INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 1

CONTEXT

1.1 INTRODUCTION

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

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

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

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

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

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

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

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

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

1.2 METHODOLOGY

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

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

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

1.2.4 For the purposes of this protocol, the term;

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

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

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

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

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

1.3 UNDERPINNING PRINCIPLES

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

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

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

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

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

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

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

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

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

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

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

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

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

1.4 BOOKING PRINCIPLES

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

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

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

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

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

1.4.6 The definition of a booked appointment is:

a) The patient is given the choice of when to attend or have a virtual appointment.

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

1.4.7 Principles for booking Cancer Pathway patients:

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

1.4.8 Principles for booking Urgent Pathway patients:

a) Maximum waiting times for urgent patients should be agreed locally with clinicians and/or service managers and made explicit, through internal processes, to booking office staff.
b) Referrals will be received, registered within one working day and forwarded to consultants for prioritisation.
c) If clinical priority is not received from consultants within 72 hours, processes should be in place to initiate booking of urgent patients according to the referrers's classification of urgency.

d) Patients will be issued with a letter inviting them to contact the Trust to agree and confirm their appointment in line with the urgent booking process.

e) In exceptional cases, some patients will require to be appointed to the next available slot. A robust process for telephone booking these patients should be developed which should be clearly auditable.

1.4.9 Principles for booking Routine Pathway patients:

a) Patients should be booked to ensure appointment (including virtual appointment) is within the maximum waiting time guarantees for routine appointments.

b) Referrals will be received, registered within one working day at booking teams and forwarded to consultants for prioritisation.

c) Approximately eight weeks prior to appointment, Trusts should calculate prospective slot capacity and immediately implement escalation policy where capacity gaps are identified.

d) Patients should be selected for booking in chronological order from the Primary Targeting List (PTL).

e) Six weeks prior to appointment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment.

1.4.10 Principles for Booking Review Patients;

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

b) Patients who require a review appointment more than 6 weeks in advance will be added to and managed on a review waiting list.

c) Patients will be added to the review waiting list with a clearly indicated date of treatment and selected for booking according to this date.

d) Six weeks prior to the indicative date of treatment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment within a clinically agreed window either side of the indicative date of treatment.

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

1.5 VIRTUAL ACTIVITY

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

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

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

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

1.6 COMPLIANCE WITH LEAVE PROTOCOL

1.6.1 It is essential that planned medical and other clinical staff leave or absence is organised in line with an agreed Trust Human Resources (HR) protocol. Thus it is necessary for Trusts to have robust local HR policies and procedures in place that minimise the cancellation/reduction of outpatient clinics and the work associated with the rebooking of appointments.

1.6.2 There should be clear medical and clinical agreement and commitment to this HR policy. Where cancelling and rebooking is unavoidable the procedures used must be equitable, efficient, comply with clinical governance principles and ensure that maximum waiting times for patients are not compromised.

1.6.3 The protocol should require a **minimum** of **six** weeks' notification of intended leave, in line with locally agreed HR policies, in order to facilitate Trusts booking teams to manage appointment processes **six** weeks in advance.

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

1.7 VALIDATION

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

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

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

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 2

GUIDANCE FOR MANAGEMENT OF OUTPATIENT SERVICES

2.1 INTRODUCTION

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

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

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

2.1.4 Fixed appointments should only be used in exceptional circumstances.

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

2.2 KEY PRINCIPLES

2.2.1 Referrals into Trusts should be pooled where possible within specialties.

2.2.2 All new referrals, appointments and outpatient waiting lists should be managed according to clinical priorities. Priorities must be identified for each patient on the waiting list and allocated according to urgency of the treatment. Trusts will manage patients in three priorities, i.e.

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

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

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

2.2.4 Patient appointments for new and review should be **partially booked.**

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

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

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

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

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

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

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

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

2.3 NEW REFERRALS

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

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

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

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

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

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

2.4 CALCULATION OF THE WAITING TIME – STARTING TIME

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

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

2.5 REASONABLE OFFERS

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

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

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

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

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

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

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

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

2.6 REVIEW APPOINTMENTS

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

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

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

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

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

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

2.7.1 DNAs – New Outpatient

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

2.7.1(a) Patients who have been partially booked will **not** be offered a second appointment and should be removed from the waiting list. The patient and referring clinician (and the patient's GP, where they

are not the referring clinician) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

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

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

2.7.1(d) *Where patients are discharged from the waiting list (ref. 2.7.1(a)) they should be advised to contact the Trust booking office within **four** weeks of the original appointment date if they consider that the appointment is still required. Where a patient makes contact within the **four** week deadline, and where the Trust considers that unforeseen or exceptional circumstances meant that the patient was unable to attend, the patient should be added to the waiting list at the date that they have made contact with the Trust. If a patient makes contact after the **four** week period they cannot be reinstated.*

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

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

2.7.1(g) If the patient DNAs this second fixed appointment they will be removed from the waiting list and the steps in 2.7.1(d) should be followed.

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

2.7.2 DNAs – Review Outpatient

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

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

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

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

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

2.7.2(e) If the patient DNAs the second review appointment which has been partially booked then the patient should **not** be offered another opportunity to be reinstated. The patient and referrer will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

2.7.2(f) Where a patient DNAs a fixed review appointment where they have not had the opportunity to agree/ confirm the date and time of their

appointment, they should be offered another appointment. If they DNA this second fixed appointment, the above should be followed.

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

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

2.7.3 CNAs – Patient Initiated Cancellations of Outpatient Appointments

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

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

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

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

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

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

2.8 CNAs – HOSPITAL INITIATED CANCELLATIONS

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

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

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

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

2.9 CLINIC OUTCOME MANAGEMENT

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

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

2.10 CLINIC TEMPLATE CHANGES

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

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

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

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

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

2.11 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

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

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

2.12 OPEN REGISTRATIONS

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

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

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

- added to a review waiting list.

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

2.13 TIME CRITICAL CONDITIONS

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

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

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

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

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

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

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

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

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

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

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

2.14 TECHNICAL GUIDANCE

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

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

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

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

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

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 3

GUIDANCE FOR MANAGEMENT OF DIAGNOSTIC SERVICES

3.1 INTRODUCTION

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

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

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

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

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

3.2 KEY PRINCIPLES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.3 NEW DIAGNOSTIC REQUESTS

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

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

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

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

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

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

3.4 CALCULATION OF THE WAITING TIME – STARTING TIME

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

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

3.5 REASONABLE OFFERS

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

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

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

3.5.3 This does not prevent patients being offered earlier appointment dates. If the patient is offered an appointment within a shorter notice period (i.e. less

than three weeks' notice) and refuses it they will not have their waiting time reset.

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

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

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

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

3.6 FOLLOW UP APPOINTMENTS

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

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

3.6.3 Follow up patients who require an appointment within **six** weeks will be asked to agree the date and time of the appointment before leaving the department and the IT system updated.

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

3.7 PLANNED PATIENTS

3.7.1 Planned patients are those who are waiting to be recalled to hospital for a further stage in their course of treatment or investigation within specific timescales. This is usually part of a planned sequence of clinical care determined on clinical criteria.

3.7.2 These patients are not actively waiting for treatment to be initiated, only for planned continuation of treatment. A patient's care is considered as planned if there are clinical reasons that determine the patient must wait set periods of time between interventions. They will not be classified as being on a waiting list for statistical purposes.

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

3.7.4 Trusts must ensure that planned patients are not disadvantaged in the management of planned backlogs.

3.8 PATIENTS LISTED FOR MORE THAN ONE DIAGNOSTIC TEST

3.8.1 Where more than one diagnostic test is required to assist with clinical decision making, the first test should be added to the waiting list with additional tests noted.

3.8.2 Where different clinicians working together perform more than one test at one time, the patient should be added to the waiting list of the clinician for the priority test (with additional clinicians noted) subject to local protocols.

3.8.3 Where a patient requires more than one test carried out on separate occasions the patient should be placed on the active waiting list for the first test and on the planned waiting list for any subsequent tests.

3.8.4 Where a patient is being managed in one Trust but has to attend another for another type of diagnostic test, monitoring arrangements must be in place between the relevant Trusts to ensure that the patient pathway runs smoothly.

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

3.9.1 DNAs – Diagnostic Appointment

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

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

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

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

3.9.1(d) *Where patients are discharged from the waiting list (ref. 3.7.1(a) above) they should be advised to contact the Trust booking office within **four** weeks of the original appointment date if they consider that the appointment is still required. Where a patient makes contact within the **four** week deadline, and where the Trust considers that unforeseen or exceptional circumstances meant that the patient was unable to attend, the patient should be added to the waiting list at the date that they have made contact with the Trust. If a patient makes contact after the **four** week period they cannot be reinstated.*

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

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

3.9.1(g) If the patient DNAs this second fixed diagnostic appointment they will be removed from the waiting list and the above steps in 3.7.1(d) should be followed.

3.9.2 DNAs – Follow up Diagnostic Appointment

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

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

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

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

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

3.9.2(e) If the patient DNAs the second follow up appointment which has been partially booked then the patient should **not** be offered another opportunity to be reinstated. The patient and referrer will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

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

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

3.9.3 CNAs – Patient Initiated Cancellations of Diagnostic Appointment

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

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

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

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

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

3.10 CNAs - HOSPITAL INITIATED CANCELLATIONS

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

3.10.2 The patient should be informed of the cancellation and the date of the new appointment.

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

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

3.11 SESSION OUTCOME MANAGEMENT

3.11.1 Changes in the patient's details must be updated on the IT system and the medical record on the date of the session.

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

3.12 SESSION TEMPLATE CHANGES

3.12.1 Session templates should be agreed with the healthcare professional and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement (SBAs).

3.12.2 Templates will identify the number of slots available for new red flag, new urgent, new routine, planned and follow up appointments; specify the time each session is scheduled to start and finish; and identify the length of time allocated for each appointment slot.

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

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

3.13 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

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

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

3.14 TECHNICAL GUIDANCE

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

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

- Diagnostic waiting time and report turnaround time.
- Patients treated (IP/DC) or seen (OP) by an independent sector provider.
- Rapid angina assessment clinic (RAAC).
- Management of waiting times of patients who transfer between NHS sites (either within NI or the rest of the UK).
- Patients who are to be treated as part of a waiting list initiative / additional in house activity.

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 4

GUIDANCE FOR MANAGEMENT OF ELECTIVE ADMISSIONS

4.1 INTRODUCTION

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

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

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

4.2 KEY PRINCIPLES

4.2.1 To aid both the clinical and administrative management of the waiting list, lists should be sub-divided and managed appropriately. Trusts will manage patients on one of three waiting lists, i.e.

1. active,
2. planned and
3. suspended.

4.2.2 All elective inpatient and daycase waiting lists should be managed according to clinical priorities. Priorities must be identified for each patient on the waiting list and allocated according to urgency of the treatment. Trusts will manage patients in four priorities, i.e.

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

No other clinical priority categories should be used for inpatient and daycase services.

4.2.3 Patients of equal clinical priority will be selected for booking in strict chronological order, taking into account planned patients expected date of admission.

4.2.4 The regional targets for a maximum inpatient and daycase waiting times are outlined in the Health and Social Care Commissioning Plan and Indicators of Performance Direction (CPD), https://www.health-ni.gov.uk/doh-management-and-structure (see Ministerial Priorities).

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

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

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

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

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

4.3 PRE-ASSESSMENT

4.3.1 All patients undergoing an elective procedure (including endoscopy procedures) must undergo a pre-assessment. This can be provided using a variety of methods including telephone, video link, postal or face to face assessment.

4.3.2 Pre-assessment may include an anesthetic assessment or guidance on how to comply with pre-procedure requirements such as bowel preparation. It will be the responsibility of the pre- assessment team, in accordance with protocols developed by the relevant clinical teams, to authorise fitness for an elective procedure.

4.3.3 Only those patients that are deemed fit for their procedure may be offered a TCI date.

4.3.4 If a patient is assessed as being unfit for their procedure, their To Come In (TCI) date may be cancelled and decision taken as to the appropriate next action.

4.3.5 Pre-assessment services should be supported by a robust booking system.

4.4 CALCULATION OF THE WAITING TIME

4.4.1 The starting point for the waiting time of an inpatient/daycase admission is the date the appropriate clinician agrees that a procedure will be pursued as an active treatment or diagnostic intervention, and that the patient is clinically and socially fit to undergo such a procedure.

4.4.2 The waiting time for each patient on the elective admission list is calculated as the time period between the original decision to admit date and the date at the end of the applicable period for the waiting list return. If the patient has been suspended at all during this time, the period(s) of suspension will be automatically subtracted from the total waiting time.

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

4.5.1 The patient should be advised of their expected waiting time during the consultation between themselves and the health care provider/practitioner.

4.5.2 All patients must be offered reasonable notice. Patients should be made reasonable offers to come in (TCI) on the basis of clinical priority. Within

clinical priority groups offers should then be made on the basis of the patient's chronological wait.

4.5.3 A reasonable offer is defined as:

- an offer of admission, irrespective of provider or location, that gives the patient a minimum of **three** weeks' notice and a choice of **two** TCI dates, and
- at least **one** of the offers must be within N. I., except for any regional specialties where there are no alternative providers within NI.

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

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

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

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

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

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

4.6 INPATIENT AND DAYCASE ACTIVE WAITING LISTS

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

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

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

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

4.7 SUSPENDED PATIENTS

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

4.7.2 A period of suspension is defined as:

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

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

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

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

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

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

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

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

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

4.8 PLANNED PATIENTS

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

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

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

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

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

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

4.9 PATIENTS LISTED FOR MORE THAN ONE PROCEDURE

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

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

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

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

DNAs – Inpatient/Daycase

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

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

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

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

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

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

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

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

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

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

4.10.2 CNAs – Patient Initiated Cancellations of inpatient/daycase admission

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

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

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

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

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

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

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

4.11. CNAs - HOSPITAL INITIATED CANCELLATIONS

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

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

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

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

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

4.12 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

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

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

4.13 TECHNICAL GUIDANCE

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

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

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

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 5

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

5.1 INTRODUCTION

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

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

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

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

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

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

5.1.7 Fixed appointments should only be used in exceptional circumstances.

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

5.2 KEY PRINCIPLES

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

1. urgent and
2. routine.

No other clinical priorities should be used for AHP services.

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

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

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

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

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

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

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

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

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

5.3 NEW REFERRALS

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

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

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

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

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

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

5.4 CALCULATION OF THE WAITING TIME

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

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

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

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

5.5 REASONABLE OFFERS

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

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

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

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

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

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

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

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

5.6 REVIEW APPOINTMENTS

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

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

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

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

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

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

5.7.1 DNAs – New AHP Appointments

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

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

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

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

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

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

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

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

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

5.7.2 DNAs – Review Appointments

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5.8 CNAs – SERVICE INITIATED CANCELLATIONS

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

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

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

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

5.9 CLINIC OUTCOME MANAGEMENT

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

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

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

5.10 CLINIC TEMPLATE CHANGES

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

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

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

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

5.11 TRANSFERS BETWEEN TRUSTS or to INDEPENDENT SECTOR

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

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

5.12 TECHNICAL GUIDANCE

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

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

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

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

DRAFT 10 – 2 January 2008

Department of Health, Social Services and Public Safety
An Roinn Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí
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NORTHERN IRELAND CANCER ACCESS STANDARDS – A GUIDE

CONTENTS

Introduction

1. The NI Cancer Control Programme was published in November 2006. Within the Strategy there is a commitment to ensuring the timeliness of referral, diagnosis and treatment for suspected cancer patients. This document provides answers to some frequently asked questions about cancer access standards

- **2007/08 - '98% of patients diagnosed with cancer (decision to treat) should begin their treatment within a maximum of 31 days'**

- **2007/08 - '75% of patients urgently referred with a suspected cancer should begin their first definitive treatment within a maximum of 62 days. Where the performance of a tumour group currently exceeds this standard, performance should be sustained or improved against current levels'**

- **2008/09 - '95% of patients urgently referred as a suspected cancer should begin their first definitive treatment within a maximum of 62 days'.**

In addition there is also the existing two week waiting time standard for breast cancer patients:

- Maximum two week wait for referral for suspected breast cancer to date first seen from 1st August 2000.

This has been reinforced in Priorities for Action 2007/08.

- **"All breast referrals deemed urgent according to regionally agreed guidelines for suspected breast cancer should be seen within two weeks of the receipt of the GP referral"**

2. All these targets are being monitored through a regional cancer waiting times database tool offered to Trusts. The core data requirements will be circulated during December 2006.

Part 1- Who is responsible for meeting the targets and returning data?

1.1 Who is responsible for meeting the standards and returning data for Cancer Access Standards?

There is shared responsibility for the patients in the 62 day target between the First Seen Trust and the Treating Trust. This includes all records, i.e. the patients achieving the target and those breaching the target. The responsibility lies with the First Seen Trust to refer the patient in a timely manner allowing the Treating Trust adequate time to plan the treatment and deliver the diagnostic investigations in an appropriate timeframe to enable the target to be met.

Any breaches of the target will count half for both the Trust to which the patient was first referred and half to the Trust where the patient was treated. Accurate data needs to be communicated proactively to minimise delays in the patient pathway and ensure robust data quality.

This gives the Treating Trust enough time to properly plan the treatment within the target time and not delay the start of first definitive treatment. Any other Trust who may be involved in a patient's care (but not the treating trust or initially referred trust), must also expedite the processes through to 'first treatment'.

Where a 62 day breach occurs a discussion **must** take place between the referring and treating Trusts and agreement reached as to the reason for the breach, prior to identifying it on the database.
The trust where a patient is first seen following an urgent suspected cancer referral for returning data on these patients up to the date first seen.

1.2 Who is responsible for meeting the targets and returning data on the 31 day decision to treat to treatment target / 62 day referral for suspected cancer to first treatment target?

The trust administering the first definitive treatment is responsible for providing the information to support the targets on time to first treatment. See 1.2 regarding the shared responsibility for breaches of the target. They are also responsible for returning data on these patients to monitor the targets and for explaining breaches on existing standards (see below). The referring Trust will be responsible for ensuring the data items are transferred to the treating Trust.

Some patients on the 62 day pathway are first seen under the Cancer Access standard at one trust and are then referred on to another trust for treatment. The independent Regulation and Quality Improvement Authority (RQIA) may decide as part of its future work to assess the performance of all trusts in the care pathway in achieving the 62 day standard, from the end of 2008. So, in this case both trusts are responsible for ensuring that the 62 day waiting time target is met.

The new Health and Social Care Authority (HSCA) is responsible for commissioning services in line with the 31 and 62 day targets for their patients and should track waiting times for their managed population through the collection of cancer waiting times.

1.3 What information is required on breaches?

Detailed reports on breaches are required on all patients that wait longer than the target time and should include how long the patient waited, reason for the breach in the target and action put in place to prevent further breaches. The reasons for the breach should still be recorded for patients where there are good clinical reasons that a patient has waited longer than the target time (see para 2.6).

1.4 How does the database support the work of Service Improvement?

The collection of data has been designed to support the focus of service improvement by the Service Delivery Unit and the Northern Ireland Cancer Network. It allows the collection of a number of additional data items on cancer patients along the patient pathway, which the best evidence has shown are useful to service improvement.

1.5 Whose activity is it? Who is responsible for recording it?

Some questions have been raised about which trust code to record when a patient receives treatment. In general this is straightforward, but there are circumstances where you will need to consider the commissioning route for the care.

Some questions elsewhere in the UK have been raised about which trust code to record when a patient receives treatment. In Northern Ireland this is straightforward and there is no need to consider the commissioning route for the care.

Part 2 - Which patients do the standards apply to?

2.1 Do the targets include patients who are not referred through the Suspected Cancer Referral route?
The 31 day target applies to all new diagnoses of cancer regardless of the route of referral. For example this will include urgent GP referrals, urgent Consultant referrals, routine referrals and screening referrals.

The General Practitioner will ensure the urgent suspected cancer referral is sent within 24 hours of their consultation with the patient.

The 62 day target applies to patients who are referred through the urgent suspected cancer referral route. However, the standard applies to ALL patients referred through this route, irrespective of whether the referral was received within 24 hours.

2.2 Which patients should be included in the monitoring?
The Cancer Control Programme has set standards for all patients cared for under the HPSS in Northern Ireland and these patients should be monitored.

In the case where a patient is initially seen by the specialist privately but is then referred for first definitive treatment under the NHS, the patient should be included under the 31 day decision to treat to treatment target.

It is anticipated, the majority of definitive first treatments will be provided in secondary or tertiary care.

2.3 Do the treatment standards apply to patients receiving treatment for recurrence of cancer?

The standards only apply to patients with a newly diagnosed cancer. Some patients have metastases at presentation and so the treatment may be to the metastatic site rather than the primary site.

The standards do not apply to a patient receiving treatment for a recurrence of cancer. Clearly good clinical practice involves treating patients with recurrence as soon as possible on the basis of clinical priority.
When a patient is diagnosed with a second new cancer, which is not a recurrence, then the standards will apply to the treatment of this cancer (see part 6 for further details).

2.4 Do the treatment targets apply to patients who decline treatment?
Patients who decline any treatment should be excluded from the monitoring. However, even if there is no anti cancer treatment almost all patients will be offered a palliative intervention (e.g. stenting) or palliative care (e.g. symptom control) and these patients should be monitored.

2.5 Do the treatment targets apply to patients who die before treatment commences?
The targets concern waiting time to treatment. Hence patients who die before treatment commences should be excluded from the monitoring.

2.6 Are there any cases when the treatment time will exceed the standard time?

In a small number of cases there will be good clinical reasons for treatment time exceeding the target time. A generic example of this is where a patient is referred under the suspected cancer referral and there is diagnostic uncertainty as to whether they have cancer or not. These patients may require repeat diagnostic tests in order to reach a diagnosis.

A patient who requires a particularly complex combination of scans and biopsies
A patient for whom there is genuine clinical uncertainty about the diagnosis and the clinician elects to observe the patient over (say) a three-month period.

These patients will exceed the 62 day wait and this should be recorded on the cancer waits system. Detailed reasons on why these patients exceeded the target time should be recorded on the data collection process. It will not be appropriate to make adjustments in these cases.

The NI Cancer Network has endorsed the details of the thresholds allowed to take account of these clinical exceptions. These are based on the Healthcare Commission threasholds published in 2005. Examples of the suggested clinical exceptions are included in 4.23.

2.7 How do we monitor the following patient pathway? A patient is referred with a small breast lump which is fully assessed (e.g. by triple assessment, examination, imaging and needle biopsy) and is thought to be benign. The patient is reassured that the risk of this being cancer is low, but the clinician wants to check progress in 3 months. At that time it is clear that the lump is larger and a repeat biopsy shows cancer.

From the patient's perspective the interval between referral and diagnosis is clearly greater than 3 months. The waiting time reported should reflect this. We have always recognised that a small number of patients will breach for clinical reasons and this would be such a case.

2.8 At what point does a 'red flag' suspected cancer patient cease to be tracked as a potential 62 day wait patient?

A suspected cancer referral patient will cease to be tracked if a formal 'non-malignant' diagnosis is made (e.g. COPD). The patient comes off the 62 day monitoring. If the patient is subsequently diagnosed with cancer, they will enter the 31 day pathway from the date of decision to treat. This will include patients that are diagnosed with in-situ disease as these patients are not included in the cancer waits targets (except DCIS in breast care).

Where a suspected cancer referral patient is followed up due to diagnostic uncertainty (e.g. TRUS biopsy negative with a raised PSA), the patient remains on '62 day tracking', but will become a clinical exception as and when prostate cancer is diagnosed, if they are treated outside the 62 days.

It should be noted that where a GP has deemed a patient to be a 'red flag' suspected cancer they should be followed through on the cancer pathway and monitored as such. If a consultant assesses a patient to be urgent based on their triage of the referral letter or on their findings at initial hospital assessment they should be tracked in the same way.

Following this examination if the Consultant or Senior Clinical Grade Doctor considers the patient is not a suspected cancer patient, they can formally notify the GP within 24 hours of their decision and remove the patient from the 62 day pathway. The decision of the Consultant or Experienced Senior Clinical Grade Doctor must confirm in the patients notes that the "the patient has now been seen and the clinical opinion is that the patient does not have any evidence of a malignancy. In view of this, I am satisfied that this patient can be removed from the cancer 62 day tracking process". A suggested template to confirm this process is shown below. This formal recording is

necessary and will allow the decision to be audited at a later stage.

Consultants should not however ‘downgrade’ referrals deemed ‘red flag’ suspect cancers by a GP, without prior consultation with the referrer or face to face assessment with the patient by a Consultant or Experienced Senior Clinical Grade Doctor. Each Trust will need to identify the appropriate means to obtain consent for the consultation with the referrer, for each of the patient pathways.

The monitoring process allows for the separate identification of these different sources of referral and the analysis of the final outcome of the process. Suspected Breast Cancer Referrals are the exception to this guidance and where appropriate, these can be re-graded ‘downwards’ by a Consultant or Senior Clinical Grade Doctor.

DATE:

Highly Suspicious of Cancer GP Red Flag Referrals.

Patient: **Consultant:**

DOB: **Hosp No:**

This patient has undergone the investigations on the HSC suspected cancer pathway:

OPD Appt:	
Investigations:	

This patient is waiting for the following investigations outstanding:

- **..**
- **..**

This patient has an outpatient appointment with you on:

- ..
- ..

In order to update this patients suspected cancer patient pathway I would be grateful if you could confirm

• The patient has now received all **appropriate diagnostic tests** for this pathway and no malignancy has been identified. In view of this a formal non malignant diagnosis has been made and I am satisfied that this patient can be removed from the cancer 62 day PTL tracking process.	SIGN:	DATE:
• This patient has now been seen and the **clinical opinion** is that the patient does not have a malignancy. In view of this a formal non malignant diagnosis has been made and I am satisfied that this patient can be removed from the cancer 62 day PTL tracking process.	SIGN:	DATE:
• This patient is to be continued on the HSC pathway and should receive any further investigations/appointments within 1 week of request:	SIGN:	DATE:

Please fax this completed form to Cancer Services as a matter of urgency.
Thank you for your time
Fax Number: <please insert details>

2.9 Does the referral to treatment standard apply when a patient is referred on suspicion of one cancer but is diagnosed with another within the same care spell?

Yes, any patient who is referred as a suspected cancer and diagnosed with cancer within that care spell should be monitored under the 62-day target from urgent referral to treatment. To meet this target trusts will require effective handover arrangements between specialities where this situation can arise.
Examples of the tumour groups where this may occur include:
* Gynae/Colorectal (symptoms non-specific)
* Breast/Lymphoma (axillary lumps)
* Head and Neck/Lymphoma/Lung (neck lumps)
* Upper GI/Lower GI (symptoms non-specific)

Part 3 - How are the waiting times calculated in the regional database?

The table below refers to data items which will be fully explained in the core data items document. Database field names are in capitals

3.1 Reports: The regional monitoring process will provide reports for each of the waiting times standards. The table below specifies how the monitoring process will select records for a report and how the waiting time for each patient is calculated. *For the reporting period starting x and ending y*

For Target	Database will select records where	Calculation of waiting time:
Urgent referral to date first seen	DATE FIRST SEEN is between x and y **and** SOURCE OF REFERRAL FOR OUTPATIENTS = 03 or 92 **and** CANCER REFERRAL PRIORITY TYPE = 01	DATE FIRST SEEN **minus** CANCER REFERRAL RECEIVED DATE **minus** WAITING TIME ADJUSTMENT (FIRST SEEN)
Urgent referral to date of first definitive treatment	START DATE (first treatment) is between x and y **and** SOURCE OF REFERRAL FOR OUTPATIENTS = 03 or 92 **and** CANCER REFERRAL PRIORITY TYPE = 01 **and** PRIMARY DIAGNOSIS (ICD) is cancer+	START DATE (first treatment) **minus** CANCER REFERRAL RECEIVED DATE **minus** the sum of ~ WAITING TIME ADJUSTMENT (FIRST SEEN) ~ WAITING TIME ADJUSTMENT (DECISION TO TREAT) ~ WAITING TIME ADJUSTMENT (TREATMENT)
Decision to treat to first definitive treatment	START DATE (first treatment) is between x and y **and** PRIMARY DIAGNOSIS (ICD) is cancer+	START DATE (first treatment) **minus** DECISION TO TREAT DATE **minus** WAITING TIME ADJUSTMENT (TREATMENT)

See Appendix D of the Core Data definitions document

3.2 Performance Monitoring Process:

The performance monitoring process will be consistent with the other Service Delivery Unit workstream. See Section 7 which includes more information concerning the proposed process for monitoring cancer access standard.

3.3 For monitoring purposes, how many days is one month?

A month is taken to be 31 calendar days. Two months is 62 calendar days. Two weeks is 14 calendar days.

3.4 How do we count the days waited?

The date at the beginning of the waiting period is day 0. Hence is order to meet the 14 day standard if a patient is referred on 1st February the patient would need to be seen on or before 15th February.

For those patients referred as a suspected cancer patient, the first day is day 0, this would then mean that a patient referred on the 1st November the patient would need to have received their first definitive treatment on or before the 2nd January

Part 4 - FIRST DEFINITIVE TREATMENT

4.1 Several questions have been raised by Trusts regarding both the definition of “first definitive treatment” and the date which should be recorded. These issues have been considered nationally in England by the Cancer Waiting Times Implementation group and the National Cancer Director. Within Northern Ireland the guidance has been reviewed and endorsed by each of the NI Cancer Network Tumour Groups. The advice is given in the following paragraphs:

4.2 It may be useful to consider the various types of primary “treatment package” that different patients may receive:

- Many patients will receive a single treatment modality aimed at removing or eradicating the cancer completely or at reducing tumour bulk (e.g. surgery, radiotherapy or chemotherapy). In these cases the definition of “first definitive treatment” and the start date are usually straightforward.

- A second group of patients will receive a combination of treatments as their primary “treatment package” (e.g. surgery followed by radiotherapy followed by chemotherapy). In these cases the “first definitive treatment” is the first of these modalities to be delivered, and the date is the start date of this first treatment.

- A third group of patients require an intervention which does not itself affect the cancer to be undertaken prior to the delivery of the anticancer treatment(s) – to enable these treatments to be given safely. Such interventions might include formation of a colostomy for an obstructed bowel or insertion of an oesophageal stent. As these interventions form part of the planned “treatment package” for the patient it has been agreed that the start date of the enabling intervention should be taken as the date of first definitive treatment.

- A fourth group of patients undergo a clearly defined palliative intervention (e.g. a colostomy or a stent) but do not then receive any specific anticancer therapy. For these patients the start date of this intervention should be recorded as the date of first treatment.

- A fifth group of patients do not receive any anticancer treatments but are referred specifically to a specialist palliative care (SPC) team. For these patients the date of the first assessment by a member of the SPC team is to be taken as the date of the first “treatment”.

- A sixth group will receive both anticancer treatment (e.g. radiotherapy) and a specialist palliative care assessment. In this instance the date of the anticancer treatment is to be taken as date of first treatment.

- Finally, some patients do not receive any specific anticancer treatment/intervention and are not referred to a SPC team. Where the patient is receiving symptomatic support and is being monitored these patients should be classified as undergoing “Active Monitoring”. It is recognised that this is somewhat unsatisfactory as this group encompasses patients with early cancer (e.g. localised prostate cancer where serial monitoring of PSA is undertaken) and those with advanced cancers for which no immediate specific interventions are considered to be warranted. These patients may, of course, require general palliative care including symptom control – given under the care of GPs and/or oncologists. [NB At a later date revisions to the dataset will be considered but these cannot be made immediately]

4.3 The first definitive treatment is normally the first intervention which is intended to remove or shrink the tumour. Where there is no definitive anti cancer treatment almost all patients will be offered a palliative intervention (e.g. stenting) or palliative care (e.g. symptom control), which should be recorded for these purposes. In more detail:

First definitive treatment type	**Circumstances where this applies**
Surgery	♦ Complete excision of a tumour ♦ Partial excision/debulking of a tumour (but not just a biopsy for diagnostic or staging purposes) ♦ Palliative interventions (e.g. formation of a colostomy for a patient with an obstructing bowel cancer, insertion of an oesophageal stent or pleurodesis)
Drug treatment: Chemotherapy, *Biological therapy*[+] OR Hormone therapy	♦ Chemotherapy (including cases where this is being given prior to planned surgery or radiotherapy)
	♦ Biological therapy includes treatments targeted against a specific molecular abnormality in the cancer cell (e.g. rituximab, trastusumab, glivec) and treatments which target the immune system (e.g. interferon, interleukin 2, BCG).
	♦ Hormone Treatments should count as first definitive treatment in two circumstances (1) Where hormone treatment is being given as the sole treatment modal ity (2) Where the treatment plan specifies that a second treatment modality should only be given after a planned interval. This may for example be the case in patients with locally advanced breast or prostate cancer where hormone therapy is given for a planned period with the aim of shrinking the tumour before the patient receives surgery or radiotherapy.
Radiotherapy	♦ Given either to the primary site or to treat metastatic disease. This should include cases where radiotherapy is being given prior to planned surgery or chemotherapy.
Specialist Palliative Care (SPC)	♦ Given via hospital SPC teams ♦ Given via community SPC teams ♦ Given via hospices (if known by the Trust)
Active monitoring	♦ When none of the other defined treatment types apply and the patient is receiving symptomatic support and is being monitored. The date of commencement of active monitoring should be the consultation date on which this plan of care is agreed with the patient, including the intervals between assessments (e.g. serial PSA measurements for prostate patients). This treatment type may be used for any tumour site if appropriate. ♦ For the purposes of waiting times the field active monitoring should also be used to record patients with advanced cancer who require general palliative care.

[+]*Biological therapy – For the purposes of the performance monitoring Biological Therapy should be recorded as "chemotherapy" in the field PLANNED CANCER TREATMENT TYPE as defined in Core Data Definitions document.*

4.4 What is the date of treatment where treatment is self-administered?
The Start date of treatment is taken to be the date of the outpatient appointment where the patient is given the prescription.

4.5 Where should palliative procedures such as stenting be recorded?
To be consistent with the Cancer Dataset any procedure should be recorded under surgery. Section 7 of the cancer dataset is designed to collect all surgery and all other procedures and hence a palliative procedure such as stenting should be recorded under surgery. Of course the waiting dataset will not tell us whether the surgery is curative, palliative or what the intervention is. Trusts and networks may want to record the intention of the surgery or the OPCS 4 code of the procedure, but that is beyond what is required nationally to monitor waiting times.

4.6 How should we record supportive care drugs on the database?
Where a patient receives palliative care only they may of course be treated with supportive care drugs, but this is not recorded as first treatment. The first treatment should be recorded as one of the following:

i. Where the patient does not receive any anticancer treatments but is referred specifically to a specialist palliative care (SPC) team. For these patients the date of the first assessment by a member of the SPC team is to be taken as the date of the first "treatment".

ii. Where the patient is not referred to an SPC team and is receiving symptomatic support and is being monitored these patients should be classified as undergoing "Active Monitoring".

4.7 How should a patient who is diagnosed incidentally for cancer be monitored?

Some patients may be diagnosed for cancer during routine investigations or while being treated for another condition. This is why we have set targets from decision to treat to treatment, and once cancer is diagnosed the patient should be treated without delay. These patients should be monitored under the 31 day decision to treat to treatment target. Where the patient is treated immediately at point of diagnosis the decision to treat will be the same date as the date of the operation. (e.g. when a patient is unexpectedly found to have a cancer during surgery for a suspected benign condition).

4.8 Can a diagnostic procedure also be counted as treatment?
A purely diagnostic procedure (including biopsies) does not count as treatment unless the tumour is effectively removed by the procedure, examples of this would be a polypectomy during a Colonoscopy or an excision biopsy of a melanoma.
If an excision biopsy is therapeutic in intent (i.e. the intention is to remove the tumour) then clearly this will count as first treatment, irrespective of whether the margins were clear.

4.9 – How are patients who are treated for cancer under a clinical trial monitored?
The cancer waits standards apply to all patients treated under the NHS and so has to include patients treated under clinical trials. A suspension does not apply simply because a patient is participating in a clinical trial.

4.10 Are Carcinoid tumours reported for cancer waits?
Carcinoids of the appendix are coded as D37.3 and so are not reported for cancer waits, but carcinoids of any other site are coded to a C code in ICD10 and so are reported for cancer waits.

Haematology

4.11 If a patient has a blood transfusion would this count as first treatment?
If a patient is not planned to have active anticancer treatment (e.g. chemotherapy or radiotherapy) then a blood transfusion should count - as a palliative care treatment (e.g. for

chronic lymphocyte leukaemia).
In all other circumstances the blood transfusion would not count as first treatment.

4.12 Would anti-biotics be counted as first treatment for low grade gastric lymphomas?
Yes anti-biotics would count as start of treatment for low grade gastric lymphoma.

4.13 What counts as treatment for lymphoma?
The removal of a lymph node is a biopsy to establish diagnosis and would not count as start of treatment as there is disease throughout the body. Patients will be treated with chemotherapy, radiotherapy or observation depending on the biopsy diagnosis.

Breast

4.14 In the treatment of breast cancer what is the position when a patient has immediate reconstruction as part of the first definitive treatment?
When a patient has immediate reconstruction as part of the first definitive treatment this should be within a month of decision to treat where this can possibly be achieved. However if a patient is offered alternative definitive treatment within a month, i.e. Mastectomy without immediate reconstruction, but instead chooses to have the immediate reconstruction at a somewhat later date, the provider should not be penalised for this. Full details on these patients should be provided by the trust in the exception report.

4.15 Does Sentinel Node Biopsy count as start of treatment in breast cancer?
This does not count as start of treatment as this is a diagnostic procedure to determine whether cancer has spread to the lymph nodes.

Lung

4.16 Would "open and close" lung surgery count?
A small number of patients will undergo open and close surgery on the lung, which does not resect the lung. Although this does not remove the tumour this should still be counted as it is a treatment procedure, although the outcome is unsuccessful.

4.17 In lung cancer would the drainage of a pleural effusion count as treatment?
If a patient is not planned to have active anticancer treatment (e.g. chemotherapy) then this should count - as a palliative care treatment
In other circumstances it will not count.

4.18 In lung cancer would a mediastinoscopy count as first treatment?
No, this would not count as start of treatment

4.19 If a patient has a non small cell lung cancer and has to be stented can this be classed as a first treatment?
Yes this would be recorded as the start of cancer treatment.

Head and Neck

4.20 Would dental clearance count as start of treatment in oral cancer?
No, this would not count as start of treatment. An adjustment to the waiting time can be made if the dental clearance means the patient is unfit for radiotherapy and so the radiotherapy treatment is delayed (see section 8.10).

4.21 Head & neck patients often require the insertion of a PEG (Percutaneous Endoscopic Gastrostomy) prior to surgery or radiotherapy, would this count as the start of a first treatment?

This procedure enables patients nutrition prior to the start of active treatment. In this case the

period they are unfit for the treatment should be an adjustment, but the insertion of the PEG is not the treatment itself. If a patient requires nutrition via a PEG to make them fit for active treatment a medical suspension may be recorded.

4.22 Would a hemi-thyroidectomy count as start of treatment in patients diagnosed with Thyroid cancer?
Yes, hemi-thyroidectomy is considered as start of treatment.

Urology

4.24 How do we monitor patients with bladder cancer?
Cancer registries do not record carcinoma in situ or pTa transitional cell carcinoma as 'cancer' as they are regarded as non invasive. Patients with these histological diagnoses are therefore not counted for the purposes of the 31 and 62 day targets. (Grade 3 pTa are registered in ICD10 as in-situ tumours (D09.0) and grade 1 and 2 as borderline (D41.4))

For bladder cancer diagnoses, the TURBT counts as the first definitive treatment provided it is carried out with the intention of debulking rather than just carrying out a biopsy of the cancer. TURBT remains the first definitive treatment even for patients who require further treatment such as cystectomy or radiotherapy.

A TUR biopsy of a bladder cancer or a biopsy of metastatic disease will not count as first definitive treatment.

If a patient has completed the standard investigations for haematuria (i.e. normal cystoscopy and normal upper tract imaging) and no malignancy has been identified then a 'benign' diagnosis can be made and these patients will not be included in the 62 day target. However if monitoring or further tests are planned (e.g. because of abnormal urine cytology or equivocal upper tract imaging) then monitoring for the 62 day target cannot be stopped until these are complete and a benign cause is diagnosed.

4.25 What counts as first definitive treatment for Upper Tract Transitional Cell Carcinoma (TCC)?
First definitive treatments include:-
• Radical surgery (e.g. nephroureterectomy)
• Local excision (open or endoscopic)
• Chemotherapy
• Palliative therapy
• Surveillance

4.26 How do we monitor patients with prostate cancer?
Patients with a raised PSA or clinically suspected prostate cancer who are referred via the suspected cancer referral will continue to be monitored until cancer is diagnosed and the first definitive treatment commenced or an unequivocal benign diagnosis is made. In practice there still remain some unclear areas.

If a patient has a raised PSA and the prostate biopsy shows benign tissue or PIN only, provided no immediate re-biopsy is planned then monitoring ceases. However, if the suspicion of cancer remains (e.g. a very high PSA, suspicious histology or inadequate tissue obtained at the first biopsy) and a further immediate biopsy is planned despite the benign first biopsy the patient continues to be monitored.

Once a patient has been told that the diagnosis is benign even if continued assessment of the PSA is recommended, the patient is no longer tracked as a potential 62 day patient whether they are discharged or not.

For patients who have locally advanced or metastatic disease, first definitive treatment will usually be hormone therapy or watchful waiting.
For patients who apparently have localised disease and are suitable for curative treatment a pelvic MR scan may be indicated (see para 8.10 for guidance on stopping the clock).
Once a patient is given a number of treatment options, they may ask for time to think before selecting their preference. The clock stops while the clinician is waiting for the patient to decide (this is generally regarded as good practice). However the clock continues while the patient is waiting to see various specialists to discuss the different options e.g. surgeon, radiotherapist or brachytherapist.

First definitive treatment options include:-
• Radical surgery
• Radical radiotherapy
• Definitive treatment with new technology
• For those patients who have neo-adjuvant hormone therapy, the date of starting hormone therapy is taken as the first definitive treatment.
• Active monitoring
• Watchful waiting
If these options are chosen it is important to note the decision date clearly in the patient's case sheets for the monitoring team.

4.27 In prostate cancer would a TURP count as first treatment?
The guidance has been reviewed after further advice from urologists.
A TURP may be performed on known prostate cancer patients to palliate symptoms (where it could be regarded as de-bulking surgery).
In other patients a TURP may be carried out for benign disease and incidentally diagnose and treat prostate cancer. In both cases this will count a start of treatment.

4.28 How do we track a suspected cancer referral patient who refuses altogether to have a TRUS biopsy but the clinician continues to review?
The TRUS biopsy will potentially diagnose the patient and by refusing altogether to have a TRUS the patient has removed themselves from the 62 day pathway. If cancer is subsequently diagnosed then the patient will be monitored under the 31 day target.
Where a patient delays a TRUS biopsy an adjustment should be made, and tracking as a potential 62 day patient should continue.

4.29 What counts as first definitive treatment for kidney cancer?
First definitive treatments include;-
• Surveillance
• Radical surgery
• Local excision (nephron sparing surgery)
• Ablation using new technology
• Immunotherapy
• Palliative care

4.30 What counts as first definitive treatment for testis cancer?
First definitive treatments include
• Orchidectomy
• Chemotherapy
• Palliative care

4.31 What counts as first definitive treatment for penile cancer?
First definitive treatments include
• Debulking operation e.g. circumcision, excision biopsy
• Radical surgery e.g. amputation, excision inguinal lymph node metastases

• Radiotherapy
• Chemotherapy
• Palliative care

Carcinoma in situ is not classed as invasive and so is not included in cancer waiting times data

Gynae

4.19 What would count as the date of first treatment in Gynaecological Cancer?

- Date of admission for surgery (or date of admission as emergency if proceeds to surgery during that admission). A cone biopsy should count as first treatment in early cervical cancer as it is a curative / definitive treatment for stage 1a disease. A diagnostic loop biopsy in more advanced cases would not usually be called a "cone" biopsy.

- Open and Close surgery - Where a patient has a major laparotomy for (usually) ovarian cancer the intention is de-bulking (not diagnosis) and so will count as start of treatment.

- Date of first radiotherapy / chemotherapy where these are first treatments

- Date of first hormonal therapy where this is used as primary treatment (eg endometrial cancer in frail patients or very young patients with low grade disease)

- Date of “treatment enabling” intervention forming part of the planned “treatment package” (eg ureteric stenting for advanced cervical cancer)

- Date of palliative intervention (e.g. colostomy or stenting) where no specific anticancer therapy is planned

- Date of the first assessment by a member of the Specialist Palliative Care team for patients who do not receive any anticancer treatments. Diagnosis does not need to be confirmed by histology / cytology for inclusion into statistics.

- “Active Monitoring”: for patients who receive symptomatic support but who do not receive any specific anticancer treatment / intervention and are not referred to a SPC team – rare in gynae oncology

4.33 How do we record the wait for a patient with ovarian cancer who requires the drainage of Ascites prior to being fit for chemotherapy?
In this situation a medical suspension would apply for the period the patient is medically unfit for the chemotherapy.

Upper GI

4.34 Would the insertion of a pancreatic stent count as start of treatment for pancreatic cancer?
After discussions with national leads it has been agreed that the **previous guidance needs to be amended.**
If the planned first treatment is resection for pancreatic or related cancers (ampullary, duodenal and distal bile duct), but subsequently the patient requires a stent due to a delay to having the surgery then stenting will not count as start of treatment. Many clinicians agree that patients with mild obstructive jaundice (a serum bilirubin below 200 micromol/l) do not require bilary stenting before resection, if surgery and imaging are planned within 7-10 days. If this is the agreed clinical practice locally then stenting for these patients will not count as start of treatment.

If the planned first treatment is to insert a stent in order to resolve jaundice before the patient has a resection or the patient starts chemotherapy stenting will count as start of treatment.

4.35 Should gastrointestinal stromal tumours (GISTs) be recorded for cancer waits?
GISTs that are described as malignant, invasive or as having metastases are coded to the relevant C code for the part of GI tract involved and are thus included in the cancer waits. GISTs not otherwise specified are coded as borderline using the relevant D code and are not recorded for cancer waits.

4.36 Would a jejunostomy count as start of treatment?
The jejunostomy would not count as start of treatment as it is a procedure to insert a feeding tube. However if a patient is medically unfit while they recover from the procedure before start of treatment (e.g. chemotherapy) it is appropriate to make an adjustment and to suspend the patient for the period they are unfit.

Brain/CNS

4.21 When a patient with a Brain tumour is given Dexamethasone would this count as first treatment?
Dexamethasone will only count if the patient is only being cared for palliatively and no other anti-cancer treatment is offered.

4.38 Should treatment of Von Hippel-Lindau syndrome be recorded on cancer waits?
No, this is a benign condition and so is outside the monitoring of cancer waiting times.

4.39 Which grades of brain tumour do we report for cancer waiting times?
Grade 3 and 4 tumours are considered malignant and should be reported for cancer waits.
Grade 1 and 2 tumours are benign and so should not be recorded for cancer waits

Skin

4.22 In skin cancer are Intraepidermal carcinomas, Lentigo malignas or bowen's disease included in the monitoring of cancer waiting times targets to treatment?

No. All these conditions are classified as carcinoma in-situ of the skin and so are outside the scope of diagnoses monitored for cancer waiting times. Full details of the diagnosis codes covered in cancer waiting times are available in the core data definitions document.

Complex pathways

4.23 What are the complex pathways/clinical exceptions and how should this be recorded?

For a very small number of patients, there will be good clinical reasons for their care pathway not to be completed within the 31/62 days. For reasons this will vary according to individual patients and the type of cancer. Such clinical exceptions should continue to be recorded on the cancer access database, and on waiting list, although they will end up breaching the standard times. It has been agreed by the Network Tumour Groups it is acceptable for these few cases to breach the standard.

For the 62 day pathway, patients may attend for diagnosis test which prove inconclusive, leaving uncertainty as to whether they have cancer or not. If is best practice for these patients to remain within the hospital system, as repeated tests over a period of time may be required before a definitive diagnosis can be made. However, the term ‘clinical exception’ cannot be applied simply because a patient requires a series of multiple diagnostic tests, for which there are long waiting times, thus a lung cancer patient who requires several staging tests is not a “clinical exception”.

The 31 day target does not cover the diagnostic phase of the pathway and so there are fewer reasons why a patient is likely to take longer than 31 days between decision to treat and the start of their treatment.

The following are a few examples of circumstances which might be categorized as clinical exceptions:

Gynaecology - There will be a few patients coming through less obvious pathway such as those presenting with a pleural effusion who turn out to have an ovarian carcinoma. Patients presenting with endometrial hyperplasia who require repeat biopsies, may also be clinical exceptions as there is diagnostic uncertainty.

Haematology - Patients with lymphoma who have solitary mediastinal (also see lung cancer) or abdominal lymph node disease.

Head and Neck - Patients with in-situ carcinoma and those presenting with an isolated lump in the neck from an unknown primary site.

Lower GI - Those patients presenting with a rectal or colonic polyp with a focus of invasive carcinoma.

Lung Cancer - Patients presenting with pulmonary nodules or shadowing of an uncertain nature that require follow-up prior to eventual diagnosis of lung cancer.

Upper GI - Patients presenting with high grade dysplasia or carcinoma in-situ.

Urology - An inconclusive trans-rectual ultrasound biopsy for suspected prostate cancer will be repeated, but there needs to be a time delay before the patient can be retested to allow the patient to recover.

The above is not intended to be an exhaustive list or clinical exceptions but instead to provide an indication of the type of patient that could be classified as such. It should be noted that the situation described above are such that the rules for adjustments and medical or social suspensions (stopping the clock) cannot be applied to them.

Part 5 - What is the “FIRST DIAGNOSTIC TEST”?

5.1 This section provides a list of first major diagnostic tests. The first major diagnostic test is the test which will move the level of suspicion of cancer from "possible/probable" (based on history, clinical examination or blood count) to "highly probable/certain". This list is not exhaustive and so should be used as a guide to help teams in recording this data.

Primary tumour type	**First major diagnostic test likely to be one of the following**
Breast	Mammogram, Ultrasound, Needle Biopsy
Lung	Bronchoscopy, CT scan or MRI
Colorectal	Barium Enema, Flexible Sigmoidoscopy, Rigid Sigmoidoscopy, Colonoscopy, biopsy, ultrasound for abdominal mass, CT, digital rectal exam, MRI
Upper GI	Barium Meal/Swallow or Gastroscopy
Urology	I.V.U., flexible cystoscopy, trans-rectal ultrasound. P.S.A., Ultrasound
Gynaecology	OVARY: Ultrasound Scan or Ca 125(usually), CT scan (in some cases) CERVIX: Biopsy VULVA: Biopsy, Vulvoscopy ENDOMETRIUM: Vaginal Ultrasound, Endometrium Assessment/Sampling, Hysteroscopy
Haematology	Full Blood Count, Bone Marrow, Node Biopsy or CT scan
Skin	Biopsy
Head and Neck	Upper airways endoscopy, biopsy, CT scan, MRI
Brain	CT or MRI scan

The date of the first diagnostic test is recorded in the field
CLINICAL INTERVENTION DATE (FIRST DIAGNOSTIC TEST)
The date of the first diagnostic test must be after the patient has been referred to secondary care.

Part 6 - When should a new record be created?

6.1 A new record is required for each new cancer care spell. This appendix provides definitions of a cancer care spell for breast, lung and skin cancers. The definitions of cancer care spells for other tumour types are being agreed through the development of the National Cancer Dataset and will be available in subsequent versions of the Dataset document (which will be made available on the Health and Social Care Information Centre website).

6.2 In general, recurrence of cancer at the same site is considered to be part of the same care spell (so it does not require a new record) but it would be the subject of a new care plan for its management. The treatment standards in the Cancer Control Programme only apply to first definitive treatment of newly diagnosed cancers.

6.3 Breast Cancer (see exceptions below)

A new Cancer Care Spell for breast cancer should be started for:

- different histology
- different laterality

So, simultaneous bilateral breast tumours with the same histology would result in two Cancer Care Spells, one for the right breast and one for the left breast.

Multi-focal tumours (i.e. discrete tumours apparently not in continuity with other primary cancers originating in the same site or tissue) would result in one Cancer Care Spell (unless they have different histology and/or different laterality).

6.4 Lung (see exceptions below)

A new Cancer Care Spell for lung cancer should be started for:

- Any tumour with a different histology, irrespective of ICD-10 code or laterality
- A tumour with a different three-character ICD-10 code, except in cases where this is considered to be recurrence of the original primary tumour
- A tumour with different laterality except in cases where this is considered to be recurrence of the original primary tumour

However, a single lesion of one histological type is considered a single primary (i.e. one Cancer Care Spell), even if the lesion crosses site boundaries above. Differences in histological type refer to differences in the first three digits of the morphology code.

So, simultaneous bilateral lung tumours with the same histology (excluding metastases) would result in two Cancer Care Spells, one for the right lung and one for the left lung.
Multi-focal tumours (i.e. discrete tumours apparently not in continuity with other primary cancers originating in the same site or tissue) would result in one Cancer Care Spell (unless they have different histology and/or different laterality) – unless these were considered to be metastatic from the primary tumour.

6.5 Skin Cancer

There are particular rules for recording skin cancers within the Cancer Dataset, which apply when collecting skin cancer data for monitoring of Cancer Waiting Times. For full details please see the Cancer Data Manual. **Please note that data on the treatment of basal cell carcinomas is not required for the cancer waiting system as they are not covered by the cancer waiting times targets to treatment (see core data definitions document for further details).**

For Squamous Cell Carcinoma – Most patients have a single lesion at presentation, but a significant number will get more primaries over a period of time. Only one cancer care spell (i.e. one record) should be recorded for all these Squamous Cell Carcinomas.

For Kaposi's sarcoma – A new cancer care spell should be started for each Kaposi sarcoma diagnosed.

Malignant Melanoma – A new cancer care spell should be started for each Malignant Melanoma diagnosed.

Cutaneous Lymphomas - A new cancer care spell should be started for each cutaneous lymphoma diagnosed.

6.6 Exceptions

The Cancer Waiting Times database works on the basis of a single dataset record for a given Cancer Referral Decision Date or a given Decision to Treat date. Hence there are rare occasions when the database cannot record both cancer care spells:

1. If a patient is referred by the GP for two different suspected cancers **on the same date,** only the first of these can be recorded.
2. If a patient is urgently referred for suspected cancer and is diagnosed with two separate cancers (which both relate to the **same Cancer Referral Decision Date),** only the cancer first treated can be recorded on this record. Where the decision to treat date for these cancers is different, treatment data for the second cancer should be recorded as a new record and information recorded from the date of decision to treat to date of first definitive treatment (start date).
3. If the decision to treat date **is the same date** for 2 separate cancers only the first of these cancers can recorded.

Part 7 – Data and the Database

There is currently no single system available regionally which will link the patients pathway across organisations. The aim in the mid to long term is to identify an IT system which is complimentary to all the existing IT systems within Northern Ireland and will enable the collection of information through a single data entry method. It is intended the collection of information to asses the timeliness of treatment should form part of the information collection process which is required to ensure effective clinical decision making and the audit of clinical outcomes.

It is recognised a number of Trusts have already established cancer patient databases which are used for the clinical decision making and audit for the cancer multi-disciplinary team. In the short term it is intended these should be developed by Trusts to allow the collection of the data items included in the core data definitions document.

A core data definitions document has been developed which lists all the information which is required to monitor the cancer patient access standard. Trust should ensure the databases are able to collect each of the listed information.

7.1 If the Trust does not have a database, what database is available?

The Cancer Registry has recognised the key forum for the collection of cancer patient treatment is the multi-disciplinary team and has developed a cancer patient database, including a cancer staging tool. A number of cancer multi-disciplinary team meetings are already using the Cancer Registry database to support the collection of cancer patient information and to facilitate timely decision-making. The Cancer Registry database will be made available to each Trust for local implementation.

7.2 What support is available for the database?

A training programme for the databases will be provided. Any supplementary IT support required will be provide from within Trust IT support staff. Any significant errors within the Cancer Registry database should be notified directly to the Clinical MDM Support Consultant, Dr Lisa Ranaghan Telephone Personal Information redacted by the USI

7.2 How will non-mandatory data recorded on the database be used?

Mandatory data on the database are required to monitor the cancer plan targets. In addition the database supports collection of a small number of additional data items that the Cancer Services Collaborative have shown are useful to support service improvement. All non mandatory data items will only be available for local use.

The core data definitions document clearly explains the data to be collected.

Only the trust(s) who manage the care of individual patients will be able to download patient identifiable information.

7.3 Will trusts be able to update data on patients for which there is an existing record on the database?

Yes. The database allows records to be automatically updated through the Cancer Multi-disciplinary Team meeting.

7.4 For which patients can we record CANCER REFERRAL DECISION DATE?

This may only be recorded on the database for Urgent Suspected Cancer Referrals from for suspected cancer. The Cancer Referral Decision Date and Health and Care Number together form the unique record identifier within the database for these records (see para 7.9).

7.5 Which data items within the database are required to monitor the Cancer plan Targets?

The table in Appendix A of the core data definitions document shows which data items are required for monitoring the Cancer Access Standards. The table splits up data required for the access standard and treatment data, as patients may be treated in a different organisation to where they are first seen.

"Trust where first seen if urgent GP referral for suspected cancer" - The M's show the data required for ALL suspected cancer referrals to allow reporting against the suspect cancer GP red flag referrals . i.e. A trust reporting the suspect cancer referrals must ensure all the M's are complete for each record. Other data is optional or not applicable.

"Trust where patient receives first definitive treatment for cancer following a referral other than an urgent GP referral for cancer" - The M's show the data required on all cancer patients who do not come through the suspect cancer red flag GP referral route for monitoring the one month diagnosis (decision to treat) to treatment target. The Trust who delivers the first definitive treatment must ensure this data is complete. Other data is optional or not applicable.

"Trust where patient receives first definitive treatment for cancer following an urgent GP referral for suspected cancer". The M's show the data required on all cancer patients who come through the 'red flag' GP suspect cancer rule to enable monitoring of the one month diagnosis (decision to treat) to treatment target and the two months urgent referral to treatment target. The Trust who delivers the first definitive treatment must ensure this data is complete. These patients will already have the data from the first column recorded on them within the database. Other data is optional or not applicable.

7.6 Why are some of the options on SOURCE OF REFERRAL FOR OUTPATIENTS not available on the database?

The source of referral relates to the initial referral into secondary care and so should relate to the DATE FIRST SEEN. Some of the options are not available on the database in order to protect the integrity of this data and to discourage trusts further down the pathway overwriting this data.

7.7 Which MDT discussion should be recorded on the database?

As stated in the Cancer Control Programme, the care of all patients should be formally reviewed by a specialist team. This will be either through direct assessment or through formal discussion with the team by the responsible clinician. This will help ensure that all patients have the benefit of the range of expert advice needed for high quality care.

In line with the manual of cancer services, the date of MDT meeting in which the patient's treatment plan is agreed should be recorded on the database.

(Standard 2A-136 " The Core MDT, at their regular meetings should agree and record individual patient's treatment plans. A record is made of the treatment plan … including the multidisciplinary planning decision".)

7.8 How should the new codes for cancer status be used?

Cancer Status codes and descriptions

1	Suspected cancer
3	No new cancer diagnosis identified by the Trust
5	Diagnosis of new cancer confirmed – treatment not yet planned
6	Diagnosis of new cancer confirmed - NHS treatment planned
7	Diagnosis of new cancer confirmed - no NHS treatment planned
8	First treatment commenced (NHS only)

The purpose of item is to identify those urgent referrals for suspected cancer who require data to be recorded on first definitive treatment.

1 Suspected cancer

3 No new cancer diagnosis identified by the Trust
Use when benign or normal diagnosis or when a patient is diagnosed with a recurrence (see below).

5 Diagnosis of new cancer confirmed - treatment not yet planned
Use for patients with a new diagnosis of cancer, but where treatment is not yet planned.

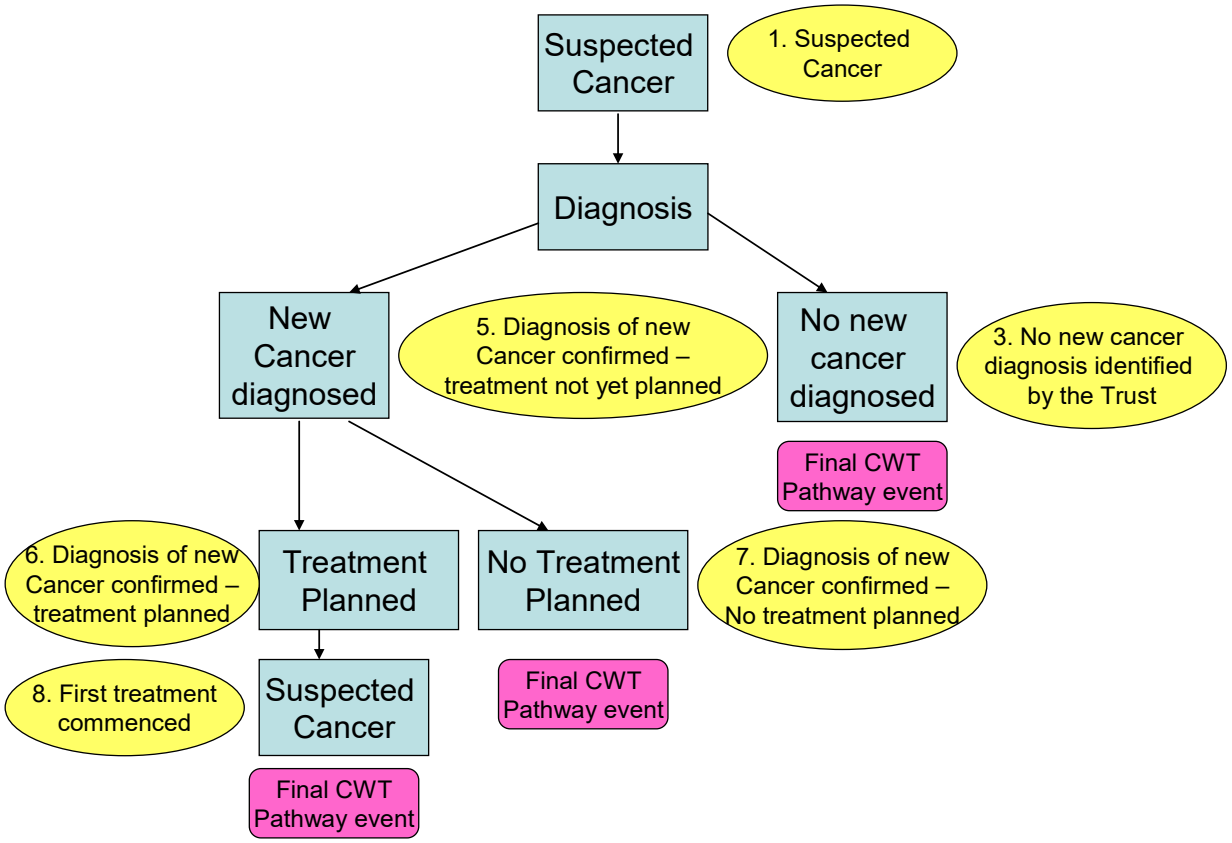
6 Diagnosis of new cancer confirmed - NHS treatment planned
Use for patients with a new diagnosis of cancer where NHS treatment is planned but has not yet commenced.

7 Diagnosis of new cancer confirmed - no NHS treatment planned
Use for patients with a new diagnosis of cancer where NHS treatment is not planned.
Use this code when a patient dies before treatment, a patient refuses all treatment or a when a patient is first treated in an independent provider or the patient is first treated privately.

8 First treatment commenced (NHS only)
This code should be used when treatment under the NHS has commenced for a patient with a new diagnosis of cancer.

Patients diagnosed with a recurrence
The standards only apply to patients with a newly diagnosed cancer. Some patients have metastases at presentation and so the treatment may be to the metastatic site rather than the primary site.
The standards do not apply to a patient receiving treatment for a recurrence of cancer. Clearly good clinical practice involves treating patients with recurrence as soon as possible on the basis of clinical priority.
When a patient is diagnosed with a second new cancer, which is not a recurrence, then the targets will apply to the treatment of this cancer.

Cancer Status and the patient care pathway



7.9 How is the primary key for a record in the CWT -db defined?

(Option 1) H&C Number + "Cancer Referral Decision Date" - If the patient is referred as an Urgent Referral for Suspected Cancer - Option 1 will be used and the trust where they are first seen has the responsibility to create the record on the system.

(Option 2) H&C Number + "Decision To Treat Date" - If the cancer patient is **NOT** an Urgent referral for Suspected Cancer, Option 2 will be used and the trust where they are **treated** has the responsibility to create the record on the system.

To add further information to a suspect cancer referral record (I.e. treatment data) it is necessary to include the "Cancer Referral Decision Date" (and the NHS Number) in any subsequent upload records. This information ensures the database will identify the correct record.

This means that there needs to be local mechanisms in place to ensure that the "Cancer Referral Decision Date" is passed along the pathway if the patient crosses trust boundaries:

7.10 What data should be recorded on patient admitted as an emergency?

Some cancer patients are admitted as emergencies and remain as an inpatient until they receive their first treatment. When a patient receives surgery as the first treatment the START DATE(SURGERY) is defined to be the date of admission. In this example the DECISION TO TREAT DATE may be after the date of admission and hence the interval between decision to treat and start date is negative. These dates will be accepted by the database.

7.11 In what circumstances should we use the code "4 – patient choice" in the field WAITING TIME ADJUSTMENT REASON (FIRST SEEN)?

This code should only be used if a patient referred by their GP as a suspected cancer makes it clear that they do not want an appointment within 14 days before an offer is made. The patient will be excluded from the reports generated on the CWT-db to monitor the Two Week Standard. However data on the patients waiting time should be uploaded onto the CWT-db, as this will be required for monitoring the Urgent Referral to treatment target if the patient is diagnosed with cancer.

Where a patient turns down an appointment offered within 14 days the code "2 – patient cancellation" should be used (for example the patient declines as they are on holiday on the date offered). The patient should be offered another appointment within 14 days of the cancelled appointment.

7.12 How do we record suspect cancer patients that are admitted as emergencies before they are seen?

When a suspected cancer patient is admitted as an emergency before they are seen. The emergency admission is the referral into the system and effectively supersedes the original referral. Where a patient is admitted for another condition the original suspected cancer referral still stands.

7.13 How do we record new cases of cancer cases where there is no pathology available?

It is well recognised that some patients with cancer never have microscopic verification (i.e. histology or cytology). This is particularly the case for internal cancers such as pancreatic and for elderly patients with lung cancer who are deemed unfit for bronchoscopy. In these cases diagnosis is made on non-microscopic information such as radiological investigations. For practical purposes if a patient has been told they have cancer and/or have received treatment for cancer the relevant primary diagnosis code should be used.

7.14 How should we record ICD10 code on Chronic Lymphocytic Leukaemia?

Chronic Lymphocytic Leukaemia should be reported using the 3-digit code C91. The CWT-db requires all acute leukaemia's to four digits in order to identify these cases separately to monitor the 2001 treatment target, but in other cases of leukaemia the ICD10 code is only required to 3 digits.

Decision to Treat

7.15 Why is “decision to treat date” used to monitor the 31 day target?

Date of diagnosis is already well defined for cancer registration purposes. In some cancers it is common for the diagnosis to take place AFTER first treatment. For example in testicular cancer, orchidectomy is counted as the first definitive treatment, although definitive diagnosis will be obtained from this operation. The start date for monitoring this target should be one that is meaningful for patients. The decision to treat date is the date of the consultation in which the patient and clinician agree the treatment plan for first treatment. If the first treatment requires an admission (e.g. Surgery) this date is recorded on hospital PAS systems, as the "Date of decision to admit" (used for calculation of waiting list statistics). A decision to treat is dependent on the agreement of the patient and so may not be on the day of the MDT meeting.

7.16 What is the date of decision to treat for chemotherapy or radiotherapy?

Oncologists have agreed that the "decision to treat date" is the date the oncologist sees the patient and agrees that the patient is suitable for treatment and that the patient agrees the treatment plan.

7.17 Can a decision to treat be made with a patient prior to completing all staging tests?

Normally staging tests are completed prior to making a decision to treat. As stated above if first treatment requires an admission (e.g. Surgery) this date is recorded as “Date of Decision to admit” on hospital PAS systems and is used for measuring elective inpatient waiting times and should also be used for cancer waiting times.

7.18 What date is the decision to treat for brachytherapy in prostate cancer?

In order to determine whether the prostate is suitable for brachytherapy a volume study has to be performed. The date of the decision to treat will be the date of the consultation where the treatment is agreed after the volume study has been completed.

Part 8 – Guidance on Adjustments for Cancer Waiting Times

8.1 There will be guidance issued which will explain the recording waiting times for the purposes of calculating inpatient waiting list and waiting time central returns.

8.2 This existing guidance also applies to the recording of waiting times in the cancer access standards database. This note provides some specific examples of adjustments in the cancer pathway.

8.3 In line with current guidance on waiting times an adjustment to the waiting time of a patient is applicable in the following circumstances.

- Patient cancelled an outpatient appointment
- Patient Did Not Attend (DNA) an outpatient appointment
- Patient defers an admission
- Suspension for patient reasons (often referred to as social suspension)
- Suspension for medical reasons

8.4 Patient cancelled an outpatient appointment

~ If this is the first outpatient appointment the clock restarts from the date the patient informs the Trust that they wished to cancel their appointment the adjustment is the number of days from date of decision to refer to date of appointment the patient refuses. (i.e. clock is reset)
For example if the referral is received on the 1 May and the appointment is offered for the 10th May, and the patient cancels it on the 5th May, this should take 5 days off your waiting time.

- If this is a follow-up appointment the adjustment is calculated as the number of days from the date the patient informs the Trust that they wished to refuse the appointment.

Note: If the provider cancels the appointment then there is no affect on the waiting time.

8.5 Patient Did Not Attend (DNA) an outpatient appointment

~ If this is the first outpatient appointment the clock restarts from the date of the appointment the patient did not attend or the date on which they informed the Trust that they wished to cancel their appointment. The adjustment is the number of days from date of decision to refer to date of DNA. (i.e. clock is reset)

- If this is a follow-up appointment the adjustment is calculated as the number of days from the date the patient was last seen to the date of appointment the patient did not attend.

8.6 Patient defers admission

~ Patient is offered a reasonable date for admission but refuses. Provided the admission date was a reasonable one (i.e. there was a sufficient amount of notice and the provider took account of personal circumstances) this is described as a self-deferral. In such a case the waiting time is adjusted by the number of days from date of decision to treat to the date the admission was scheduled to take place.

Example

A patient is contacted by the trust and offered an admission date for surgery to treat their breast cancer. At this time they declare that they are unable to attend on this date as they have booked a holiday. This is a patient deferral. In this case the period between the admission date they declined and the decision to treat date is to be removed by an adjustment.

Note: if the provider cancels the admission then there is no affect on the waiting time. (e.g. the 31 day target waiting times is calculated from the original decision to treat date)

8.7 Suspension for patient reasons (often referred as social suspensions)

The clock stops when

- When a patient has other commitments they wish to pursue prior to treatment or investigation (e.g. Holiday)
- When a patient requests a period of time to think (e.g. to decide on treatment options)
- When a patient requests a second opinion before making a decision on treatment. (The clock does not stop if the clinician requires a second opinion)
- **Suspensions must be clearly recorded in the patient notes**
- **The position of any patient suspended must be reviewed regularly.**

The clock does not stop

- When a patient chooses a treatment with a longer waiting time (e.g. radiotherapy rather than surgery)
- A patient should not be suspended once an admission date has been agreed, unless the date is later than normal due to the need to resolve other medical problems prior to treatment.

8.8 Examples of social suspensions

A patient with cancer is seen by the oncologist and is suitable for a clinical trial. The patient is given the details and told he/she needs to make a choice about whether or not they wish to take part in the trial. This two-step process is good practice in terms of informed consent. Whilst taking the time to make the decision, the patient will be classed as suspended for patient reasons as he/she is technically unavailable for treatment. The clock starts again as soon as the patient has told the oncologist of their decision.

Note: Allowing patients time to consider treatment options is part of good clinical practice and is not confined to clinical trials.

A young patient is advised that potentially curative treatment involves significant risk of serious side effects (which may include peri-operative death). The patient wishes to be referred for a second opinion to see if they might avoid these outcomes but yet still achieve cure. The patient is suspended for patient reasons as they have made themselves unavailable for treatment whilst seeking a second opinion.

A patient is discussing their care-plan with a clinician and states (before any offer of an admission date is made) that they would like to take the holiday they have booked prior to treatment starting. As no offer of a TCI date had been made by the trust this can be classified as a suspension for patient reasons. The period which the patient has made themselves unavailable should be adjusted out of the calculated waiting time.

8.9 Suspension for medical reasons

The clock stops when

- When a patient is unavailable for admission for a period of time due to another medical condition that needs to be resolved
- When a patient is unavailable for a diagnostic or staging test or treatment due to another medical condition that needs to be resolved (e.g. reduce weight)
- **Suspensions must be clearly recorded in the patient notes**
- **The position of any patient suspended must be reviewed regularly.**

The clock does not stop

- When the trust is unable to offer treatment within the required timescales.
- For a patient who requires repeat biopsies or scans because of uncertainty the first time round.
- In patients for whom there is genuine clinical uncertainty about the diagnosis and the clinician elects to observe the patient over (say) a three month period.
- A patient should not be suspended once an admission date has been agreed, unless the date is later than normal due to the need to resolve other medical problems prior to treatment

8.10 Examples of suspension for medical reasons

 Some cancer patients will have co-morbidities, which will require investigation and/or treatment prior to administering cancer treatment. For example a cancer patient with angina may be referred for a cardiology opinion prior to treatment. In this case the clock will only stop if the cardiology opinion is that the patient is medically unfit for cancer treatment. If the opinion is that the patient is fit for cancer treatment then the clock does not stop. Hence the clock does not stop whilst an opinion on the co-morbidity is being sought. A similar example would be where a patient with mouth cancer requires dental extraction prior to ommencement of radiotherapy treatment – the clock would stop while the patient was not fit for treatment following the extraction, but not whilst they were waiting for the extraction.

 Patients with severe frailty/cachexia related to the cancer. A patient who requires intensive nutritional support (e.g. through intravenous feeding or through nasogastric feeding) before they are fit for surgery. The clock stops for the period the patient is medically unfit for surgery, with the start date of this period of suspension being defined as the date when a medical opinion as to their being unfit for treatment was received.

 A patient with cancer also has COPD. He/she is technically suitable for surgical resection but considered in need of a medical opinion (in this case usually a respiratory physician). The respiratory physician confirms the patient is medically unfit for the surgery at that time (clock stops at this point) (see above) and wishes to institute a changed therapeutic regime to optimise their respiratory function before surgery. The patient is suspended until medically fit for the surgery.

 In prostate cancer following a transrectal ultrasound-guided biopsy there may be swelling of the prostate gland. This makes interpretation of MRI scans unreliable. Many clinicians would advocate that there should be a planned interval of up to 4 weeks between biopsy and MRI, as the gland swelling means the patient is medically unfit for the scan and so a medical suspension is appropriate. Where this is agreed in local clinical protocols and if the clinician agrees this with the patient, then an adjustment can be made to the waiting time for the period that the patient is unfit to progress to the scan (i.e. where the MRI is requested after biopsy the clock can be stopped from date of MRI request until the date that is a maximum of 4 weeks after the biopsy). The patient notes need to make it clear that a medical suspension was necessary. Of course this must not be used to mask delays to MRI scans or subsequent delays to surgery.

 In the absence of conclusive research regarding the optimum time interval from TRUS biopsy to radical prostate surgery, it has been agreed through clinical consensus that there could

be a period of up to six weeks, depending on clinical judgement, between TRUS biopsy and radical prostate surgery. If this is agreed in local clinical protocols the patient should only be medically suspended for the period they are unfit (i.e. from the date it is agreed they will have radical surgery until the date 6 weeks after biopsy).

- If a cancer is found on barium enema a CT cannot be performed for up to 10 days as barium sulphate cannot be penetrated by X-Ray. A medical suspension may be recorded for the period the patient is unfit (following the decision that the patient requires a CT) if no other diagnostic activities can be carried out in this period and a CT scan was available within 10 days.

- Some patients diagnosed with primary liver cancer (Hepatoma) have an organ transplant as their first treatment. A patient should be suspended for the period that matched organs are not available.

8.11 Can we make an adjustment for radiographic investigations in menstruating females?
The Royal College issued guidance a few years ago indicating that, while the 28 day rule was satisfactory for most radiographic investigations, in menstruating females, the 10 day rule was safer for high dose investigations particularly barium enema and CT of the abdomen and pelvis (i.e. the procedure should be performed in the first 10 days of the menstrual cycle). Many departments also apply the 10 day rule for barium studies of the small bowel. Where this delays a patients investigation a medical suspension may be applied for the time the patient is unfit for the test.

8.12 How do we monitor a patient who agrees a treatment and then a week later changes their mind and wishes to receive a different treatment altogether?
The patient will have to agree a new decision to treat and hence the 31 day target clock is reset. For the 62 day target it is appropriate to remove the period from decision to treat to the date of cancellation and should be coded as a self-deferral.

8.13 How do we monitor a patient that refuses altogether the diagnostic test that may diagnose cancer but continues to be cared for by the trust?
In effect the patient, by refusing the diagnostic test, has taken them self off the 62 day pathway. The trust can not deliver on a patient who is not prepared to "be on the pathway". If the patient agrees at a later stage to have the test and is subsequently diagnosed with cancer, they should be monitored against the 31 day standard.

8.14 How do we monitor a patient that turns up for their diagnostic test but then refuses the test and has to be re-booked at a later date?
If the trust has done everything possible to avoid this happening (e.g. the patient is fully informed about what to expect) then the patient can be considered as having been self-deferred (or patient cancellation) and so an adjustment may be made.

8.15 How are adjustments to waiting times made?
There are three adjustment fields within the Cancer Waiting Times Database (CWT-Db) to record adjustment values depending on which point on the referral to treatment pathway the adjustment is appropriate.
WAITING TIMES ADJUSTMENT (FIRST SEEN) – To record adjustment (in days) between referral received date and date first seen.

WAITING TIMES ADJUSTMENT (DECISION TO TREAT) – To record adjustment (in days) between date first seen and date of decision to treat.

WAITING TIMES ADJUSTMENT (TREATMENT) – To record adjustment (in days) between date of decision to treat and start date of treatment.

If an adjustment is recorded a user is also required to give the reason for adjustment (using the fields WAITING TIME ADJUSTMENT REASON (FIRST SEEN), WAITING TIME ADJUSTMENT

REASON (DECISION TO TREAT), and WAITING TIME ADJUSTMENT REASON (TREATMENT)

Please Note: A comment in the delay reason comment field will **not** result in a patient's waiting time being adjusted. The system requires the adjustment fields above to be completed in order to calculate an adjusted waiting time.

8.16 Examples of adjusting a patients waiting time

Example A: The patient and surgeon agreed first definitive treatment of surgery on 01/11/2002. The date of admission for this surgery was 25/11/2002, but the patient defers treatment. The patient is then admitted on 09/12/2002 for the surgery.
DECISION TO TREAT DATE (SURGERY) = 01/11/2002
START DATE (SURGERY HOSPITAL PROVIDER SPELL) = 09/12/2002
WAITING TIME ADJUSTMENT (TREATMENT) = 25/11/2002 – 01/11/2002 = 24 days
The database will then calculate the waiting time for the decision to treat to treatment target which will be reported as 14 (START DATE (SURGERY HOSPITAL PROVIDER SPELL) - DECISION TO TREAT DATE (SURGERY) - WAITING TIME ADJUSTMENT (TREATMENT))

If however, the patient cancels on the 20/11/02 the waiting times will be adjusted and calculated as 20/02/02-01/02/07 = 11 days

Example B: A GP decides to refer a patient under the suspected cancer referral standard on 03/02/2003 and the referral is received on the 04/02/2003 and the patient is given an appointment for 11/02/2003. The patient cancels this appointment on the 07/02/2003 and is given another appointment for 18/02/2003, which the patient attends.
CANCER REFERRAL RECEIVED DATE = 04/02/2003
DATE FIRST SEEN = 18/02/2003
WAITING TIME ADJUSTMENT (FIRST SEEN) = 18/02/2003 – 04/02/2003 = 3 days
The database will calculate the waiting time from the above information and the reported waiting time will be 11 days (DATE FIRST SEEN - CANCER REFERRAL RECEIVED - WAITING TIME ADJUSTMENT (FIRST SEEN))

Example C: The patient above (who was first seen on 18/02/2003) cancels their follow-up appointment on 23/02/2003. This is an adjustment of 5 days from the date the patient cancels or DNAs. The patient is given another appointment for 04/03/2003, which the patient attends. The consultant and patient agree the first definitive treatment of surgery on 11/03/2003.
Date Last Seen = 18/02/2003
WAITING TIMES ADJUSTMENT (DECISION TO TREAT)
= Cancelled follow-up appointment – Date last seen
= 23/02/2003 – 18/02/2003 = 5 days

Example D: If the patient in examples B and C is admitted for the surgical treatment on 07/04/2003 then the waiting time from urgent referral to treatment is calculated as follows.
Waiting time from urgent referral to first treatment
= START DATE (SURGERY HOSPITAL PROVIDER SPELL) - CANCER REFERRAL RECEIVED DATE – WAITING TIME ADJUSTMENT (FIRST SEEN) - WAITING TIME ADJUSTMENT (DECISION TO TREAT) – WAITING TIME ADJUSTMENT (TREATMENT). This is when they cancel on the 25th Feb.
= 07/04/2003 – 04/02/2003 –(3 +7) – 10 = 52 days

References

http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Cancer/CancerArticle/fs/ en?CONTENT_ID=4001800&chk=dpRNWQ

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- HSC 2002/005 - Cancer Waiting times: Guidance on Making and Tracking Progress on Cancer Waiting Times
- Achieving the two week standard: Questions and Answers
- Cancer Waiting Targets – A guide

http://www. performance.doh.gov.uk/cancerwaits/

- Cancer Waiting Times Data

http://www. nhsia.nhs.uk/cancer/pages/waiting//documentation.asp

- The user manual for the Cancer Waiting Database (including CSV upload format for multiple records)
- System security document

http://www. nhsia.nhs.uk/nhais/pages/products/vaprod/openexe/

- User Access form for Cancer Waiting Times System

www. n hsia. n hs. u k/dscn

- DSCN 22/2002 – National Cancer Waiting Times Monitoring
- DSCN 31/2003 – Extension of Active Monitoring to all tumour sites
- DSCN 15/2004 – Cancer Waiting Times – First Definitive Treatment
- DSCN 27/2004 – Cancer Waiting Times - Cancer Status

www. nocancerwaits.org

- Information and slide packs from National Briefing and Cancer Waits executive delivery days
- Information on 27th June 2005 National Briefing
- **Materials for clinicians**
  - The ABC of Cancer Waits
    The "one page guide" of key definitions for MDTs.
    Power point slide pack

http://www.cancerimprovement.nhs.uk/scripts/default.asp?site_id=26&id=5620

- ***Applying High Impact Changes to Cancer***
- ***The "How to" Guide: Achieving Cancer Waiting Times***

Discussion Forum

The discussion forum is designed to give the opportunity for those interested in cancer access standards information to discuss ideas or share good practice. This discussion forum is located on the <> web site<>?
To check out the discussion forum please visit:
www.dhsspsweb site

SOUTHERN HEALTH AND SOCIAL CARE TRUST

Targets for Cancer 2020/21

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

SOUTHERN HEALTH AND SOCIAL CARE TRUST

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

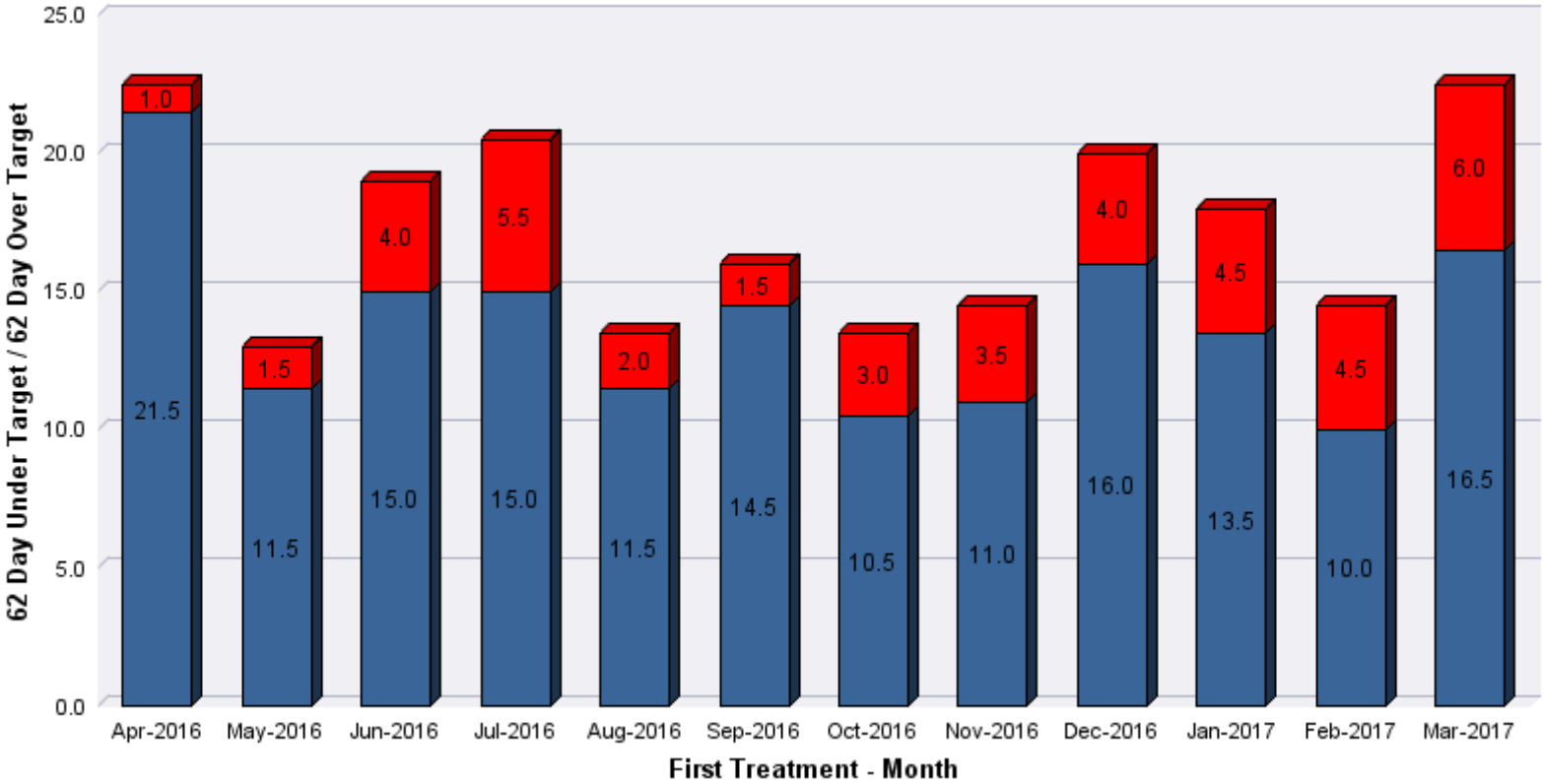
62 DAY COMPLETED WAITS FROM REFERRAL TO FIRST DEFINITIVE TREATMENT DATE - MONTHLY AND CUMULATIVE VIEW

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

MONTHLY

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

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



SOUTHERN HEALTH AND SOCIAL CARE TRUST

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

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

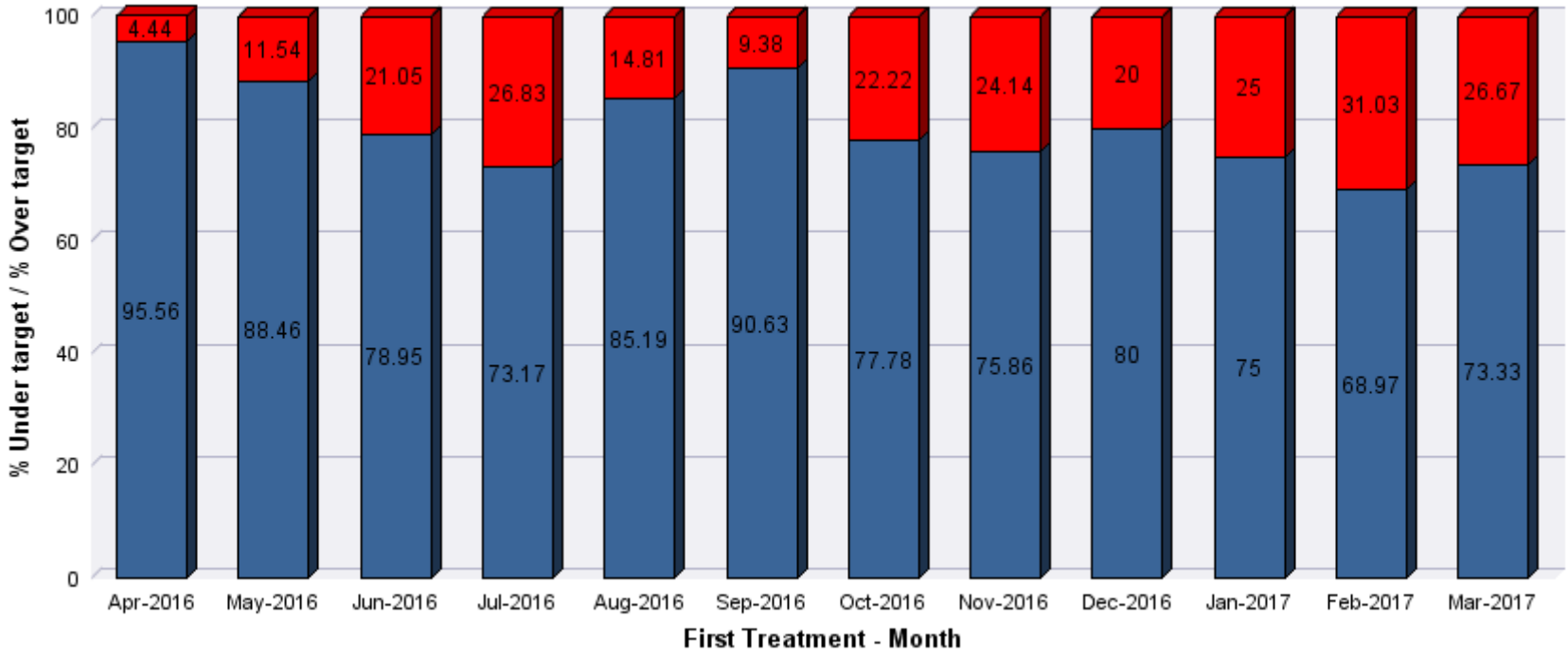
FROM 01/04/2016 TO 31/03/2017

MONTHLY

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

CUMULATIVE

% Under target	% Over target
80.24	19.76



Received from SHSCT on 16/05/22. Annotated by the Urology Services Inquiry.

SOUTHERN HEALTH AND SOCIAL CARE TRUST

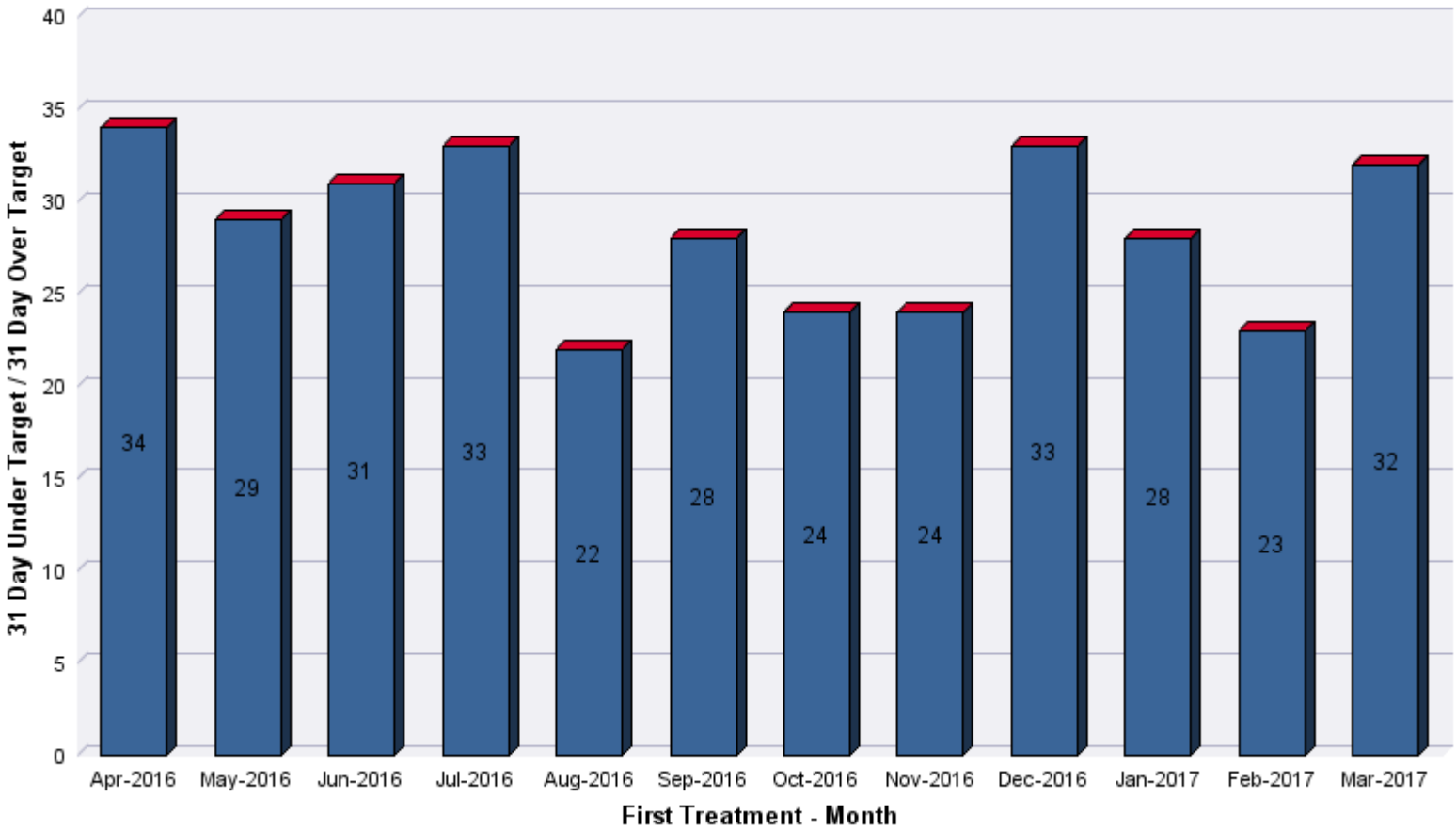
CANCER TARGET MONITORING - 'SUSPECT TUMOUR SITE' = UROLOGICAL CANCER

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

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

MONTHLY

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



SOUTHERN HEALTH AND SOCIAL CARE TRUST

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

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

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

MONTHLY

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

CUMULATIVE

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