

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

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5.1 INTRODUCTION

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

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

5.2 KEY PRINCIPLES

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

1. urgent and
2. routine.

No other clinical priorities should be used for AHP services.

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

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

5.3 NEW REFERRALS

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

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

5.4 CALCULATION OF THE WAITING TIME

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

5.5 REASONABLE OFFERS

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

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

5.6 REVIEW APPOINTMENTS

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

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

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

5.7.1 DNAs – New AHP Appointments

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

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

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

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

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

5.7.2 DNAs – Review Appointments

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

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

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

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

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

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

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

5.9 CLINIC OUTCOME MANAGEMENT

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

5.10 CLINIC TEMPLATE CHANGES

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

5.11 TRANSFERS BETWEEN TRUSTS or to INDEPENDENT SECTOR

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

5.12 TECHNICAL GUIDANCE

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

Administrative & Clerical Standard Operating Procedure

No:

| | | |
|-----------------------------------|---|--------------------|
| TITLE | Procedures for Referral & Booking Centre | |
| S.O.P. | | |
| Version Number | 1.0 | Supersedes: |
| Author | Katherine Robinson, Helen Forde, Marie Loughran/Leeanne Browne | |
| Page Count | 11 | |
| Date of implementation | 1.1.10 | |
| Date of Review | 1.1.12 | |
| Approved by | A&C Implementation Group | |

Standard Operating Procedure (S.O.P) Referral and Booking Centre Procedures

Introduction

This SOP outlines the procedures followed by the Referral and Booking Centre from initial receipt of referral letters to booking the appointment.

It also highlights the procedures which need to be followed should a clinic need to be cancelled or reduced.

Implementation

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

Referral Letters

There are 3 deliveries of post to the post room each day

Morning
Lunchtime
Afternoon

Post room staff open the post and sort.

Electronic Referrals

There are referrals now coming from some GP practices electronically. These are currently opened in the post room and printed. Red flag referrals are redirected to the Mandeville Unit/DHH. This project is in initial stages.

New Referrals

Date stamp the letter with the current date.

The post is then sorted out into the relevant teams and left in the appropriate trays in the RBC. Each team within the Booking Centre has responsibility for booking certain specialties.

If there are any discrepancies or queries with hospital numbers these referral letters should be placed in the registration tray in the RBC for registering on PAS. Hospital numbers should always be written in Red on the top right hand corner of the referral.

Triaged Referrals

Referrals received back following triage should be sorted into team specialties and put in appropriate trays for Add to Waiting List in RBC, **with the exception of Urology letters which are handed to directly to that team.**

ORE'ing

Priority is given to ORE'ing the referral letters – all members of the team ORE and the supervisor will monitor the flow. Referral letters should be ore'd within 24 hrs. The function set required is DWA – ORE.

You are required to ORE in site related to referral e.g, STH address has to be ORE'd in STH site. Relevant hospital number related to site is also required. All referrals are to be ORE'd to GP Specification, i.e. Urgent – GPU, priority type 2.

Creating an Episode

The function on PAS to be used when creating an episode is ORE. You will need to know which consultant code/speciality code to use – each team has a table of instructions which contains information relating to the codes and any special instructions, eg optician. You will need to check this each time you create an episode until you become familiar with the consultant's requirements.

When you have recorded the patient on PAS you then need to send the referral letters up to the consultant for triage (grading of the letter into routine / urgent).

For most specialities in Daisy Hill Hospital (DHH), South Tyrone Hospital (STH) and Armagh Community Hospital (ACH) referral letters are scanned and e-mailed to relevant secretaries for triage. In CAH referral letters are sent by post or delivered by hand.

Letters returned from Triage

When the letter is returned from the consultant they are ready to be added to the Waiting List. Each team is responsible for their own specialities. Check if:

- Priority has been changed, eg from urgent to routine
- The patient has been assigned to a named consultant in same speciality – previously an unnamed referral

Changes like this will mean you have to go into PAS and amend the OP REG using the function RBA which will allow you to make the amendments and also add to W/L) ensuring the correct hospital number.

To add to the Waiting List if there are no amendments to the OP REG – use the function OWL select your OP REG and then get the Waiting List code from the table of instructions and add in. Also add in additional details to the Procedure Field such as Bowels, Gastro, x-ray needed.

During this updating of PAS you must check to ensure that the date of the OP REG is the same as the date stamp on the letter and the same as the date on list on PAS.

For Dermatology ICATS and Urology ICATS the original episode needs discharged on PAS – function OD with reason code CICT. Referral is then re-ored using relevant ICATS specification.

Selecting from Waiting List

Each month there is a “big select”. Before you do your “big select” you will need to:

- Check the front of the Select file for guidance/clinic instructions
- Check the back of the file to see what instructions are recorded on the calendar – if clinics are to be cancelled or reduced check PAS to make sure that this has been done
- Phone the consultant’s secretary to double check all holidays/reduced clinics are correct, and that there are no changes to the information
- Check that the cancelled clinic details are recorded on the cancelled clinic spreadsheet

To determine how many slots you have for NR (New Routine) patients use the function CBK and look at each individual clinic and see how many NR slots there are for the time period you are working on and this will let you know the number of patients you can send for.

The same procedure above applies for NU (New Urgent) and R (review) patients.

You’re now ready to select your patients so using SWO select the appropriate number of patients and on PAS record in the comment field:

- PB1,
- the date it was sent (today’s date) and
- the code of the clinic that the patient is to be booked to, and the consultant or clinician code if appropriate eg Ortho Icats and Paeds staff grade clinics.
- the month they have to be booked into.

Patients must be selected in chronological order – your SWO screen and your PTL will guide you with this.

Only one person per speciality will work on the selection at a time to avoid duplication.

When you have completed your select you must then record the patient details etc on the **SELECT SHEET** You should also remove all the referral letters that you’ve selected and keep them with this list at the front of the select file.

In two weeks’ time when you’re checking to see who needs to have a PB2 sent you can use this check together with SWO to ensure that all patients have been actioned. You may also check function EPI to see if patients have responded to their PB1 letter.

When sending out the PB2 letters remember to update the comment field with your appropriate PB2 code, today’s date, the clinic code/consultant code if appropriate to be booked into, and also the month the patient is to be seen in.

PB1 letter sent – if no response within 14 days from the date in the comment field the PB2 letter is sent. PB2 letter is sent – if no response within 7 days from the date in the comment field the patient is discharged and a letter sent to the patient and the GP.

Discharging a Patient

Before you can discharge a patient on PAS you must do a check on their address – phone their GP to confirm address. If this is different from what is recorded on PAS then you must get in contact with the patient to offer them an appointment – this is usually done by telephoning the patient. If no contact can be made by telephone then the PB1 will be re-issued to the correct address.

If the address is correct then you can discharge the patient, issue a letter to the patient and to the GP, and forward the referral letter to the consultant. There are however exceptions where you need to email the secretary details of the non-responders and forward the referral letter.

Children – you cannot discharge a child (child = under 17 years and 364 days old). Fill in “Under 18’s O/P Discharge” form and forward to the consultant with the referral letter. They must inform you of the follow up action, eg discharge, send for again.

Primary Target Lists (PTL’s)

Every Monday you will get a new PTL (can be requested more frequently if required). When you get your PTL you will need to:

Look for any blanks (ie patient episodes where the W/L code is not entered)
Are there any episodes where a PB2 is now required
Are there any PB2’s that now need to be closed
Check, using CBK and SWO, if there is capacity in any of your clinics
Check, using CBK and SWO, if there is a shortfall in any of your clinics

Diary

Each team has a diary which is used as a checking mechanism. The diary is date stamped with the following headings and also includes the codes of the clinics that are held on that day:

Completed Clinic
PB1
PB2
PBG

Example

Today's date is Tuesday 19th April – the diary entry will look like this:

| | | |
|-------------------------|-----------------|-------------------------------|
| Completed Clinic | 26/04/11 | (this is one week in advance) |
| PB1 | 31/05/11 | (this is 6 weeks in advance) |
| PB2 | 05/04/11 | (this is 2 weeks previously) |
| PBG | 29/03/11 | (this is 3 weeks previously) |

Completed Clinic

Today is the 19th April, so you want to check the clinics held on the 26th April to make sure they are all fully booked. The clinic codes are all on this page for reference.

PB1

Today you want to send out your PB1 letters for the clinics that are 6 weeks away – so you will be checking the clinics on the 31st May to check their capacity and then selecting your patients to send. The clinic codes are all on this page for reference.

PB2

Today you want to check who needs a PB2 letter sent – so you want to check the clinics that are held on a Friday that have had a PB1 sent on the 05/04/11 and that haven't responded, as they now require the PB2 letter. Use both the list at the front of the select file and also the function SWO.

PBDG

Today you want to check who has received a PB2 letter on the 29/03/11 and who have not responded – use the list at the front of the select file and also the function SWO. These patients now need discharged on PAS (except if they are a child).

Booking an appointment

When a patient phones up to make their appointment having received their letters you use function BWL.

You have to remember here:

- Breach Codes – being aware of target dates i.e. 9/17/21/26/41 weeks
- Letter codes – remember to use the relevant letter codes depending on the clinic, this gives information to patients what to expect at the clinic.
- Letter options i.e. U6/DB/VA

You may also have to use function RBA if the patient has come of an unnamed list, the consultant will have to be changed from unnamed to named. You have to ensure that when using RBA that you use the correct hospital number for the appointment.

Resetting

If a patient has an appointment for the 2nd July and phones up on the 23rd June to cancel the appointment then the date that they are reset on the PTL will be 23/6/09 – in other words PAS will always take the reset from the date the appointment was cancelled, not the date of the clinic. Their new date will be calculated to 23/6/09 by the PTL. Do not ever change the date on list for New Patients EXCEPT SFA following NRPB – no response to Partial Booking.

Cancelling a clinic

You may only cancel a clinic if you are in receipt of an e-mail containing a cancel clinic proforma from the consultant or their secretary giving the details of the clinic to be cancelled and confirming that you should now proceed and cancel same.

If the clinic is to be within 6 weeks then clearance is required from the heads of service before any action can be taken.

If the clinic is 6 weeks or beyond then clearance is not required and relevant action can be taken.

Some clinics are set up on PAS to build well into the future (on screen) while others are set up to build a few weeks into the future (not on screen).

Do a CBK, enter in clinic code and check if this date is built on PAS. At this stage make a note of the number of NU, NR, RF, REV slots on the clinic as you will need to record this information on a spreadsheet*.

Built on PAS

Function Set = ODM and Function = CCL (cancelled clinic)

Enter in clinic code and date of clinic to be cancelled.

If there are patients booked onto this clinic a Rebook List will be automatically produced. It is best practice to phone the patients on the Rebook List and cancel the appointment, giving them a new appointment if possible.

If you do not have capacity to rebook the patients into the correct month then this should be escalated to your supervisor/referral and booking centre manager.

- Now go to the cancelled clinic *spreadsheet and fill in the clinic details including the number of slots cancelled by category.
- Record the cancelled clinic details on the calendar at the back of the Select File.
- Record the cancelled clinic details in the diary.
- File the e-mail in the cancelled clinics team folder.

Not Yet Built on PAS

If the date of the clinic you have to cancel is not built on PAS then you need to:

- Record the information on the calendar at the back of the Select File
- Record the information in the diary
- File the e-mail in the cancelled clinic team folder

Reducing a Clinic

You may only reduce a clinic if you are in receipt of an e-mail containing a proforma to reduce the relevant clinic from the consultant or their secretary giving the details of the clinic to be reduced and confirming that you should now proceed and reduce same.

If the clinic is to be within 6 weeks then clearance is required from the heads of service before any action can be taken.

If the clinic is 6 weeks or beyond then clearance is not required and relevant action can be taken.

CBK – get details of the timeslots as you need to record the reduced clinic details on the cancelled clinic spreadsheet.

Some clinics are manned by one doctor while other clinics are manned by several doctors, some occur once a week, and some once a day. Therefore you need to know your clinic set up so when you get confirmation that a clinic is to be reduced you need to check:

Follow relevant instructions per consultant template.

- How many doctors are at this clinic?
- How many patients would need cancelled?
- What types of appointments should be cancelled – eg NR or Rev?

To reduce the clinic use the function TBO – this will allow you to view the clinic and see what the timeslots are and how they are set up, eg every 10 minutes, with 2 NR and 1 Rev at each timeslot.

Example of a clinic set up (using only NR and Rev as the categories)

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

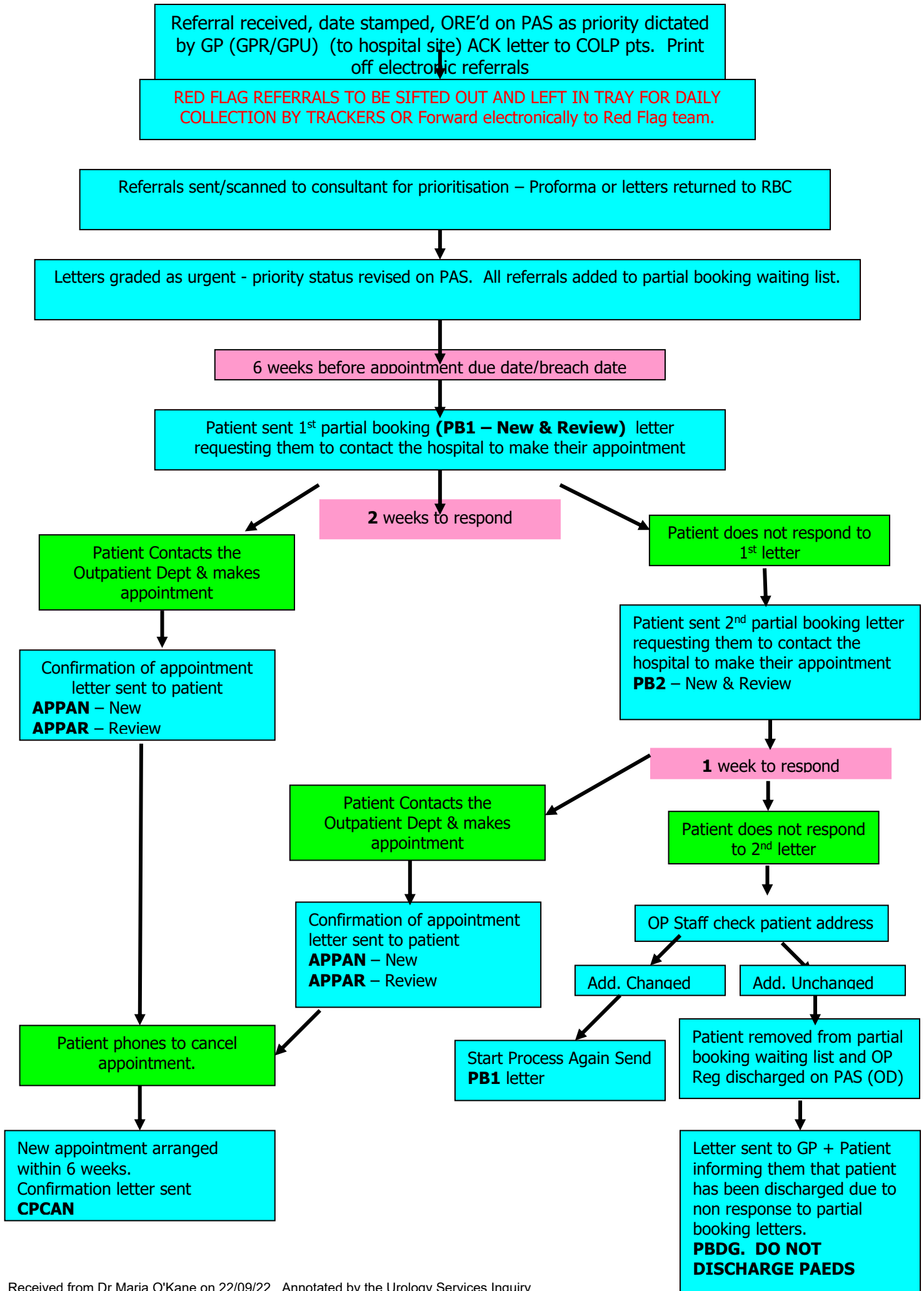
If you were asked to reduce this clinic by 4 NR and 3 R as there will be one doctor on leave from the clinic then you need to make sure that the reductions

you make still ensure patient flow, ie you don't have all the reductions at the start of the clinic, leaving the 2 remaining doctors with no patients at 9 am. The reductions should be spread throughout the clinic. It's also important to consider the category of the patient, ie a doctor can generally see a review patient in a shorter time than a new patient.
Function set required is ODM – MS

Remember not to take away new patients from the start of an afternoon clinic to allow for ambulance patients.

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

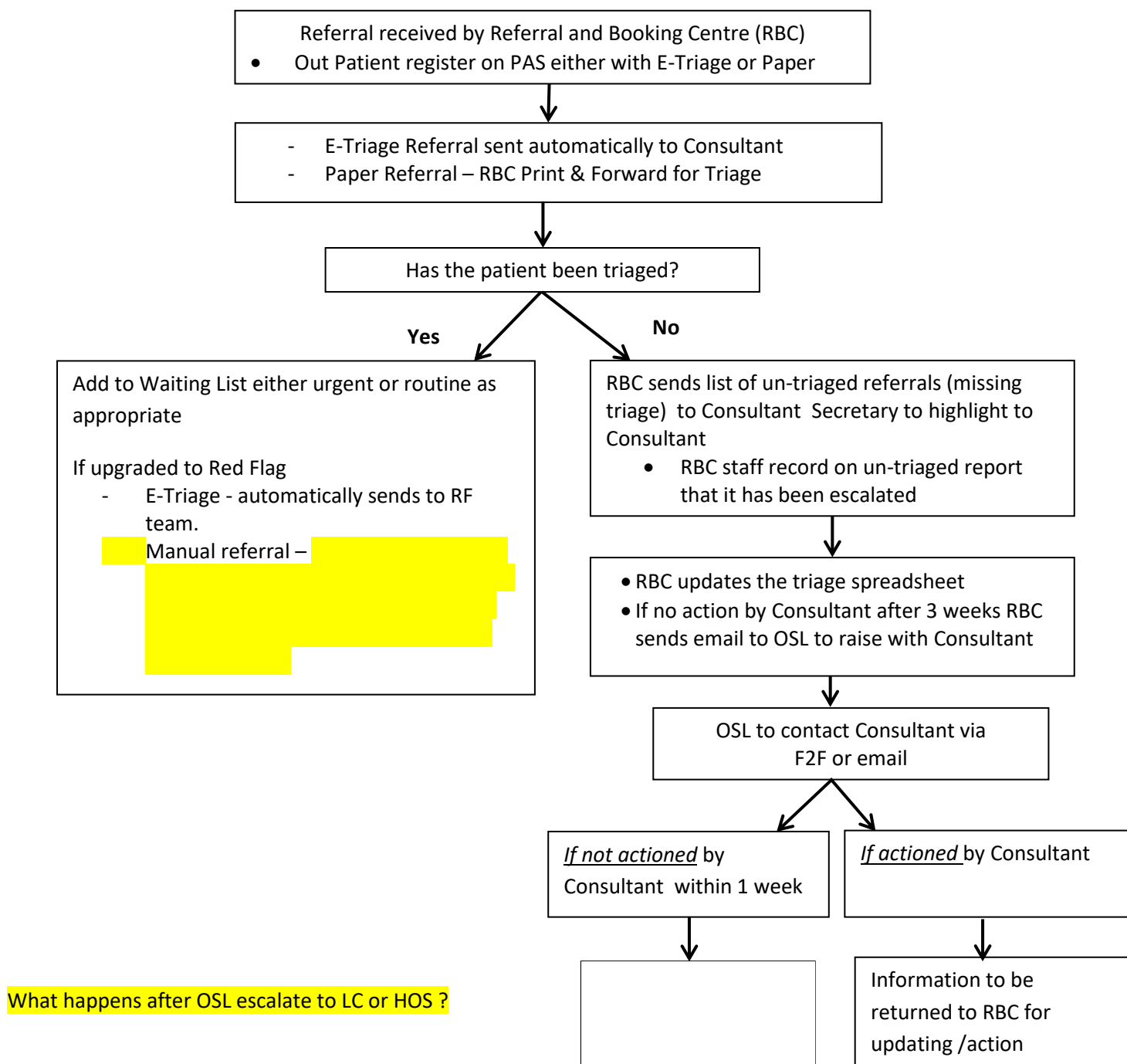
PARTIAL BOOKING ROUTINE APPOINTMENTS – RBC



- Red Flag referrals should be returned from Triage within 24hrs
- Urgent referrals should be returned from Triage within 72hrs
- Routine referrals should be returned from Triage within week.

PURPOSE OF TRIAGE

- Consultant triage is to confirm that the speciality is appropriate and the clinical urgency is appropriate.
- It also serves a purpose to direct the referral to an appropriate service within the speciality (e.g. to vascular surgeons etc.)
- It allows the Consultant to request any investigations which the patient will require prior to outpatient attendance
- The Consultant can return referrals with advice and no outpatient attendance where appropriate.



What happens after OSL escalate to LC or HOS ?

Please Note: This process will incur a minimum of 7 weeks in total if referral is un-triaged within the target times which means that if the referral is upgraded to Red Flag it is in excess of 14 day Red Flag turnaround.

It is the responsibility of the Consultant to ensure Triage is done within the appropriate timescales detailed above



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 the 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 | |

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| 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? | | |

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| | |
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- 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

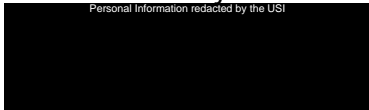
I ask that as well as taking appropriate clinical follow up actions regarding any of the above that you pass the details of the same to Martina Corrigan, Head of Service to ensure we can use this information to direct our patient safety reviews moving forward.

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 the USI



DR MARIA O'KANE
MEDICAL DIRECTOR

Montgomery, Ruth

From: Wallace, Stephen
Sent: 27 January 2021 20:55
To: O'Neill, Michael (DoH) (Personal Information redacted by the USI); paul.cavanagh (Personal Information redacted by the USI)
Cc: OKane, Maria; Haynes, Mark; Corrigan, Martina; McClements, Melanie; Carroll, Ronan; Gormley, Damian
Subject: Urology Patient Review Form
Attachments: Proforma for patient lists.docx

Follow Up Flag: Follow up
Flag Status: Flagged

Michael / Paul,

Please find attached a proforma developed by the Trust taking into account the 6 questions identified to be asked regarding the care provided by Mr O'Brien from patients undergoing review who were previously under his care. The purpose of this form is to standardise the format and information collected as a supplementary note to the patient clinical record.

Grateful if you can provide any comments, we intend to commence using this form from Monday.

Thanks
Stephen

Stephen Wallace
Interim Assistant Director of Clinical and Social Care Governance
Mob: (Personal Information redacted by the USI)

UROLOGY PATIENT REVIEW FORM

Patient Details

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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? | | |
| Was 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 | |

Wallace, Stephen

Sent: 02 February 2021 11:51
To: O'Neill, Michael (DoH); paul.cavanagh [Personal Information redacted by the USI]
Subject: RE: Urology Patient Review Form

Thanks Michael, we have spoken to Mark Harvey re this - just checking if you had any comments re the form.

Stephen

From: O'Neill, Michael (DoH) [Personal Information redacted by the USI]
Sent: 27 January 2021 22:19
To: Wallace, Stephen; paul.cavanagh [Personal Information redacted by the USI]
Cc: OKane, Maria; Haynes, Mark; Corrigan, Martina; McClements, Melanie; Carroll, Ronan; Bovill, AnneMarie; Gormley, Damian; Johnston, Jackie (DoH)
Subject: RE: Urology Patient Review Form

Stephen – thanks for this. It would be worth engaging too with Mark Harvey in DLS who is taking forward the Neurology related litigation claims on behalf of BHSCT.

He will likely have views on the extent of info available to him and colleagues following the BHSCT recalls. Clinical colleagues in BHSCT may have lessons learned from the process too.

Will return to you with DOH comments asap.

M.

Michael O'Neill

General Healthcare Policy | Department of Health

Contact: [Personal Information redacted by the USI] | **Tel:** [Personal Information redacted by the USI] | **DD:** [Personal Information redacted by the USI]

From: Wallace, Stephen <[Personal Information redacted by the USI]>
Sent: 27 January 2021 20:55
To: O'Neill, Michael (DoH) <[Personal Information redacted by the USI]>; paul.cavanagh [Personal Information redacted by the USI]
Cc: OKane, Maria <[Personal Information redacted by the USI]>; Haynes, Mark <[Personal Information redacted by the USI]>;
Corrigan, Martina <Martina.Corrigan [Personal Information redacted by the USI]>
<[Personal Information redacted by the USI]>; Carroll, Ronan <[Personal Information redacted by the USI]>;
Gormley, Damian <[Personal Information redacted by the USI]>
Subject: Urology Patient Review Form

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Stephen Wallace
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Mob: Personal Information redacted by the USI

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Urology Oversight Group Minutes

Wednesday 3rd February 2020, 5:00pm

Via Zoom

| | Item | Actions |
|--------------------------------------|--|---|
| | In Attendance Stephen Wallace Melanie McClements Martina Corrigan Dr Maria O’Kane Vivienne Toal Ronan Carroll Patricia Kingsnorth | |
| 1 | Apologies Melanie McClements | |
| 2 | Minutes Minutes of the 8 th December were agreed | |
| Management of Patient Reviews | | |
| 3 | Private Practice Private practice – no update. BSO internal audit are progressing with their audit of private practice work. All patients identified to date have been reviewed. | |
| 4 | Update on Radiology and MDM Review Prof Sethia is ready to commence work pending finalization of review proforma this week. | |
| 6 | IPT for Review Process IPT has been finalized, the high level cost is being brought to SMT for review in the next two weeks. Cost will be carried by the Trust for 2020/21 | |
| 7 | Additional Subject Matter Expertise BAUN have made contact regarding nursing expertise. Ronan Carroll and Mr. Haynes and Martina to progress. Martina Corrigan noted that some additional patients have been identified in a review backlog. Mr. Haynes is to speak to Mr. Keane to ask if he would be able to do additional clinics using the proforma. Martina to speak with Mr. Glackin to do a pilot of 10 charts using the proforma to see how much time it takes to do each patient as Mr Glackin may be able to support additional clinics. | Mark Haynes, Ronan Carroll and Martina Corrigan to contact to progress Martina Corrigan to speak with Mr Glackin |
| 8 | Royal College of Surgeons Engagement Stephen Wallace updated the group on the engagement with the RCS engagement and advised that a team had been selected. ToR to be agreed with the DoH on Friday then issued to the DoH. Group conscious of the need for administration support to collate the 100 records for the review team. | ToR to be agreed by DoH and issued to RCS Melanie McClements/ Ronan |

Corrigan to discuss admin support

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| 9 | Bicalutamide Patient Review Mr Haynes to share database with Martina Corrigan and to return completed audit form | Mr Haynes to return completed audit form |
| 10 | Engagement of ISP to undertake waiting list work Discussed under point 7 | |
| 11 | Information Telephone Line One caller to the Information line (2 nd time to contact the information line) and Martina Corrigan has passed to Mr Haynes for review. | Mr Haynes to advise on one recent contact to information line. |
| 12 | MDM Processes Stephen to work with Martina to process map MDM processes | Stephen and Martina to discuss and map MDM processes |
| Professional Governance | | |
| 12 | GMC Discussions Maria updated on the meeting with the GMC ELA on 20 th January, to update GMC as Designated Body. | |
| 13 | Litigation / DLS Update New case received today, part of an SAI. Dr O'Kane, Dr Gormley and Stephen to meet to discuss | Dr O'Kane, Gormley and Stephen to meet to discuss |
| 15 | Previous SAI / Complaints Agenda to consider previous SAI / complaints going forward | |
| 16 | Grievance Process Grievance panel being set up, response has been asked for from AOB however no response received to date. | |
| 18 | Administration Review Update Martina Corrigan updated on the admin review, progress is ongoing and an update will be provided next week. Dr O'Kane asked was there early learning regarding administrative processes, Patricia Kingsnorth agreed to discuss these themes with Dr Hughes. | Patricia to discuss themes with Dr Hughes |
| Serious Adverse Incident Reviews | | |
| 19 | Update on Current SAIs Patricia Kingsnorth updated on the SAI progress, and the Panel is working to end of February for completion of the 10 SAI's (9 individual and 1 overarching). Dr Hughes has agreed that the information should be sent that has been requested by AOB where appropriate. A meeting with DLS is arranged to discuss some elements of the questions that have returned by AOB. Patient with Penile cancer deceased on the the patient died in Personal Information redacted by the USI . | Dr O'Kane to speak to Dr Hughes |

| | | |
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| 22 | Family Liaison Role Fiona Sloan has been appointed to the role of acute liaison officer and will be taking up post at the end of February. | |
| Communications | | |
| 23 | Media / Assembly Questions No update this week | |
| Any Other Business | | |
| 24 | Coronial Processes For next meeting | |
| 25 | Letter to Staff re AOB Patient Reviews For next meeting | |
| 26 | Declaration re CURE Stephen advised some forms outstanding | Stephen to follow up on CURE declarations |
| 27 | Securing Records for Public Inquiry Stephen to speak to Bernie Owens. Claire Lundy re learning from BHSCT. | |
| Date of Next Meeting | | |
| 28 | Via Zoom – 10th February 2021 | |

Wallace, Stephen

From: Wallace, Stephen <[REDACTED]>
Sent: 08 February 2021 11:47
To: Corrigan, Martina
Cc: Haynes, Mark; OKane, Maria
Subject: UPDATED UROLOGY PATIENT REVIEW FORM
Attachments: UROLOGY PATIENT REVIEW FORM v1.docx

Hi Martina, I have updated the form based on comments from DLS and discussion with Ted.

Would you be able to share with Krishna for comment

Thanks
Stephen

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

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Appointment Details

| | |
|------------------------|--|
| Presenting Condition | |
| Summary of Appointment | |

Regarding the patients current care

| Question | Y/N | Details |
|--|-----|---------|
| Is the present diagnosis secure? | | |
| Is the current prescribed treatment appropriate? | | |
| Is a secure clinical management plan currently in place? | | |

While under Mr O'Briens care please answer the following to the best of your knowledge

| Question | Y/N | Details |
|--|-----|---------|
| Where appropriate and complete investigations carried out? | | |
| Was the prescribed treatment appropriate at the time? | | |
| Was the diagnosis secure? | | |
| Was the clinical management | | |



| | | |
|--|--|--|
| approach taken reasonable? | | |
| Was there unexplained delays with any aspect of care (reviews, prescribing, diagnostics etc) | | |
| Do you have reason to believe the problem lead to harm? | | |

Clinical Professional Reviewing Care

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

Corrigan, Martina

From: Corrigan, Martina <[REDACTED]>
Sent: 08 February 2021 20:20
To: krishna sethia
Subject: RE: UPDATED UROLOGY PATIENT REVIEW FORM
Attachments: Headings for review spreadsheets.xlsx; UROLOGY PATIENT REVIEW FORM v1.docx

Dear Professor Sethia

Just preparing the information for forwarding on to you and I was just checking which would be easier for you when completing?

- a. The review form for each patient
- b. A spreadsheet with the headings and an area for comment? (sample attached)

Either way is fine by me so happy with whichever you fine works best for you.

Kind regards

Martina

From: krishna sethia <[REDACTED]>
Sent: 08 February 2021 15:06
To: Corrigan, Martina
Subject: Re: UPDATED UROLOGY PATIENT REVIEW FORM

Dear Martina

Thank you

The form looks fine to me.

I will await your further instructions

Kind regards

Krishna

From: Corrigan, Martina <[REDACTED]>
Sent: 08 February 2021 12:52
To: kksethia <[REDACTED]>
Subject: FW: UPDATED UROLOGY PATIENT REVIEW FORM

Good afternoon Professor Sethia,

We are ready to start sending the data over for review and attached is the review form that has been shared and approved by our Department of Health colleagues/ Mark Haynes/ Ted McNaboe (Clinical Director for Urology) and our Department of Legal Services.

I have been asked now to share this with you to see if you have any final comments/additions and if happy I plan to add the questions to the data spreadsheet for you to start working through the patients.

My apologies again for the delay in getting this started and hoping that if you are happy with the form that we can start the review process.

Kind regards

Martina

From: Wallace, Stephen
Sent: 08 February 2021 11:47
To: Corrigan, Martina
Cc: Haynes, Mark; OKane, Maria
Subject: UPDATED UROLOGY PATIENT REVIEW FORM

Hi Martina, I have updated the form based on comments from DLS and discussion with Ted.

Would you be able to share with Krishna for comment

Thanks

Stephen

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Southern Health & Social Care Trust IT Department Personal Information redacted by the USI

| Demographic information | | | Regarding patient's current care | | | While under Mr O'Briens care please answer the following to the best of your knowledge | | | | | | |
|-------------------------|------|---------------|----------------------------------|--|--|--|--|---------------------------|--|---|--|----------|
| HCN | Name | Date of birth | Is the present diagnosis secure | is the current prescribed treatment appropriate? | Is a secure clinical management plan currently in place? | Where appropriate Investigations carried out? | Was the Prescribed treatment appropriate at the time/ is it appropriate now? | Was the Diagnosis secure? | Was the Clinical Management approach taken reasonable? | Was there unexplained delays with any aspect of care (reviews, prescribing, diagnostics etc)? | Do you have reason to believe the problem led to harm? | Comments |

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

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Appointment Details

| | |
|------------------------|--|
| Presenting Condition | |
| Summary of Appointment | |

Regarding the patients current care

| Question | Y/N | Details |
|--|-----|---------|
| Is the present diagnosis secure? | | |
| Is the current prescribed treatment appropriate? | | |
| Is a secure clinical management plan currently in place? | | |

While under Mr O'Briens care please answer the following to the best of your knowledge

| Question | Y/N | Details |
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| Where appropriate and complete investigations carried out? | | |
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| Was the diagnosis secure? | | |
| Was the clinical management | | |



| | | |
|--|--|--|
| approach taken reasonable? | | |
| Was there unexplained delays with any aspect of care (reviews, prescribing, diagnostics etc) | | |
| Do you have reason to believe the problem lead to harm? | | |

Clinical Professional Reviewing Care

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

Corrigan, Martina

From: Corrigan, Martina <[Personal Information redacted by the USI]>
Sent: 08 February 2021 15:34
To: krishna sethia
Subject: RE: UPDATED UROLOGY PATIENT REVIEW FORM

Much appreciated,

Good to get this started and I will be in touch within the next few days

Many thanks

Martina

From: krishna sethia [Personal Information redacted by the USI]
Sent: 08 February 2021 15:06
To: Corrigan, Martina
Subject: Re: UPDATED UROLOGY PATIENT REVIEW FORM

Dear Martina

Thank you

The form looks fine to me.

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Kind regards

Krishna

From: Corrigan, Martina <[Personal Information redacted by the USI]>
Sent: 08 February 2021 12:52
To: kksethia [Personal Information redacted by the USI] <kksethia [Personal Information redacted by the USI]>
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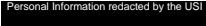
Thanks

Stephen

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Thanks
Stephen






Incident Oversight Group

Wednesday 10th February 2021, 17:00hrs

Via Zoom

AGENDA

| | | |
|---|---|---|
| | | |
| 1 | Apologies | |
| 2 | Minutes |  MINUTES - Incident Group 03.02.2021.dc |
| 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 |  UROLOGY PATIENT REVIEW FORM v4.do |
| 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 |  RE Subject Matter Expertise.msg |
| 8 | Royal College of Surgeons Engagement <ul style="list-style-type: none"> - Terms of Reference - Team Membership - Selection of Records - Costing |  ToR_Southern_V2.d ocx  RCS Review Team.txt  RE CONFIDENTIAL - Urology Assurance Gr |
| 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 <ul style="list-style-type: none"> - Erica O'Toole DoH Call | |
| 12 | MDM Processes | |
| Professional Governance | | |
| 13 | GMC Discussions | |
| 14 | Litigation / DLS Update |  Item 4428 - Personal Information |
| 15 | Grievance Process | |
| 16 | Administration Review Update | |
| Serious Adverse Incident (SAI) Reviews | | |

| | | |
|-----------------------------|---|--|
| 17 | Update on Current SAI Progress | WIT-56640 |
| 18 | Initial SAI Recommendations |  Action plan Personal Information.docx |
| 19 | Structured Judgement Review Process | |
| 20 | Family Liaison Role | |
| Communications | | |
| 21 | Media / Assembly Questions | |
| Any Other Business | | |
| 22 | Eileen Gorman Complaint |  Patient 85 .pdf |
| 23 | Albert Bibb Complaint |  Personal Information.txt |
| 24 | Coronial Processes | |
| 25 | Counter Fraud | |
| 26 | Declaration re CURE | |
| 27 | Securing Records for Public Inquiry |  Complaints from Closed Records.txt |
| 28 | Urology Timeline for the HSCB |  SHSCT Urology Timeline 2 Feb 21 MC |
| Date of Next Meeting | | |
| 29 | Via Zoom – 17 th February 2021 | |

Urology Oversight Group Minutes

Wednesday 3rd February 2020, 5:00pm

Via Zoom

| | Item | Actions |
|--------------------------------------|--|---|
| | In Attendance Stephen Wallace Melanie McClements Martina Corrigan Dr Maria O’Kane Vivienne Toal Ronan Carroll Patricia Kingsnorth | |
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| 2 | Minutes Minutes of the 8 th December were agreed | |
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Appointment Details

| | |
|------------------------|--|
| Presenting Condition | |
| Summary of Appointment | |

Regarding the patients current care

| Question | Y/N | Details |
|--|-----|---------|
| Is the present diagnosis secure? | | |
| Are the current medications prescribed appropriate? | | |
| Is a secure clinical management plan currently in place? | | |

Based on the information available at the time, while under Mr O'Briens care please answer the following to the best of your knowledge. If a determination cannot be made please give reasons why.

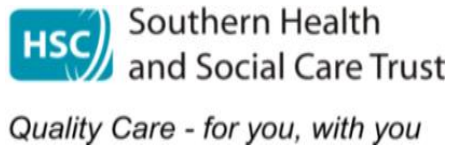
| Question | Y / N / Unable to Determine | Details |
|---|-----------------------------------|---------|
| Were appropriate and complete investigations carried out? | | |
| Were the medications prescribed reasonable? | | |



| | | |
|--|--|--|
| Was the diagnosis reasonable at the time? | | |
| Was the clinical management approach taken reasonable? | | |
| Were there unreasonable delays with any aspect of care (reviews, prescribing, diagnostics etc) | | |
| On balance, did the patient suffer any harm or detriment as a result? | | |

Clinical Professional Reviewing Care

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



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.

Formatted: Highlight

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

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

Table 3-2 – Clinic Staffing Requirements

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

3.3 Procedure Requirements

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

Table 3-3 – Procedure Staffing Requirements

| Title | Band | WTE |
|-----------|------|------|
| Secretary | 4 | |
| Reception | 2 | |
| Nurses | 5 | 0.64 |

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

3.4 Multi-Disciplinary Weekly Meetings Requirements

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

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

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

3.5 Serious Adverse Incident Requirements

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

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

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

3.6 Inquiry Requirements

Costs are included in Appendix 1.

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

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

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

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

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

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

-
- Support for corporate complaints department

Costs are included in Appendix 1.

Table 3-7 - Professional Governance, Learning and Assurance

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

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

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

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

4.0 Identified Risks

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

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

5.0 Monitoring

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

TERMS OF REFERENCE FOR CLINICAL RECORDS REVIEW

Review of Urology clinical records at Southern Health and Social Care Trust
('the Trust') under the Invited Review Mechanism.

Background

The review team will consider the standard of care provided to patients in a sample of clinical records provided by Southern Health and Social Care Trust for patients that had been under the care of a Trust Consultant Urologist.

Review

The review will involve:

- A clinical record review of up to 100 cases who were under the care of the consultant between the period January 2015 – December 2015 [PH1] put forward by the Southern Health and Social Care Trust

Terms of Reference

In conducting the review, the review team will consider the standard of care demonstrated in the clinical records provided by the Southern Health and Social Care Trust including with specific reference to:

- Assessment including history taking, examination and diagnosis;
- Investigations and imaging undertaken;
- Treatment including clinical decision-making, case-selection, operation or procedures and prescribing practices;
- Communication with the patient, their family and general practitioner(s), and patient consent;
- ~~Communication with General Practitioners;~~
- Team working including communication with other members of the care team, MDT discussions and working with colleagues;
- Follow-up action on the patient care (for example, ordering diagnosis/onward referral to other specialties (oncology etc).
- Actions taken by the Trust/consultant(?) [PH2] as a result of Multidisciplinary Team (MDT) Meeting recommendations ;
- Administration [PH3] in connection to the patients episodes of care;
- Identifying instances where harm may have occurred – if so whether serious or moderate;
- Identifying if any harm that has occurred is such that might be expected from any consultant surgeon working in similar circumstances;

- Identifying patients that may require further follow up by the Trust.

Conclusions and recommendations

The review team will, where appropriate:

- Raise any immediate patient safety issues that are identified during the course of the engagement with the Medical Director of Southern Health and Social Care Trust
- Form conclusions as to the standard of care provided and whether there is a basis for concern in light of the findings of the review.
- May make recommendations for the consideration to the Medical Director of Southern Health and Social Care Trust as to courses of action which may be taken to address any specific areas of concern which have been identified or otherwise improve patient care.

The above terms of reference were agreed by the College, the healthcare organisation and the review team on [date].

Dear Dr O’Kane,

I hope you are well.

I am writing with further information about the invited review that you have commissioned from the Royal College of Surgeons of England.

The invited review team

The team appointed to undertake this review is as follows:

- Clinical Reviewer: Mr David Jones FRCS
- Clinical Reviewer: Mr Jonathan Glass FRCS
- Clinical Reviewer: Mr Mark Speakman FRCS
- Clinical Reviewer: Mr Brian Birch FRCS

With best wishes,
Jessica

Jessica Govier-Spiers
Invited Review Coordinator

Royal College of Surgeons of England
35-43 Lincoln's Inn Fields
London WC2A 3PE

T: Personal Information redacted by the USI
E: Personal Information redacted by the USI
W: www.rcseng.ac.uk

Disclaimer

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Kelly, Elaine

From: Wallace, Stephen
Sent: 28 January 2021 11:58
To: 'O'Neill, Michael (DoH)'
Subject: RE: CONFIDENTIAL - Urology Assurance Group Meeting - Friday 8th January 2021

| Area | Number of Charts |
|----------------------------------|------------------|
| All Penile, testicular and renal | 6 Cases in total |
| Prostate | 15 |
| Invasive Bladder | 10 |
| Raised PSA (Out Patients) | 15 |
| Haematuria (Out Patients) | 15 |
| Female Lower UTI | 10 |
| Male Lower UTI | 10 |
| Ureteric Colic | 10 |
| Andrology | 10 |

| | | | |
|--|---------------|---|--|
| 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 |
| 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 | | | | | | | | | | | | |
| <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 |

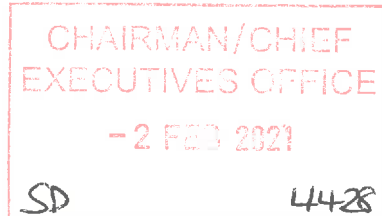
Your Ref:

Our Ref: Personal Information
redacted by the USI

Date: 29 January 2021

All post to be delivered to Personal Information redacted by the
USI

Southern Health & Social Care Trust
Headquarters
College of Nursing, Craigavon Area Hospital
68 Lurgan Road
Portadown
Co Armagh
BT63 5QQ



Dear Sirs,

To: Litigation

Patient's Daughter

personal Representative of

Patient 90

(deceased) who was born on the [redacted] and died on the [redacted]
Personal Information redacted by the USI

We are instructed by the above named to claim damages in connection with medical treatment provided at Craigavon Area Hospital between [redacted] Personal Information redacted by the USI and the [redacted] Personal Information redacted by the USI under Hospital Number [redacted] 4. Personal Information redacted by the USI

The facts

In [redacted] Personal Information redacted by the USI the deceased was admitted to hospital with ureteric stent irritation. A CT scan during this admission showed moderate bilateral hydronephrosis despite appropriately positioned stents. It was decided he would be admitted the following month on an elective basis for a cystoscopy, replacement of his ureteric stents and bilateral ureterolysis.

He was admitted to hospital on the [redacted] 9th [redacted] Personal Information redacted by the USI The procedure was undertaken the following day.

The intraoperative course was uneventful and his condition was stable during the procedure but afterwards his blood pressure fell and his heart rate increased. He was administered a number of drugs in an attempt to improve his blood pressure but with little success and he died that night.

Personal Information redacted by the USI

Personal Information redacted by the USI

Personal Information redacted by the USI

Breach of duty

It is alleged that the Trust failed in its duty of care to the deceased in that the deceased should have had a formal preadmission pre-operative assessment with optimisation of his clinical condition prior to surgery. This assessment should have been organised sufficiently in advance of the surgery to allow for all appropriate investigations to be completed. Such an assessment would have identified any specific anaesthetic risk.

We understand that Ureterolysis is a high risk surgical procedure which is rarely performed in the SHSCT urology department, with only a few per year. As stated above the deceased did not have a full preoperative outpatient assessment which would have identified all his individual anaesthetic risks to be assessed and discussed with him to ensure informed consent. It would appear that no medical professional discussed alternatives to the procedure with the deceased such as nephrostomies or referral to other centres.

We understand that the Trust have carried out a review following the death of Mr Patient 90 and have accepted that there was no timely formal preadmission pre-operative assessment.

Causation

As stated above the deceased did not have a full preoperative outpatient assessment which would have identified all his individual anaesthetic risks to be assessed and discussed with him to ensure informed consent before such a high risk surgical procedure.

Post-mortem revealed that death was due to bleeding, or haemorrhage, into the abdominal cavity itself and into the fatty tissues at the back of the abdomen. A total of 600 ml of blood was present in the abdomen and there was significant bleeding into the retroperitoneal tissues. The pathologist concluded that it was *“undoubtedly the effect of this blood loss which was responsible for his deterioration after the operation and ultimately his death.”*

The postmortem examination also revealed that the heart, and in particular its two main pumping chambers the ventricles, was enlarged. The pathologist commented that: *“such*

enlargement of the heart, termed cardiomegaly, would without doubt have made him less able to withstand the stresses placed upon the body by the effects of the blood loss.” The conclusion was: “Therefore as his pre-existing heart disease would have made him more susceptible to the effects of the haemorrhage it would be best regarded as a contributory factor in his death.”

It is therefore the Plaintiff’s case that had a pre-operative assessment been carried out, this would have identified that the deceased had pre-existing heart disease and given his condition, doctors would not have permitted this high risk procedure to have gone ahead and alternatives would have been discussed with the deceased.

The Plaintiff’s case is that a proper pre-operative assessment would have prevented this procedure going ahead and saved the life of Mr [Patient 90]

Alleged injuries/current condition and prognosis

Mr [Patient 90] died following the procedure.

Request for clinical notes (if not previously provided)

We would ask the Trust to provide all medical notes relating to the treatment of the deceased from [Personal Information redacted by the USI] to [Personal Information redacted by the USI] and any medical notes available which relate to the deceased’s heart condition.

We will be seeking the deceased’s GP notes.

Furthermore at this stage of our enquiries, we would expect you to disclose any further documentation that you hold that is relevant and material to this action.

Quantum

The Plaintiff’s claim relates to the untimely loss of life of Mr [Patient 90] and the pain and suffering caused as a result of same.

Meetings/discussions

Our client is willing to discuss the case with regard to an early settlement of the proposed action if deemed appropriate.

Action required

You are obliged to acknowledge receipt of this correspondence within **14 days** and to provide a detailed Letter of Response to each of the allegations/headings detailed within **4 months**. You will note that we have enclosed two copies of this correspondence. We suggest that you forward a copy of it immediately to your legal representatives/medical defence organisation/professional indemnity insurer

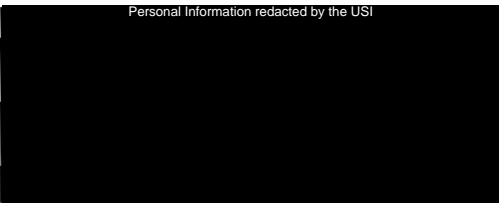
We look forward to receiving both your acknowledgment and Letter of Response in accordance with the Protocol, failing which we will have no alternative but to issue proceedings without further reference to yourselves.

We consider that this correspondence provides sufficient information to enable you to commence investigations and to put an initial valuation upon the claim.

Finally, you will be aware that the Protocol makes clear that this correspondence is not intended to have the formal status of a pleading and, therefore, we reserve the right to provide further information under each of the headings above in due course.

Yours sincerely







Personal Information redacted by the USI








Action Plan Urology

 Personal
Information
Excluded from public release

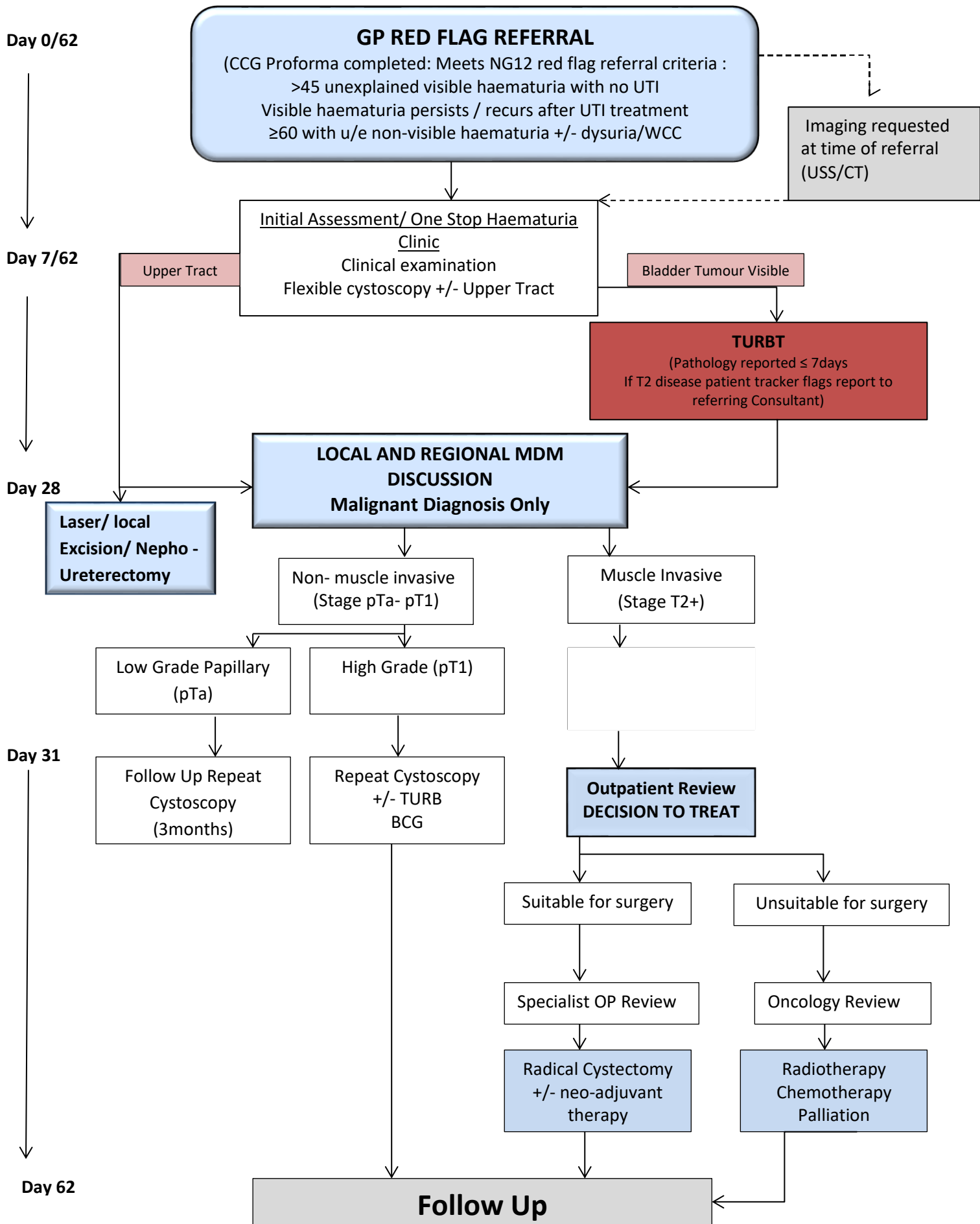
| Reference number | Recommendations | Designated responsible person | Action required | Date for completion / timescale | Date recommendation completed with evidence |
|------------------|--|-------------------------------|----------------------|---------------------------------|---|
| 1 | HSCB should 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



NICaN SUSPECT PROSTATE CANCER DIAGNOSTIC PATHWAY**GP RED FLAG REFERRAL**Initial Assessment

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

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)

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

**Prostate biopsy (TP or TRUS) + targeted
biopsies of MRI abnormality**

(Consider prostate volume as part of the initial assessment of a patient with a raised PSA and before MRI)

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

**Watchful Waiting /
Symptomatic management**

(Refer to NICaN Watch and Wait Pathway)

Guidance Notes

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

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

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

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**

www.dhsspsni.gov.uk

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

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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 |
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| 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).

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.

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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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and Public Safety**

An Roinn

**Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí**

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

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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