data quality.
- 5.9.2 Changes in the patient's details must be updated on PAS and the medical records on the date of clinic.
- 5.9.3 When the consultation has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic.

5.10 CLINIC TEMPLATE CHANGES

- 5.10.1 Clinic templates should be agreed between the relevant AHP professional and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement (SBAs).
- 5.10.2 Templates will identify the number of slots available for new urgent and routine and review appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated for each appointment slot.
- 5.10.3 All requests for template and temporary clinic rule changes will only be accepted in writing. A minimum of six weeks' notice will be provided for clinic template changes.
- 5.10.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager.

5.11 TRANSFERS BETWEEN TRUSTS or to INDEPENDENT SECTOR

- 5.11.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between Trusts or to independent sector (IS) providers.
- 5.11.2 Transfers to alternative providers must always be with the consent of the patient and the receiving AHP professional, (see also Reasonable Offers, ref. 5.5). Administrative speed and good communication are very important to ensure this process runs smoothly.

5.12 TECHNICAL GUIDANCE

- 5.12.1 See also Public Health Agency;
<https://www.publichealth.hscni.net/publications/ahp-services-data-definitions-guidance-june-2015> re Guidance for monitoring the Ministerial AHP 13 week access target.
- 5.12.2 See also Regional ISB Standards and Guidance
<https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Standards%20and%20Guidance.aspx> re acute activity definitions.
- 5.12.3 See also PAS technical guidance
<https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Technical%20Guidance.aspx> for recording;
- ICATS waiting times and activity (including paper triage).
 - Patients treated (IP/DC) or seen (OP) by an independent sector provider.
 - Management of waiting times of patients who transfer between NHS sites (either within NI or the rest of the UK).
 - Patients who are to be treated as part of a waiting list initiative / additional in house activity.
 - Recording Consultant Virtual Outpatient Activity (June 2020).
 - AHP Virtual Consultation Guidance (to be issued).

Kelly, Elaine

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

Update

2.3 NEW REFERRALS

- 2.3.1 All outpatient referrals (including those sent via Clinical Communication Gateway (CCG)) sent to Trusts will be registered within **one** working day of receipt. Referrer priority status must be recorded at registration.
- 2.3.2 Trusts will work towards a system whereby the location of all referrals (paper and electronic) not yet prioritised can be identified and tracked.
- 2.3.3 All referrals must be prioritised and clinical urgency must be clearly identified. Clinicians and management will be responsible for ensuring that cover is provided for referrals to be read and prioritised during any absence.
- 2.3.4 All referrals will be prioritised (including those prioritised via E-Triage) within **a maximum of three** working days of date of receipt of referral. Note; Red flag referrals require **daily** triage.
- 2.3.5 Following prioritisation, referrals must be actioned on PAS and appropriate correspondence (including electronic), e.g. acknowledgement or appointment letter, issued to patients within **one** working day.
- 2.3.6 Inappropriate and inadequate referrals should be returned to the referral source immediately and the referral closed and managed in line with the PAS technical guidance.

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

IEAP April 2008 – Page 34 3.4.5

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

Thanks

Regards

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Department of
**Health, Social Services
and Public Safety**

An Roinn

**Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí**

www.dhsspsni.gov.uk

**INTEGRATED ELECTIVE ACCESS PROTOCOL
30th April 2008**

DOCUMENT CONTROL			
INTEGRATED ELECTIVE ACCESS PROTOCOL			
Authors	Michelle Irvine – Programme Director, Elective Workstream Maria Wright – Associate Director, Outpatients Rosemary Hulatt – Associate Director, Diagnostics		
Issue Date 1st Draft	Wednesday 20 th February 2008		
Comments by	Close of Play - Friday 7 th March 2008		
2nd Draft	27 th March 08		
Final Protocol Date Approved	30 th April 08		
Issue Date	Friday 9 th May 2008		
Screened By	Service Delivery Unit, DHSSPSNI		
Approved By		Signature	
Distribution	Trust Chief Executives; Directors of Planning and Performance; Directors of Acute Care; DHSSPS		
Review Date	April 2009		

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ABBREVIATIONS

AHP	Allied Health Professional
BCC	Booking and Contact Centre (ICATS)
CNA	Could Not Attend (Admission or Appointment)
DHSSPSNI	Department of Health, Social Services and Public Safety
DNA	Did Not Attend (Admission or Appointment)
DTLs	Diagnostic Targeting Lists
ERMS	Electronic Referrals Management System
GP	General Practitioner
HIC	High Impact Changes
HROs	Hospital Registration Offices
ICATS	Integrated Clinical Assessment and Treatment Services
ICU	Intensive Care Unit
LOS	Length of Stay
PAS	Patient Administration System
PTLs	Primary Targeting Lists
SDU	Service Delivery Unit
TCI	To Come In (date for patients)

SECTION 1

CONTEXT

1.1 INTRODUCTION

- 1.1.1 This protocol has been developed to encompass the elective pathway within a hospital environment. The principles can be applied to primary and community settings, however it is recommended that guidance is developed which recognises the specific needs of the care pathway provided in these settings.
- 1.1.2 The length of time a patient needs to wait for elective treatment is an important quality issue and is a visible public indicator of the efficiency of the hospital services provided by the Trust. The successful management of patients who wait for outpatient assessments, diagnostic investigations and elective inpatient or day case treatment is the responsibility of a number of key individuals within the organisation. General Practitioners, commissioners, hospital medical staff, managers and clerical staff have an important role in ensuring access for patients in line with maximum waiting time guarantees, managing waiting lists effectively, treating patients and delivering a high quality, efficient and responsive service. Ensuring prompt timely and accurate communications with patients is a core responsibility of the hospital and the wider local health community.
- 1.1.3 The purpose of this protocol is to define those roles and responsibilities, to document how data should be collected, recorded and reported, and to establish a number of good practice guidelines to assist staff with the effective management of outpatient, diagnostic and inpatient waiting lists. It will be a step-by-step guide to staff, and act as a reference work, for the successful management of patients waiting for hospital treatment.
- 1.1.4 This protocol will be updated, as a minimum, on an annual basis to ensure that Trusts' policies and procedures remain up to date, and reflect best practice locally and nationally. Trusts will ensure a flexible approach to getting patients treated, which will deliver a quick response to the changing nature of waiting lists, and their successful management.
- 1.1.5 This protocol will be available to all staff via Trusts' Intranet.

- 1.1.6 The DHSSPSNI has set out a series of challenging targets for Trusts in Northern Ireland in the field of elective treatment management. Trusts will recognise the need to move the treatment agenda forward in the context of its shared responsibility for the delivery of these goals.
- 1.1.7 There is an imperative to identify capacity constraints that could threaten the delivery of these key access targets and speed up the planning and delivery of extra capacity, where it is needed, to address these constraints. The health community will need to develop a co-ordinated approach to capacity planning taking into account local capacity on a cross Trust basis and independent sector capacity on an on-going partnership basis.
- 1.1.8 In this context, this protocol has been prepared to provide clarity of purpose within Trusts with a view to merging seamlessly with the policies of other agencies in the wider health community as they emerge.
- 1.1.9 The intention is that this protocol will be further developed to consider all aspects of access to a range of quality healthcare at a date and time of the patients' choice.
- 1.1.10 This protocol has been prepared to clarify Trusts' medium and long-term objectives, set the context in which they will be delivered and establish the parameters within which staff at divisional, specialty and departmental levels will operate.
- 1.1.11 Delivery of this protocol will require a step change in the way Trusts function. Trusts will need to transform themselves and this can only be achieved through a change in the way its staff approach their work on a day-to-day basis. Through this protocol, Trusts will aspire to work with patients and staff to raise expectations basing them not on where we are but on where we need to be.
- 1.1.12 For the purposes of this protocol, the term inpatient refers to inpatient and day case elective treatment. The term 'PAS' refers to all patient

administration systems, whether in a hospital or community setting, or an electronic or manual system.

- 1.1.13 All staff involved in the administration of waiting lists will ensure that Trusts' policies and procedures with respect to data collection and entry are strictly adhered to. This is to ensure the accuracy and reliability of data held on PAS and the waiting times for treatment. All staff involved in the implementation of this protocol, clinical and clerical, will undertake initial training and regular annual updating. Trusts will provide appropriate information to staff so they can make informed decisions when implementing and monitoring this protocol. All staff involved in the administration of waiting lists will be expected to read and sign off this protocol.

1.2 UNDERPINNING PRINCIPLES

- 1.2.1 Patients will be treated on the basis of their clinical urgency with urgent patients seen and treated first. The definition of clinical urgency will be defined specifically by specialty / procedure / service.
- 1.2.2 Patients with the same clinical need will be treated in chronological order on grounds of fairness, and to minimise the waiting time for all patients.
- 1.2.3 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to admit, i.e. if there was a bed available tomorrow in which to admit a patient - they are fit, ready, and able to come in.
- 1.2.4 Trusts should design processes to ensure that inpatient care is the exception for the majority of elective procedures, not the norm. The principle is about moving care to the most appropriate setting, based on clinical judgement. This means moving day case surgery to outpatient care, and outpatient care to primary care or alternative clinical models where appropriate.

- 1.2.5 Change No 1 within the publication “10 High Impact Changes for Service Improvement and Delivery”¹ focuses on day surgery and the document provides Trusts with tools and resources to help implement this high impact change.
- 1.2.6 Trusts will introduce booking systems aimed at making hospital appointments more convenient for patients. Booking systems are chronologically based and will move Trusts onto a system of management and monitoring that is chronologically as opposed to statistically based.
- 1.2.7 As part of a plan for the implementation of booking, Trusts must ensure their elective admission selection system is managed on a chronological basis within clinical priority with immediate effect. The intention is to provide patients with certainty and choice enabling them to access services that are sensitive to their needs.
- 1.2.8 This will require changes in working practices. It will also require technological change to information systems to enable provision of quality information to support the booking process.
- 1.2.9 There is a need to balance the flow of patients from primary care through outpatients and on to booking schedules should they need elective admission. It follows that the level of activity in the Service and Budget Agreements and the level of provision of outpatient and inpatient capacity must be linked. If one changes, all should change.
- 1.2.10 This “bottom up” approach is based on the belief that services need to be built on firm clinical foundations. Trusts need a clinical vision built up specialty by specialty and department by department through debate and agreement between clinicians across the health community as to the best way to meet patient needs locally.
- 1.2.11 It is essential that patients who are considered vulnerable for whatever reason have their needs identified at the point of referral.

¹ “10 High Impact Changes for Service Improvement and Delivery” – September 2004, NHS Modernisation Agency, www.modern.nhs.uk/highimpactchanges

- 1.2.12 All relevant information must be recorded to ensure that when selecting a vulnerable patient for admission, their needs are identified early and appropriate arrangements made. This information should be recorded in detail in the episodic comment field of PAS relating to the listing. The patient master index comment field should not be used due to confidentiality issues.
- 1.2.13 Communication with this patient group will recognise their needs and, where appropriate, involve other agencies.
- 1.2.14 An operational process should be developed by Trusts to ensure that children and vulnerable adults who DNA or CNA their outpatient appointment are followed up by the most appropriate healthcare professional and a clear link to the referring clinician established.
- 1.2.15 In implementing this protocol the needs of ethnic groups and people with special requirements should be considered at all stages of the patient's pathway.

1.3 OWNERSHIP

- 1.3.1 Ownership is key to delivering quality of care. Trusts must ensure that all staff are conversant with the Departmental targets and standards and are comfortable with the local health communities' approach to their delivery.
- 1.3.2 These targets and standards must be seen to be core to the delivery of all aspects of care provision by all levels of staff within the Trust.
- 1.3.3 This is a major change agenda requiring significant commitment and investment at corporate and individual level. An Executive Director will take lead responsibility for ensuring all aspects of this Protocol are adhered to.

- 1.3.4 Trusts must be committed to training and developing staff and providing the supporting systems to ensure that together we can bring about the improvement in patient care.

1.4 REGIONAL TARGETS

- 1.4.1 The targets in respect of elective treatments are:

- A maximum waiting time of 13 weeks for inpatient and daycase admissions by March 2009
- A maximum waiting time of 9 weeks for a 1st outpatient appointment by March 2009
- A maximum waiting time of 9 weeks for a diagnostic test by March 2009
- A maximum waiting time of 13 weeks from referral to treatment by an Allied Health Professional (AHP) by March 2009
- By March 2009, sustain the target where 98% of patients diagnosed with cancer should begin treatment within a maximum of 31 days of the diagnosis
- By March 2009, 95% of patients with suspected cancer who have been referred urgently should begin their first definitive treatment within a maximum of 62 days

1.5 DELIVERY OF TARGETS

- 1.5.1 The waiting time targets are based on the “worst case” i.e. they reflect the minimum standards with which every Trust must comply.
- 1.5.2 The expectation is that these targets are factored into plans at Trust Board, divisional, specialty and departmental levels as part of the normal business

and strategic planning processes. Divisional, specialty and departmental managers will be expected to have produced implementation plans setting out the key steps they need to take to ensure the delivery of the Trust and Departmental protocol objectives within the area(s) of their responsibility. Trusts will manage implementation through a regular review of “local” divisional, specialty and departmental plans for the implementation of waiting and booking targets.

- 1.5.3 It is expected that Trusts will develop robust information systems to support the delivery of these targets. Daily management information should be available at both managerial and operational level so that staff responsible for selecting patients are working from up to date and accurate information. Future developments should also look towards a clinic management system which will highlight the inefficiencies within the outpatient setting.

1.6 CAPACITY

- 1.6.1 It is important for Trusts to understand their baseline capacity, the make-up of the current cohort of patients waiting and the likely changes in demand that will impact on their ability to treat patients and meet the Departmental Targets.

- 1.6.2 To manage at specialty and departmental level it is anticipated that managers will have, as a minimum, an overview of their core capacity including:

- Number of clinic and theatre sessions
- Session length
- Average procedure / slot time
- Average length of stay

- 1.6.3 It is expected that similar information will be available at consultant level. For inpatients this is at procedure level, and for outpatients and diagnostics at service level.

- 1.6.4 This information will enable Trusts to evaluate its waiting/booked lists in terms of theatre sessions (time in hours) and length of stay (time in bed days).
- 1.6.5 Each specialty should understand its elective bed requirements in terms of both inpatients and daycases, setting challenging daycase and LOS targets and agreeing plans to deliver them. In addition, systems must be developed to ensure assessment can be made of available capacity and flexible working arrangements developed accordingly.
- 1.6.6 Theatre sessions should be seen as corporate resources and used flexibly to ensure the delivery of waiting list and waiting time targets across consultants within the same specialty and specialties within the same Trust. This ties in with the Real Capacity Paper which also requires commissioners to demonstrate that they have used capacity flexibly across Trusts. The expectation is that divisions and/ or specialties will be able to demonstrate that they have optimised the use of existing capacity to maximise the treatment of patients within existing resources.
- 1.6.7 Trusts will treat patients on an equitable basis across specialties and managers will work together to ensure consistent waiting times for patients of the same clinical priority.
- 1.6.8 Trusts will set out to resource enough capacity to treat the number and anticipated casemix of patients agreed with commissioners. The Real Capacity Planning exercise will support this process locally.
- 1.6.9 Divisions/specialties will monitor referrals and additions to lists in terms of their impact on clinic, theatre time, bed requirements and other key resources e.g. ICU facilities, to ensure a balance of patients in the system and a balance between patients and resources.
- 1.6.10 When the balance in the system is disturbed to the extent that capacity is a constraint, divisional/specialty managers will be expected to produce plans

to expedite solutions and agree these through the accountability review process.

- 1.6.11 It is important for all services to understand their baseline capacity, the make-up of the cohort of patients waiting to be treated and the likely changes in demand that will impact on their ability to initiate treatment and meet the maximum waiting time guarantees for patients.
- 1.6.12 Trusts should ensure that robust prospective capacity planning arrangements are in place, with clear escalation procedures to facilitate capacity gaps to be identified and solutions found in a timely manner to support operational booking processes and delivery of the targets.
- 1.6.13 In summary, the intention is to link capacity to the Service and Budget Agreement i.e. to agree the plan, put in place the resources to achieve the plan, monitor the delivery of the plan and take corrective action in the event of divergence from the plan proactively. The existing arrangements whereby patients are added to waiting lists irrespective of whether Trusts have the capacity to treat them must change.

1.7 BOOKING PRINCIPLES

- 1.7.1 These booking principles have been developed to support all areas across the elective pathway where appointment systems are used.
- 1.7.2 Offering the patient choice of date and time is essential in agreeing and booking appointments with patients. Trusts should ensure booking systems enable patients to choose and agree hospital appointments that are convenient for them. This takes away the uncertainty of not knowing how long the wait will be as patients are advised of their expected wait. Advanced booking in this way also gives patients notice of the date so that they can make any necessary arrangements, such as child care or work arrangements.

- 1.7.3 Facilitating reasonable offers to patients should be seen within the context of robust booking systems being in place.
- 1.7.4 Booking development work within Trusts should be consistent with regional and local targets, which provide a framework for progress towards ensuring successful and consistent booking processes across the health community in Northern Ireland.
- 1.7.5 All booking processes should be underpinned with the relevant local policies and procedures to provide clarity to operational staff of the day to day requirements and escalation route, for example: management of patients who cancel / DNA their appointment, process for re-booking patients, and monitoring of clinical leave and absence.
- 1.7.6 Trusts should ensure booking processes are continually reviewed and updated as required to reflect local and regional requirements at an operational level.
- 1.7.7 The definition of a booked appointment is:
- a) The patient is given the choice of when to attend.
 - b) The patient is advised of the total waiting time during the consultation between themselves and the healthcare provider / practitioner or in correspondence from them.
 - c) The patient is able to choose and confirm their appointment within the timeframe relevant to the clinical urgency of their appointment
 - d) The range of dates available to a patient may reduce if they need to be seen quickly, e.g. urgent referrals or within 2 weeks if cancer is suspected.
 - e) The patient may choose to agree a date outside the range of dates offered or defer their decision until later

1.7.8 Booking Process

1.7.9 There are 3 main patient appointment types to be booked. Booking systems for these appointments should be designed around an agreed patient pathway and accepted clinical practice. They are:

- a) New Urgent patients (including suspected cancer)
- b) New Routine patients
- c) Review patients

1.7.10 Clinic templates should be constructed to ensure that sufficient capacity is carved out to meet the local and maximum waiting time guarantees for new patients, and the clinical requirements of follow-up patients.

1.7.11 Principles for booking Cancer Pathway patients

- a) All suspected cancer referrals should be booked in line with the agreed clinical pathway requirement for the patient and a maximum of 14 days from the receipt of referral
- b) Dedicated registration functions for red flag and suspected cancer referrals should be in place within centralised HROs
- c) Clinical teams must ensure triage is undertaken daily, irrespective of leave, in order to initiate booking patients
- d) Patients will be contacted by telephone twice (morning and afternoon)
- e) If telephone contact cannot be made, a fixed appointment will be issued to the patient within a maximum of 3 days of receipt of referral
- f) Systems should be established to ensure the Patient Tracker / MDT Co-ordinator is notified of the suspected cancer patient referral, to allow them to commence prospective tracking of the patient

1.7.12 Principles for booking Urgent Pathway patients

- a) Local agreements should be in place with consultants to determine the timeframe within which urgent patients should be booked, and made explicit to booking teams

- b) Referrals will be received, registered within one working day and forwarded to consultants for prioritisation
- c) If clinical priority is not received from consultants within 72 hours, processes should be in place to initiate booking of urgent patients according to the GP's classification of urgency
- d) Patients will be issued with a letter inviting them to contact the Trust to agree and confirm their appointment in line with the urgent booking process.
- e) In exceptional cases, some patients will require to be appointed to the next available slot. A robust process for telephone booking these patients should be developed which should be clearly auditable.

1.7.13 Principles for booking Routine Pathway patients

- a) Patients should be booked to ensure appointment within the maximum waiting time guarantees for routine appointments
- b) Referrals will be received, registered within one working day at HRO's and forwarded to consultants for prioritisation
- c) Patients will receive an acknowledgement from the Trust indicating their expected length of wait and information on the booking process they will follow
- d) Approximately eight weeks prior to appointment, Trusts should calculate prospective slot capacity and immediately implement escalation policy where capacity gaps are identified
- e) Patients should be selected for booking in chronological order from the PTL
- f) Six weeks prior to appointment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment

1.7.14 Principles for Booking Review Patients

- a) Patients who need to be reviewed within 6 weeks will agree their appointment before they leave the clinic

- b) Patients who require a review appointment more than 6 weeks in advance will be added to and managed on a review waiting list
- c) Patients will be added to the review waiting list with an indicative date of treatment and selected for booking according to this date
- d) Six weeks prior to the indicative date of treatment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment within a clinically agreed window either side of the indicative date of treatment

1.7.15 It is recognised that some groups of patients may require booking processes that have additional steps in the pathway. These should be designed around the principles outlined to ensure choice and certainty as well as reflecting the individual requirements necessary to support their particular patient journey. Examples of this include:

- a) midwives contacting patients directly by telephone to arrange their appointment
- b) clinical genetics services where family appointments are required
- c) mental health or vulnerable children's services where patients may need additional reminders or more than one professional contacted if patients fail to make an appointment.

SECTION 2

GUIDANCE FOR MANAGEMENT OF ICATS SERVICES

2.1 INTRODUCTION

- 2.1.1 The administration and management of ICATS referrals and ICATS requests for diagnostics must be consistent, easily understood, patient focused, and responsive to clinical decision-making.
- 2.1.2 ICATS services are managed in accordance with the Data Definitions and Guidance Document for Monitoring of ICATS Services Sept 2007 (**Appendix 1**).
- 2.1.3 The level of functionality available on the Electronic Referral Management System to support the administration of patients in an ICATS setting is developmental. Achievement of the standards outlined will be where functionality permits.
- 2.1.4 Referrals will be managed through a centralised registration process in the nominated Hospital Registration Offices (HRO's) within Trusts to receive, register and process all ICATS referrals. The Trust should ensure that a robust process is in place to ensure that referrals received outside the HRO are date stamped, forwarded to the HRO and registered onto ERMS according to the date received by the Trust.
- 2.1.5 All new patients should be able to book their appointment in line with the guidance outlined in Booking Principles Section 1.7 The expectation is that follow up patients should also be offered an opportunity to choose the date and time of their appointment.

2.2 KEY PRINCIPLES

- 2.2.1 Where ICATS is in place for a specialty, all referrals should be registered and scanned onto Electronic Referral Management System (ERMS) within 24 hours of receipt.
- 2.2.2 Each ICATS must have a triage rota to ensure that every referral is triaged and the appropriate next step is confirmed, according to the clinically agreed

rules, within three working days of receipt in any Hospital Registration Office (HRO). Triage rotas must take multi-site working into account. A designated officer in ICATS should oversee the triage arrangements.

- 2.2.3 The outcome of the triage will be confirmed by letters to the GP and patient within a further two working days of triage (five working days in total from receipt).
- 2.2.4 ICATS clinical staff will be aware of all exclusions that prevent patients from being assessed or treated within the ICATS setting.
- 2.2.5 Patients of equal clinical priority will be selected for booking in chronological order in order to meet the maximum waiting time guarantee for patients and local access standards.
- 2.2.6 All patients deemed appropriate will be offered an ICATS appointment within six weeks from the triage date.
- 2.2.7 Data collection should be accurate, timely, complete and subject to regular audit and validation.
- 2.2.8 Staff should be supported by appropriate training programmes.

2.3 CALCULATION OF THE WAITING TIME

- 2.3.1 The waiting time clock for ICATS starts after the triage decision has been taken that an appointment in ICATS clinic is the appropriate next step.
- 2.3.2 The ICATS clock stops when the patient attends for first appointment or when the patient has been discharged from ICATS.
- 2.3.3 Patients who cancel an appointment will have their waiting time clock reset to the date the hospital was informed of the cancellation. Patients who refuse a reasonable offer of an appointment will also have their waiting time clock reset to the date the reasonable offer was refused. To ensure the

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

- 2.3.4 Patients who fail to attend their appointment without giving prior notice (DNA) will have their waiting time clock reset to the date of the DNA.
- 2.3.4 No patient should have his or her appointment cancelled. If the ICATS service cancels a patient's appointment, the patient's waiting time clock will not be reset and the patient should be offered another appointment, ideally at the time of the cancellation, and which is within six weeks of the original appointment date.

2.4 NEW REFERRALS

- 2.4.1 All ICATS referrals will be registered and scanned onto ERMS within 24 hours of receipt. All referrals forwarded for ICATS triage must be triaged or assessed to make a clear decision on the next step of a referral within three working days of the referral being logged by the HRO onto ERMS.
- 2.4.2 Within five working days of the referral being recorded onto ERMS, the GP and patient must be issued with written confirmation of the next stage of the patient's treatment.
- 2.4.3 Where there is insufficient information for the professional to make a decision, they have the option to either return the referral to the referrer requesting the necessary information or contact the referrer in the first instance to access the necessary information. If this cannot be gained, the referral should be returned to the referrer requesting the necessary information and a new referral may be initiated.
- 2.4.4 Those patients identified for outpatients and diagnostic services following triage will be managed in line with the relevant sections of this IEAP.

Flowcharts illustrating the Triage Outcomes Process can be found in **Appendix 2.**

2.5 BOOKING

- 2.5.1 All patients requiring an appointment in an ICATS will have the opportunity to agree the date and time of their appointment, in line with the booking principles outlined in Section 1.7.
- 2.5.2 If a patient requests an appointment beyond the six week ICATS standard the patient will be discharged and told to revisit their GP when they are ready to be seen at the ICATS clinic. This will ensure that all patients waiting for an ICATS appointment are fit and ready to be seen. It is accepted that local discretion may be required where short periods of time are involved, for example, if patients are requesting dates up to a week over their breach date. Trusts should ensure that reasonableness is complied with to facilitate recalculation of the patient's waiting time and to facilitate booking the patient into the date they requested.
- 2.5.3 Trusts must ensure that all communication to patients is clear, easily understood and complies with all relevant legislation.

2.6 REASONABLE OFFERS

- 2.6.1 All patients must be offered reasonable notice. A reasonable offer is defined as an offer of appointment, irrespective of provider, that gives the patient a minimum of three weeks' notice and two appointments. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date of the second appointment date declined.
- 2.6.2 If the patient is offered an appointment within a shorter notice period and it is refused, the waiting time cannot be recalculated.

2.6.3 If the patient however accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date the service was notified of the cancellation, as the patient has entered into an agreement with the Trust.

2.6.4 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above. The Implementation Procedure on Reasonableness can be found in **Appendix 3**.

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

2.7.1 If a patient DNAs their first ICATS appointment the following process must be implemented.

- Where a patient has had an opportunity to agree the date and time of their appointment, they will not normally be offered a second appointment. These patients will be referred back to the care of their referring clinician.
- Under exceptional circumstances a clinician may decide that a patient should be offered a second appointment. The second appointment must be booked.

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

- The patient will be given a second opportunity to book an appointment, which should be within six weeks of the original appointment date.
- If a second appointment is cancelled, the patient will not normally be offered a third opportunity and will be referred back to their referring clinician.

- 2.7.3 If a patient has been referred back to their referring clinician and the referrer still wishes a patient to be seen in ICATS, a new referral is required.
- 2.7.4 The Implementation Procedure for the Management of Patients who DNA or Cancel can be found in **Appendix 4**.

2.8 MAXIMUM WAITING TIME GUARANTEE

- 2.8.1 If a patient requests an appointment date that is beyond the maximum waiting time guarantee, the patient will be discharged and advised to revisit their GP when they are ready to be seen. This will ensure that all patients waiting for an appointment are fit and ready to be seen. It is accepted that local discretion may be required where short periods of time are involved, for example, if patients are requesting dates up to a week over their breach date. Trusts should ensure that reasonableness is complied to facilitate re-calculation of the patient's waiting time, and to facilitate booking the patient into the date they requested.

2.9 COMPLIANCE WITH TRUST LEAVE PROTOCOL

- 2.9.1 It is essential that leave/absence of ICATS practitioners is organised in line with Trusts' notification of leave protocol. It is also necessary for Trusts to have robust policies and procedures that minimise the cancellation/reduction of ICATS clinics.
- 2.9.2 The protocol should require a minimum of six weeks' notification of intended leave. A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

2.10 CLINIC OUTCOME MANAGEMENT

- 2.10.1 There are a number of locations within Trusts where patients present for their ICATS consultation. This protocol applies to all ICATS locations. It is the responsibility of the ERMS user managing the attendance to maintain data quality.
- 2.10.2 Changes in the patient's details must be updated on ERMS and the medical records on the date of clinic.
- 2.10.3 When the assessment has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on ERMS.

2.11 REVIEW APPOINTMENTS

- 2.11.1 All review appointments must be made within the time frame specified by the ICATS practitioner. If a review appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the ICATS practitioner.
- 2.11.2 As previously stated, the Booking Centres will be responsible for partially booking all new appointments. Booking Centres will also book review appointments that are required to be more than 6 weeks in the future. ICATS administration staff will make bookings directly with the patient at the clinic for any further appointments needing to occur within 6 weeks.

2.12 TEMPLATE CHANGES

- 2.12.1 Templates should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement.

- 2.12.2 Templates will identify the number of slots available for new and follow up appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated to each appointment slot.
- 2.12.3 All requests for template and temporary clinic rule changes will only be accepted in writing. A minimum of six weeks notice will be provided for clinic template changes.
- 2.12.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager. The Implementation Procedure for management of Clinic Template Changes can be found in **Appendix 5**.

2.13 VALIDATION

- 2.13.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. Trusts should ensure that all relevant data fields are completed in ERMS. This should be undertaken as a minimum on a monthly basis and ideally on a weekly basis as waiting times reduce.
- 2.13.2 The data validation process will apply to both new and follow up appointments. The Implementation Procedure for data validation can be found in **Appendix 6**.

SECTION 3

GUIDANCE FOR MANAGEMENT OF OUTPATIENT SERVICES

3.1 INTRODUCTION

- 3.1.1 The following protocol is based on nationally recommended good practice guidelines to assist staff with the effective management of outpatient services.
- 3.1.2 The administration and management of the outpatient pathway from receipt of referral to appointment within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.
- 3.1.3 There will be dedicated Hospital Registration Offices (HROs) within Trusts to receive, register and process all outpatient referrals. The HROs will be required to register and scan referrals (where appropriate) onto the Electronic Referrals Management System (ERMS) and PAS.
- 3.1.4 There will be dedicated booking functions within Trusts and all new and review outpatients should have the opportunity to book their appointment. The booking process for non-routine groups of outpatients or those with additional service needs should be designed to identify and incorporate the specific pathway requirements of these patients.

3.2 CALCULATION OF THE WAITING TIME

- 3.2.1 The starting point for the waiting time of an outpatient new referral is the date the clinician's referral letter is received by Trusts. All referral letters, including faxed, emailed and electronically delivered referrals, will be date stamped on the date received into the organisation.
- 3.2.2 In cases where referrals bypass the dedicated HRO's, (e.g. sent directly to a consultant), the Trust must have a process in place to ensure that these are date stamped on receipt, immediately forwarded to the HRO and registered at the date on the date stamp.
- 3.2.2 Patients who cancel an appointment will have their waiting time clock reset to the date the hospital was informed of the cancellation. Patients who

refuse a reasonable offer of an appointment will also have their waiting time clock reset to the date the reasonable offer was refused. To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

- 3.2.3 Patients who fail to attend their appointment without giving prior notice (DNA) will have their waiting time clock reset to the date of the DNA.

3.3 KEY PRINCIPLES

- 3.3.1 Referrals into Trusts should be pooled where possible within specialties. Referrals to a specific consultant by a GP should only be accepted where there are specific clinical requirements or stated patient preference. As a minimum, all un-named referrals should be pooled.
- 3.3.2 All referrals, appointments and waiting lists should be managed according to clinical priorities. Priorities must be identified for each patient on the waiting list, allocated according to urgency of the treatment. Trusts will manage patients in 2 streams, i.e. urgent and routine. Templates should be constructed to ensure enough capacity is available to treat each stream within agreed maximum waiting time guarantees. The Implementation Procedure for Template Redesign can be found in **Appendix 7**.
- 3.3.3 The regional target for a maximum OP waiting time is outlined in Section 1.4. Maximum waiting times for urgent patients should be agreed locally with clinicians.
- 3.3.4 Maximum waiting times for urgent patients should be agreed locally with clinicians, and made explicit to staff booking these patients to ensure that they are appointed within the clinical timeframe indicated by the consultant and capacity issues quickly identified and escalated.

- 3.3.5 Patients of equal clinical priority will be selected for booking in strict chronological order. Trusts must ensure that Department waiting and booking targets and standards are met.
- 3.3.6 Data collection should be accurate, timely, complete and subject to regular audit and validation.
- 3.3.7 Trusts should provide training programmes for staff which include all aspects of this IEAP and its Implementation Procedures. It is expected that training will be cascaded at and by each clinical, managerial or administrative tier within Trusts, providing the opportunity where required, for staff to work through operational scenarios.
- 3.3.8 Trusts will work towards providing a single point of contact for all patients with respect to outpatient appointment services. It is recognised that there may be services which require alternative processes.

3.4 NEW REFERRALS

- 3.4.1 All outpatient referrals sent to Trusts will be received at the dedicated HRO's and registered within one working day of receipt. GP priority status must be recorded at registration.
- 3.4.2 Trusts will work towards a system whereby the location of all letters can be tracked at all times through the referral and appointment system, and that letters sent to be prioritised and which are not returned can be identified.
- 3.4.3 All referrals must be prioritised and clinical urgency must be clearly identified. Clinicians will be responsible for ensuring that cover is provided for referrals to be read and prioritised during their absence. A designated officer should oversee this and a protocol will be required for each department.
- 3.4.5 All outpatient referrals letters will be prioritised and returned to the HRO within 3 working days. It will be the responsibility of the health records

manager or departmental manager to monitor this performance indicator. Monitoring will take place by consultant on a monthly basis. Following prioritisation, referrals must be actioned on PAS and appropriate correspondence issued to patients within 1 working day.

- 3.4.6 Where clinics take place, or referrals can be reviewed less frequently than weekly, a process must be put in place and agreed with clinicians whereby GP prioritisation is accepted in order to proceed with booking urgent patients.
- 3.4.7 Inappropriate and inadequate referrals should be returned to the referral source. A minimum referral criteria dataset has been agreed and is outlined in **Appendix 8**
- 3.4.8 An Effective Use of Resources Policy is in place for some services and Trusts should ensure that this is adhered to. The policy is included for reference in **Appendix 9**.

3.5 URGENT AND ROUTINE APPOINTMENTS

- 3.5.1 All consultant led outpatient appointments where the patient attends the Trust should be booked. The key requirements are that the patient is directly involved in negotiating the appointment date and time, and that no appointment is made more than six weeks into the future.
- 3.5.2 All routine patients must be booked within the maximum waiting time guarantee. Urgent patients must be booked within the maximum wait agreed locally with clinicians, from the date of receipt. It is recognised that there will be occasional exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Trusts should ensure that when accommodating these patients, the appointment process is robust and clinical governance requirements met.
- 3.5.3 Acknowledgment letters will be sent to routine patients within five days of receipt of the referral. The estimated length of wait, along with information on

how the patient will be booked, should be included on the acknowledgement letter.

3.5.4 A minimum of three weeks' notice should be provided for all routine patients. This does not prevent patients being offered earlier appointment dates. Patients refusing short notice appointments (i.e. less than three weeks' notice) will not have their waiting time reset, in line with guidance on reasonable offers.

3.5.5 Trusts must ensure that all communication to patients is clear, easily understood and complies with all relevant legislation.

3.6 BOOKING

3.6.1 All new and review consultant led outpatient clinics should be able to book their appointment. This will entail patients having an opportunity to contact the hospital and agree a convenient date and time for their appointment. The use of the Patient Choice field on PAS is mandatory. The only fields that should be used are 'Y' to indicate that the appointment has been booked or 'N' to indicate that an appointment has not been booked. No other available field should be used as compliance with booking requirements will be monitored via the use of the Patient Choice field. For non-ISOFT and manual administration systems, Trusts should ensure that they are able to record and report patients who have been booked.

3.7 REASONABLE OFFERS

3.7.1 For patients who have been able to book their appointment, a reasonable offer is defined as an offer of appointment, irrespective of provider, that gives the patient a minimum of three weeks' notice and two appointments. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused.

3.7.2 If the patient is offered an appointment within a shorter notice period and it is refused, the waiting time cannot be recalculated.

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

3.7.4 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above. The Implementation Procedure on Reasonableness can be found in **Appendix 3**.

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

3.8.1 If a patient DNAs their outpatient appointment, the following process must be implemented.

- Where a patient has had an opportunity to agree the date and time of their appointment, they will not normally be offered a second appointment. These patients will be referred back to the care of their referring clinician.
- Under exceptional circumstances a clinician may decide that a patient should be offered a second appointment. The second appointment must be booked.

3.8.2 There may be instances for review patients where the clinician may wish to review notes prior to any action to remove a patient because of DNA or failure to respond to partial booking invitation letters. Trusts should ensure that robust and locally agreed rules and processes are in place so that booking clerks are clear about how to administer these patients.

3.8.3 In a transition period where fixed appointments are still being issued, patients should have two opportunities to attend.

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

- The patient will be given a second opportunity to book an appointment, which should be within six weeks of the original appointment date.
- If a second appointment is cancelled, the patient will not normally be offered a third opportunity and will be referred back to their referring clinician.

3.8.5 Following discharge, patients will be added to the waiting list at the written request of the referring GP and within a four week period from the date of discharge. Patients should be added to the waiting list at the date the written request is received.

3.8.6 The Implementation Procedure on DNAs and Cancellations can be found in **Appendix 4.**

3.9 MAXIMUM WAITING TIME GUARANTEE

3.9.1 If a patient requests an appointment date that is beyond the maximum waiting time guarantee, the patient will be discharged and advised to revisit their GP when they are ready to be seen in the Outpatient Clinic. This will ensure that all patients waiting for an outpatient appointment are fit and ready to be seen. It is accepted that local discretion may be required where short periods of time are involved, for example, if patients are requesting dates up to a week over their breach date. Trusts should ensure that reasonableness is complied to facilitate re-calculation of the patient's waiting time, and to facilitate booking the patient into the date they requested.

3.10 COMPLIANCE WITH LEAVE PROTOCOL

3.10.1 Capacity lost due to cancelled or reduced clinics at short notice has negative consequences for patients and on the Trust's ability to successfully

implement booking processes. Clinic cancellation and rebooking of appointments is an extremely inefficient way to use such valuable resources.

- 3.10.2 It is essential that planned medical and other clinical leave or absence is organised in line with an agreed Trust Human Resources (HR) protocol. Thus it is necessary for Trusts to have robust local HR policies and procedures in place that minimise the cancellation/reduction of outpatient clinics and the work associated with the rebooking of appointments. There should be clear medical and clinical agreement and commitment to this HR policy. Where cancelling and rebooking is unavoidable the procedures used must be equitable, efficient, comply with clinical governance principles and ensure that maximum waiting times for patients are not compromised.
- 3.10.3 The protocol should require a minimum of six weeks' notification of intended leave, in line with locally agreed HR policies.
- 3.10.4 A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit. The Implementation Procedure for Compliance with Leave Protocol can be found in **Appendix 10**.

3.11 CLINIC OUTCOME MANAGEMENT

- 3.11.1 There are a number of locations within Trusts where patients present for their outpatient consultation. This protocol applies to all outpatient areas. It is the responsibility of the PAS user managing the attendance to maintain data quality.
- 3.11.2 All patients will have their attendance registered on PAS upon arrival in the clinic. The patient must verify their demographic details on every visit. The verified information must be cross-checked on PAS and the medical records.
- 3.11.3 Changes in the patient's details must be updated on PAS and the medical records on the date of clinic.

- 3.11.4 When the consultation has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic. The implementation procedure for the Management of Clinic Outcomes can be found in **Appendix 11**.

3.12 REVIEW APPOINTMENTS

- 3.12.1 All review appointments must be made within the time frame specified by the clinician. If a review appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the consultant. Trusts should actively monitor patients on the review list to ensure that they do not go past their indicative month of treatment and take the necessary action to ensure capacity is available for this cohort.
- 3.12.2 Review patients who require an appointment within six weeks will negotiate the date and time of the appointment before leaving the department and PAS updated. Patients requiring an appointment outside six weeks will be placed on a review waiting list, with the indicative appointment date recorded, and be booked in line with implementation guidance for review pathway patients.

3.13 CLINIC TEMPLATE CHANGES

- 3.13.1 Clinic templates should be agreed between the consultant and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement and ensure that there is sufficient capacity allocated to enable each appointment type to be booked in line with clinical requirements and maximum waiting time guarantees for patients.

- 3.13.2 Templates will identify the number of slots available for new urgent, new routine and follow up appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated for each appointment slot.
- 3.13.3 All requests for template and temporary clinic rule changes will only be accepted in writing. A minimum of six weeks notice will be provided for clinic template changes.
- 3.13.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager. The Implementation Procedure for the management of Clinic Template Changes can be found in **Appendix 5**.

3.14 VALIDATION

- 3.14.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a weekly basis and continually reviewed as waiting times reduce. This is essential to ensure PTLs are accurate and robust at all times. The Implementation Guidance for Data Validation can be found in **Appendix 6**.
- 3.14.2 As booking processes are implemented and waiting times reduce, there is no longer the need to validate patients by letter.
- 3.14.3 For patients in specialties that are not yet booked, they will be contacted to establish whether they will still require their appointment.

3.15 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

- 3.15.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between hospitals or to Independent Sector Providers. Transfers should not be a feature of an effective scheduled system.

3.15.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant. Administrative speed and good communication are very important to ensure this process runs smoothly. The Implementation Procedure and Technical Guidance for Handling Outpatient Transfers can be found in **Appendix 15a**.

SECTION 4

PROTOCOL GUIDANCE FOR MANAGEMENT OF DIAGNOSTIC SERVICES

4.1 INTRODUCTION

- 4.1.1 The following protocol is based on nationally recommended good practice guidelines to assist staff with the effective management of diagnostic waiting lists. Where possible, the principles of good practice outlined in the Outpatient and Elective Admissions Section of this document should be adopted in order to ensure consistent standards and processes for patients as they move along the pathway of investigations, assessment and treatment. This section aims to recognise areas where differences may be encountered due to the nature of specific diagnostic services.
- 4.1.2 The administration and management of requests for diagnostics, waiting lists and appointments within and across Trust should be consistent, easily understood, patient focused and responsive to clinical decision making.
- 4.1.3 There will be a centralised registration process within Trusts to receive, register and process all diagnostic referrals. It is expected that this will be in a single location, where possible.
- 4.1.4 The Trust should work towards introducing choice of the date and time of tests to all patients. The Booking Principles outlined in Section 1 of this document should be considered in the development of this strategy.

4.2 CALCULATION OF THE WAITING TIME

- 4.2.1 The starting point for the waiting time of a request for a diagnostic test is the date the clinician's request is received into the department, in line with the guidance on Completing Diagnostic Waiting Times Collection (Definitions Document), September 2007. This can be found in **Appendix 14**. All referral letters and requests, including faxed, emailed and electronically delivered referrals, will be date stamped on the date received.
- 4.2.2 Patients who cancel an appointment will have their waiting time clock reset to the date the service was informed of the cancellation.

4.2.3 Patients who refuse a reasonable offer of an appointment will also have their waiting time clock reset to the date the reasonable offer was refused. To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

4.2.4 Patients who fail to attend their appointment without giving prior notice (DNA) will have their waiting time clock reset to the date of the DNA.

4.3 KEY PRINCIPLES

4.3.1 Trusts must have in place arrangements for pooling all referrals unless there is specific clinical information which determines that the patient should be seen by a particular consultant with sub-specialty interest.

4.3.2 All diagnostic requests, appointments and waiting lists should be managed according to clinical priority. A clinical priority must be identified for each patient on a waiting list, and patients managed in 2 streams, i.e. urgent and routine. Session or clinic templates should be constructed to ensure enough capacity is available to treat each stream within the maximum waiting time guarantees outlined in Section 1.4. Maximum waiting times for urgent patients should be agreed locally with clinicians.

4.3.3 Data collection should be accurate, timely, complete and subject to regular audit and validation.

4.3.4 Staff should be supported by appropriate training programmes.

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

4.4 NEW DIAGNOSTIC REQUESTS

- 4.4.1 All diagnostic requests sent to Trusts will be received at a single location within the specialty Department. Trusts should explore the setting of one centralised diagnostic registration centre.
- 4.4.2 All requests will be registered on PAS / relevant IT system within one working day of receipt. Only authorised staff will have the ability to add, change or remove information in the outpatient module of PAS or other diagnostic system.
- 4.4.3 Trusts will work towards a system whereby the location of all letters can be tracked at all times through the referral and appointment system and that letters sent for prioritisation and not returned can be identified. Trusts should consider the introduction of clinical tracking systems similar to that used in patient chart tracking.
- 4.4.4 All requests must be prioritised and clinical urgency must be clearly identified. Clinicians will be responsible for ensuring that cover is provided for requests to be read and prioritised during their absence. A designated officer should oversee this and a protocol will be required for each department.
- 4.4.5 All requests will be prioritised and returned to the central registration point within 3 working days. It will be the responsibility of the health records manager or departmental manager to monitor this performance indicator. Monitoring on a consultant level will take place by consultant on a monthly basis. Following prioritisation, requests must be actioned on PAS / IT system and appropriate correspondence issued to patients within 1 working day.
- 4.4.6 Where clinics take place, or requests can be reviewed less frequently than weekly, a process must be put in place and agreed with clinicians whereby the GP's priority is accepted in order to proceed with booking urgent patients.

- 4.4.7 Inappropriate and inadequate requests should be returned to the referral source. Minimum referral criteria is being developed to ensure the referral process is robust.

4.5 URGENT AND ROUTINE APPOINTMENTS

- 4.5.1 All requests must be booked within the maximum waiting time guarantee. The key requirement is that the patient is directly involved in negotiating the date and time of the appointment and that no appointment is made more than six weeks in advance.
- 4.5.2 Urgent requests must be booked within locally agreed maximum waits from the date of receipt. It is recognised that there will be exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Trusts should ensure that when accommodating these patients, the appointment process is robust and clinical governance requirements met.
- 4.5.3 All routine patients must be booked within the maximum waiting time guarantee. Acknowledgement letters will be issued to routine patients within 5 working days of receipt of request. The estimated wait, along with information on how the patients will be booked should be included on the acknowledgement letter.
- 4.5.4 A minimum of three weeks notice should be provided for all routine patients. This does not prevent patients being offered earlier appointment dates. Patients who refuse short notice appointments (i.e. less than three weeks notice) will not have their waiting time reset in line with guidance on reasonable offers.
- 4.5.5 Trusts must ensure that all communication to patients is clear, easily understood and complies with all relevant legislation.

4.6 CHRONOLOGICAL MANAGEMENT

- 4.6.1 Patients of equal clinical priority will be selected for appointment in chronological order and Trusts must ensure that regional standards and targets in relation to waiting times and booking requirements are met. The process of selecting patients for diagnostic investigations is a complex activity. It entails balancing the needs and priorities of the patient and the Trust against the available resources.
- 4.6.2 It is expected that Trusts will use two prioritisation categories; urgent and routine.

4.7 BOOKING METHODS

- 4.7.1 Booking will enable patients to have an opportunity to contact the service and agree a convenient time for their appointment. As outlined in paragraph 4.1.4, booking strategies should be developed in line with these Booking Principles. In the interim period, while fixed appointments are being issued, Trusts should ensure that the regional guidance is followed in the management of patients.

4.8 REASONABLE OFFERS

- 4.8.1 For patients who have been able to book their appointment, a reasonable offer is defined as an offer of appointment, irrespective of provider, that gives the patient a minimum of three weeks' notice and two appointments. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused. To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

- 4.8.2 If the patient is offered an appointment within a shorter notice period and it is refused, the waiting time cannot be recalculated.
- 4.8.3 If the patient however accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the Trust.
- 4.8.4 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above. The Implementation Procedure on Reasonableness can be found in **Appendix 3**.

4.9 PATIENT CANCELLATIONS (CNAS) AND DID NOT ATTENDS (DNAS)

- 4.9.1 If a patient DNAs their diagnostic test, the following process must be implemented.
- Where a patient has had an opportunity to agree the date and time of their appointment, they will not normally be offered a second appointment. These patients will be referred back to the care of their referring clinician.
 - Under exceptional circumstances a clinician may decide that a patient should be offered a second appointment. The second appointment must be booked.
- 4.9.2 There may be instances for follow-up patients where the clinician may wish to review notes prior to any action to remove a patient because of DNA or failure to respond to booking invitation letters. Trusts should ensure that robust and locally agreed rules and processes are in place so that booking clerks are clear about how to administer these patients.
- 4.9.3 In a transition period where fixed appointments are still being issued, patients should have two opportunities to attend.

4.9.4 If a patient cancels their appointment, the following process must be implemented.

- The patient will be given a second opportunity to book an appointment, which should be within six weeks of the original appointment date.
- If a second appointment is cancelled, the patient will not normally be offered a third opportunity and will be referred back to their referring clinician.

4.9.5 Following discharge, patients will be added to the waiting list at the written request of the referring GP and within a four week period from the date of discharge. Patients should be added to the waiting list at the date the written request is received.

4.10 TRANSFERS BETWEEN HOSPITALS

4.10.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between hospitals. Transfers should not be a feature of an effective scheduled system.

4.10.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant. Administrative speed and good communication are very important to ensure this process runs smoothly.

4.11 COMPLIANCE WITH TRUST LEAVE PROTOCOL

4.11.1 One of the major issues regarding the operation of healthcare services is the capacity lost due to cancelled or reduced clinics at short notice. This has negative consequences for patients and on the ability to successfully implement booking requirements. Clinic or session cancellation and rebooking of appointments is an extremely inefficient way to use such valuable resources.

- 4.11.2 It is therefore essential that leave/absence is organised in line with the Trust's Human Resources leave protocol. It is necessary for Trusts to have robust policies and procedures that minimise the cancellation/reduction of diagnostic sessions and the work associated with the rebooking of appointments. Where cancelling and rebooking is unavoidable the procedures used must be equitable and comply with clinical governance principles.
- 4.11.3 The local absence/leave protocol should require a minimum of six weeks' notification of intended leave, in line with locally agreed policies.
- 4.11.4 A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

4.12 SESSION OUTCOME MANAGEMENT

- 4.12.1 There are a number of locations within Trusts where patients present for their diagnostic tests. This protocol applies to all diagnostic services. It is the responsibility of the PAS / relevant system user administrating the clinic to maintain data quality.
- 4.12.2 All patients will have their attendance registered on PAS / IT system upon arrival at the clinic. The patient must verify their demographic details on every visit. The verified information must be cross-checked on PAS / IT system and the medical record.
- 4.12.3 Changes in the patient's details must be updated on PAS / IT system and the medical record on the date of clinic.
- 4.12.4 When the test has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic.

4.13.1 DIAGNOSTIC TEST OUTCOME

- 4.13.1 The outcome of the diagnostic test must be available to the referrer without undue delay. A standard for the reporting turnaround time of tests will be introduced during 2008 and Trusts will be expected to monitor and report compliance to the standard.

4.14 FOLLOW UP APPOINTMENTS

- 4.14.1 All follow up appointments must be made within the time frame specified by the clinician. If a follow up appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the clinician.
- 4.14.2 Where follow up appointments are not booked, patients who require a review within six weeks will negotiate the date and time of this appointment before leaving the department and PAS / IT system updated. Patients requiring an appointment outside six weeks will have their appointment managed through a 'hold and treat' system. They will be managed on a review waiting list, with an indicative date of treatment and sent a letter confirming their appointment date six weeks in advance.

4.15 TEMPLATE CHANGES

- 4.15.1 Session templates should be agreed with the healthcare professional and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement.
- 4.15.2 Templates will identify the number of slots available for new urgent, new routine, planned and follow up appointments; specify the time each session is scheduled to start and finish; and identify the length of time allocated for each appointment slot.

4.15.3 All requests for template and temporary session rule changes will only be accepted in writing. A minimum of six weeks notice will be provided for session template changes.

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

4.16 VALIDATION

4.16.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a monthly basis and ideally on a weekly basis as waiting times reduce. This is essential to ensure PTLs are accurate and robust at all times.

4.16.2 As booking processes are implemented and waiting times reduce, there is no longer the need to validate patients by letter.

4.16.3 For patients in specialties which still issue fixed appointments, they will be contacted to establish whether they require their appointment.

4.16.4 Until follow-up and planned appointments are booked, the validation process will apply to follow up appointments.

4.17 PLANNED PATIENTS AND DIAGNOSTICS TESTS CLASSIFIED AS DAY CASES

4.17.1 Trusts should ensure that the relevant standards in the Elective Admissions section of this document are adhered to.

4.18 PLANNED PATIENTS

- 4.18.1 Planned patients are those who are waiting to be recalled to hospital for a further stage in their course of treatment or investigation within specific timescales. This is usually part of a planned sequence of clinical care determined on clinical criteria.
- 4.18.2 These patients are not actively waiting for treatment to be initiated, only for planned continuation of treatment. A patient's care is considered as planned if there are clinical reasons that determine the patient must wait set periods of time between interventions. They will not be classified as being on a waiting list for statistical purposes.
- 4.18.3 Trusts should be able to demonstrate consistency in the way planned patients are treated and that patients are being treated in line with the clinical constraints. Planned patients must have a clearly identified month of treatment in which it can be shown that the patients are actually being treated.

4.19 HOSPITAL INITIATED CANCELLATIONS

- 4.19.1 No patient should have his or her admission cancelled. If Trusts cancel a patient's admission, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity, which should must be within the maximum waiting time guarantee.
- 4.19.2 Trusts should aim to have processes in place to have the new proposed admission date arranged before that patient is informed of the cancellation.
- 4.19.3 The patient should be informed in writing of the reason for the cancellation and the date of the new admission. The correspondence should include an explanation and an apology on behalf of the Trust.
- 4.19.4 Trusts will make best efforts to ensure that a patient's admission is not cancelled a second time for non-clinical reasons.

- 4.19.5 Where patients are cancelled on the day of a test as a result of not being fit, they will be suspended, pending a clinical review of their condition. The patient should be fully informed of this process.
- 4.19.6 Hospital initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment as a result of hospital initiated reasons, i.e. equipment failure, a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

4.20 PATIENTS LISTED FOR MORE THAN ONE DIAGNOSTIC TEST

- 4.20.1 Where more than one diagnostic test is required to assist with clinical decision making, the first test should be added to the waiting list with additional tests noted.
- 4.20.2 Where different clinicians are working together will perform more than one test at one time the patient should be added to the waiting list of the clinician for the priority test with additional clinicians noted, subject to local protocols.
- 4.20.3 Where a patient requires more than one test carried out on separate occasions by different (or the same) clinician, the patient should be placed on the active waiting list for the first test and on the planned waiting list for any subsequent tests.
- 4.20.4 Where a patient is being managed in one Trust but has to attend another for another type of diagnostic test, monitoring arrangements must be in place between the relevant Trusts to ensure that the patient pathway runs smoothly.

SECTION 5

GUIDANCE FOR MANAGEMENT OF ALLIED HEALTH PROFESSIONAL (AHP) SERVICES

5.1 INTRODUCTION

- 5.1.1 Allied Health Professionals work with all age groups and conditions, and are trained in assessing, diagnosing, treating and rehabilitating people with health and social care needs. They work in a range of settings including hospital, community, education, housing, independent and voluntary sectors. This guidance provides an administrative framework to support the management of patients waiting for AHP services.
- 5.1.2 Although it is written primarily for services provided in Trusts, it is recognised that there are a number of AHPs who provide services for children with physical and learning disabilities within special schools and with special educational needs within mainstream schools. Operational practices in these settings should be in line with the principles of the IEAP and provide consistency and equity for patients. Trusts should collaborate with colleagues within the Department of Education and the relevant schools to harmonise practices and ensure that children are able to access services equitably and within the maximum waiting time guarantees. A robust monitoring process will be required.
- 5.1.3 For the purposes of this section of the protocol, the generic term 'clinic' will be used to reflect AHP activity undertaken in hospital, community or domiciliary settings as it is recognised that AHPs provide patient care in a variety of care locations.

5.2 KEY PRINCIPLES

- 5.2.1 Trusts should ensure that there is a systematic approach to modernising AHP services which will help to improve access to services and quality of care for patients. This section should be read within the overall context of both the IEAP and the specific section governing the management of hospital outpatient services.

- 5.2.2 When looking at the experience of the patient it is important to consider the whole of their journey, with both the care and administrative pathways designed to support the patient's needs at each stage. The wait to receive outpatient therapy is likely to be one of many they experience in different parts of the system. It is the responsibility of all those involved to ensure that the patient wastes as little time as possible waiting and is seen by the right person as quickly as possible.
- 5.2.3 Booking will enable patients to have an opportunity to contact the hospital and agree a convenient time for their appointment. As outlined in paragraph 4.1.4, booking strategies should be developed in line with these Booking Principles. In the interim period, while fixed appointments are being issued, Trusts should ensure that the regional guidance is followed in the management of patients.

5.3 CALCULATION OF THE WAITING TIME

- 5.3.1 The waiting time clock for an AHP referral commences on the date the referral letter is received by the AHP service within the Trust. All referral letters, including faxed, emailed and electronically received referrals, will be date stamped on the date received.
- 5.3.2 The waiting time clock stops when the first definitive AHP treatment has commenced or when a decision is made that treatment is not required. Further information on definitions and sample patient pathways is contained in the Data Definitions and Guidance Document for AHP Waiting Times and can be found in **Appendix 12**.
- 5.3.3 As booking systems are introduced, patients should be made a reasonable offer, where clinically possible. Patients who refuse a reasonable offer of treatment, or fail to attend an AHP appointment, will have their waiting time clock re-set to the date the service was informed of the cancellation (CNAs) or the date the patient failed to attend (DNAs).

5.4 NEW REFERRALS

- 5.4.1 All AHP referrals will be registered on the relevant information system within 1 working day of receipt.
- 5.4.2 Trusts should work towards a system whereby all AHP referrals sent to the Trust are received at a dedicated registration function (s). Trusts should ensure that adequate systems are in place to deal with multiple referrals for the same patient regarding the same condition from a number of sources.
- 5.4.3 All referrals must be triaged or assessed to make a clear decision on the next step of a referral and clinical urgency (urgent or routine) clearly identified and recorded. All referrals will be prioritised and returned to the registration point with 3 working days.
- 5.4.4 Trusts must ensure that protocols are in place to prevent unnecessary delay from date stamping / logging of referrals to forwarding to the AHP department responsible for referral triage and/or initiation of treatment. It will be the responsibility of the relevant manager to monitor this performance indicator.
- 5.4.5 A robust system should be in place to ensure that cover is provided for referrals to be read and prioritised during practitioners' absence. A designated officer should oversee this and a protocol will be required for each service.
- 5.4.6 Where referrals can be reviewed less frequently than weekly, a process must be put in place and agreed with AHPs whereby the referrer's prioritisation is accepted in order to proceed with booking patients.
- 5.4.7 Following prioritisation, referrals must be updated on the relevant information system and appropriate correspondence issued to patients within 1 working day. Where there is insufficient information for the AHP to make a decision, they should contact the originating referrer in the first instance to access the

necessary information. If this cannot be gained, the referral should be returned to the referral source.

- 5.4.8 Trusts will work towards a system whereby the location of all letters can be tracked at all times through the referral and appointment system, and that letters sent to be prioritised and letters which are not returned can be identified.
- 5.4.9 If at the referral stage the patient / client is identified as being clinically or socially unfit to receive the necessary service the referral should not be accepted (not added to a waiting list) and returned to the originating referrer with a request that they re-refer the patient / client when they are clinically or socially fit to be treated.

5.5 URGENT AND ROUTINE APPOINTMENTS

- 5.5.1 All routine patients should be appointed within the maximum waiting time guarantee. Urgent patients must be booked within locally agreed maximum waits from the date of receipt. Local booking process should be based upon the principles outlined in Section 1.7.
- 5.5.2 For routine waiting list patients, an acknowledgement letter will be sent to patients within 5 working days of receipt of the referral, which should provide information to patients on their anticipated length of wait and details of the booking process.
- 5.5.3 A minimum of three weeks' notice should be provided for all routine patients. This does not prevent patients being offered an earlier appointment. Patients refusing short notice appointments (i.e. less than three weeks notice) will not have their waiting time clock reset, in line with guidance on reasonable offers.
- 5.5.4 Trusts must ensure that all communication to patients is clear, easily understood and complies with all relevant legislation.

5.6 CHRONOLOGICAL MANAGEMENT

- 5.6.1 Patients, within each clinical priority category, should be selected for booking in chronological order, i.e. based on the date the referral was received. Trusts should ensure that local administrative systems have the capability and functionality to effectively operate a referral management and booking system that is chronologically based.

5.7 CAPACITY PLANNING AND ESCALATION

- 5.7.1 It is important for AHP services to understand their baseline capacity, the make-up of the cohort of patients waiting to be treated and the likely changes in demand that will impact on their ability to initiate treatment and meet the maximum waiting time guarantees for patients.
- 5.7.2 Trusts should ensure that robust prospective capacity planning arrangements are in place, with clear escalation procedures to facilitate capacity gaps to be identified and solutions found in a timely manner to support operational booking processes and delivery of the targets.

5.8 REASONABLE OFFERS

- 5.8.1 As booking systems are introduced, patients should be offered reasonable notice, where clinically possible. A reasonable offer is defined as an offer of appointment, irrespective of provider, that gives the patient a minimum of three weeks notice and two appointments. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused. To ensure a verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.
- 5.8.2 If the patient is offered an appointment within a shorter notice period and it is refused, the waiting time cannot be recalculated.

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

5.8.3 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above.

5.9 AHP SERVICE INITIATED CANCELLATIONS

5.9.1 No patient should have his or her appointment cancelled. If Trusts cancel a patient's appointment, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable appointment date, ideally at the time of cancellation, and no more than 6 weeks in advance. The Trust must ensure that the new appointment date is within the maximum waiting time guarantee.

5.9.2 The patient should be informed of the reason for the cancellation and the date of the new appointment. This should include an explanation and an apology on behalf of the Trust.

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

5.9.4 AHP service initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment as a result of AHP service initiated reasons, i.e. equipment failure, staff sickness, a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

5.10 MAXIMUM WAITING TIME GUARANTEE

- 5.10.1 If a patient requests an appointment date that is beyond the maximum waiting time guarantee, the patient will be discharged and advised to revisit their referrer when they are ready to be seen. This will ensure that all patients waiting for an AHP appointment / treatment are fit and ready to be seen.
- 5.10.2 There will undoubtedly be occasions and instances where local discretion is required and sensitivity should be applied when short periods of time are involved; for example, if patients are requesting dates up to a week over their breach date. Trusts should ensure that reasonableness is complied with to facilitate re-calculation of the patient's waiting time, and to facilitate booking the patient into the date they requested.

5.11 COMPLIANCE WITH LEAVE PROTOCOL

- 5.11.1 Capacity lost due to cancelled or reduced clinics or visits at short notice has negative consequences for patients and on the Trust's ability to successfully implement robust booking processes. Clinic cancellation and rebooking of appointments is an extremely inefficient way to use such valuable resources.
- 5.11.2 It is therefore essential that AHP practitioners and other clinical planned leave or absence is organised in line with an agreed Trust Human Resources (HR) protocol. Thus it is necessary for Trusts to have robust local HR policies and procedures in place that minimise the cancellation/reduction of AHP clinics and the work associated with rebooking patient appointments. There should be clear practitioner agreement and commitment to this HR policy. Where cancelling and rebooking is unavoidable the procedures used must be equitable, efficient and comply with clinical governance principles.
- 5.11.3 The protocol should require a minimum of six weeks' notification of planned leave, in line with locally agreed HR policies.

- 5.11.4 A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

5.12 CLINIC OUTCOME MANAGEMENT

- 5.12.1 All patients will have their attendance recorded or registered on the relevant information system upon arrival for their appointment. The patient must verify their demographic details on every visit. The verified information must be cross-checked on information system and the patient records. Any changes must be recorded and updated in the patient record on the date of the clinic.
- 5.12.2 When the assessment/treatment has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic.

5.13 REVIEW APPOINTMENTS

- 5.13.1 All review appointments must be made within the time frame specified by the practitioner. If a review appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the practitioner. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the practitioner.
- 5.13.2 Review patients who require an appointment within six weeks will negotiate the date and time of the appointment before leaving the service and PAS / information system updated. Patients requiring an appointment outside six weeks should be managed on a review waiting list, with the indicative date recorded when appointment is required and booked in line with the booking principles outlined.

- 5.13.3 If domiciliary review appointment is required within 6 weeks, the appointment date should be agreed with the patient and confirmed in writing by the booking office. Where a domiciliary review appointment is required outside 6 weeks, the patient should be managed on a review waiting list, within the indicative date recorded, and booking in line with the booking principles outlined.

5.14 CLINIC TEMPLATE MANAGEMENT

- 5.14.1 Clinic templates should be agreed between the practitioner and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement.
- 5.14.2 Templates will identify the number of slots available for new urgent, new routine and follow up appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated for each appointment slot.
- 5.14.3 All requests for template and temporary clinic rule changes will only be accepted in writing to the relevant service manager. A minimum of six weeks notice will be provided for clinic template changes.
- 5.14.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager.

5.15 ROBUSTNESS OF DATA / VALIDATION

- 5.15.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a weekly basis and continually reviewed as waiting times reduce. This is essential to ensure Primary Targeting Lists are accurate and robust at all times.

- 5.15.2 As booking processes are implemented and waiting times reduce, there is no longer the need to validate patients by letter.
- 5.15.3 For patients in AHP services that are not yet booked, they will be contacted to establish whether they will still require their appointment.

**SECTION 6 PROTOCOL GUIDANCE FOR MANAGEMENT
OF ELECTIVE ADMISSIONS**

6.1 INTRODUCTION

- 6.1.1 The following protocol is based on nationally recommended good practice guidelines to assist staff with the effective management of elective waiting lists.
- 6.1.2 The administration and management of elective admissions within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.

6.2 COMPUTER SYSTEMS

- 6.2.1 To ensure consistency and the standardisation of reporting with Commissioners and the Department, all waiting lists are to be maintained in the PAS system.
- 6.2.2 Details of patients must be entered on to the computer system within two working days of the decision to admit being made. Failure to do this will lead to incorrect assessment of waiting list size when the daily / weekly downloads are taken.
- 6.2.3 As a minimum 3 digit OPCS codes should be included when adding a patient to a waiting list. Trusts should work towards expanding this to 4 digit codes.

6.3 CALCULATION OF THE WAITING TIME

- 6.3.1 The starting point for the waiting time of an inpatient is the date the consultant agrees with the patient that a procedure will be pursued as an active treatment or diagnostic intervention, and that the patient is medically fit to undergo such a procedure.
- 6.3.2 The waiting time for each inpatient on the elective admission list is calculated as the time period between the original decision to admit date and the date

at the end of the applicable period for the waiting list return. If the patient has been suspended at all during this time, the period(s) of suspension will be automatically subtracted from the total waiting time.

- 6.3.3 Patients who refuse a reasonable offer of treatment, or fail to attend an offer of admission, will have their waiting time reset to the date the hospital was informed of the cancellation (CNAs) or the date the patient failed to attend (DNAs). Any periods of suspension are subtracted from the patients overall waiting time.

6.4 STRUCTURE OF WAITING LISTS

- 6.4.1 To aid both the clinical and administrative management of the waiting list, lists should be sub-divided into a limited number of smaller lists, differentiating between active waiting lists, planned lists and suspended patients.
- 6.4.2 Priorities must be identified for each patient on the active waiting list, allocated according to urgency of the treatment. The current priorities are urgent and routine.

6.5 INPATIENT AND DAY CASE ACTIVE WAITING LISTS

- 6.5.1 Inpatient care should be the exception in the majority of elective procedures. Trusts should move away from initially asking “is this patient suitable for day case treatment?” towards a default position where they ask “what is the justification for admitting this patient?” The Trust’s systems, processes and physical space should be redesigned and organized on this basis.
- 6.5.2 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to admit, i.e. if there was a bed available tomorrow in which to admit a patient they are fit, ready, and able to come in.

- 6.5.3 All decisions to admit will be recorded on PAS within two working days of the decision to admit being taken.
- 6.5.4 Robust booking and scheduling systems will be developed to support patients having a say in the date and time of their admission. Further guidance will be provided on this.
- 6.5.5 Where a decision to admit depends on the outcome of diagnostic investigation, patients should not be added to an elective waiting list until the outcome of this investigation is known. There must be clear processes in place to ensure the result of the investigation is timely and in accordance with the clinical urgency required to admit the patient.
- 6.5.6 The statements above apply to all decisions to admit, irrespective of the decision route, i.e. direct access patients or decisions to directly list patients without outpatient consultation.

6.6 COMPLIANCE WITH TRUST HR LEAVE PROTOCOL

- 6.6.1 Trusts should have in place a robust protocol for the notification and management of medical and clinical leave and other absence. This protocol should include a proforma for completion by or on behalf of the consultant with a clear process for notifying the theatre scheduler of leave / absence.
- 6.6.2 The protocol should require a minimum of six weeks' notification of intended leave, in line with locally agreed consultant's contracts.
- 6.6.3 A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

6.7 TO COME IN (TCI) OFFERS OF TREATMENT

- 6.7.1 The patient should be advised of their expected waiting time during the consultation between themselves and the health care provider/practitioner and confirmed in writing.
- 6.7.2 Patients should be made reasonable offers to come in on the basis of clinical priority. Within clinical priority groups offers should then be made on the basis of the patient's chronological wait.
- 6.7.3 All patients must be offered reasonable notice. A reasonable offer is defined as an offer of admission, irrespective of provider, that gives the patient a minimum of three weeks' notice and two TCI dates. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date of the refused admission.
- 6.7.4 If the patient is offered an admission within a shorter notice period and it is refused, the waiting time cannot be recalculated.
- 6.7.5 If the patient however accepts an admission at short notice, but then cancels the admission, the waiting time can be recalculated from the date of that admission as the patient has entered into an agreement with the Trust.
- 6.7.6 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above.

6.8 SUSPENDED PATIENTS

- 6.8.1 A period of suspension is defined as:
- A patient suspended from the active waiting list for medical reasons, or unavailable for admission for a specified period because of family commitments, holidays, or other reasons i.e. a patient may be suspended during any periods when they are unavailable for treatment for social or

medical reasons (but not for reasons such as the consultant being unavailable, beds being unavailable etc).

- A maximum period not exceeding 3 months.
- 6.8.2 At any time a consultant is likely to have a number of patients who are unsuitable for admission for clinical or social reasons. These patients should be suspended from the active waiting list until they are ready for admission. All patients who require a period of suspension will have a personal treatment plan agreed by the consultant with relevant healthcare professionals. One month prior to the end of the suspension period, these plans should be reviewed and actions taken to review patients where required.
- 6.8.3 Every effort will be made to minimise the number of patients on the suspended waiting list, and the length of time patients are on the suspended waiting list.
- 6.8.4 Should there be any exceptions to the above, advice should be sought from the lead director or appropriate clinician.
- 6.8.5 Suspended patients will not count as waiting for statistical purposes. Any periods of suspension will be automatically subtracted from the patient's total time on the waiting list for central statistical returns.
- 6.8.6 No patient added to a waiting list should be immediately suspended. Patients should be recorded as suspended on the same day as the decision was taken that the patient was unfit or unavailable for surgery.
- 6.8.7 No patient should be suspended from the waiting list without a review date. All review dates must be 1st of the month to allow sufficient time for the patient to be treated in-month to avoid breaching waiting times targets.
- 6.8.8 No more than 5% of patients should be suspended from the waiting list at any time. This indicator should be regularly monitored.

- 6.8.9 Trusts should ensure that due regard is given to the guidance on reasonableness in their management of suspended patients.

6.9 PLANNED PATIENTS

- 6.9.1 Planned patients are those who are waiting to be recalled to hospital for a further stage in their course of treatment or surgical investigation within specific timescales. This is usually part of a planned sequence of clinical care determined on clinical criteria (e.g. check cystoscopy).
- 6.9.2 These patients are not actively waiting for treatment, but for planned continuation of treatment. A patient is planned if there are clinical reasons that determine the patient must wait set periods of time between interventions. They will not be classified as being on a waiting list for statistical purposes.
- 6.9.3 Trusts should be able to demonstrate consistency in the way planned patients are treated and that patients are being treated in line with the clinical constraints. Planned patients should have a clearly identified month of treatment in which it can be shown that the patients are actually being treated.
- 6.9.4 Ideally, children should be kept under outpatient review and only listed when they reach an age when they are ready for surgery. However, where a child has been added to a list with explicit clinical instructions that they cannot have surgery until they reach the optimum age, this patient can be classed as planned. The Implementation Procedure for Planned Patients can be found in **Appendix 13**.

6.10 CANCELLATIONS AND DNA'S

6.10.1 Patient Initiated Cancellations

Patients who cancel a reasonable offer will be given a second opportunity to book an admission, which should be within six weeks of the original admission date. If a second admission offer is cancelled, the patient will not normally be offered a third opportunity and will be referred back to their referring clinician.

6.10.2 Patients who DNA

If a patient DNAs their first admission date, the following process must be implemented:

- Where a patient has had an opportunity to agree the date and time of their admission, they will not normally be offered a second admission date.
- Under exceptional circumstances a clinician may decide that a patient should be offered a second admission. The second admission date must be agreed with the patient.

6.10.3 In a period of transition where fixed TCIs are still being issued, patients should have two opportunities to attend.

6.10.4 Following discharge patients will be added to the waiting list at the written request of the referring GP and within a four week period from date of discharge. Patients should be added to the waiting list at the date of the written request is received.

6.10.5 It is acknowledged that there may be exceptional circumstances for those patients identified as being 'at risk' (children, vulnerable adults).

6.10.6 No patient should have his or her operation cancelled prior to admission. If Trusts cancel a patient's admission/operation in advance of the anticipated TCI date, the waiting time clock (based on the original date to admit) will not be reset and the patient will be offered an alternative reasonable guaranteed future date within a maximum of 28 days.

- 6.10.7 Trusts should aim to have processes in place to have the new proposed admission date arranged before the patient is informed of the cancellation.
- 6.10.8 The patient should be informed in writing of the reason for the cancellation and the date of the new admission. The correspondence should include an explanation and an apology on behalf of the Trust.
- 6.10.9 Trusts will make best efforts to ensure that a patient's operation is not cancelled a second time for non clinical reasons.
- 6.10.10 Where patients are cancelled on the day of surgery as a result of not being fit for surgery / high anaesthetic risk, they will be suspended, pending a clinical review of their condition either by the consultant in outpatients or by their GP. The patient should be fully informed of this process.
- 6.10.11 Hospital-initiated cancellations will be recorded and reported to the relevant department on a monthly basis.

6.11 PERSONAL TREATMENT PLAN

- 6.11.1 A personal treatment plan must be put in place when a confirmed TCI date has been cancelled by the hospital, a patient has been suspended or is simply a potential breach. The plan should:
- Be agreed with the patient
 - Be recorded in the patient's notes
 - Be monitored by the appropriate person responsible for ensuring that the treatment plan is delivered.
- 6.11.2 The listing clinician will be responsible for implementing the personal treatment plan.

6.12 CHRONOLOGICAL MANAGEMENT

- 6.12.1 The process of selecting patients for admission and subsequent treatment is a complex activity. It entails balancing the needs and priorities of the patient and the Trust against the available resources of theatre time and staffed beds.
- 6.12.2 The Booking Principles outlined in Section 1.7 should underpin the development of booking systems to ensure a system of management and monitoring that is chronologically as opposed to statistically based.
- 6.12.3 It is expected that Trusts will work towards reducing the number of prioritisation categories to urgent and routine.

6.13 PRE-OPERATIVE ASSESSMENT

- 6.13.1 All patients undergoing an elective procedure (including endoscopy procedures) must undergo a pre-operative assessment. This can be provided using a variety of methods including telephone, postal or face to face assessment. Please refer to the Design and Deliver Guide 2007 for further reference.
- 6.13.2 Pre operative assessment will include an anaesthetic assessment. It will be the responsibility of the pre-operative assessment team, in accordance with protocols developed by surgeons and anaesthetists, to authorise fitness for surgery.
- 6.13.3 If a patient is unfit for their operation, their date will be cancelled and decision taken as to the appropriate next action.
- 6.13.4 Only those patients that are deemed fit for surgery may be offered a firm TCI date.
- 6.13.5 Pre-operative services should be supported by a robust booking system.

6.14 PATIENTS WHO DNE THEIR PRE OPERATIVE ASSESSMENT

6.14.1 Please refer to the guidance outlined in the Outpatient section.

6.15 VALIDATION OF WAITING LISTS

6.15.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a monthly basis, and ideally on a weekly basis as waiting times reduce. This is essential to ensure the efficiency of the elective pathway at all times.

6.15.2 As booking processes are implemented and waiting times reduce, there will no longer be the need to validate patients by letter. For patients in specialties that are not yet booked, they will be contacted to establish whether they will still require their admission.

6.15.3 Involvement of clinicians in the validation process is essential to ensure that waiting lists are robust from a clinical perspective. Trusts should ensure an ongoing process of clinical validation and audit is in place.

6.16 PATIENTS LISTED FOR MORE THAN ONE PROCEDURE

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

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

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

6.17 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

- 6.17.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between hospitals or to Independent Sector Providers. Transfers should not be a feature of an effective scheduled system.
- 6.17.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant. Administrative speed and good communication are very important to ensure this process runs smoothly. The Implementation Procedure and Technical Guidance for Handling Inpatient Transfers can be found in **Appendix 15b**.

INTEGRATED ELECTIVE ACCESS PROTOCOL

DRAFT

June 2020

Integrated Elective Access Protocol

Protocol Summary -

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

Version	2.0 This guidance replaces the Integrated Elective Access Protocol, 30 th April 2008.
Status	Draft for approval
Date	30 June 2020

Integrated Elective Access Protocol**Version**

Version	Date of issue	Summary of change	Author
1.0	25 August 2006	New Regional Guidance: Integrated Elective Access Protocol	M Irvine M Wright S Greenwood
2.0	30 April 2008	Protocol refresh to encompass guidance on all aspects of the elective care pathway	M. Irvine, M. Wright, R. Hullat
3.0		Update and relaunch IEAP to provide updated regional guidance on administration of patients on elective care pathways.	L. Mc Laughlin, Regional IEAP Review Group.

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Integrated Elective Access Protocol**Document control**

The current and approved version of this document can be found on the Department of Health website <https://www.health-ni.gov.uk> and on the Health and Social Care Board and Trusts intranet sites.

Document:	Integrated Elective Access Protocol 3.0
Department:	Department of Health
Purpose:	To advise and inform patients and clinical, administrative and managerial staff of the approved processes for managing patients access to outpatient, diagnostic, elective and elective Allied Health Professional (AHP) services.
For use by:	All clinical, administrative and managerial staff who are responsible for managing referrals, appointments and elective admissions.
This document is compliant with:	Northern Ireland Health and Social Care (NI HSCC) and Department of Health (DOH) Information Standards and Guidance and Systems Technical Guidance. https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Home.aspx
Screened by:	
Issue date:	
Approval by:	
Approval date:	
Distribution:	Trust Chief Executives, Directors of Planning and Performance, Directors of Acute Care, Department of Health.
Review date:	1 April 2021

Monitoring compliance with protocol

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

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Abbreviations

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

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 1

CONTEXT

DRAFT

1.1 INTRODUCTION

- 1.1.1 This protocol has been developed to define the roles and responsibilities of all those involved in the elective care pathway and to outline good practice to assist staff with the effective management of outpatient appointments, diagnostic, elective admissions and allied health professional (AHP) bookings, including cancer pathways and waiting list management.
- 1.1.2 The length of time a patient needs to wait for elective treatment is an important quality issue and is a visible public indicator of the efficiency of the hospital and AHP services provided by the Trust. The successful management of patients who wait for outpatient assessments, diagnostic investigations, elective inpatient or daycase treatment and AHP services is the responsibility of a number of key individuals within the organisation. General Practitioners (GPs), commissioners, hospital medical staff, allied health professionals, managers and clerical staff have an important role in ensuring access for patients in line with maximum waiting time targets as defined in the Department of Health (DOH) Commissioning Plan Direction (CPD) and good clinical practice, managing waiting lists effectively, treating patients and delivering a high quality, efficient and responsive service. Ensuring prompt timely and accurate communication with patients is a core responsibility of the hospital and the wider local health community.
- 1.1.3 The purpose of this protocol is to outline the approved processes for managing referrals to outpatient clinics, diagnostic procedures, elective procedures and operations and AHP booking procedures, through to discharge, to allow consistent and fair care and treatment for all patients.
- 1.1.4 The overall aim of the protocol is to ensure patients are treated in a timely and effective manner, specifically to:
- Ensure that patients receive treatment according to their clinical priority, with routine patients and those with the same clinical priority treated in chronological order, thereby minimising the time a patient spends on the waiting list and improving the quality of the patient experience.

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

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

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

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

1.2 METHODOLOGY

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

- 1.2.2 In this context, this protocol has been prepared to provide clarity of purpose within Trusts with a view to merging seamlessly with the policies of other agencies in the wider health community as they emerge.
- 1.2.3 This protocol has been prepared to clarify Trusts' medium and long-term objectives, set the context in which they will be delivered and establish the parameters within which staff at divisional, specialty and departmental levels will operate.
- 1.2.4 For the purposes of this protocol, the term;
- outpatient refers to a patient who has a clinical consultation. This may be face to face or virtual,
 - elective admissions refer to inpatient and daycase admissions,
 - inpatient refers to inpatient and daycase elective treatment,
 - diagnostic refers to patients who attend for a scan / test or investigation,
 - AHP refers to allied health professionals who work with people to help them protect and improve their health and well-being. There are thirteen professions recognised as allied health professions in Northern Ireland (NI),
 - partial booking refers to the process whereby a patient has an opportunity to agree the date and time of their appointment,
 - fixed booking refers to processes where the patient's appointment is made by the Trust booking office and the patient does not have the opportunity to agree/confirm the date and time of their appointment,
 - virtual appointment refers to any appointment that does not involve the physical presence of a patient at a clinic, (see also 1.5 Virtual Activity).
 - PAS refers to all electronic patient administration systems, including PARIS, whether in a hospital or community setting and those used in diagnostic departments such as NIPACS and systems used for other diagnostics / physiological investigations.

- 1.2.5 Trusts must maintain robust information systems to support the delivery of patient care through their clinical pathway. Robust data quality is essential to ensure accurate and reliable data is held, to support the production of timely operational and management information and to facilitate clinical and clerical training. All patient information should be recorded and held on an electronic system (PAS). Manual patient information systems should not be maintained.
- 1.2.6 All staff involved in the administration of waiting lists will ensure that Trusts' policies and procedures with respect to data collection and entry are strictly adhered to. This is to ensure the accuracy and reliability of data held on electronic hospital/patient administration systems and the waiting times for treatment.
- 1.2.7 Trusts should provide training programmes for staff which include all aspects of this Integrated Elective Access Protocol (IEAP). It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts. Trusts will provide appropriate information to staff so they can make informed decisions when delivering and monitoring this protocol. All staff involved in the administration of waiting lists will be expected to read and sign off this protocol.
- 1.2.8 This protocol will be available to all staff via Trusts' Intranet.

1.3 UNDERPINNING PRINCIPLES

- 1.3.1 Patients will be treated on the basis of their clinical urgency with urgent patients seen and treated first. The definition of clinical urgency will be defined and agreed at specialty / procedure / service level.
- 1.3.2 Patients with the same clinical need will be treated in chronological order on grounds of fairness, and to minimise the waiting time for all patients.

- 1.3.3 As part of a plan for the implementation of booking, Trusts must ensure their elective admission selection system is managed on a chronological basis within clinical priority.
- 1.3.4 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to add the patient to the waiting list, i.e. the patient must be “fit, ready, and able” to come in (TCI).
- 1.3.5 Trusts should design processes to ensure that inpatient care is the exception for the majority of elective procedures and that daycase is promoted. The principle is about moving care to the most appropriate setting, based on clinical judgement. This means moving daycase surgery to outpatient care and outpatient care to primary care or alternative clinical models where appropriate.
- 1.3.6 Referrals into Trusts should be pooled where possible as the norm within specialties.
- 1.3.7 Trusts will maintain and promote electronic booking systems aimed at making hospital appointments more convenient for patients. Trusts should move away from fixed appointments to partially booked appointments.
- 1.3.8 Trusts should also promote direct access services where patients are directly referred from primary and community care to the direct access service for both assessment and treatment. Direct access arrangements must be supported by clearly agreed clinical pathways and referral guidance, jointly developed by primary and secondary care.
- 1.3.9 For the purposes of booking/arranging appointments, all patient information should be recorded and held on an electronic system. Trusts should not use manual administration systems to record and report patient's information.
- 1.3.10 In all aspects of the booking processes, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language**. It is essential that patients who are considered at risk for whatever reason have their needs identified

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

Have we anything in place for 1.3.10

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

1.3.12 Trusts must ensure that the needs of ethnic groups and people with special requirements should be considered at all stages of the patient's pathway.

1.4 BOOKING PRINCIPLES

1.4.1 These booking principles will support all areas across the elective and AHP pathways where appointment systems are used.

1.4.2 Offering the patient choice of date and time where possible is essential in agreeing and booking appointments with patients through partial booking systems. Trusts should ensure booking systems enable patients to choose and agree hospital appointments that are convenient for them.

1.4.3 Facilitating reasonable offers to patients should be seen within the context of robust booking systems being in place.

1.4.4 All booking principles should be underpinned with the relevant local policies to provide clarity to operational staff.

1.4.5 Trusts should ensure booking processes are continually reviewed and updated as required to reflect local and regional requirements at an operational level.

1.4.6 The definition of a booked appointment is:

- a) The patient is given the choice of when to attend or have a virtual appointment.
- b) The patient is able to choose and confirm their appointment within the timeframe relevant to the clinical urgency of their appointment.
- c) The range of dates available to a patient may reduce if they need to be seen quickly, e.g. urgent referrals or within two weeks if cancer is suspected.
- d) The patient may choose to agree a date outside the range of dates offered or defer their decision until later.

1.4.7 Principles for booking Cancer Pathway patients:

- a) All suspected cancer referrals should be booked in line with the agreed clinical pathway requirement for the patient and a maximum of 14 days from the receipt of referral.
- b) Dedicated registration functions for red flag (suspect cancer) referrals should be in place within centralised booking teams.
- c) Clinical teams must ensure triage, where required, is undertaken daily, irrespective of leave, in order to initiate booking patients.
- d) Patients will be contacted by telephone twice (morning and afternoon).
- e) If telephone contact cannot be made, a fixed appointment will be issued to the patient within a maximum of three days of receipt of referral.
- f) Systems should be established to ensure the Patient Tracker / Multidisciplinary Team (MDT) Co-coordinator is notified of the suspected cancer patient referral, to allow them to commence prospective tracking of the patient.

1.4.8 Principles for booking Urgent Pathway patients:

- a) Maximum waiting times for urgent patients should be agreed locally with clinicians and/or service managers and made explicit, through internal processes, to booking office staff.
- b) Referrals will be received, registered within one working day and forwarded to consultants for prioritisation.

- c) If clinical priority is not received from consultants within 72 hours, processes should be in place to initiate booking of urgent patients according to the referrers's classification of urgency.
- d) Patients will be issued with a letter inviting them to contact the Trust to agree and confirm their appointment in line with the urgent booking process.
- e) In exceptional cases, some patients will require to be appointed to the next available slot. A robust process for telephone booking these patients should be developed which should be clearly auditable.

1.4.9 Principles for booking Routine Pathway patients:

- a) Patients should be booked to ensure appointment (including virtual appointment) is within the maximum waiting time guarantees for routine appointments.
- b) Referrals will be received, registered within one working day at booking teams and forwarded to consultants for prioritisation.
- c) Approximately eight weeks prior to appointment, Trusts should calculate prospective slot capacity and immediately implement escalation policy where capacity gaps are identified.
Rotas are not normally available 8 weeks out (annual leave/study leave notification period is 6 weeks. What escalation policy is being followed and where are the capacity gaps being escalated to? If this is an already known and accepted capacity gap, eg, through discussions with HSCB, vacant posts, do we always have to escalate?
- d) Patients should be selected for booking in chronological order from the Primary Targeting List (PTL).
- e) Six weeks prior to appointment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment.

1.4.10 Principles for Booking Review Patients;

- a) Patients who need to be reviewed within 6 weeks will agree their appointment (including virtual appointment) before they leave the clinic, where possible.

- b) Patients who require a review appointment more than 6 weeks in advance will be added to and managed on a review waiting list.
- c) Patients will be added to the review waiting list with a clearly indicated date of treatment and selected for booking according to this date.
- d) Six weeks prior to the indicative date of treatment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment within a clinically agreed window either side of the indicative date of treatment.

1.4.11 It is recognised that some groups of patients may require booking processes that have additional steps in the pathway. These should be designed around the principles outlined to ensure choice and certainty as well as reflecting the individual requirements necessary to support their particular patient journey.

Is there any provision to change date required if patient does not accept reasonable offer?

1.5 VIRTUAL ACTIVITY

1.5.1 Virtual Activity relates to any planned contact by the Trust with a patient (or their proxy) for healthcare delivery purposes i.e. clinical consultation, advice, review and treatment planning. It may be in the form of a telephone contact, video link, telemedicine or telecommunication, e.g. email.

1.5.2 The contact is in lieu of a face-to-face contact of a patient/client, i.e. a face-to-face contact would have been necessary if the telephone/video link/etc. had not taken place.

1.5.3 The call/contact should be prearranged with the patient and /or their proxy. Patients should not be disadvantaged where a decision is made to assess their clinical need through the use of virtual clinics.

Not all patient contact is pre-arranged, there has been a number of virtual clinics following validation when contact is made with the patient at the point of validation and a decision/treatment plan agreed.

- 1.5.4 The contact must be auditable with a written note detailing the date and substance of the contact is made following the consultation and retained in the patient's records.

1.6 COMPLIANCE WITH LEAVE PROTOCOL

- 1.6.1 It is essential that planned medical and other clinical staff leave or absence is organised in line with an agreed Trust Human Resources (HR) protocol. Thus it is necessary for Trusts to have robust local HR policies and procedures in place that minimise the cancellation/reduction of outpatient clinics and the work associated with the rebooking of appointments.
- 1.6.2 There should be clear medical and clinical agreement and commitment to this HR policy. Where cancelling and rebooking is unavoidable the procedures used must be equitable, efficient, comply with clinical governance principles and ensure that maximum waiting times for patients are not compromised.
- 1.6.3 The protocol should require a minimum of six weeks' notification of intended leave, in line with locally agreed HR policies, in order to facilitate Trusts booking teams to manage appointment processes six weeks in advance.
- 1.6.4 The booking team should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

1.7 VALIDATION

- 1.7.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a monthly basis. This is essential to ensure the efficiency of the elective pathway at all times. In addition, Trusts should ensure that waiting lists are regularly validated to ensure that only those patients who want or still require a procedure are on the waiting list.

- 1.7.2 Involvement of clinicians in the validation process is essential to ensure that waiting lists are robust from a clinical perspective. Trusts should ensure an ongoing process of clinical validation and audit is in place.

Have we anything set up for the ongoing clinical validation

DRAFT

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 2

**GUIDANCE FOR MANAGEMENT OF OUTPATIENT
SERVICES**

DRAFT