Urology Services Inquiry

Urology Services Inquiry | 1 Bradford Court | Belfast BT8 6RB
T: 02890 251005 | E: info@usi.org.uk | W: www.urologyservicesinquiry.org.uk

Shauna McVeigh
Cancer Tracker/MDT Co-ordinator
C/O Southern Health and Social Care Trust
Craigavon Area Hospital,
68 Lurgan Road, Portadown,
BT63 5QQ

26 September 2022

Dear Madam,

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

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

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

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

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

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

The Inquiry is aware that you have held posts relevant to the Inquiry's Terms of Reference. The Inquiry understands that you will have access to all of the relevant information required to provide the witness statement required now or at any stage

throughout the duration of this Inquiry. Should you consider that not to be the case, please advise us of that as soon as possible.

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

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

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

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

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

Given the tight time-frame within which the Inquiry must operate, the Chair of the Inquiry would be grateful if you would comply with the requirements of the Section 21 Notice as soon as possible and, in any event, by the date set out for compliance in the Notice itself.

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

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

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

Yours faithfully

Personal Information redacted by the USI

Anne Donnelly
Solicitor to the Urology Services Inquiry

Tel: Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI

Issued by the Urology Services Inquiry on 26 September 2022. Annotated by the Urology Services Inquiry.

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

Chair's Notice

[No 86 of 2022]

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

WARNING

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

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

TO:

Shauna McVeigh
Cancer Tracker/MDT Co-ordinator
C/O Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

IMPORTANT INFORMATION FOR THE RECIPIENT

1. This Notice is issued by the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust on foot of the powers given to her by the Inquiries Act 2005.

2. The Notice requires you to do the acts set out in the body of the Notice.

3. You should read this Notice carefully and consult a solicitor as soon as possible about it.

4. You are entitled to ask the Chair to revoke or vary the Notice in accordance with the terms of section 21(4) of the Inquiries Act 2005.

5. If you disobey the requirements of the Notice it may have very serious consequences for you, including you being fined or imprisoned. For that reason you should treat this Notice with the utmost seriousness.

WITNESS STATEMENT TO BE PRODUCED

TAKE NOTICE that the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust requires you, pursuant to her powers under section 21(2)(a) of the Inquiries Act 2005 ('the Act'), to produce to the Inquiry a Witness Statement as set out in the Schedule to this Notice by **noon on 24th October 2022.**

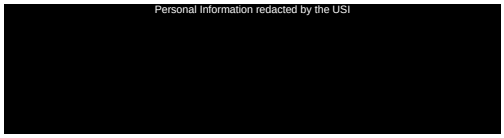
APPLICATION TO VARY OR REVOKE THE NOTICE

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

If you wish to make such a claim you should do so in writing to the Chair of the Inquiry at: **Urology Services Inquiry, 1 Bradford Court, Belfast, BT8 6RB** setting out in detail the basis of, and reasons for, your claim by **noon on 17th October 2022**.

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

Dated this day 26th September 2022

Signed: 

Christine Smith QC
Chair of Urology Services Inquiry

Urology Services Inquiry

SCHEDULE
[No 86 of 2022]

SECTION 1 – GENERAL NARRATIVE

General

1. Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with or by you, meetings you attended, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order.

2. Please also provide any and all documents within your custody or under your control relating to the terms of reference of the *Urology Services Inquiry* ("USI"). Provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below. Place any documents referred to in the body of your response as separate appendices set out in the order referred to in your answers. If you are in any doubt about document provision, please do not hesitate to contact the Trust's Solicitor, or in the alternative, the Inquiry Solicitor.

3. Unless you have specifically addressed the issues in your reply to Question 1 above, please answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, please specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed and, as far as possible, to address your answers in a chronological format.

If there are questions that you do not know the answer to, or if you believe that someone else is better placed to answer a question, please explain and provide the name and role of that other person.

Your role

4. Please set out all roles held by you within the Southern Trust, including dates and a brief outline of duties and responsibilities in each post.

5. Please provide a description of your line management in each role, naming those roles/individuals to whom you directly report/ed and those departments, services, systems, roles and individuals whom you manage/d or had responsibility for.

6. If your current role involves managing staff, please set out how you carry out this role, e.g. meetings, oral/written reports, assessments, appraisals, etc.

7. What systems were and are in place during your tenure to assure you that appropriate standards were being met by you and maintained by you in fulfilling your role?

8. Was your role subject to a performance review or appraisal? If so, please explain how and by whom this was carried out and provide any relevant documentation including details of your agreed objectives for this role, and any guidance or framework documents relevant to the conduct of performance review or appraisal.

9. Where not covered by question 8 above, please set out any relevant policy and guidelines, both internal and external as applicable, governing your role. How, if at all, are you made aware of any updates on policy and guidance relevant to you?

Urology Services Inquiry

10. What performance indicators, if any, are used to measure performance for your role?

11. How do you assure yourself that you adhere to the appropriate standards for your role? What systems were in place to assure you that appropriate standards were being met and maintained?

12. Have you experience of these systems being by-passed, whether by yourself or others? If yes, please explain in full, most particularly with reference to urology services.

13. What systems of governance do you use in fulfilling your role?

14. Have you been offered any support for quality improvement initiatives during your tenure? If yes, please explain and provide any supporting documentation.

15. During your tenure, who did you understand was responsible for overseeing the quality of services in urology?

16. In your experience, who oversaw the clinical governance arrangements of urology and, how was this done?

17. Did you feel able to provide the requisite service and support to urology services which your role required? If not, why not? Did you ever bring this to the attention of management and, if so, what, if anything, was done? What, if any, impact do you consider your inability to properly fulfill your role within urology had on patient care, governance or risk?

18. Did you feel supported by staff within urology in carrying out your role? Please explain your answer in full.

Urology Services Inquiry

Urology services

19. Please explain those aspects of your role and responsibilities which are relevant to the operation, governance or clinical aspects of urology services.

20. With whom do you liaise directly about all aspects of your job relevant to urology? Do you have formal meetings? If so, please describe their frequency, attendance, how any agenda is decided and how the meetings are recorded. Please provide the minutes as appropriate. If meetings are informal, please provide examples.

21. In what way is your role relevant to the operational, clinical and/or governance aspects of urology services? How are these roles and responsibilities carried out on a day to day basis (or otherwise)?

22. What is your overall view of the efficiency and effectiveness of governance processes and procedures within urology as relevant to your role?

23. Through your role, did you inform or engage with performance metrics or have any other patient or system data input within urology? How did those systems help identify concerns, if at all?

24. Do you have any specific responsibility or input into any of the following areas within urology? If yes, please explain your role within that topic in full, including naming all others with whom you engaged:

    (i) Waiting times
    (ii) Triage/GP referral letters
    (iii) Letter and note dictation
    (iv) Patient care scheduling/Booking
    (v) Prescription of drugs

(vi) Administration of drugs
(vii) Private patient booking
(viii) Multi-disciplinary meetings (MDMs)/Attendance at MDMs
(ix) Following up on results/sign off of results
(x) Onward referral of patients for further care and treatment
(xi) Storage and management of health records
(xii) Operation of the Patient Administrative System (PAS)
(xiii) Staffing
(xiv) Clinical Nurse Specialists
(xv) Cancer Nurse Specialists
(xvi) Palliative Care Nurses
(xvii) Patient complaints/queries

Concerns

25. Please set out the procedure which you were expected to follow should you have a concern about an issue relevant to patient care and safety and governance.

26. Did you have any concerns arising from any of the issues set out at para 24, (i) – (xvii) above, *or any other matter* regarding urology services? If yes, please set out in full the nature of the concern, who, if anyone, you spoke to about it and what, if anything, happened next. You should include details of all meetings, contacts and outcomes. Was the concern resolved to your satisfaction? Please explain in full.

27. Did you have concerns regarding the practice of any practitioner in urology? If so, did you speak to anyone and what was the outcome? Please explain your answer in full, providing documentation as relevant. If you were aware of concerns but did not report them, please explain why not.

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28. If you did have concerns regarding the practice of any practitioner in urology, what, in your view was the impact of the issue giving rise to concern on the provision, management and governance of urology services?

29. What steps were taken by you or others (if any) to risk assess the potential impact of the concerns once known?

30. Did you consider that the concern(s) raised presented a risk to patient safety and clinical care? If yes, please explain by reference to particular incidents/examples. Was the risk mitigated in any way?

31. Was it your experience that once concerns were raised, systems of oversight and monitoring were put in place? If yes, please explain in full.

32. In your experience, if concerns are raised by you or others, how, if at all, are the outcomes of any investigation relayed to staff to inform practice?

33. Did you have any concerns that governance, clinical care or issues around risk were not being identified, addressed and escalated as necessary within urology?

34. How, if at all, were any concerns raised or identified by you or others reflected in Trust governance documents, such Governance meeting minutes or notes, or in the Risk Register, whether at Departmental level or otherwise? Please provide any documents referred to.

35. What could improve the ways in which concerns are dealt with to enhance patient safety and experience and increase your effectiveness in carrying out your role?

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Staff

36. As relevant, what was your view of the working relationships between urology staff and other Trust staff? Do you consider you had a good working relationship with those with whom you interacted within urology? If you had any concerns regarding staff relationships, did you speak to anyone and, if so, what was done?

37. In your experience, did medical (clinical) managers and non-medical (operational) managers in urology work well together? Whether your answer is yes or no, please explain with examples.

Learning

38. Are you now aware of governance concerns arising out of the provision of urology services which you were not previously aware of? Identify any governance concerns which fall into this category and state whether you could and should have been made aware of the issues at the time they arose and why.

39. Having had the opportunity to reflect on these governance concerns arising out of the provision of urology services, do you have an explanation as to what went wrong within urology services and why?

40. What do you consider the learning to have been from a governance perspective regarding the issues of concern within urology services and, to the extent that you are aware, the concerns involving Mr. O'Brien in particular?

41. Do you think there was a failure to engage fully with the problems within urology services? If so, please identify who you consider may have failed to engage, what they failed to do, and what they may have done differently. Your answer may, for example, refer to an individual, a group or a particular level of staffing, or a particular discipline.

If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom.

42. Do you consider that, overall, mistakes were made by you or others in handling the concerns identified? If yes, please explain what could have been done differently within the existing governance arrangements during your tenure? Do you consider that those arrangements were properly utilised to maximum effect? If yes, please explain how and by whom. If not, what could have been done differently/better within the arrangements which existed during your tenure?

43. Do you think, overall, the governance arrangements were and are fit for purpose? Did you have concerns specifically about the governance arrangements and did you raise those concerns with anyone? If yes, what were those concerns and with whom did you raise them and what, if anything, was done?

44. If not specifically asked in this Notice, please provide any other information or views on the issues raised in this Notice. Alternatively, please take this opportunity to state anything you consider relevant to the Inquiry's Terms of Reference and which you consider may assist the Inquiry.

NOTE:

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

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 86 of 2022

Date of Notice: 26 September 2022

Witness Statement of: Shauna McVeigh

I, Shauna McVeigh, will say as follows:-

SECTION 1 – GENERAL NARRATIVE

General

1. **Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with or by you, meetings you attended, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order.**

1.1 On 8th December 2008 I commenced my employment in the Southern Trust in the Red Flag ('RF') booking office. This involved:

a. Sending RF referral for triage.
b. Booking RF patients into RF clinics.
c. Cancelling RF patients as appropriate
d. Updating Cancer Access Patient Pathway System ('CAPPS')

1.2 On 13th April 2015, I began a new role within the Trust as a Cancer Tracker and MDT Co-ordinator for Urology. I am currently still in this role. This role involves:

a. Tracking patients on the Urology pathway from their 1st Outpatient appointment.
b. Checking patients' clinic outcomes.
c. Updating CAPPs to add patients' investigations, diagnoses and treatment.
d. Preparing for and attending weekly MDT meetings for Urology, noting the MDT meeting outcome and adding this to CAPPS, drafting the minutes of the MDT meeting and sending out reviews and minutes to appropriate persons after each meeting.

2. Please also provide any and all documents within your custody or under your control relating to the terms of reference of the *Urology Services Inquiry* ("USI"). Provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below. Place any documents referred to in the body of your response as separate appendices set out in the order referred to in your answers. If you are in any doubt about document provision, please do not hesitate to contact the Trust's Solicitor, or in the alternative, the Inquiry Solicitor.

2.1 I have provided all relevant documentation.

3. Unless you have specifically addressed the issues in your reply to Question 1 above, please answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, please specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to

the relevant paragraphs. The key is to address all questions posed and, as far as possible, to address your answers in a chronological format.

If there are questions that you do not know the answer to, or if you believe that someone else is better placed to answer a question, please explain and provide the name and role of that other person.

Your role

4. **Please set out all roles held by you within the Southern Trust, including dates and a brief outline of duties and responsibilities in each post.**

4.1. Please see my response to Question 1.

5. **Please provide a description of your line management in each role, naming those roles/individuals to whom you directly report/ed and those departments, services, systems, roles and individuals whom you manage/d or had responsibility for.**

5.1. Angela Muldrew was my manager when I worked in the RF booking office from December 2008 until April 2015.

5.2. While working in the tracking team I have been managed by the following people:

a. Vicki Graham: from April 2015 until 2nd August 2020.

b. Sinead Catherine Lee: from 3rd August 2020 until 1st November 2020.

c. Ciaran McCann: from 2nd November 2020 until 28th March 2021.

d. Sinead Catherine Lee: from 29th March 2021 until 3rd January 2022.

e. Angela Muldrew: from 4th January 2022 until present.

5.3. Throughout my tenure within the Southern Trust, I have not had any management roles.

6. **If your current role involves managing staff, please set out how you carry out this role, e.g. meetings, oral/written reports, assessments, appraisals, etc.**

6.1. Not applicable. My current role as Cancer Tracker / MDT co-ordinator for the Southern Trust does not involve any management off staff.

7. **What systems were and are in place during your tenure to assure you that appropriate standards were being met by you and maintained by you in fulfilling your role?**

7.1. There are a number of systems that were and still are in place to assure appropriate standards were, and continue to be, met. For example, the integrated elective access protocol ('IEAP') was implemented on 30th April 2008. In this document there are guidelines for RF suspected cancer referrals regarding triaging times and calculation of waiting times. The performance team within the Southern Trust monitors the waiting time targets which are, as set out in the guidance, as follows:

a. 14-day target – suspected cancer patients need to be booked within 14 days
b. 31-day target – these are referrals from other sources (not GP referrals) that are calculated from the decision to treat date to 1st definitive treatment.
c. 62-day target – These are GP referrals that are calculated from receipt of referral to 1st definitive treatment.

Please see 1. IEAP inquiry question 7

7.2. Within Urology Services I provide administrative support for the weekly MDM meetings where patients are discussed and I record the individual outcomes. I then send the MDM outcomes to the Chair of the MDM for Urology to approve. Once this is completed I draft the MDM minutes. I then send the minutes and the approved MDM outcomes to the Urology MDM circulation list. I also record the outcomes onto CAPPS diary page for each individual patient as part of my cancer tracking for Urology.

7.3 In my current role as Cancer tracker / MDT co-ordinator I follow the escalation policy which was put in place on 13th April 2016 to meet the regional cancer targets for Northern Ireland.

8. **Was your role subject to a performance review or appraisal? If so, please explain how and by whom this was carried out and provide any relevant documentation including details of your agreed objectives for this role, and any guidance or framework documents relevant to the conduct of performance review or appraisal.**

8.1. NHS Knowledge and Skills Framework ('KSF') appraisal was introduced in 2015. This is an annual appraisal completed by management to ensure that staff training is up to date and to ensure that staff understand their job role, responsibilities and objectives for the following year.

8.2. The appraisal is carried out annually by my line manager and the objectives are to keep mandatory training up to date, to work accurately and to a high standard, to communicate effectively with everyone and to treat everyone equally.

8.3. Staff are also be given the opportunity to comment and reflect on their performance over the previous year.

8.4. KSF PDR/PDP 2014/15 08/01/2014 08/01/2015

KSF PDR/PDP 2015/1615/06/2015 15/06/2016
KSF PDR/PDP 2016/1715/07/2016 15/07/2017
KSF PDR/PDP 2017/1805/12/2017 05/12/2018
KSF PDR/PDP 2021/2022 26/08/2021 26/08/21
KSF PDR/PDP 2021/2231/08/2021 30/08/2022

9. **Where not covered by question 8 above, please set out any relevant policy and guidelines, both internal and external as applicable, governing your role. How, if at all, are you made aware of any updates on policy and guidance relevant to you?**

9.1. In my first role we had Standard Operation Procedures ('SOP') for using Patient Administration System (PAS) to book RF patients to clinics for all tumour sites.

9.2. In my current role, as Cancer Tracker for Urology, there are SOP including an operating policy which came into force in 2012. There were changes made to this SOP in March 2022 as a lot had changed within Urology services, to include the introduction of regional meetings with Belfast, the introduction of a small renal mass MDT, staff changes, new nurses, secretaries to be emailed with reviews and a new email address for Cancer Oncology referrals to be sent to Belfast.

9.3. As we had new members of staff join our cancer tracking team from 2020 it was part of our roles to help with job specific training. I would have updated and circulated the Urology SOP for guidance to the new staff.

Please see 2. Urology MDM SOP August 2012

10. **What performance indicators, if any, are used to measure performance for your role?**

10.1. Within Cancer Services we have performance indicators to monitor the cancer performance against the cancer access standard targets. These targets are set out in my response to Question 7 at 7.1. a. – c. These cancer targets are monitored by the performance team for the Southern Trust. I would use these targets as an indicator for escalating patients to my line manager to highlight any patients that have breached their cancer pathway or likely to breach. It was then the responsibility of my line manager to follow the escalation policy and escalate these patients higher up the chain.

10.2. I am aware that 'peer review' was undertaken within Urology. I cannot recall the dates that this was undertaken. It was organised by Mary Haughey who is the Macmillan Service Improvement Lead. I would have provided Urology MDM minutes to Mary Haughey.

11. **How do you assure yourself that you adhere to the appropriate standards for your role? What systems were in place to assure you that appropriate standards were being met and maintained?**

11.1. In my first Trust role, within RF booking, I followed policies and procedures and ensured confidentiality was met at all times. I ensured to keep all patient information up-to-date and accurate.

11.2. In my current role as Cancer Tracker for Urology I ensure that all aspects of my job are undertaken to the best of my ability and that the appropriate standards are met and maintained. For example:

a. Actioning emails: Emails are sent to me in relation to patients to be added for MDM discussion. If I am absent from work, emails are also sent to a generic cancer tracker email address which assures me that they will be received and actioned in my absence.

b. New proforma: Urology services introduced a new proforma for patients being added to the system for MDM discussion on 4th February 2022. The referring Clinician adds a patient's clinical summary, their scans, the reasons for referral to MDM discussion and any questions for the MDM to the system.

c. Targets: We have a lot of targets working within Cancer Services and each individual patient is given a timeframe. I ensure to follow each patient's timeframe and, in circumstances where time frames are unmet, I escalate patients to management (who, in turn, escalate patients to HOS (Head of Service)).

12. **Have you experience of these systems being by-passed, whether by yourself or others? If yes, please explain in full, most particularly with reference to urology services.**

12.1. Not applicable. I have no experience of systems being by passed whether by myself or others.

13. **What systems of governance do you use in fulfilling your role?**

13.1. I use the escalation policy to help me fulfil my roles and support my line manager with escalations for patients not meeting their cancer targets.

Please see 3. Cancer Pathway Escalation Policy Final August 2019 updated

14. **Have you been offered any support for quality improvement initiatives during your tenure? If yes, please explain and provide any supporting documentation.**

14.1. I have not been offered any support for any quality improvement initiatives during my tenure.

15. **During your tenure, who did you understand was responsible for overseeing the quality of services in urology?**

15.1. I understand that all staff within Urology Services (to include Consultants, Clinical Nurse Specialists, Nurses, Head of Service for Urology, Secretaries, and myself as an MDT co-ordinator for Urology) have a responsibility for the overseeing of the quality of services within our Department.

16. **In your experience, who oversaw the clinical governance arrangements of urology and, how was this done?**

16.1. I am unsure of the Clinical Governance arrangements, and how these were overseen, within Urology services.

17. **Did you feel able to provide the requisite service and support to urology services which your role required? If not, why not? Did you ever bring this to the attention of management and, if so, what, if anything, was done? What, if any, impact do you consider your inability to properly fulfill your role within urology had on patient care, governance or risk?**

17.1. I have always been able to provide the service and support to Urology Services that is required within my role. Except for the responsibilities outlined in my response to Question 1, I do not have direct involvement with patient care, governance or risk within my role.

17.2. There are general challenges which myself and my colleagues face within Urology Services such as delays, capacity issues, delays with reviews and obstacles to patients moving forward on their cancer pathways. I have raised these with my line manager, in the form of escalations and these would have been sent on a daily weekly basis.

Please see:

4. RE UROLOGY referrals for escalation

5. FW Urology escalation - Personal Information redacted by the USI

18. **Did you feel supported by staff within urology in carrying out your role?**

Please explain your answer in full.

18.1. I have been supported within my role in Urology as Cancer Tracker and MDT Co-Ordinator. I have always found the team to be helpful.

18.2. Urology has evolved over the years. I can recall capacity issues and high demands which were difficult to manage during my time in the Urology RF booking office.

Urology services

19. **Please explain those aspects of your role and responsibilities which are relevant to the operation, governance or clinical aspects of urology services.**

19.1. Not applicable. There are no aspects of my role or responsibilities which are relevant to the operation, governance or clinical aspects of Urology services.

Urology Services Inquiry

20. **With whom do you liaise directly about all aspects of your job relevant to urology? Do you have formal meetings? If so, please describe their frequency, attendance, how any agenda is decided and how the meetings are recorded. Please provide the minutes as appropriate. If meetings are informal, please provide examples.**

20.1. I regularly liaise with my manager and all persons involved with Urology Services to include Consultants, nurses, secretaries, radiology, pathology and Oncology/ Medical Oncology. I also liaise with Belfast City Hospital, Belfast staff in relation to Urology as our patients are now discussed regionally at the Belfast meeting.

20.2. A formal MDT cancer meeting is held every Thursday at 2.15pm. The meeting has to be quorate; meaning that it requires the attendance of Consultant Urologists, Pathologist, Radiology, Oncology, Medical Oncology, CNS (clinical nurse specialist), Palliative care and an MDT Co-Ordinator.

20.3. The MDT is a set meeting. There is no agenda. The objective of MDT meetings is to discuss each patient, their care and to decide on a treatment plan for each patient. I am the MDT meeting co-ordinator and my role involves adding patients to MDT for discussion. In the past Consultants would have emailed a clinical summary in advance. Since 4th February 2022 a proforma needs to be completed by Consultants who seek to refer a patient to MDT. The preview list is sent out on a Wednesday morning to the Urology distribution list. At the meeting the Chair dictates clinical outcomes for each patient.

20.4. I note the MDT outcomes and add these onto CAPPS. I also draft the minutes. The Chair checks and approves the MDM outcomes before I circulate these with the minutes. Attendances of MDT meetings are also recorded on CAPPS and noted on the minutes.

Urology Services Inquiry

21. **In what way is your role relevant to the operational, clinical and/or governance aspects of urology services? How are these roles and responsibilities carried out on a day to day basis (or otherwise)?**

21.1 Not applicable. I have no involvement in the operational, clinical or governance aspects of Urology.

22. **What is your overall view of the efficiency and effectiveness of governance processes and procedures within urology as relevant to your role?**

22.1. Not applicable. I have no involvement in governance processes and procedures within Urology and I am therefore unable to express an opinion on their efficiency and effectiveness.

23. **Through your role, did you inform or engage with performance metrics or have any other patient or system data input within urology? How did those systems help identify concerns, if at all?**

23.1. I do not inform or engage with performance metrics.

23.2. I regularly use CAPPS which is a data system. I can access a patient's overview on this system to identify if they are on the cancer pathway, waiting on their first appointments, waiting on investigations, waiting on surgery or if they are considered to be 'long waiters'. The Covid-19 pandemic has had a big impact on all services with the effect that there have been longer delays due to surgeries and clinics being cancelled. This has had a detrimental effect on all tumour sites. I am able to escalate individual patients to management, who can escalate a patients' case to HOS (Head of Service) to try and speed up their pathway.

Urology Services Inquiry

24. **Do you have any specific responsibility or input into any of the following areas within urology? If yes, please explain your role within that topic in full, including naming all others with whom you engaged:**

(i) Waiting times:

24.1 Yes,

a. When I worked in the RF booking office we would advise our manager, Angela Muldrew, of the shortage of clinics available.
b. In my role as Cancer Tracker for Urology I escalate patients that encounter delays on their cancer pathway. This would be highlighted to management. For example, the delays could be due to the lack of clinics, delays with investigations, scans or biopsies or surgery dates not being kept due to capacity issues.

(ii) Triage/GP referral letters:

24.2 Yes,

a. In the RF booking office I triaged RF referrals which were sent to the allocated Consultants who would advise if they were to stay on RF pathway (who would be booked into the next available clinic) or if they were to be downgraded (and referred to the RBC (booking centre)). In this role I liaised with all Departments regarding the triage for all tumour sites. Different Consultants were on triage at different times.

(iii) Letter and note dictation:

24.3 No.

(iv) Patient care scheduling/Booking:

24.4 Yes,

a. In my role as RF booking office I was responsible for booking patients appointments onto PAS which was their 1st RF outpatient appointment. Following this we didn't book any further reviews or appointments.

(v) Prescription of drugs:

24.5 No.

(vi) Administration of drugs:

24.6 No.

(vii) Private patient booking:

24.7 No.

(viii) Multi-disciplinary meetings (MDMs)/Attendance at MDMs:

24.8 Yes,

a. My current job is MDT Co-ordinator for Urology. I am involved in arranging MDT meetings. See my response to Question 1 where I have outlined my roles and responsibilities.

b. Attendances at MDM would include Consultants. For example:

i. Urology: Mr O'Brien, Mr Suresh, Mr Jacob, Mr Young, Mr Glackin, Mr Haynes, Mr O'Donoghue, Mr Tyson, Mr Khan

ii. Radiology: Marc Williams and Ryan Connolly.
iii. Pathology: Gareth McClean
iv. Oncology: Dr Elizabeth Baird & Dr Adam Uprichard
v. Palliative Care: Stephanie Reid

c. The following persons would also be present:

i. Urology secretaries: Elizabeth Troughton, Leanne Hanvey, Teresa Lougran, Nicola Robinson, Allix Mollon.
ii. Nurse Specialists: Kate O'Neill, Leanne McCourt, Patricia Thompson, & Janice Holloway.
iii. Noleen Elliott and Paulette Dignam, (now moved elsewhere).

(ix) Following up on results/sign off of results:

24.9 No.

(x) Onward referral of patients for further care and treatment:

24.10 Yes,

a. I have responsibility for patients who are to be referred to Belfast City Hospital for treatment. These patients can be directly referred from MDT or by Consultants based on the patient's preference at their review appointment.

b. Since 2017 we have sent our referrals to Belfast City Hospital's generic email address.

c. I would notify the tracker in Belfast if a patient was actively being tracked and ITT over or if a patient had not had their first definitive treatment for cancer.

(xi) Storage and management of health records:

24.11 No.

(xii) Operation of the Patient Administrative System (PAS):

24.12 Yes,

a. I used PAS system more when I worked in the RF booking office. I used PAS to book and cancel appointments when required.

b. In my current role I use PAS to check if a patient has been given a review date post-MDM, to check for surgery dates if patient has a preadmission date upcoming, to check if patients have been added to a RF WL and to check if they have cancelled any procedures.

(xiii) Staffing:

24.13 No.

(xiv) Clinical Nurse Specialists:

24.14 No.

(xv) Cancer Nurse Specialists:

24.15 No.

(xvi) Palliative Care Nurses:

24.16 No.

(xvii) Patient complaints/queries:

24.17 No.

Concerns

25. **Please set out the procedure which you were expected to follow should you have a concern about an issue relevant to patient care and safety and governance.**

25.1. If I had any concerns about patient care, safety and/or governance I would highlight it to management or the Urology Consultants. It would also be appropriate to make an incident report on DATIX.

26. **Did you have any concerns arising from any of the issues set out at para 24, (i) – (xvii) above, *or any other matter* regarding urology services? If yes, please set out in full the nature of the concern, who, if anyone, you spoke to about it and what, if anything, happened next. You should include details of all meetings, contacts and outcomes. Was the concern resolved to your satisfaction? Please explain in full.**

26.1. I was concerned about the lack of radiology cover and I raised this with management and Consultants at MDT meetings. However, as of May 2022, we now have 2 radiologists who attend the meeting. This issue has since resolved.

26.2. In my tenure I was aware of clinic capacity issues within the Urology services through my escalations to my line manager. It was the responsibility of my line manager to escalate this to the Head of Service, Wendy Clayton (previously Martina Corrigan until October 2020).

26.3. With regards to onwards referrals, there was a specific testicular cancer patient in July 2019 who was to be referred to the Testicular MDM in Belfast City Hospital, Belfast. This patient was discussed at local Urology MDM under Mr O'Brien on the 25th July 2019. I continued to track this patient

as they were waiting to be reviewed by Mr O'Brien and onward referral to regional MDM. Through my tracking I could see that the patient still had not been reviewed post-MDM or referred on to the testicular team in Belfast. I emailed Mr O'Brien on 9th August 2019 to query about this patient's post MDM review and referral to the testicular team. I did not get a response from Mr O'Brien, however, through my tracking I could see the patient was reviewed on 23rd August 2019. There was a 33-day delay for the patient's clinic letter and Oncology referral to be dictated. On 5th September 2019 as I had received no response in relation to this patient I added the patient for discussion at the testicular MDM as not to delay any further on their cancer pathway. Consultant Oncologist Darren Mitchell in Belfast City Hospital emailed Mr Glackin, Consultant Urologist (SHSCT), to query the time delay for this patient.

Please see 6. Patient 2 Personal Information redacted by the USI ***- Testicular MDM***

27. **Did you have concerns regarding the practice of any practitioner in urology? If so, did you speak to anyone and what was the outcome? Please explain your answer in full, providing documentation as relevant. If you were aware of concerns but did not report them, please explain why not.**

27.1. I was aware of long delays in Urology for some patients under the care of Mr Aidan O'Brien. This included delays with his patient's clinic letters being typed up, his patient outcomes being recorded and delays in referring his patients for further investigations.

27.2. My job was to escalate the cases of patients experiencing delay to my manager. I emailed Vicki Graham who would have emailed HOS (Head of Service) Martina Corrigan. I also emailed Mr O'Brien and his secretary (Noleen Elliott). There were delays with some of the patients that I had escalated as a result of clinic dictations not being typed timeously or at all.

Urology Services Inquiry

Please see:

7. FW Urology escalation – Personal Information redacted by the USI

8. RE Personal Information redacted by the USI

9. FW Urology escalation - Personal Information redacted by the USI

28. **If you did have concerns regarding the practice of any practitioner in urology, what, in your view was the impact of the issue giving rise to concern on the provision, management and governance of urology services?**

28.1. I escalated all of my concerns to my line manager. These were mostly cancer patient delays which could have been due to a number of reasons.

29. **What steps were taken by you or others (if any) to risk assess the potential impact of the concerns once known?**

29.1. I escalated all of my concerns to my line manager. I did not receive any feedback or updates regarding the cases that I escalated to management.

30. **Did you consider that the concern(s) raised presented a risk to patient safety and clinical care? If yes, please explain by reference to particular incidents/examples. Was the risk mitigated in any way?**

30.1. In my view I believe that the concerns raised by myself did present a risk to patient safety and clinical care.

30.2. In circumstances where it was apparent that patients were not going to meet their cancer targets, or if I had other concerns about their

pathways, I would have escalated this to my line manager in line with the escalation policy. It was the responsibility of my line manager to further escalate to the Head of Service. My escalations contained active waiters on the cancer pathway awaiting 1st appointments, clinic outcomes, diagnostics, investigations or treatment. In my view there were concerns for patient safety caused by the delays with clinic dictations. Please see my response to question 26.

31. **Was it your experience that once concerns were raised, systems of oversight and monitoring were put in place? If yes, please explain in full.**

31.1. In relation to any of the concerns that I raised, I did not receive any feedback or updates regarding the cases that I escalated to management and therefore I cannot say if systems of oversight and monitoring were put in place.

3.2. I am not aware of concerns raised by others and whether systems of oversight and monitoring were put in place.

32. **In your experience, if concerns are raised by you or others, how, if at all, are the outcomes of any investigation relayed to staff to inform practice?**

32.1. Outcomes of investigations were not relayed back to me following concerns being raised.

33. **Did you have any concerns that governance, clinical care or issues around risk were not being identified, addressed and escalated as necessary within urology?**

33.1. Not applicable. I am unaware if issues around governance, clinical care or issues around risk were being identified, addressed and escalated as necessary as I do not have involvement with these areas and issues.

34. **How, if at all, were any concerns raised or identified by you or others reflected in Trust governance documents, such Governance meeting minutes or notes, or in the Risk Register, whether at Departmental level or otherwise? Please provide any documents referred to.**

34.1. I am unaware of whether the concerns that I raised and/or identified are reflected in Trust governance documents or if they were logged by my line management in the form of a Datix.

35. **What could improve the ways in which concerns are dealt with to enhance patient safety and experience and increase your effectiveness in carrying out your role?**

35.1. Upon reflection it is my view that communication around escalations could be improved by providing an outcome or update back to the relevant cancer tracker. This would highlight any capacity issues to the cancer trackers which is relevant when updating the patients' cancer pathways.

Staff

36. **As relevant, what was your view of the working relationships between urology staff and other Trust staff? Do you consider you had a good working relationship with those with whom you interacted within urology? If you had any concerns regarding staff relationships, did you speak to anyone and, if so, what was done?**

36.1. I have limited interaction with the urology team (once per week at MDT) and therefore I do not have an understanding of, or any concerns about, their working relationships with other Trust staff.

37. **In your experience, did medical (clinical) managers and non-medical (operational) managers in urology work well together? Whether your answer is yes or no, please explain with examples.**

37.1. Not applicable. I do not have an understanding or knowledge of how medical managers and non-medical managers worked together in Urology. I do not have any concerns to raise.

Learning

38. **Are you now aware of governance concerns arising out of the provision of urology services which you were not previously aware of? Identify any governance concerns which fall into this category and state whether you could and should have been made aware of the issues at the time they arose and why.**

38.1. No. I have not been made aware of any governance concerns arising out of the provision of urology services.

39. **Having had the opportunity to reflect on these governance concerns arising out of the provision of urology services, do you have an explanation as to what went wrong within urology services and why?**

39.1. Not applicable. I have not been made aware of what went wrong with Urology Services.

40. **What do you consider the learning to have been from a governance perspective regarding the issues of concern within urology services**

and, to the extent that you are aware, the concerns involving Mr. O'Brien in particular?

40.1. Not applicable. I was not made aware of any governance concerns nor do I have any involvement in governance. The concerns involving Urology Services and specifically Mr O'Brien were kept confidential.

41. **Do you think there was a failure to engage fully with the problems within urology services? If so, please identify who you consider may have failed to engage, what they failed to do, and what they may have done differently. Your answer may, for example, refer to an individual, a group or a particular level of staffing, or a particular discipline. If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom**

41.1. I am generally aware that there were ongoing problems within Urology Services. With reference to my response to Question 26, at 26.3., in my view I believe there was oversight on Mr O'Brien's part as he was accountable for the patient's management plan. I am not aware of any issues being addressed by the Senior management team.

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42. **Do you consider that, overall, mistakes were made by you or others in handling the concerns identified? If yes, please explain what could have been done differently within the existing governance arrangements during your tenure? Do you consider that those arrangements were properly utilised to maximum effect? If yes, please explain how and by whom. If not, what could have been done differently/better within the arrangements which existed during your tenure?**

42.1. I believe that mistakes were made by Consultants who failed to update management plans, undertake clinic dictations and add patients onto the Urology MDM in a timely manner.

43. **Do you think, overall, the governance arrangements were and are fit for purpose? Did you have concerns specifically about the governance arrangements and did you raise those concerns with anyone? If yes, what were those concerns and with whom did you raise them and what, if anything, was done?**

43.1. Not applicable. I do not have any involvement in, or appropriate knowledge of governance arrangements within Urology Services.

44. **If not specifically asked in this Notice, please provide any other information or views on the issues raised in this Notice. Alternatively, please take this opportunity to state anything you consider relevant to the Inquiry's Terms of Reference and which you consider may assist the Inquiry.**

44.1. I do not have anything further to add.

NOTE:

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

Urology Services Inquiry

Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

Statement of Truth

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

Signed: Shauna Mcveigh_____

Date: 19.10.22_____

Section 21 Notice Number 86 of 2022

Witness Statement: Shauna McVeigh

Index

Attachment	Document
1	IEAP inquiry question 7
2	Urology MDM SOP August 2012
3	Cancer Pathway Escalation Policy Final August 2019 updated
4	RE UROLOGY referrals for escalation
5	FW Urology escalation - Personal Information redacted by the USI
6	Patient 2 Personal Information redacted by the USI - Testicular MDM
7	FW Urology escalation - Personal Information redacted by the USI
8	RE Personal Information redacted by the USI
9	FW Urology escalation - Personal Information redacted by the USI

INTEGRATED ELECTIVE ACCESS PROTOCOL

June 2020

Integrated Elective Access Protocol

Protocol Summary -

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

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

Integrated Elective Access Protocol

Version

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

Integrated Elective Access Protocol Review Group

The Integrated Elective Access Protocol Review Group consisted of;

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

Integrated Elective Access Protocol

Document control

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

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

Monitoring compliance with protocol

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

Contents

Abbreviations

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

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 1

CONTEXT

1.1 INTRODUCTION

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

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

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

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

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

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

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

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

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

1.2 METHODOLOGY

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

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

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

1.2.4 For the purposes of this protocol, the term;

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

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

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

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

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

1.3 UNDERPINNING PRINCIPLES

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

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

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

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

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

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

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

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

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

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

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

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

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

1.4 BOOKING PRINCIPLES

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

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

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

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

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

1.4.6 The definition of a booked appointment is:

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

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

1.4.7 Principles for booking Cancer Pathway patients:

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

1.4.8 Principles for booking Urgent Pathway patients:

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

d) Patients will be issued with a letter inviting them to contact the Trust to agree and confirm their appointment in line with the urgent booking process.
e) In exceptional cases, some patients will require to be appointed to the next available slot. A robust process for telephone booking these patients should be developed which should be clearly auditable.

1.4.9 Principles for booking Routine Pathway patients:

a) Patients should be booked to ensure appointment (including virtual appointment) is within the maximum waiting time guarantees for routine appointments.
b) Referrals will be received, registered within one working day at booking teams and forwarded to consultants for prioritisation.
c) Approximately eight weeks prior to appointment, Trusts should calculate prospective slot capacity and immediately implement escalation policy where capacity gaps are identified.
d) Patients should be selected for booking in chronological order from the Primary Targeting List (PTL).
e) Six weeks prior to appointment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment.

1.4.10 Principles for Booking Review Patients;

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

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

1.5 VIRTUAL ACTIVITY

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

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

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

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

1.6 COMPLIANCE WITH LEAVE PROTOCOL

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

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

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

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

1.7 VALIDATION

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

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

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 admission 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. 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).

Southern Health and Social Care Trust

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DRAFT

ADMINISTRATIVE & CLERICAL Standard Operating Procedure No.

Title	Urology Multi-disciplinary Administrative Process	
S.O.P. Number		
Version Number	v1.0	**Supersedes:** v0.1
Author	Vicki Graham	
Page Count		
Date of Implementation		
Date of Review		**To be Reviewed by: OSL's**
Approved by		

Urology Multi-disciplinary Meeting (MDM) Administrative Process

The Breast MDM is held every Thursday at 2.15 pm in Tutorial Room 1, Medical Education Centre. The meeting membership consists of:

Consultant Urologist
Consultant Oncologists
Consultant Radiologists
Associate Specialists
Consultant Pathologist
Specialist Urology Nurse
GP with specialist interest
Palliative Care Nurse
MDT Co-Ordinator

It is the responsibility of the MDM Co-ordinator to undertake the following tasks to ensure the efficient and smooth running of the meeting:

Patients listed for MDM

There are 6 methods of patients being added to the Urology MDM:

1) Prostate Assessment Clinic: Kate O'Neill, Urology Nurse Specialist e-mails me through a list in advance of planned biopsies and details are added onto Capps if not a 62 day patient. I also receive a confirmation of biopsies performed on the day. Patients are then added to the correct MDM and pathology discussed.

2) Tracking: Whilst updating tracking if there are any patients who have had investigations performed and tracker is unsure of results, or if results are reported and are not normal name is added to MDT to clarify further management.

3) Haematuria clinic DHH: Clinic outcome from haematuria clinic are e-mailed through to tracker. This informs tracker if patient is being discharged or requires further investigations and if patient is needed to be discussed @ MDM.

4) Secretaries/ Audio typist: If typing up a clinic and Doctor has requested for case to be discussed @ MDM, the letter is either e-mailed or posted via internal mail to tracker. Information is then updated onto CaPPs so all relevant information is available for discussion.

5) Surgery lists: Paulette (Mr Young's Secretary) e-mails Tracker through a copy of the scheduled theatre list. This allows tracker to check and add any confirmed cases. Tracker is not included in any other Consultants Theatre list distribution list.
6) Consultants: To discuss change of management plans, results, radiology etc.

7) Mr O'Brien leaves down with Tracker all patient's with updated narrative on patients that he would like discussed. All information is to be copied onto Capps. (Narratives can be quite lengthy)

8) Radiology:-Tracker can be advised of radiology results and details are added so case can be discussed @ MDM as most of these tend to be incidental findings.

9) Cases that are deferred from the previous week's MDM.

Administrative process before MDM

1. Copy of the patient list emailed to Urology Distribution list on the Wednesday at 1.00pm. Cut off time for adding patients to MDM is Tuesday lunch time. Copy list of MDM patients is given to Band 2 to allow time for tracking and requesting charts.

2. List of patients who have to be discussed for radiology results is emailed to Radiologist including clinical background on the patient & why they need discussed. MDM Co-ordinator has a copy of Radiology rota & sends this email to whichever radiologist was on the Assessment clinic that week.

3. On Wednesday, the day before the MDM, Mr O'Brien has requested an MDM update report on every patient and pathology printed out and put into a folder to allow time for preparation prior to the meeting. Tracker prints off the individual MDM update.

4. 8 copies of the patient list are printed off prior to the MDM meeting. (Band 3 when available)

5. Band 2 pulls charts & tracks charts prior to MDM.

6. MDM Co-ordinator goes to Tutorial Room 1 MEC

Administrative process after MDM

1. Go through histopathology & radiological reports for each patient & type results into MDM outcome if these were not available prior to MDM.

2. Update MDM outcomes that has been dictated verbally and hand written down during MDM Copy all MDM discussions into diary.

3. Create Letters & MDM reports.

4. E-mail each Secretary each individual patient's MDM outcome if patient is to be reviewed, added to W/L etc. and advise them what is to be actioned following MDM.

   Mr Glackin: Liz Troughton EXT Personal Information
   Mr Young: Paulette Dignam EXT Personal Information
   Mr O'Brien: Monica McCorry EXT Personal Information

   E-Mail Leanne Hanvey, Urology Specialist Nurse Secretary any patient's names that require Day4 appointments. Leanne EXT Personal Information

   E-mail all DHH outcomes individually to Mr Brown's Secretary, Joanne Brown & advise of what is to be actioned post MDM.

   If there are any ward histologies to be cancelled / appointed I e-mail Sharon McDermott, Ward Clerk in 3ESU.

Any patients that will require BCG or MMC (Mitomycin C), bladder chemotherapy I e-mail Emma McCann who is a Nurse in 3ESU and advise that patient will be requiring treatment. Janis deals with all chemotherapies in 3ESU but she does not have an e-mail.

5. E- Mail MDM update to distribution list once all outcomes are updated.

6. Print off any histopathology reports for patients being referred to oncology.

7. Oncology referral being e-mailed directly to Dr Houghton @ Belfast Trust and her Secretary, Hazel Cantley and advise that paper copy will follow.

8. GP Letter and MDM reports printed for each patient that was discussed. (Band 3 when available)

9. Oncology referrals printed off and attached to histopathology report

10. GP Letters & oncology referrals taken to Mr O'Brien, Chair of Urology MDM to sign on Friday morning. (Band 2) Mr O'Brien usually has a clinic in Thorndale Unit.

11. When documents are signed GP letters are posted out to GP and oncology referrals are posted along with a copy of pathology report to the relevant oncologist.

12. GP letters are photocopied as are oncology referrals and are joined up with MDM outcome and are filed into chart. (Tracker)

13. Tracker goes through returned letters and checks that there have been no corrections, if corrections are required to be made, CaPPs is undated, letter's & MDM outcome is reprinted and returned for signing.

14. Tracker checks through MDM outcomes and splits into "CANCER" & "NON CANCER" to be filed into chart by Band 2.

15. MDM minutes are performed, including number on list, cases discussed etc.

16. MDM minutes are emailed to Urology team.

17. Once the MDM outcome have been filed into medical chart, the tracker goes through each individual chart and has to check, PAS & CaPPs to see if patient is to be re discussed . Each chart is then tracked out to previous location. Tracker re tracks charts back. Most weeks there are between 30-40 charts (This can take at least 1-2 hours.)

18. Tracker brings charts over to Medical Records and slots into appropriate place for return to location)

Cancer Pathway Escalation Policy

1.0 Background

This policy is to inform Cancer Tracker/ Multi-Disciplinary Team (MDT) Co-ordinators, Clinicians and Divisional Management Teams of the escalation policy for Cancer Access targets.

The current cancer access standard targets are:
14 days – 100% for the 2 week wait breast symptomatic outpatient appointment
31 days – 100% date decision to treat to first definitive treatment
62 days – 98% date of receipt of referral to first definitive treatment

The purpose of this policy to illustrate the actions that may be required at specific points along the patient's pathway. These actions will be escalated from the first trigger point. (Please see Table 1)

2.0 General Principles of Escalation

General principles of escalation are as follows:

(a) The earlier the better.
It is easier to stand people down once the problem is resolved than to catch up lost time
(b) Try everything you know to resolve the problem
(c) Recognise that you can't solve all of the problems – but by escalating it will give others a chance to help find a solution.
(d) Record on the escalation proforma the steps you have taken
(e) Take action in a timely manner
Be clear of the timescale of escalation
If a response is not received from Consultant/Clinician within outlined timescale for escalation the relevant Chair of the MDT is to be notified.

3.0 Trigger Points for Escalation

For a patient to progress along the pathway, the Cancer Trackers will start the tracking process and be responsible for escalations throughout the pathway. In order for the Trackers to track they have been given the authority to expedite referrals (either appointments/diagnostics) within their own level of responsibility. While the Red Flag Appointments Team will escalate patients outside of expected 1st appointment timescales, the tracker will track the full cancer pathway.

In the event of delays in the patient pathway, as detailed in Appendix 1, the tracker will escalate to the Cancer Services Co-ordinator (CSC) or in her absence the Operational Support lead (OSL), who will in turn advise the Head of Cancer Service. The CSC will advise the relevant Head of Service (HOS) /OSL for that specialty, of any actions required to be taken or ongoing delays.

The HOS/OSL for the specialty will escalate patients who trigger key points on the pathways to the relevant Assistant Directors and Clinical leads as required.

Table 1 - Key trigger points on the Cancer pathway for escalation if patient not booked or completed

Key Trigger	Trigger Point	Escalate To	Further Escalation Point	Also Escalate To
First appointment	By day 10	>Head of Service >OSL	By Day 21	>Assistant Director for the Specialty >Director for Acute Services
Investigations/ Diagnostics	By day 17	>Head of Service >OSL	Greater than 10 days for diagnostic investigation or reporting	>Head of Service for Radiology >Assistant Director for Cancer & Clinical Services
MDM	By day 25	>Head of Service >OSL		
ITT	By day 28	>Head of Service >OSL		
Treatment	By day 31 or 62 (relevant to pathway	>Head of Service >OSL	Breaches of 31 or 62 day pathway	>Assistant Director for the Specialty

**please note that red flag appointments will escalate 1st out-patient appointment, the tracker will be responsible for liaising with red flag team if patient is not booked or on red flag out-patient waiting list for appointment.*

3.4 Delayed Escalation Response:

If the Cancer Trackers are awaiting a response for longer than 1 week regarding a management plan for a patient on a cancer pathway, and all relevant steps have been taken as per escalation policy, the relevant Multi Disciplinary Meeting Chair will be notified to avoid any further delays for the patient and copied to HOS for the specialty.

3.5 MDT Meetings:

The tracker will raise all on going risks at the Multidisciplinary meeting which will be minuted, and communicate the outcome and any unresolved issues to the CSC. If no solution is found, the risk will be escalated through a series of senior managers (see table 2) ultimately to the Clinical Lead for Cancer, who will inform the Chief Executive in the event of failure to resolve this issue.

3.6 Deferment from MDT:

If a patient is deferred from MDT discussion, this must be escalated to the releveant specialty HOS and OSL. It is the HOS and OSL responsibility to ensure the patient is discussed the following week and this is highlighted to the Chair of the MDT.

3.7 Inter-Trust transfers:

It is recognised good practice that where a potential breach or confirmed breach requires an Inter Trust Transfer (ITT), it is the responsibility of the Southern Trust's Executive Lead for Cancer to contact the Executive Lead for Cancer in the 'referred to' Trust to discuss delayed referrals (received after 28 days) and breach situations in order to understand reasons for delay and to agree "shared breaches".

Unfortunately, as pathways for some tumour sites continue to come under increased pressure, it may not always be practical for this level of contact/discussion to take place. The Trust will continue to liaise closely with the 'referred to' Trust in these circumstances to ensure patients receive treatment and care as quickly as possible on the pathway

4.0 Escalation Chain

Table 2 – Escalation chain for trigger points throughout cancer pathway

Escalation Chain	Role Responsible for Escalating	Escalation Point	Timescale for escalation	Cumulative Timescale for escalation
1.	Red Flag Appointments Team/ Cancer Tracker/MDT Co-ordinator	Cancer Services Co-Ordinator	24 hours	24 hours
2.	Cancer Services Co-ordinator	Head of Service for the Specialty Head of Service for Cancer copied to relevant OSLs	24 hours	48 hours
3.	Head of Service for the Specialty	Assistant Director for the Specialty Assistant Director for Cancer Services *Copied to Head of Service for Cancer and Cancer Services Co-ordinator*	24 hours	3 days
4.	Assistant Director for the Specialty	Chair of MDM *Copied to Head of Service for Cancer and Cancer Services Co-ordinator*	24 hours	4 days
5.	Chair of MDM	Executive Lead for Cancer *Copied to Head of Service for Cancer and Cancer Services Co-ordinator*	24 hours	5 days
6.	Executive Lead for Cancer	Director of Acute Services *Copied to Head of Service for Cancer and Cancer Services Co-ordinator*	24 hours	6 days
7.	Director of Acute Services	Chief Executive Officer *Copied to Head of Service for Cancer and Cancer Services Co-ordinator*	24 hours	7 days

Note – these timescales are the longest periods expected.

Each Cancer Tracker/MDT Co-ordinator will be aware of individual patient pathways for each tumour site and the reasonable timescales expected. A generic pathway is attached as Appendix 1, specific site pathways are are also available.

Each step of the pathway is a potential weak link in the chain; and clear observation is required at all stages to ensure:

(a) patient appointment is booked
(b) patient attends appointment
(c) the next review appointment is booked
(d) treatment is commenced

The table above illustrates the escalation chain with each level escalating as required until the delay has been addressed.

Escalation reporting and actions taken will be noted by the tracker in the diary page of the Capps system.

Table 3 – Escalation Chain Roles and Contacts

Roles	Contact Name
Cancer Tracker/ MDT Co-Ordinator	Marie Dabbous Anne Turkington Hilda Shannon Wendy Kelly Shauna McVeigh Griania White Rachel McCartney Catherine Glenny Sinead Lee Sarah Moore
Cancer Services Co-Ordinator	Vicki Graham Angela Muldrew
Heads of Service	Fiona Reddick - Cancer Services Martina Corrigan - Urology/ENT Amie Nelson - UGI / LGI / Breast Kay Carroll – Derm / Lung Wendy Clarke – Gynaecology Louise Devlin - Gastroenterology
Operational Support Lead	Sharon Glenny – IMWH & CCS Wendy Clayton – SEC Lisa McAreavey - MUSC
Assistant Director	Barry Conway – IMWH & CCS Anne McVey – MUSC Ronan Carroll – SEC
Chair of MDM	Dr McCracken – Gynae Mr Neill – LGI Mr Glackin – Urology Dr Mathers – Breast Dr Convery – Lung Dr O'Hagan – Skin Dr Boyd – Haematology Dr McCaul – Head & Neck
Executive Lead for Cancer	Dr McCaul
Director of Acute Services	Esther Gishkori
Chief Executive Officer	Shane Devlin

5.0 Pathway Breaches

Breach reports will be commenced by the Cancer Tracker/MDT Co-ordinator where patients breach the targets, i.e. 14 day for breast, 28 day for inter–trust transfers, day 31 and day 62 breaches.

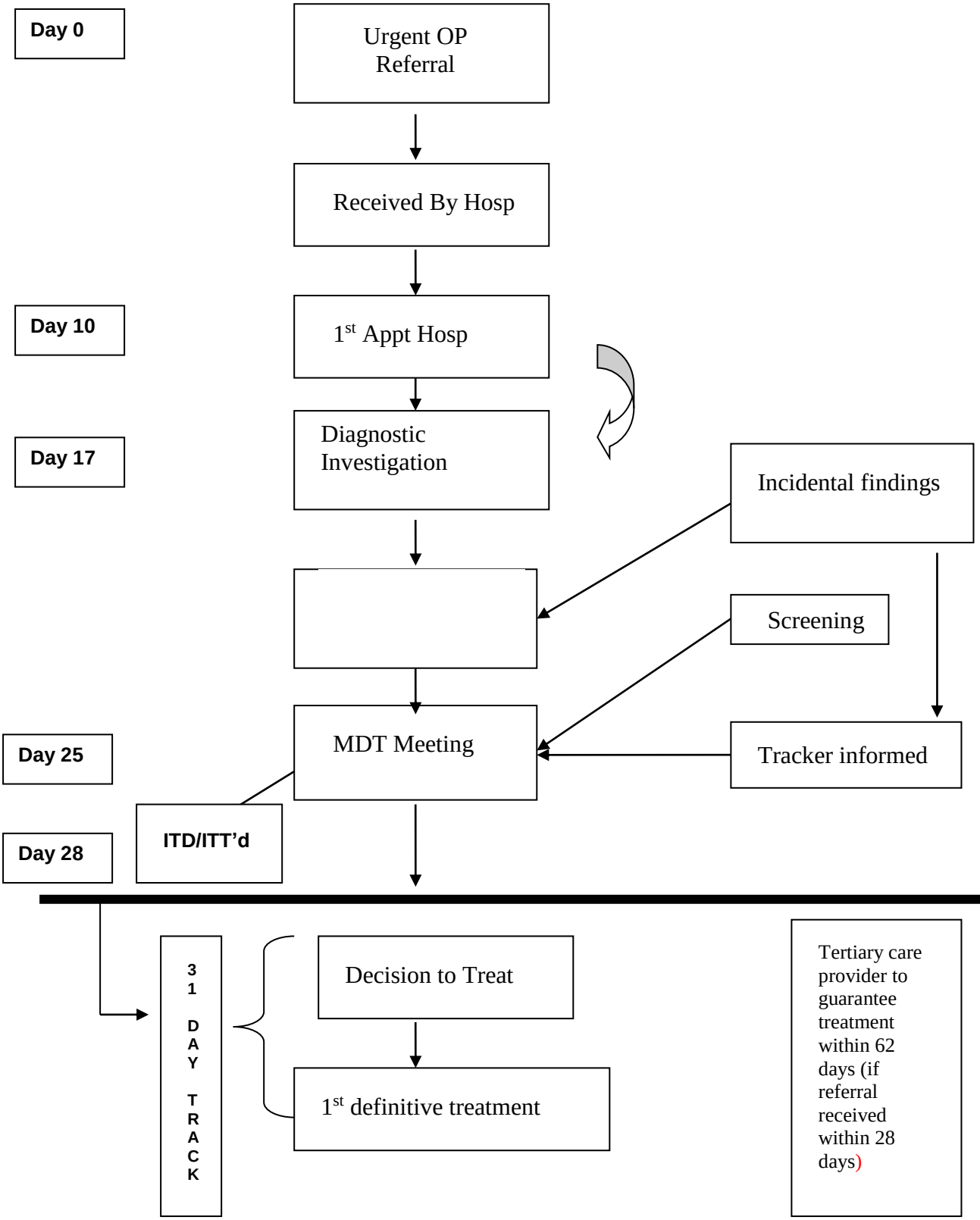
A copy of the breach report will be forwarded to the relevant Assistant Director, and the team's Clinical lead for action as appropriate.

Monthly breaches by tumour site will be discussed at the Cancer Monthly Performance Meeting and areas for improvement analysed.

This policy must be followed by all members of staff, in every event. This policy is designed to ensure problems are resolved at the lowest level, but that an Executive Director is informed within 24 hours of any failure of the system that has not been resolved at lower organisational/divisional levels.

Appendix 1

PATIENT PATHWAY



31 day target:
Maximum 1 month wait from decision to treat to first treatment for all cancers

62 day target:
Maximum 2 month wait from an urgent GP referral to first treatment for all cancers

From: Corrigan, Martina
Sent: 23 March 2017 18:06
To: Graham, Vicki
Cc: Glenny, Sharon; Clayton, Wendy; McVeigh, Shauna
Subject: RE: UROLOGY referrals for escalation

Thanks Vicki

I am a bit concerned we seem to getting a glut of referrals that we can't appoint and we have really had no loss of capacity in the system (we had Mr Brown, Mr Jacob and Mr Aslam) available to do clinics. I know we had a peak in January and maybe that is why but Sharon and Wendy can you have a wee look at what we are getting in and if there is a loss of capacity anywhere as I would like to try and get a clearer picture before going back to the consultants

Thanks

Mar na

Mar na Corrigan
Head of ENT, Urology, Ophthalmology and Outpa ents
Craigavon Area Hospital

INTERNAL: EXT Personal Information ***if dialling from Avaya phone. If dialling from old phone please dial*** Personal Information redacted by the USI
EXTERNAL : Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI

From: Graham, Vicki
Sent: 23 March 2017 12:30
To: Corrigan, Martina
Cc: Glenny, Sharon; Clayton, Wendy; McVeigh, Shauna
Subject: FW: UROLOGY referrals for escalation
Importance: High

HI Martina,

Please see below Urology referrals that we have been unable to appoint by Day 14. These could be brought forward if anything sooner became available. The bottom pa ent, Personal Information redacted by the USI was booked ahead of other patients as the triaging Consultant had indicated that patient was to be seen by a certain date.

Regards,

Vicki Graham
Cancer Services Co-ordinator
Office 10
Level 2
MEC

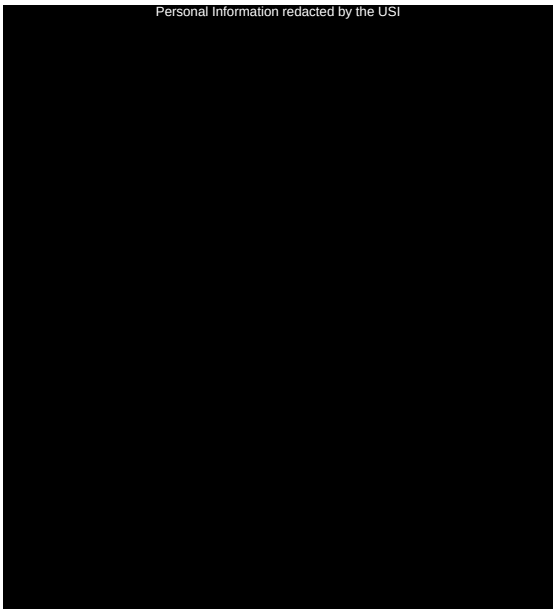
EXT Personal Information ***if dialling from Avaya phone. If dialling from old phone please dial*** Personal Information redacted by the USI

From: ri Personal Information redacted by the USI
Sent: 22 March 2017 18:00
To: Graham, Vicki
Subject: UROLOGY referrals for eclation

Hi Vicki

The following Urology referrals are for escalation:-

Name	H&C no	Referral	Type	Clinic	Clinic Date	Day
Personal Information redacted by the USI		27/2/17 DNA	Prost	CZATDU	28/3/17	29
		27/3/17	Haem	CZATDU	28/3/17	
		28/2/17	Prost	CMDHREG	27/3/17	
		28/2/17	Prost	CZATDU	28/3/17	
		28/2/17	Haem	CZATDU	28/3/17	
		28/2/17	Haem	CCHAEM	30/3/17	
		1/3/17	Haem	CCHAEM	30/3/17	



1/3/17		Prost	CMDHTDU	3/4/17
2/3/17		Haem	CCHAEM	30/3/17
2/3/17	DNA	Haem	CMDHTDU	3/4/17
2/3/17		Prost	CJODTDU	3/4/17
3/3/17		Haem	CJODTDU	3/4/17
16/3/17		Kidney	CJODTDU	3/4/17

18 – urgent referral upgraded – rec'd RF office 22/3/17 – triage note to book within next could of weeks (Sinead spoke with you about this one

Regards

Carol

Red Flag Appointment Team
Tel: Personal Information redacted by the USI

From: McVeigh, Shauna
Sent: 18 July 2019 10:43
To: Graham, Vicki
Cc: Moore, SarahM
Subject: FW: Urology escalation - Personal Information redacted by the USI

Importance: High

Hi,

Please see update on this man who is now on day 82 was seen at clinic by Mr O'Brien but clinic outcome not dictated. His MRI had suggested that he should have a TRUS biopsy. I had checked with Kate if she was aware of this man for biopsy, but she wasn't and she emailed Mr O'Brien secretary asking was there a dictation from clinic 05.07.19, secretary advised there isn't.

75 11/07/2019 Clinic outcome awaited from 05.07.19 - Mr O'Brien had not advised if patient needed biopsy. Will update OSL on this man.
80 16/07/2019 Clinic outcome awaited from 05.07.19 letter not dictated, will check if Kate knows if he is to proceed to biopsy.
82 18/07/2019 No clinic outcome on NIECR - patient now on day 82, MRI had suggested that this man needs a TRUSB. Kate not aware of this man for biopsy.

Thanks
Shauna

From: McVeigh, Shauna
Sent: 11 July 2019 10:38
To: 'Graham, Vicki (Personal Information redacted by the USI)'
Subject: FW: Urology escalation - Personal Information redacted by the USI
Importance: High

Hi,

Please see update on this man who is on day 75, Mr O'Brien had reviewed him on 05.07.19 – day 69, clinic outcome is awaited from this and letter is to be dictated. There was no specimens taken for prostate biopsies on labs, I am unsure if this man is proceeding to TRUS biopsy, if he does and cancer is confirmed he has breached his pathway.

66 02/07/2019 Apt with Mr O'Brien for 05/07/19
73 09/07/2019 Await clinic outcome from 05.07.19 - don't see that prostate biopsies were performed no specimens on LABS.
75 11/07/2019 Clinic outcome awaited from 05.07.19 - Mr O'Brien had not advised if patient needed biopsy. Will update OSL on this man.

Thanks
Shauna

From: Graham, Vicki
Sent: 10 July 2019 12:11
To: Corrigan, Martina
Cc: Clayton, Wendy; Reddick, Fiona; McVeigh, Shauna
Subject: FW: Urology escalation - Personal Information redacted by the USI
Importance: High

Hi Martina

Please see below patient who is on Day 74 – patient has had MRI scanning performed and was reviewed in clinic by Mr O'Brien on 05.07.19 but outcome of this is awaited – this outcome is required to know what patients further management will be, if TRUSB is required then patient will be at high risk of breaching.

Many thanks,

Vicki Graham
Cancer Services Co-ordinator
Office 10
Level 2
MEC
EXT Personal Information redacted by

From: McVeigh, Shauna
Sent: 09 July 2019 15:59
To: Graham, Vicki
Subject: FW: Urology escalation - Personal Information redacted by the USI

Hi,

Please see update on this man who is on day 73 of his pathway, he had an MRI performed on day 53, the report was sent to Mr O'Brien for a decision to be made about TRUS biopsy. Mr O'Brien has reviewed this man at clinic 05.07.19 – day 69 and clinic outcome from this is awaited. There was no prostate biopsies performed at clinic.

40 06/06/2019 MRI has been requested and is to be appointed, this man could be at risk of breaching. Will escalate to OSL.
46 12/06/2019 MRI booked for 19.06.19 - day 53, patient has been escalated to OSL.
53 19/06/2019 MRI(Expected on 19/06/19) at Craigavon
55 21/06/2019 MRI reported - 3 signal change within both sides of the peripheral zone, as described and more significant on the right side. There is a tiny volume of reduced T2 signal change outside the expected position of the prostatic capsule at the right gland apex. If tumour should be present, this, in combination with a sizeable contact of reducted T2 signal change with the prostatic capsule, suggests early extracapsular disease. The imaging should be reviewed at the Urology MDT following biopsy.

55 21/06/2019 Have sent MRI to Mr O'Brien for decision to be made about biopsy, have cc Kate into email.
61 27/06/2019 No response regarding this man's MRI he most likely needs a prostate biopsy, Mr O'Brien has been emailed.
66 02/07/2019 Apt with Mr O'Brien for 05/07/19
73 09/07/2019 Await clinic outcome from 05.07.19 - don't see that prostate biopsies were performed no specimens on LABS.

Thanks
Shauna

From: McVeigh, Shauna
Sent: 06 June 2019 10:52
To: 'Graham, Vicki ([redacted])'
Subject: Urology escalation - [redacted]

Hi,

Please see escalation of patient that is a suspect cancer and is on day 40 of his pathway, delay with 1st OP he was seen on day 31. His PSA was rechecked at clinic and this remained elevated, an MRI has been requested which is to be appointed. This man could be at high risk of breaching if cancer is confirmed.

[redacted]

Day Date Event
0 27/04/2019 Consultant Upgrade to 'Red Flag' referred to Craigavon
20 17/05/2019 booked 28/5/19 10.30 - CTPTLODHE (D31) - earlier appointments available but unable to contact - put in post tray 17/5/19 - escalated to Vicki
31 28/05/2019 First Seen at Craigavon
34 31/05/2019 Clinic outcome - His DRE is 30-40g and feels benign. We checked his BP today and it was satisfactory. I am going to recheck his PSA and based on this result I will be ordering a MRI scan
34 31/05/2019 This man's PSA is 8.58, have advised Derek.
40 06/06/2019 MRI has been requested and is to be appointed, this man could be at risk of breaching. Will escalate to OSL.

Thanks
Shauna

Shauna Mcveigh
Cancer Tracker / MDT Co-ordinator
Ext [redacted]

From: McVeigh, Shauna
Sent: 09 August 2019 15:45
To: O'Brien, Aidan
Subject: Patient 2 Personal Information redacted by the USI - Testicular MDM

Hi Mr O'Brien,

With regards to reviews post MDM, I don't think you have many slots to book these patients into.

This man was discussed at MDM on 25 July 2019 and needs referred to the testicular MDM, would you like me to list him? he does not need any staging as he has had his CT completed.

Thanks
Shauna

Shauna Mcveigh
Cancer Tracker / MDT Co-ordinator
Ext Personal Information redacted by the

From: Graham, Vicki
Sent: 20 March 2019 15:11
To: Corrigan, Martina
Cc: Glenny, Sharon; Reddick, Fiona; Clayton, Wendy; McVeigh, Shauna
Subject: FW: Urology escalation - Personal Information redacted by the USI

Importance: High

Hi Martina,

Please see below update on patient who has been previously escalated. Now on Day 124 and is a confirmed cancer (muscle invasive bladder). and has been reviewed by Mr O'Brien on 11th March. We are unsure of what the outcome of this clinic is, and what patients further management will be. Would you be able to see if you could get an update from Mr O'Brien?

Many thanks,

Vicki Graham
Cancer Services Co-ordinator
Office 10
Level 2
MEC
EXT Personal Information redacted by

From: McVeigh, Shauna
Sent: 20 March 2019 13:40
To: Graham, Vicki
Subject: FW: Urology escalation - Personal Information redacted by the USI

Hi,

Please see update on this man who is now on day 124 of his pathway, he has a diagnosis of muscle invasive bladder cancer. Following on from last escalation he has been reviewed by Mr O'Brien at SWAH on 11 March, clinic outcome not available, secretary has advised clinic outcome not dictated on.

102 26/02/2019 Escalated to urology HoS- advised of breach and asked to chase up review
103 27/02/2019 Mr O'Brien has responded regarding this patient and has advised this patient has transport difficulties and he had been unwell, he has requested staging scans and is going to review him at SWAH 11.03.19. Defer for regional discussion as patient unaware of his diagnosis.
103 27/02/2019 Emailed Urology HoS with update
108 04/03/2019 Update from Hos - Appointment arranged for 11 March 2019.
116 12/03/2019 Await clinic outcome from 11.03.19 - and update from AOB.

124 20/03/2019 Clinic outcome not on ECR for this man, will email secretary. Havent had an update from AOB on this man whether he needs central discussion.
124 20/03/2019 Secretary advised no letter dictated on yet. This man is now on D124. Will update OSL on this man.
124 20/03/2019 I had asked should this man be listed for central MDM for 07.02.19 due to high grade bladder cancer - AOB advised to wait until he has reviewed him. Bone scan has been performed don't see that a CT chest has been requested.

Thanks
Shauna

From: McVeigh, Shauna
Sent: 26 February 2019 14:46
To: Muldrew, Angela
Subject: FW: Urology escalation - Personal Information redacted by the USI

Hi

Please see update on this man who is on day 100 and is a confirmed cancer, his pathology had confirmed muscle invasive bladder cancer therefore TURBT does not count as 1st definitive treatment. He had been discussed at MDM on day 75, he needs a review with Mr O'Brien and further staging requested, review post MDM remains to be booked, I have sent Mr O'Brien an email today as I had provisionally listed him for regional this week, but I was advised to defer until he had been seen in clinic and scans have been performed.

Personal Information redacted by the USI

Trust First Seen : Southern
Trust First Treated : No Trust First Treated Recorded

Day Date Event
67 09/11/2018 Suspension Start : Suspension - Medical Patient needs passed fit
67 13/11/2018 Clinic outcome dictated 13.11.18 - this man is to proceed to TURBT - he has been added to Mr O'Briens WL - this man will be a breach if cancer is confirmed. Will escalate to OSL. Will email secretary to ask if there is a date in mind.
67 04/12/2018 This man needs further pre op work up for anaesthetics - adjustment has been added.
67 24/01/2019 Suspension End : Suspension - Medical Patient needs passed fit
68 25/01/2019 OSL escalated to Hos to see if date for surgery could be arranged. HoS emailed Consultant to see if date could be provided.
71 28/01/2019 Added to MDM 07/02/18 - Patient for MDT and review in 2 weeks, unable to book any appointment so added patient to WL. TURBT 23/01/19
74 31/01/2019 Pathology has confirmed muscle invasive bladder cancer - for MDM today.
74 31/01/2019 MDM Action : Discussed at Urology MDM 31.01.19. Personal Information redacted by the USI has muscle invasive, high risk TCC of his bladder recently resected. For review by Mr O'Brien to arrange a CT chest, a bone scan and subsequent MDM discussion.

75 01/02/2019 I had asked should this man be listed for central MDM for 07.02.19 due to high grade bladder cancer - AOB advised to wait until he has reviewed him.
79 05/02/2019 Review is to be booked post MDM.
81 07/02/2019 Have emailed secretary about a review for this man - as he has a diagnosis of muscle invasive bladder cancer but was advised to defer central MDM discussion until Mr O'Brien has reviewed the man.
94 20/02/2019 Will provisionally list for regional MDM 28.02.19.
99 25/02/2019 Inter Trust Discussion referred from Craigavon to Belfast City
100 26/02/2019 Review remains to be booked post MDM - have emailed Mr O'Brien about this man as he needs staging requested and listed for regional MDM - have updated OSL on him also.
102 28/02/2019 MDM Action : Discussed at Urology MDM 28.02.19.
102 28/02/2019 MDM Action :

Thanks
Shauna

From: McVeigh, Shauna
Sent: 31 January 2019 12:10
To: 'Graham, Vicki ([redacted])'
Subject: FW: Urology escalation - [redacted]

Hi

Please see update on this man who has had surgery performed on day 57, he is on day 65 and pathology has confirmed muscle invasive bladder cancer, graded as Grade III Pt2, therefore TURBT will not count as 1st definitive for this patient. For MDM discussion today.

Thanks
Shauna

From: McVeigh, Shauna
Sent: 24 January 2019 10:47
To: 'Graham, Vicki ([redacted])'
Subject: FW: Urology escalation - [redacted]

Hi Vicki,

Please see update on this man who is on day 58 of his pathway, an adjustment had been added as it looked like he had not been passed fit by pre op. I had chased this up with pre op on a few occasions and didn't get a response. The secretary managed to get a response from them and they had advised that the correct proforma needs to be completed for this man prior to TURBT. This has been forwarded to Mr O'Brien, this man is likely to be a breach if cancer is confirmed.

58 13/11/2018 Clinic outcome dictated 13.11.18 - this man is to proceed to TURBT - he has been added to Mr O'Briens WL - this man will be a breach if cancer is confirmed. Will escalate to OSL. Will email secretary to ask if there is a date in mind.

58 20/11/2018 Surgery date remains outstanding - on Mr O'Briens WL for a TURBT patient has been escalated to OSL.
58 27/11/2018 Surgery date remains outstanding - have emailed secretary to ask if she has been given a date as yet, this man has been escalated to OSL.
58 04/12/2018 This man needs further pre op work up for anesthetics - adjustment has been added.
58 19/12/2018 This man needs passed fit by anaes adjustment in place, WLA for a date for TURBT under Mr O'Brien.
58 28/12/2018 This man has not been passed fit as yet, have sent pre op an email asking when he will be seen again as nothing booked on PAS.
58 09/01/2019 No response from pre op have emailed again asking about this man who is on Mr O'Brien's WL for surgery.
58 16/01/2019 Have emailed secretary to ask if this man is to proceed to surgery has he been passed fit.
58 17/01/2019 Was advised this man has been passed fit on 30.12.18 - He is on Warfarin and his notes were requested to check IPWL re instructions for management of Warfarin prior to surgery. I have just received his notes and the IPWL in his notes is not the correct proforma. He will need another one completed . I will forward his notes to Mr O?Brien for completion of the correct proforma
58 24/01/2019 No response from AOB, had sent this email, this man remains on WL for surgery will update OSL on this patient.
58 24/01/2019 Suspension End : Suspension - Medical Patient needs passed fit

Thanks

Shauna

From: McVeigh, Shauna
Sent: 13 November 2018 16:24
To: Glenny, Sharon
Cc: 'Graham, Vicki (Personal Information redacted by the USI)'
Subject: Urology escalation - Personal Information redacted by the USI

Hi,

Please see escalation of patient that is a suspect cancer and is on day 62 of his pathway. Delay with 1st OP he was seen on day 40, he could not have a flexible cystoscopy performed as he had an infection and was given antibiotics, an adjustment was added. He was preadmitted for a flexible cystoscopy on 02.11.18 – day 51. Following on from his flex he has been added to Mr O'Brien's WL for a TURBT. Date is to be defined, have emailed secretary to ask for a date. This man will be a breach if cancer is confirmed.

Personal Information redacted by the USI

Day Date Event
0 03/09/2018 Suspect Cancer 'Red Flag' referral from GP referred to Craigavon

10 13/09/2018 First appointment is on 22/10/18. Day 49. Letter sent on 13/09/18. Escalated to Vicki.
49 22/10/2018 First Seen at Craigavon
50 23/10/2018 Suspension Start : Suspension - Medical Patient was given antibiotics
50 25/10/2018 Clinic outcome - On the assumption that the nocturia is indicative of a degree of bladder outlet obstruction, I requested that he be prescribed Tamsulosin 400 micrograms daily, and on which he could remain indefinitely. I have also arranged for him to attend our department at Craigavon Area Hospital on Friday the 2nd of November 2018 for flexible cystoscopy.
50 01/11/2018 Suspension End : Suspension - Medical Patient was given antibiotics
57 08/11/2018 Await outcome from flex on 02.11.18 - he looks like he has been discharged following flex, await letter.
62 13/11/2018 I have explained to Personal Information redacted by the USI about this finding today and consented for a transurethral resection of the bladder tumour and explained the risks involved as well. I think he does need to have a CT urogram to complete all investigations here and I have sent him for pre-op assessment. He will need to have a date for a TURBT in the near future
62 13/11/2018 Clinic outcome dictated 13.11.18 - this man is to proceed to TURBT - he has been added to Mr O'Briens WL - this man will be a breach if cancer is confirmed. Will escalate to OSL. Will email secretary to ask if there is a date in mind.

Thanks
Shauna

Shauna Mcveigh
Cancer Tracker / MDT Co-ordinator
Ext Personal Information redacted by the

From: O'Brien, Aidan
Sent: 27 March 2019 20:34
To: McVeigh, Shauna
Cc: Elliott, Noleen
Subject: RE: Personal Information redacted by the USI

Hello Shauna,

I regret that I had not had the time to provide you with an update.
I would have preferred if he had not been listed for MDM discussion until I had submitted an update, following his review on 11 March 2019, particularly as his CT Brain is also significant.
Please append the following update to previous on CaPPS:

Personal Information redacted by the USI had recovered from severe, postoperative delirium by the time that he was able to attend for review on 11 March 2019. He reported no significant urinary symptoms. He was advised that he had been found to have a cerebral arterial aneurysm, and a lesion in the lower lobe of his left lung, on CT scanning on 06 March 2019. He was advised that the pulmonary lesion may be infective or malignant or both. Otherwise, there was no evidence of metastatic disease elsewhere on CT scanning and on Bone scanning.

He was referred to a Respiratory Physician at South West Acute Hospital for further assessment of the pulmonary lesion, and to a Neurosurgeon at Royal Victoria Hospital for advice regarding the further management of the cerebral aneurysm.'

Thank you,

Aidan

From: McVeigh, Shauna
Sent: 27 March 2019 10:18
To: O'Brien, Aidan
Subject: Personal Information redacted by the USI

Hi Mr O'Brien

I have listed Personal Information redacted by the USI for local MDM discussion this week, his scans have been reported. Would you like to provide an update?

Thanks
Shauna

Shauna Mcveigh
Cancer Tracker / MDT Co-ordinator
Ext Personal Information redacted by the

From: Graham, Vicki
Sent: 22 January 2020 14:07
To: Corrigan, Martina
Cc: Muldrew, Angela; Reddick, Fiona; Conway, Barry; Reddick, Fiona; Scott, Jane M; McVeigh, Shauna
Subject: FW: Urology escalation - Personal Information redacted by the USI

Importance: High

Hi Martina,

Please see below patient who is on Day 62 of his pathway – PSA was repeated in clinic but there has been no recent activity. Shauna has emailed Mr O'Brien to ask for management update, but as yet no reply has been received.

Would there be any way that you could obtain outcome?

Many thanks,

Vicki Graham
Cancer Services Co-ordinator
Office 10
Level 2
MEC
EXT Personal Information redacted by

From: McVeigh, Shauna
Sent: 22 January 2020 10:59
To: Graham, Vicki
Subject: Urology escalation - Personal Information redacted by the USI

Hi,

Please see escalation of patient that is a suspect cancer and is on day 62, 1st OP he was seen on day 32. His PSA was repeated at clinic, I have emailed Mr O'Brien for an outcome for this man response awaited. No requests on Sectra or anything pending on PAS.

Personal Information redacted by the USI

Day	Date	Event
0	21/11/2019	Suspect Cancer 'Red Flag' referral from GP referred to Craigavon

5 26/11/2019 First appt. 23/12/19 - Day 32. Patient conf'd appt. Letter sent 26/11/19. escalated to Vicki.
15 06/12/2019 Ultrasound at Craigavon
32 23/12/2019 First Seen at Craigavon
49 09/01/2020 US reported - The bladder outline is normal in appearance. No requests on sectra, PSA was rechecked and is elevated. Will ask Mr O'Brien for management plan.
62 22/01/2020 Await response from Mr O'Brien regarding this man - no letter typed on NIECR. No requests on NIECR.

Thanks
Shauna