Southern Health and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT
Telephone: Personal Information redacted by the USI
E mail:
Secretary: Mrs N. Elliott

Personal Information redacted by the USI

Hospital No: Personal Information redacted by the USI
HCN: Personal Information redacted by the USI

Dear Personal Information redacted by the USI

I was pleased to have the opportunity of speaking with you by telephone on Saturday the 7th of March 2020, though it was regrettable that I had to advise you that your serum PSA level had increased to 5.37ng/ml by the 5th of March 2020.

I have written to your Family Doctor, Personal Information redacted by the USI requesting that a further prescription be issued for Bicalutamide 150mgs to be taken once daily. When you receive this letter, I would be grateful if you would collect a prescription from the Personal Information redacted by the USI at the Personal Information redacted by the USI and continue to take 1 daily until I have the opportunity of reviewing you at my clinic at Personal Information redacted by the USI once again on Monday the 27th of April 2020.

I would also be grateful if you would arrange an appointment with the Practice Nurse at the Health Centre to have your serum PSA level repeated 1 week prior to my reviewing you on the 27th of April 2020.

Yours sincerely

Dictated but not signed by

Mr A O'Brien FRCS
Consultant Urological Surgeon

Date Dictated: 07/03/20	**Date Typed:** 11/03/20-NE

Southern Health and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT
Telephone: Personal Information redacted by the USI
E mail:
Secretary: Mrs N. Elliott

Personal Information redacted by the USI

Dear Personal Information redacted by the USI

Re: Patient Name: Personal Information redacted by the USI
D.O.B.:
Address:
Hospital No: Personal Information redacted by the USI **HCN:** Personal Information redacted by the USI

Date/Time of Clinic: 11/11/19	**Follow Up:** Review 27/1/20

I last wrote to you in October 2019 when I requested that you prescribe for Personal Information the lower daily dose of 50mgs of Bicalutamide as he had been intolerant of the higher dose of 150mgs due to a sensation of lightheadedness. When I reviewed Per on the 11th of November 2019, I was pleased to find him keeping somewhat better, and able to tolerate the lower dose of Bicalutamide. He undertook to continue to take that lower dose until his further review, and whilst on holiday abroad during December 2019.

I have been able to speak with Personal Information re by telephone on the 2nd of January 2020, and was pleased to advise him that I had found his serum PSA level to have decreased further to 3.84ng/ml on the 11th of November 2019. I have asked Personal Information to arrange an appointment with your Practice Nurse to have his serum PSA level repeated and so that the result will be available when he returns for further review on Monday the 27th of January 2020.

It would be ideal for Personal Information re to have an optimal biochemical response to androgen blockade or androgen deprivation prior to consideration of radical radiotherapy. If his serum PSA level has not decreased further, it may be necessary to take an incremental approach to increased androgen blockade by increasing the dose of Bicalutamide to 50mg twice daily, and hopefully subsequently to taking the higher dose of 150mgs once again, as I suspect that the addition of a LHRH agonist may be more intolerable.

In any case, I look forward to reviewing him with the recent result of a further serum PSA level, and I will advise you in due course of plans for his further management.

Yours sincerely

Dictated but not signed by

Mr A O'Brien FRCS
Consultant Urological Surgeon

Date Dictated: 02/01/19	**Date Typed:** 10/01/20-NE

Southern Health and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT
Telephone: Personal Information redacted by the USI
E mail: Personal Information redacted by the USI
Secretary: Mrs N. Elliott

Personal Information redacted by the USI

Hospital No: Personal Information redacted by the USI
HCN:

Dear [redacted]

I was pleased to have the opportunity of speaking with you by telephone on Monday the 14th of October 2019. I have to confess that I have not previously experienced anyone having the sensation of lightheadedness or of having a fuzzy head as a conseqence of taking either Bicalutamide or Tamoxifen. In any case, I do believe that it is entirely safe and preferable that you do not take any more of either medication from now until the 1st of November 2019.

I write to confirm that I have written to your Family Doctor, Personal Information redacted by the USI requesting that he issue a prescription for the lower dose of Bicalutamide 50mgs to be taken once daily. When you receive this letter, I would be grateful if you would collect a prescription from Personal Information redacted by the USI Personal Information redacted by the USI lower dose of Bicalutamide alone on Friday the 1st of November 2019, and so that you may be able to advise me of your tolerance of this lower dose when you return for review at my clinic at Personal Information redacted by the USI on Monday the 11th of November 2019.

I would also be grateful if you would arrange an appointment with the Practice Nurse to have your serum PSA level repeated during the 1st week of November 2019, and so that the result will also be available when you return for further review on Monday the 11th of November 2019. I also write to confirm that I have requested the Department of Radiology at South West Acute Hospital in Enniskillen to arrange an appointment for you to attend there to have a CT scan of your chest, abdomen and pelvis performed.

Equally, I also write to confirm that I have requested the Department of Radiology at Craigavon Area Hospital to arrange an appointment for you to attend there to have a bone scan performed.

I look forward to reviewing you at my clinic at Personal Information redacted by the USI on Monday the 11th of November 2019, and I do hope that I will find you to be keeping better by then.

Yours sincerely

Dictated but not signed by

Mr A O'Brien FRCS
Consultant Urological Surgeon

Date Dictated: 14/10/19	**Date Typed:** 15/10/19-NE

Southern Health and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT
Telephone: Personal Information redacted by the USI
E mail:
Secretary: Mrs N. Elliott

Personal Information redacted by the USI

Dear DR Personal Information redacted by the

Re: Patient Name: Personal Information redacted by the USI
D.O.B.:
Address:
Hospital No: Personal Information redacted by the USI

Date/Time of Clinic: 23/09/19 | **Follow Up:** Review 11th November 2019

I last wrote to you in August 2019 when I arranged for Personal Information r to have prostatic biopsies performed on the 20th of August 2019. There was no evidence of any prostatic adenocarcinoma in any of the 9 cores taken from the right lateral lobe of his prostate gland. He was however found to have Gleason 4+3 adenocarcinoma found in 7 of the 11 cores taken from the right lateral lobe of his prostate gland. The maximum tumour length was 6mm, and tumour was considered to occupy approximately 8% of total core tissue volume. There was no evidence of perineural infiltration, lymphovascular infiltration or extracapsular invasion.

I advised Personal Information re of the histopathological diagnosis at review at my clinic at Personal Information Personal Information redacted by the USI on the 23rd of September 2019. I advised him that the nature of the adenocarcinoma that had been found was considered to be of high risk category, particularly in view of he having elevated serum total PSA levels of almost 20ng/ml, and even though he had been taking Finasteride since 2010. For this reason, I initiated androgen blockade by prescribing Bicalutamide 150mgs daily, in addition to Tamoxifen 10mgs daily in order to minimise the risk of gynaecomastia arising as a consequence of androgen blockage. However, Personal Information re subsequently contacted my secretary to advise that the combination of Bicalutamide and Tamoxifen had resulted in adverse toxicity which he found difficult to tolerate. When I spoke with him by telephone on Monday the 14th of October 2019, he reported that he was quite fuzzy headed, and to the extent that he was concerned that it was safe for him to drive. I therefore advised him to discontinue taking both for a period of time.

I had found that his serum PSA level had increased to 21.8ng/ml at review on the 23rd of September 2019. I found him to have very normal serum testosterone level of 19.3nmols/L, and which would hopefully indicate that the prostatic carcinoma would be androgen dependent, and that androgen blockade or

deprivation would result in an optimal biochemical response. I have requested a radioisotope bone scan and a CT scan of his chest, abdomen and pelvis as advised when his further assessment and management was discussed at the Urology Multidisciplinary Meeting of the 29th of August 2019. I have arranged to review him at my clinic at Personal Information redacted by the USI on Monday the 11th of November 2019 when the reports of both scans should be available and when his further management will have been discussed again at the Urology Multidisciplinary Meeting.

In the interim, I would be grateful if you would issue a further prescription for Bicalutamide 50mgs daily. I have asked Personal Information redacted not to take any more of the higher dose of Bicalutamide, or of the Tamoxifen, until the end of October 2019. I have asked Personal Information redacted to collect the prescription for the lower dose of Bicalutamide, 50mgs daily, from your practice, and to begin taking that alone, once daily, on the 1st of November 2019, and so that I may be able to review his tolerance of it when he returns for review on the 11th of November 2019. I have also asked Personal Information redacted to arrange an appointment with your Practice Nurse to have his serum PSA level repeated during the 1st week of November 2019 and so that the result may also be available when he returns for further review.

Yours sincerely

Dictated but not signed by

Mr A O'Brien FRCS
Consultant Urological Surgeon

Date Dictated: 14/10/19	**Date Typed:** 15/10/19-NE

Southern Health and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT
Telephone: Personal Information redacted by the USI
E mail:
Secretary: Mrs N. Elliott

Personal Information redacted by the USI

Dear Personal Information redacted by the USI

Re: Patient Name: Personal Information redacted by the USI
D.O.B.:
Address:
Hospital No: Personal Information redacted by the USI **HCN:** Personal Information redacted by the USI

Date/Time of Clinic: 20/08/19	**Follow Up:** Review by Mr O'Brien
Procedure (if applicable) TRUS biopsies	

Personal Information redacted by the USI attended the Thorndale Unit today. Written consent was obtained, local anaesthetic inserted and following guidance from his recent MRI scan, a total of 20 core biopsies of prostate were collected.

He was provided with a 3 day course of prophylactic antibiotics and was discharged home in the company of a family member. His histology results will be discussed at the Urology Multidisciplinary Meeting and he will be reviewed by Mr O'Brien thereafter.

Yours sincerely

Dictated but not signed by

Personal Information redacted by the USI
Clinical Nurse Specialist in Urology to:
Mr A O'Brien FRCS
Consultant Urological Surgeon

Date Dictated: 20/08/19	**Date Typed:** 30/08/19-NE

Personal Information redacted by the USI

MDM Report from Urology MDM @ The Southern Trust

~~Noleen Elliott CHT Clinic 20.08.19~~

RE: Personal Information redacted by the USI

Personal Information redacted by the USI

DOB: Personal Information redacted by, Hospital Number: Personal Information redacted by the US , HCN: Personal Information redacted by t

Contact Tel: Personal Information redacted by the

Library 2

MDM Report from the Urology MDM @ The Southern Trust on 29/08/2019.

MDM Update

CONSULTANT MR O'BRIEN: This Persona l Informat year old man was referred in June 2019 with serum PSA levels of 19.16 ng/ml in May 2019 and of 19.81 ng/ml in June 2019. He reported mild urinary symptoms at review in July 2019, consisting of a sensation of unsatisfactory voiding following micturition, and of nocturia, having to rise once or twice each night to pass urine. He was noted to have been taking Finasteride since 2010 and Oxybutynin since 2016. He was found to have an indurated prostate gland on examination. He was reported to have a prostatic volume of 40 ml on MRI scanning in July 2019, when it was reported that he had a PIRADS 3 lesion within the anterior transition zone, and PIRADS 5 features with the peripheral zones of both lateral lobes.

An ultrasound scan of urinary tract and transrectal, ultrasound guided, prostatic biopsies were requested.

TRUS biopsy, 20.08.19 -
Prostatic adenocarcinoma of overall Gleason sum score 4 + 3 = is present in 7 of 20 cores with a maximum tumour length of 6 mm. The tumour occupies approximately 8% of the total tissue volume.

MDM Action

Discussed at Urology MDM 29.08.19.
Mr Personal Information redacted has high risk prostate cancer. For review with Mr O'Brien to organise a Bone Scan, CT Chest, Abdomen and Pelvis. For further discussion at MDM with radiology results.

adiology

MRI Findings

MDM Report from Urology MDM @ The Southern Trust

RE: Personal Information redacted by the USI

DOB: Personal Information redacted by Hospital Number: Personal Information redacted by the U , HCN: Personal Information redacted by the USI

Contact Tel: Personal Information redacte

Latest Findings from MRI performed on 10/07/2019
10/07/2019 10:17 MRI Pelvis prostate, Author: Personal Information redacted by the USI

INDICATION:
Serum PSA levels increasing to 19.81 ng/ml. MRI Pelvis performed in July 2018, he was reported to have benign prostatic enlargement.

TECHNIQUE:
Standard prostate protocol (sagittal, coronal oblique and axial oblique T2-w, axial oblique T1-w and axial T2-w turbo-spin-echo sequences, diffusion--w EPI-spin-echo (b50, 400 and 800 values, and b1400 calculated from lower b values) and ADC map, and axial T2-w and truFISP at the pelvis).

COMPARISON:
None.

FINDINGS:
Dimensions of the prostate: transverse 4 cm, anteroposterior 3.5 cm and craniocaudal 4.4 cm; ellipsoid volume: 32 cc; bullet volume: 40 cc.

Hypertrophy of the transition zone with no suspicious areas on T2-w assessment (mostly encapsulated nodules and heterogeneous signal areas with obscured margins) and a small focus of marked hyperintensity on diffusion-w images and hypointensity on ADC at the left anterior mid portion abutting the fibromuscular stroma but no corresponding suspicious lesion noted on T2-w images (PI-RADS assessment 3).

The peripheral zone shows an area of circumscribed homogeneous moderate hypointensity on T2-w of about 2.5 cm abutting the capsule in the bilateral posteromedial and left posterolateral and anterior apex with corresponding marked hyperintensity on diffusion-w and hypointensity on ADC map (PI-RADS assessment 5). There is no definite extraprostatic extension but the lesion largely abuts the capsule with no bulging or irregular contour. The lesion abuts the external urethral sphincter as well but there is no evidence of invasion of this structure.

The periprostatic compartment and seminal vesicles show normal.

No regional lymphadenopathy demonstrated.

No significant bony signal alteration visualized in the pelvis.

The urinary bladder, external urethral sphincter and perineal tissues, penis root and visible scrotum, anorectum, mesorectum and presacral space, pelvic sidewall, etc. appear within normal limits.

IMPRESSION:
PI-RADS assessment 5 for the peripheral zone (left apical lesion), MRI staging T3 N0 M0. PI-RADS assessment 3 for the transition zone.

MDM Report from Urology MDM @ The Southern Trust

RE: [redacted]

DOB: [redacted] Hospital Number: [redacted] , HCN: [redacted]

Contact Tel: [redacted]

Urology MDM @ The Southern Trust

[redacted]

RE: [redacted]

DOB: [redacted], Hospital Number: [redacted], HCN: [redacted]

Dear Dr

This patient was discussed at the Urology MDM @ The Southern Trust

On 29/08/2019.

MDM Update:

CONSULTANT MR O'BRIEN: This [redacted] year old man was referred in June 2019 with serum PSA levels of 19.16 ng/ml in May 2019 and of 19.81 ng/ml in June 2019. He reported mild urinary symptoms at review in July 2019, consisting of a sensation of unsatisfactory voiding following micturition, and of nocturia, having to rise once or twice each night to pass urine. He was noted to have been taking Finasteride since 2010 and Oxybutynin since 2016. He was found to have an indurated prostate gland on examination. He was reported to have a prostatic volume of 40 ml on MRI scanning in July 2019, when it was reported that he had a PIRADS 3 lesion within the anterior transition zone, and PIRADS 5 features with the peripheral zones of both lateral lobes.

An ultrasound scan of urinary tract and transrectal, ultrasound guided, prostatic biopsies were requested.

TRUS biopsy, 20.08.19 -
Prostatic adenocarcinoma of overall Gleason sum score 4 + 3 = is present in 7 of 20 cores with a maximum tumour length of 6 mm. The tumour occupies approximately 8% of the total tissue volume.

MDM Plan:

Discussed at Urology MDM 29.08.19.
[redacted] has high risk prostate cancer. For review with Mr O'Brien to organise a Bone Scan, CT Chest, Abdomen and Pelvis. For further discussion at MDM with radiology results.

If you have any queries or require further information, please do not hesitate to contact us.

Yours sincerely,

Urology MDM @ The Southern Trust

RE: [redacted]

DOB [redacted] Hospital Number: [redacted] , HCN: [redacted]

Chairman of Urology MDM
[redacted]
Consultant Urologist

Urology MDM @ The Southern Trust

RE: [redacted]

DOB [redacted] Hospital Number: [redacted] , HCN: [redacted]

Dear Dr

This patient was discussed at the Urology MDM @ The Southern Trust

On 29/08/2019.

MDM Update:

CONSULTANT MR O'BRIEN: This [redacted] year old man was referred in June 2019 with serum PSA levels of 19.16 ng/ml in May 2019 and of 19.81 ng/ml in June 2019. He reported mild urinary symptoms at review in July 2019, consisting of a sensation of unsatisfactory voiding following micturition, and of nocturia, having to rise once or twice each night to pass urine. He was noted to have been taking Finasteride since 2010 and Oxybutynin since 2016. He was found to have an indurated prostate gland on examination. He was reported to have a prostatic volume of 40 ml on MRI scanning in July 2019, when it was reported that he had a PIRADS 3 lesion within the anterior transition zone, and PIRADS 5 features with the peripheral zones of both lateral lobes.

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Discussed at Urology MDM 29.08.19.
[redacted] has high risk prostate cancer. For review with Mr O'Brien to organise a Bone Scan, CT Chest, Abdomen and Pelvis. For further discussion at MDM with radiology results.

If you have any queries or require further information, please do not hesitate to contact us.

Yours sincerely,

DIOMETER ABL800 FLEX

Theatre
ORT — Syringe - S 195uL — 02:37 PM — 6/17/2020
Sample # 1415

ns
Name [redacted]
Name
Arterial
37.0 °C
21.0 %
[redacted]

Values

	7.372		[7.350 - 7.450]
	4.92	kPa	[4.30 - 6.40]
	17.3	kPa	[11.0 - 14.4]
(P,st)c	21.7	mmol/L	[22.0 - 29.0]
(P)c	21.0	mmol/L	[22.0 - 29.0]
tatus			
ecf)c	-3.4	mmol/L	[-3.0 - 3.0]
tus			
	98.1	%	[94.0 - 98.0]
	3.58	kPa	[3.30 - 3.90]
Corrected Values			
	7.372		[7.350 - 7.450]
	17.3	kPa	[11.0 - 14.4]
	4.92	kPa	[4.30 - 6.40]
es			
	116	g/L	[115 - 180]
	95.8	%	[94.0 - 98.0]
	0.9	%	[0.0 - 2.0]
	1.9	%	[1.0 - 5.0]
	1.4	%	[0.0 - 2.0]
	0.357		[0.370 - 0.530]
alues			
	6.4	mmol/L	[3.5 - 5.3]
	0.6	mmol/L	[0.4 - 0.8]
alues			
	3.2	mmol/L	[3.5 - 4.5]
	137	mmol/L	[136 - 145]
	1.19	mmol/L	[1.15 - 1.33]
	106	mmol/L	[98 - 107]
c	10.4	mmol/L	[12.0 - 18.0]

e(s) above reference range
e(s) below reference range
ault value(s)
culated value(s)

RADIOMETER ABL800 FLEX

ABL835 DHH Theatre
PATIENT REPORT — Syringe - S 195uL — 02:37 PM — 6/17/20
Sample # 14

Identifications
Patient ID [redacted]
Patient Last Name
Patient First Name
Date of birth
Sample type Arterial
T 37.0 °C
FO_2(I) 21.0 %
Operator [redacted]

Blood Gas Values			
pH	7.372		[7.350 - 7.450]
pCO_2	4.92	kPa	[4.30 - 6.40]
↑ pO_2	17.3	kPa	[11.0 - 14.4]
↓ $cHCO_3^-(P,st)_c$	21.7	mmol/L	[22.0 - 29.0]
↓ $cHCO_3^-(P)_c$	21.0	mmol/L	[22.0 - 29.0]
Acid Base Status			
↓ cBase(Ecf)c	-3.4	mmol/L	[-3.0 - 3.0]
Oxygen Status			
↑ sO_2	98.1	%	[94.0 - 98.0]
$p50(st)_d$	3.58	kPa	[3.30 - 3.90]
Temperature Corrected Values			
pH(T)	7.372		[7.350 - 7.450]
↑ $pO_2(T)$	17.3	kPa	[11.0 - 14.4]
$pCO_2(T)$	4.92	kPa	[4.30 - 6.40]
Oximetry Values			
ctHb	116	g/L	[115 - 180]
FO_2Hb	95.8	%	[94.0 - 98.0]
FCOHb	0.9	%	[0.0 - 2.0]
FHHb	1.9	%	[1.0 - 5.0]
FMetHb	1.4	%	[0.0 - 2.0]
↓ Hct_c	0.357		[0.370 - 0.530]
Metabolite Values			
↑ cGlu	6.4	mmol/L	[3.5 - 5.3]
cLac	0.6	mmol/L	[0.4 - 0.8]
Electrolyte Values			
↓ cK^+	3.2	mmol/L	[3.5 - 4.5]
cNa^+	137	mmol/L	[136 - 145]
cCa^{2+}	1.19	mmol/L	[1.15 - 1.33]
cCl^-	106	mmol/L	[98 - 107]
↓ Anion Gap_c	10.4	mmol/L	[12.0 - 18.0]

Notes
↑ Value(s) above reference range
↓ Value(s) below reference range
d Default value(s)
c Calculated value(s)

RADIOMETER ABL800 FLEX

ABL835 DHH Theatre
PATIENT REPORT — Syringe - S 195uL — 11:48 AM — 6/17/2020
Sample # 1413

Identifications
Patient ID [redacted]
Patient Last Name
Patient First Name
Date of birth 12/13/1944
Sample type Arterial
T 37.0 °C
FO_2(I) 21.0 %
Operator [redacted]

Mc-on.

Blood Gas Values			
↓ pH	7.332		[7.350 - 7.450]
pCO_2	5.54	kPa	[4.30 - 6.40]
? pO_2		kPa	[-]
↓ $cHCO_3^-(P,st)_c$	21.3	mmol/L	[22.0 - 29.0]
↓ $cHCO_3^-(P)_c$	21.4	mmol/L	[22.0 - 29.0]
Acid Base Status			
↓ cBase(Ecf)c	-3.5	mmol/L	[-3.0 - 3.0]
Oxygen Status			
sO_2	96.5	%	[94.0 - 98.0]
Temperature Corrected Values			
↓ pH(T)	7.332		[7.350 - 7.450]
$pCO_2(T)$	5.54	kPa	[4.30 - 6.40]
Oximetry Values			
↓ ctHb	114	g/L	[115 - 180]
FO_2Hb	94.7	%	[94.0 - 98.0]
FCOHb	0.5	%	[0.0 - 2.0]
FHHb	3.4	%	[1.0 - 5.0]
FMetHb	1.4	%	[0.0 - 2.0]
↓ Hct_c	0.352		[0.370 - 0.530]
Metabolite Values			
↑ cGlu	5.5	mmol/L	[3.5 - 5.3]
↑ cLac	1.3	mmol/L	[0.4 - 0.8]
Electrolyte Values			
↓ cK^+	3.2	mmol/L	[3.5 - 4.5]
cNa^+	138	mmol/L	[136 - 145]
cCa^{2+}	1.22	mmol/L	[1.15 - 1.33]
cCl^-	106	mmol/L	[98 - 107]
↓ Anion Gap_c	11.2	mmol/L	[12.0 - 18.0]

Notes
↑ Value(s) above reference range
↓ Value(s) below reference range
c Calculated value(s)
pO_2 0210: Calibration error(s) present
pO_2 0476: Measurement unstable

RADIOMETER ABL800 FLEX

ABL835 DHH Theatre
PATIENT REPORT — Syringe - S 195uL — 12:53 PM — 6/17/2020
Sample # 1414

Identifications
Patient ID [redacted]
Patient Last Name [redacted by the USI]
Patient First Name
Date of birth
Sample type Arterial
T 37.0 °C
FO_2(I) 21.0 %
Operator [redacted]

Blood Gas Values			
pH	7.382		[7.350 - 7.450]
pCO_2	4.79	kPa	[4.30 - 6.40]
↑ pO_2	21.9	kPa	[11.0 - 14.4]
↓ $cHCO_3^-(P,st)_c$	21.8	mmol/L	[22.0 - 29.0]
↓ $cHCO_3^-(P)_c$	20.9	mmol/L	[22.0 - 29.0]
Acid Base Status			
↓ cBase(Ecf)c	-3.4	mmol/L	[-3.0 - 3.0]
Oxygen Status			
↑ sO_2	98.7	%	[94.0 - 98.0]
$p50(st)_d$	3.58	kPa	[3.30 - 3.90]
Temperature Corrected Values			
pH(T)	7.382		[7.350 - 7.450]
↑ $pO_2(T)$	21.9	kPa	[11.0 - 14.4]
$pCO_2(T)$	4.79	kPa	[4.30 - 6.40]
Oximetry Values			
↓ ctHb	114	g/L	[115 - 180]
FO_2Hb	96.5	%	[94.0 - 98.0]
FCOHb	0.9	%	[0.0 - 2.0]
FHHb	1.3	%	[1.0 - 5.0]
FMetHb	1.3	%	[0.0 - 2.0]
↓ Hct_c	0.350		[0.370 - 0.530]
Metabolite Values			
↑ cGlu	5.4	mmol/L	[3.5 - 5.3]
cLac	0.7	mmol/L	[0.4 - 0.8]
Electrolyte Values			
↓ cK^+	3.3	mmol/L	[3.5 - 4.5]
cNa^+	137	mmol/L	[136 - 145]
cCa^{2+}	1.16	mmol/L	[1.15 - 1.33]
cCl^-	106	mmol/L	[98 - 107]
↓ Anion Gap_c	10.6	mmol/L	[12.0 - 18.0]

Notes
↑ Value(s) above reference range
↓ Value(s) below reference range
d Default value(s)
c Calculated value(s)

PREOPERATIVE ASSESSMENT

ASA status: 1 2 3 4 5 6 E

CHART

PFN

Personal Information redacted by the USI

PERSONNEL

Anaesthetist (grade):

Surgeon:

PROCEDURE DETAILS

Diagnosis:

Operation:

NCEPOD: Scheduled / Urgent / Emergency

Ward staff to complete

Weight (kg) 75

Height (m)

BMI (Kg/m2)

Temp (°C)

Pulse (/min)

BP (mm Hg)

RR (/min)

O2 Sat (%)

Fasting time: Solids Liquids

Allergy:

NSAID ok? Y N

MEDICATIONS (generic)

See MA.

MEDICAL HISTORY

Fit & well	Y	N
CVS disease		
RS disease		
Endocrine		
CNS		
Arthritis		
GORD		

PHYSICAL EXAMINATION & NOTES

Type II DM

NCI 2017 post MI

+ fatigue

+ Anxious

ANAESTHETIC HISTORY

Previous anaesthesia Y N Problems? Family Hx?

Teeth Intact Y N Airway

Risk of dental damage explained & accepted

Smoking C_2H_5OH Aspiration Risk

PLAN/PATIENT INFORMATION

GA (+/- RSI)		Risks		Benefits
Sedation		Risks		Benefits
RA		Risks		Benefits
Invasive monitoring		Risks		Benefits
Postop Care/Analgesia		Risks		Benefits

Written information

Opportunity for questions

LAB RESULTS (/ /)

Hb

Plts

Na

K

Urea

Creat

X Match/G & S

ECG

CXR

PREOPERATIVE INSTRUCTIONS

1 - Needs mood + lift.

- Refused FA

POSTOPERATIVE INSTRUCTIONS/ MONITORING

SURGICAL PROCEDURE: TURP.

Oxygen @ ..... L/min ..... % for ..... hrs/overnight/humidified

Target SpO_2 ≥ ..... %

ANALGESIA

Morphine IV (.....mg/ml) up to max ..... mls

Paracetamol .....mg IV/PO/NG/PR ..... hrly PRN/Regular

Other -

ANTIEMETICS Maxolon.

Routine Observations

Discharge at Sister's advi Personal Information redacted by USI

Anaesthetist's Signature

Please see:

Drug Kardex

Fluid balance chart

PCA Form

Epidural Form

Intrathecal opiate Form

CVC Audit sheet

POSTOP INVESTIGATIONS

Full ICU profile .....

FBP, U&E .....

ABG .....

CXR .....

Time	Resp	SpO_2	Pulse	BP	O_2 deliv.	Temp	Drugs	Notes

HSS TRUST _____ | GP PRACTICE or other _____

Hospital Unit _____ | Primary Care Provider _____

FORM 1 – CONSENT FOR EXAMINATION, TREATMENT OR CARE

Personal details (or pre-printed label)

Surname/family name .....

First names .....

Date of Birth .....

❑ Male ❑ Female H+C No. (or other identifier) .....

Special requirements (language or other) .....

.....

Personal Information redacted by USI

Personal Information redacted by the USI

Statement of healthcare professional

Responsible healthcare professional ..... Job Title .....

Name of proposed procedure or course of treatment *(include side of body or site and brief explanation if medical term not clear)*

TURP PROSTATE

I have explained the procedure. In particular, I have explained:

The intended benefits .....

Serious or frequently occurring risks BLEEDING, INFECTION, CATHETER PROBLEM, RETROGRADE EJACULATION, URINARY STRICTURE

Possible additional procedures which may become necessary during the procedure.

❑ Blood transfusion ❑ other procedure (please specify).....

This procedure will involve: ❑ general and/or regional anaesthesia ❑ local anaesthesia ❑ sedation

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment), any samples of tissue that may be taken and any particular concerns of this individual.

❑ The following leaflet/tape has been provided.....

Signed ..... Date 17/6/20

Name (Print) ..... Job Title .....

Contact details *(if patient wishes to discuss options later)* .....

Personal Information redacted by the USI

Statement of interpreter (where appropriate)

I have interpreted the information above to the person giving consent to the best of my ability and in a way which I believe s/he can understand.

Signed ..... Date .....

Name (Print) .....

Copy accepted by person giving consent Yes/No (please circle)

Statement of person giving consent

Please read this form carefully. If your treatment has been planned in advance, you shoul already have your own copy which describes the benefits and risks of the propose treatment. If not, you will be offered a copy now. If you have any further questions, do as - we are here to help you. You have the right to change your mind at any time, includin after you have signed the form.

I agree to the procedure or course of treatment described on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia).

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I have been told about possible additional procedures which may become necessary during my treatment I have listed below any procedures **which I do not wish to be carried out** without further discussion.

.....

.....

I agree that healthcare students, who will be supervised by healthcare professionals, may observe or assist in my care. **You may remove this sentence without affecting your care.*

Signature ..... Date .....

Personal Information redacted by the USI

Name **(Print)** .....

A witness should sign below if the person is unable to sign but has indicated his or her consent. Young people/children may also like a parent to sign here (see notes)

Signature ..... Date .....

Name **(Print)**.....

Confirmation of consent (to be completed by a healthcare professional when the person is admitted for the procedure, if s/he has signed the form in advance). I have confirmed that s/he has no further questions and wishes the procedure to go ahead.

Signature ..... Date .....

Name **(Print)** ..... Job Title .....

Important notes: **(tick if applicable)**

☐ **See also advance directive/living will (eg Jehovah's Witness form)**

☐ **Person has withdrawn consent** ..... Date.....

(ask person to sign/date here)

LPC 03/08/031

Urology MDM @ The Southern Trust

RE: [redacted]

DOB: [redacted], Hospital Number: [redacted], HCN: [redacted]

Dear Dr

This patient was discussed at the Urology MDM @ The Southern Trust
On 07/11/2019.

Diagnosis: Prostate cancer
Gleason Score 4 + 3

MDM Update:

RE: Patient 1 Personal Information redacted by USI

DOB: Personal Information redacted by USI Hospital Number: Personal Information redacted by USI , HCN: Personal Information redacted by USI

CONSULTANT MR O'BRIEN: This Personal Information redacted year old man was referred in June 2019 with serum PSA levels of 19.16 ng/ml in May 2019 and of 19.81 ng/ml in June 2019. He reported mild urinary symptoms at review in July 2019, consisting of a sensation of unsatisfactory voiding following micturition, and of nocturia, having to rise once or twice each night to pass urine. He was noted to have been taking Finasteride since 2010 and Oxybutynin since 2016. He was found to have an indurated prostate gland on examination. He was reported to have a prostatic volume of 40 ml on MRI scanning in July 2019, when it was reported that he had a PIRADS 3 lesion within the anterior transition zone, and PIRADS 5 features with the peripheral zones of both lateral lobes.

An ultrasound scan of urinary tract and transrectal, ultrasound guided, prostatic biopsies were requested.

TRUS Biopsy, 20.08.19 - Prostatic adenocarcinoma of overall Gleason sum score 4 + 3 = is present in 7 of 20 cores with a maximum tumour length of 6 mm. The tumour occupies approximately 8% of the total tissue volume.

Discussed at Urology MDM 29.08.19. Mr Personal Information redacted has high risk prostate cancer. For review with Mr O'Brien to organise a Bone Scan, CT Chest, Abdomen and Pelvis. For further discussion at MDM with radiology results.

Patient 1 was advised of the histopathological diagnosis of prostatic carcinoma on 23 September 2019 when his serum PSA had increased to 21.8 ng/ml and his serum testosterone was 19.3 nmol/L. He was prescribed Bicalutamide 150 mg daily and Tamoxifen 10 mg daily while awaiting completion of imaging. The medication was accompanied by intolerable adverse toxicity, mainly in the form of light headedness, and to the extent that he lost the confidence to drive. He was advised to discontinue taking both on 14 October 2019, and to resume taking Bicalutamide 50 mg daily alone on 01 November 2019. A bone scan and CT scan of chest, abdomen and pelvis were requested. A review on 11 November 2019 was arranged.

CT, 28.10.19 - No evidence of metastatic disease.

Bone scan, 31.10.19 - The bone scan appearances are considered to be unremarkable. Presumed degenerative change at L5. No convincing evidence to suggest a pattern of osteoblastic metastasis.

Discussed at Urology MDM 31.10.19. Review with Mr O'Brien as arranged. Patient 1 has intermidate risk prostate cancer to start ADT and refer for ERBT.

Patient 1 has review appointment with Mr O'Brien on 11.11.19.

Urology MDM @ The Southern Trust

RE: Mr [Patient 1]
[Personal Information redacted by USI]
DOB [Personal Information redacted by USI] Hospital Number: [Personal Information redacted by USI] , HCN: [Personal Information redacted by USI]

MDM Plan:
Discussed at Urology MDM 07.11.19. This patient is not for discussion. **NO GP LETTER**

If you have any queries or require further information, please do not hesitate to contact us.

Yours sincerely,

Chairman of Urology MDM
[Personal Information redacted by the USI]
Consultant Urologist

Southern Health and Social Care Trust.

This job plan started 01 April 2018.

Job plan for Mr O'Brien, Aidan in Urology

Basic Information

Job plan status	Locked down
Appointment	Full Time
Cycle	Rolling cycle - 12 weeks
Start Week	1
Report date	30 Jul 2020
Expected number of weeks in attendance	42 weeks
Usual place of work	Craigavon Area Hospital
Alternate employer	None Specified
Contract	New
Private practice	No

Job plan stages

Job plan stages	Comment	Date stage achieved	Who by
In 'Discussion' stage		24 Apr 2018	Mr Zircadian Support
In 'Discussion' stage - awaiting doctor agreement		24 Sep 2018	Mr Colin Weir
In 'Discussion' stage - request cancelled		31 Oct 2018	Mr Colin Weir
In 'Discussion' stage - awaiting doctor agreement		31 Oct 2018	Mr Colin Weir
In 'Discussion' stage - request cancelled		31 Oct 2018	Mr Colin Weir
In 'Discussion' stage - awaiting doctor agreement		21 Nov 2018	Mr Colin Weir
Locked down		9 Dec 2019	Dr Edward James McNaboe

Hours Breakdown

	Main Employer PAs	Core PAs	APA PAs	Total PAs	Core hours	APA hours	Total hours
Direct Clinical Care (DCC)	10.271	10.271	0.000	10.271	41:03	0:00	41:03
Supporting Professional Activities (SPA)	1.462	1.462	0.000	1.462	5:51	0:00	5:51
Total	11.733	11.733	0.000	11.733	46:54	0:00	46:54

On-call summary

Rota Name	Location	Weekday Freq	Weekend Freq	Category	Supplement	PAs
On-call Rota	Craigavon Area Hospital	5	5	A	5%	1.000

Type	Normal	Premium	Cat.	PA
			Total:	1.000
Predictable	n/a	n/a	DCC	0.000
Unpredictable	n/a	n/a	DCC	1.000

The total PAs arising from your on-call work is:	1.000
Your availability supplement is:	5% (based on the highest supplement from all your rotas)

On-call rota details

On-call Rota (PA entry)

General information	
What is your on-call activity?	On-call Rota
Where does your on-call rota take place in?	Craigavon Area Hospital
What is your on-call classification?	A
Weekday work	
What is the frequency of your weekday on-call work?	1 in 5.00
	Predictable Unpredictable
How many PAs arise from your weekday on-call work?	**0.000 1.000**
Weekend work (A weekend is classed as Saturday to Sunday for this rota)	
What is the frequency of your weekend on-call work?	1 in 5.00
	Predictable Unpredictable
How many PAs arise from your weekend on-call work?	**0.000 0.000**
Other information	
Which objective does this on-call work relate to?	
Comments	

Sign off

Role: Clinical Manager	Role: Clinical Director	Role: Board Member
Name: Dr McNaboe, Edward James (Con)	Name: Mr Haynes, Mark Dean (Con)	Name: Mr Carroll, Ronan
Signed:	Signed:	Signed:
Date:	Date:	Date:

Timetable

Hot Activities

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Surgeon of the week 09:00 - 17:30 Week 1,7 (12 week cycle)	Surgeon of the week 09:00 - 17:30 Week 1,7 (12 week cycle)	Surgeon of the week 09:00 - 17:30 Week 1,7 (12 week cycle)	Surgeon of the week 09:00 - 12:00 Week 6,12 (12 week cycle) Surgeon of the week 09:00 - 17:30 Week 1,7 (12 week cycle)	Surgeon of the week 09:00 - 17:30 Week 1,7 (12 week cycle)		

Week 1

There are no activities this week

Week 2

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	Core SPA 09:00 - 13:00 Core SPA 13:30 - 17:00	Pre-op ward round 08:30 - 09:00 Planned in-patient operating sessions 09:00 - 18:00 Post-op ward round 18:00 - 19:00	Core SPA 09:00 - 12:00 Surgery MDT 14:00 - 17:00	Sub Specialty clinic 09:00 - 13:00 Sub Specialty clinic 13:30 - 17:00		

Week 3

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
New patient Clinic 08:30 - 13:00 Patient related admin (reports, results etc) 13:30 - 17:00	Core SPA 09:00 - 13:00 Core SPA 13:30 - 17:00	Pre-op ward round 08:30 - 09:00 Planned in-patient operating sessions 09:00 - 18:00 Post-op ward round 18:00 - 19:00	Core SPA 09:00 - 12:00 Surgery MDT 14:00 - 17:00	Sub Specialty clinic 09:00 - 13:00 Core SPA 13:30 - 17:00		

Week 4

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Patient related admin (reports, results etc) 09:00 - 17:00	Day surgery 08:30 - 13:00 New patient Clinic 13:30 - 17:00	Pre-op ward round 08:30 - 09:00 Planned in-patient operating sessions 09:00 - 18:00 Post-op ward round 18:00 - 19:00	Core SPA 09:00 - 12:00 Surgery MDT 14:00 - 17:00	Sub Specialty clinic 09:00 - 13:00 Surgery MDT 13:15 - 17:15		

Week 5

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Patient related admin (reports, results etc) 13:30 - 17:00	Day surgery 08:30 - 13:00 New patient Clinic 13:30 - 17:00	Pre-op ward round 08:30 - 09:00 Planned in-patient operating sessions 09:00 - 18:00 Post-op ward round 18:00 - 19:00	Core SPA 09:00 - 12:00 Surgery MDT 14:00 - 17:00	Sub Specialty clinic 09:00 - 13:00 Core SPA 13:30 - 17:00		

Week 6

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	Core SPA 09:00 - 13:00 Core SPA 13:30 - 17:00	Pre-op ward round 08:30 - 09:00 Planned in-patient operating sessions 09:00 - 18:00 Post-op ward round 18:00 - 19:00	Surgery MDT 14:00 - 17:00	Sub Specialty clinic 09:00 - 13:00 Sub Specialty clinic 13:30 - 17:00		

Week 7

There are no activities this week

Week 8

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
New patient Clinic 08:30 - 13:00 Patient related admin (reports, results etc) 13:30 - 17:00	Core SPA 09:00 - 13:00 Core SPA 13:30 - 17:00	Pre-op ward round 08:30 - 09:00 Planned in-patient operating sessions 09:00 - 18:00 Post-op ward round 18:00 - 19:00	Core SPA 09:00 - 12:00 Surgery MDT 14:00 - 17:00	Sub Specialty clinic 09:00 - 13:00 Surgery MDT 13:15 - 17:15		

Week 9

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Patient related admin (reports, results etc) 09:00 - 17:00	Day surgery 08:30 - 13:00 New patient Clinic 13:30 - 17:00	Pre-op ward round 08:30 - 09:00 Planned in-patient operating sessions 09:00 - 18:00 Post-op ward round 18:00 - 19:00	Core SPA 09:00 - 12:00 Surgery MDT 14:00 - 17:00	Sub Specialty clinic 09:00 - 13:00 Core SPA 13:30 - 17:00		

Week 10

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Patient related admin (reports, results etc) 09:00 - 17:00	Day surgery 08:30 - 13:00 New patient Clinic 13:30 - 17:00	Pre-op ward round 08:30 - 09:00 Planned in-patient operating sessions 09:00 - 18:00 Post-op ward round 18:00 - 19:00	Core SPA 09:00 - 12:00 Surgery MDT 14:00 - 17:00	Sub Specialty clinic 09:00 - 13:00 Sub Specialty clinic 13:30 - 17:00		

Week 11

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Patient related admin (reports, results etc) 09:00 - 17:00	Day surgery 08:30 - 13:00 New patient Clinic 13:30 - 17:00	Pre-op ward round 08:30 - 09:00 Planned in-patient operating sessions 09:00 - 18:00 Post-op ward round 18:00 - 19:00	Core SPA 09:00 - 12:00 Surgery MDT 14:00 - 17:00	Sub Specialty clinic 09:00 - 13:00 Core SPA 13:30 - 17:00		

Week 12

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	Core SPA 09:00 - 13:00 Core SPA 13:30 - 17:00	Pre-op ward round 08:30 - 09:00 Planned in-patient operating sessions 09:00 - 18:00 Post-op ward round 18:00 - 19:00	Surgery MDT 14:00 - 17:00	Sub Specialty clinic 09:00 - 13:00 Surgery MDT 13:15 - 17:15		

Activities

A Additional Programmed Activities
H Hot Activity
U Unaffected by hot activity
S Shrunk by hot activity

Type	Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
							Total:	Core APA	10.120 0.000	40:27 0:00
	Mon	08:30 - 13:00	wks 3, 8	New patient Clinic 30 minutes travel from Craigavon Area Hospital.	Southern Health and Social Care Tru..	Armagh Community Hospital	DCC	7	0.188	0:45
U	Mon	08:45		New patient	Southern Health and Social Care Tru..	Erne Hospital	DCC	12	0.625	2:30

Type	Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
		- 17:30		Clinic 75 minutes travel from Craigavon Area Hospital.						
S	Mon	09:00 - 17:00	wks 4, 9-11	Patient related admin (reports, results etc)	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	12.19	0.580	2:19
H	Mon	09:00 - 17:30	wks 1, 7 12 wk cycle	Surgeon of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.67	0.438	1:45
S	Mon	13:30 - 17:00	wks 3, 5, 8	Patient related admin (reports, results etc)	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	9.14	0.190	0:46
S	Tue	08:30 - 13:00	wks 4-5, 9-11	Day surgery	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	16.67	0.446	1:47
S	Tue	09:00 - 13:00	wks 2-3, 6, 8, 12	Core SPA	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	16.67	0.397	1:35
H	Tue	09:00 - 17:30	wks 1, 7 12 wk cycle	Surgeon of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.67	0.438	1:45
S	Tue	13:30 - 17:00	wks 4-5, 9-11	New patient Clinic	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	16.67	0.347	1:23
S	Tue	13:30 - 17:00	wks 2-3, 6, 8, 12	Core SPA	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	16.67	0.347	1:23
	Wed	08:30 - 09:00	wks 2-6, 8-12	Pre-op ward round	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	35	0.104	0:25
H	Wed	09:00 - 17:30	wks 1, 7 12 wk cycle	Surgeon of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.67	0.438	1:45
S	Wed	09:00 - 18:00	wks 2-6, 8-12	Planned in-patient operating sessions	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	33.33	1.786	7:09
	Wed	18:00 - 19:00	wks 2-6, 8-12	Post-op ward round	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	35	0.208	0:50
H	Thu	09:00 - 12:00	wks 6, 12 12 wk cycle	Surgeon of the week Comments: Handover to oncoming Urologist of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.67	0.155	0:37
S	Thu	09:00 - 12:00	wks 2-5, 8-11	Core SPA	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	24.67	0.440	1:46
H	Thu	09:00 - 17:30	wks 1, 7 12 wk cycle	Surgeon of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.67	0.438	1:45
S	Thu	14:00 - 17:00	wks 2-6, 8-12	Surgery MDT	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	33.33	0.595	2:23
S	Fri	09:00 -	wks 2-6,	Sub Specialty clinic	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	33.33	0.794	3:10

Type	Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
		13:00	8-12							
H	Fri	09:00 - 17:30	wks 1, 7 12 wk cycle	Surgeon of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.67	0.438	1:45
S	Fri	13:15 - 17:15	wks 4, 8, 12	Surgery MDT Comments: Reconstruction MDM Lagan Valley Hospital 45 minutes travel from Craigavon Area Hospital. 45 minutes travel to Craigavon Area Hospital.	Southern Health and Social Care Tru..	Royal Victoria Hospital, Belfast	DCC	10	0.238	0:57
S	Fri	13:30 - 17:00	wks 2, 6, 10	Sub Specialty clinic	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	10	0.208	0:50
S	Fri	13:30 - 17:00	wks 3, 5, 9, 11	Core SPA	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	13.33	0.278	1:07

No specified day

"( )" Refers to an activity that replaces or runs concurrently
A Additional Programmed Activities
H Hot Activity

Type	Normal	Premium	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
						Total:	Core APA Replaced	0.613 0.000 (0.000)	6:27 0:00 (0:00)
	3:00	0:00	Surgery MDT Comments: MDT Chair preparation	Southern Health and Social Care Trust.	Craigavon Area Hospital	DCC	13	0.232	0:56
	8:00	0:00	Triaging of new patients referrals	Southern Health and Social Care Trust.	Craigavon Area Hospital	DCC	8	0.381	1:31

Resources

Staff

Equipment

Clinical Space

Other

Additional information

Additional comments

No comments made

Southern Health and Social Care Trust.

This job plan started 01 April 2013 and ended 31 March 2018.

Job plan for Mr O'Brien, Aidan in Urology

Basic Information

Job plan status	Locked down
Appointment	Full Time
Cycle	Rolling cycle - 5 weeks
Start Week	1
Report date	30 Jul 2020
Expected number of weeks in attendance	42 weeks
Usual place of work	Craigavon Area Hospital
Alternate employer	None Specified
Contract	New
Private practice	No

Job plan stages

Job plan stages	Comment	Date stage achieved	Who by
In 'Discussion' stage		20 Mar 2013	Mr Malcolm Clegg
Locked down		16 Apr 2015	Mr Malcolm Clegg

Hours Breakdown

	Main Employer PAs	Total PAs	Total hours
Direct Clinical Care (DCC)	9.800	9.800	38:54
Supporting Professional Activities (SPA)	1.475	1.475	5:54
Total	11.275	11.275	44:48

On-call summary

Rota Name	Location	Weekday Freq	Weekend Freq	Category	Supplement	PAs
On-call Rota	Craigavon Area Hospital	5	5	A	5%	1.000

Type	Normal	Premium	Cat.	PA
			Total:	1.000
Predictable	n/a	n/a	DCC	0.000
Unpredictable	n/a	n/a	DCC	1.000

The total PAs arising from your on-call work is:	1.000
Your availability supplement is:	5% (based on the highest supplement from all your rotas)

On-call rota details

On-call Rota (PA entry)

General information	
What is your on-call activity?	On-call Rota
Where does your on-call rota take place in?	Craigavon Area Hospital

What is your on-call classification?	A
Weekday work	
What is the frequency of your weekday on-call work?	1 in 5.00
	Predictable Unpredictable
How many PAs arise from your weekday on-call work?	**0.000 1.000**
Weekend work (A weekend is classed as Saturday to Sunday for this rota)	
What is the frequency of your weekend on-call work?	1 in 5.00
	Predictable Unpredictable
How many PAs arise from your weekend on-call work?	**0.000 0.000**
Other information	
Which objective does this on-call work relate to?	
Comments	

Sign off

Role: Consultant	Role: Consultant	Role: Board Member
Name: Mr Hall, Samuel (Con)	Name: Mr Mackle, Edward (Con)	Name: Mrs Trouton, Heather
Signed:	Signed:	Signed:
Date:	Date:	Date:

Timetable

Week 1

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Patient related admin (reports, results etc) 09:00 - 13:00	Day surgery 08:30 - 13:00	Surgery MDT 09:00 - 11:00	Uroradiology meeting 08:30 - 09:30	Planned in-patient operating sessions 08:30 - 17:00		
Continuous professional development. 13:00 - 17:00	New patient Clinic 13:00 - 17:00	Urodynamics 11:00 - 12:30	Grand Round 10:00 - 12:00	Post-op ward round 17:00 - 17:30		
			Continuous professional development. 12:00 - 14:00			
			Surgery MDT 14:00 - 17:00			

Week 2

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Day surgery 07:15 - 13:00	New patient Clinic 13:00 - 17:00	Surgery MDT 09:00 - 11:00	Uroradiology meeting 08:30 - 09:30	New patient Clinic 09:00 - 13:00		
New patient Clinic 13:00 - 18:15		Urodynamics 11:00 - 12:30	Grand Round 10:00 - 12:00	Patient related admin (reports, results etc) 13:00 - 17:00		
		Pre-op ward round 12:30 - 13:00	Continuous professional development. 12:00 - 14:00			
		Planned in-patient operating sessions 13:00 - 20:00	Surgery MDT 14:00 - 17:00			
		Post-op ward round 20:00 - 20:30				

Week 3

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Patient related admin (reports,	Continuous professional	Surgery MDT	Uroradiology meeting	New patient Clinic		

results etc) 09:00 - 13:00 Continuous professional development. 13:00 - 17:00	development. 09:00 - 13:00 New patient Clinic 13:00 - 17:00	09:00 - 11:00 Continuous professional development. 11:00 - 12:30 Pre-op ward round 12:30 - 13:00 Planned in-patient operating sessions 13:00 - 20:00 Post-op ward round 20:00 - 20:30	08:30 - 09:30 Grand Round 10:00 - 12:00 Continuous professional development. 12:00 - 14:00 Surgery MDT 14:00 - 17:00	09:00 - 13:00		

Week 4

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
New patient Clinic 08:30 - 13:00 Continuous professional development. 13:00 - 17:00	Continuous professional development. 09:00 - 13:00 New patient Clinic 13:00 - 17:00	Surgery MDT 09:00 - 11:00 Urodynamics 11:00 - 12:30 Pre-op ward round 12:30 - 13:00 Planned in-patient operating sessions 13:00 - 20:00 Post-op ward round 20:00 - 20:30	Uroradiology meeting 08:30 - 09:30 Grand Round 10:00 - 12:00 Continuous professional development. 12:00 - 14:00 Surgery MDT 14:00 - 17:00	New patient Clinic 09:00 - 13:00 Patient related admin (reports, results etc) 13:00 - 17:00		

Week 5

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Emergency operating sessions 09:00 - 13:00 New patient Clinic 13:00 - 17:00	Emergency operating sessions 09:00 - 13:00 New patient Clinic 13:00 - 17:00	Emergency operating sessions 09:00 - 13:00 Day surgery 13:00 - 17:00	Uroradiology meeting 08:30 - 09:30 Pre-op ward round 09:30 - 10:00 Emergency operating sessions 10:00 - 14:00 Surgery MDT 14:00 - 17:00	Emergency operating sessions 09:00 - 13:00 Planned in-patient operating sessions 13:00 - 17:00 Post-op ward round 17:00 - 17:30		

Activities

A Additional Programmed Activities
H Hot Activity
U Unaffected by hot activity
S Shrunk by hot activity

Type	Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
								Total:	10.275	40:48
	Mon	07:15 - 13:00	wk 2	Day surgery 75 minutes travel from Craigavon Area Hospital.	Southern Health and Social Care Tru..	Erne Hospital	DCC	8.4	0.288	1:09
	Mon	08:30 - 13:00	wk 4	New patient Clinic 30 minutes travel from Craigavon	Southern Health and Social Care Tru..	Armagh Community Hospital	DCC	8.4	0.225	0:54

Type	Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
				Area Hospital.						
	Mon	09:00 - 13:00	wk 5	Emergency operating sessions Comments: CONSULTANT OF THE WEEK - Ward Round, Emergency Operating, Triage and Virtual clinic	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.4	0.200	0:48
	Mon	09:00 - 13:00	wks 1, 3	Patient related admin (reports, results etc)	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	16.8	0.400	1:36
	Mon	13:00 - 17:00	wks 1, 3-4	Continuous professional development.	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	25.2	0.600	2:24
	Mon	13:00 - 17:00	wk 5	New patient Clinic Comments: CONSULTANT OF THE WEEK	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.4	0.200	0:48
	Mon	13:00 - 18:15	wk 2	New patient Clinic 75 minutes travel to Craigavon Area Hospital.	Southern Health and Social Care Tru..	Erne Hospital	DCC	8.4	0.263	1:03
	Tue	08:30 - 13:00	wk 1	Day surgery	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.4	0.225	0:54
	Tue	09:00 - 13:00	wk 4	Continuous professional development.	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	8.4	0.200	0:48
	Tue	09:00 - 13:00	wk 5	Emergency operating sessions Comments: consultant of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.4	0.200	0:48
	Tue	09:00 - 13:00	wk 3	Continuous professional development.	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	8.4	0.200	0:48
	Tue	13:00 - 17:00	wks 1-4	New patient Clinic	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	33.6	0.800	3:12
	Tue	13:00 - 17:00	wk 5	New patient Clinic Comments: CONSULTANT OF THE WEEK	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.4	0.200	0:48
	Wed	09:00 - 11:00	wks 1-4	Surgery MDT Comments: SURGERY MDT PREPARATION	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	33.6	0.400	1:36
	Wed	09:00 - 13:00	wk 5	Emergency operating sessions Comments: CONSULTANT OF THE WEEK - Ward Round,	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.4	0.200	0:48

Type	Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
				Emergency operating, triage and virtual clinic						
	Wed	11:00 - 12:30	wk 1	Urodynamics	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.4	0.075	0:18
	Wed	11:00 - 12:30	wks 2, 4	Urodynamics	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	16.8	0.150	0:36
	Wed	11:00 - 12:30	wk 3	Continuous professional development.	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	8.4	0.075	0:18
	Wed	12:30 - 13:00	wks 2-4	Pre-op ward round	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	25.2	0.075	0:18
	Wed	13:00 - 17:00	wk 5	Day surgery Comments: CONSULTANT OF THE WEEK	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.4	0.200	0:48
	Wed	13:00 - 20:00	wks 2-4	Planned in-patient operating sessions	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	25.2	1.100	4:12
	Wed	20:00 - 20:30	wks 2-4	Post-op ward round	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	25.2	0.100	0:18
	Thu	08:30 - 09:30	wks 1-5	Uroradiology meeting	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	42	0.250	1:00
	Thu	09:30 - 10:00	wk 5	Pre-op ward round	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.4	0.025	0:06
	Thu	10:00 - 12:00	wks 1-4	Grand Round	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	33.6	0.400	1:36
	Thu	10:00 - 14:00	wk 5	Emergency operating sessions Comments: CONSULTANT OF THE WEEK	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.4	0.200	0:48
	Thu	12:00 - 14:00	wks 1-4	Continuous professional development.	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	33.6	0.400	1:36
	Thu	14:00 - 17:00	wks 1-4	Surgery MDT	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	33.6	0.600	2:24
	Thu	14:00 - 17:00	wk 5	Surgery MDT Comments: CONSULTANT OF THE WEEK	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.4	0.150	0:36
	Fri	08:30 - 17:00	wk 1	Planned in-patient operating sessions	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.4	0.425	1:42
	Fri	09:00 - 13:00	wk 5	Emergency operating sessions Comments: CONSULTANT OF THE WEEK - Ward round, Emergency Operating, Triage and Virtual clinic	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.4	0.200	0:48

Type	Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
	Fri	09:00 - 13:00	wks 2-4	New patient Clinic	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	25.2	0.600	2:24
	Fri	13:00 - 17:00	wk 5	Planned in-patient operating sessions Comments: CONSULTANT OF THE WEEK	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.4	0.200	0:48
	Fri	13:00 - 17:00	wks 2, 4	Patient related admin (reports, results etc)	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	16.8	0.400	1:36
	Fri	17:00 - 17:30	wk 1	Post-op ward round	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.4	0.025	0:06
	Fri	17:00 - 17:30	wk 5	Post-op ward round	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.4	0.025	0:06

No specified day

"( )" Refers to an activity that replaces or runs concurrently
A Additional Programmed Activities
H Hot Activity

Type	Normal	Premium	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
You have not added any activities.									

Resources

Staff

Equipment

Clinical Space

Other

Additional information

Additional comments

No comments made

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APPENDIX 6

Revised November 2016 (Version 1.1)

Root Cause Analysis report on the review of a Serious Adverse Incident including Service User/Family/Carer Engagement Checklist

Organisation's Unique Case Identifier: [redacted]

Date of Incident/Event: January 2016 – September 2016

HSCB Unique Case Identifier: S11471

Service User Details: (*complete where relevant*)

Responsible Lead Officer: Dr J R Johnston

Designation: Consultant Medical Advisor

Report Author: The Review Team

Date report signed off: 22 May 2020

1.0 EXECUTIVE SUMMARY

During an internal review in 2016, following an Index Case, the Trust identified a number of GP Urology referrals who were not triaged by one particular Consultant Urologist; 30 patients should have been red-flag referrals and of these 4 had cancer. A fifth patient [redacted], discovered during an outpatient clinic, was included as he was also not triaged and subsequently had a cancer confirmed.

[redacted] – a [redacted]-year-old male was referred to Urology Outpatients on 30 August 2015 for assessment and advice for an elevated Prostate specific antigen (PSA) (The blood level of PSA is often elevated in men with prostate cancer). The referral was marked Routine by the GP. The referral was not triaged on receipt. However, a second GP referral was received on 29 January 2016 marked Suspected Cancer Red Flag and had received a red flag appointment. Following this referral, he was seen in clinic on 8 February 2016 (D153). On day 166, [redacted] was diagnosed with a confirmed cancer; a resultant 6-month delay in obtaining diagnosis and a recommendation of treatment for a prostate cancer.

[redacted] – a [redacted]-year-old male was referred to Urology Outpatients on 3 June 2016 for assessment and advice for an elevated PSA. The referral was marked Urgent by the GP. The referral was not triaged on receipt. As part of the internal review, the referral was upgraded to Red Flag and was seen in clinic on day 246. On day 304, the patient had a confirmed cancer diagnosis. There has been a resultant 10-month delay in obtaining diagnosis and a recommendation of treatment for a prostate cancer.

[redacted] – a [redacted]-year-old male was referred to Urology Outpatients on 28 July 2016 for assessment and advice for an elevated PSA. The referral was marked Urgent by the GP. The referral was not triaged on receipt. As part of an internal review the referral was upgraded to Red Flag and seen in clinic on day 217. On day 258, [redacted] was diagnosed with a confirmed cancer; a resultant 9-month delay in obtaining diagnosis and a recommendation of treatment for a prostate cancer.

[redacted] – a [redacted]-year-old male referred to Urology following an episode of haematuria on 28 July 2016. The referral was marked Routine by the GP. The letter was not triaged and [redacted] was placed on a routine waiting list on 30 September 2016. As part of an internal review this patient's referral letter was upgraded to a Red Flag referral. [redacted] was reviewed at OPD on 31January 2017. Subsequent investigations diagnosed with bladder and prostate cancer. [redacted] has locally advanced bladder cancer. There has been a resultant 6-month significant delay in obtaining a diagnosis and a recommendation of treatment for his bladder cancer.

[redacted] – a [redacted]-year-old male was referred to Urology Outpatients on 8 Sept 2016 for assessment and advice on lower tract symptoms and elevated PSA. The referral was marked Urgent by the GP. The referral was not triaged on receipt. As part of the internal review the referral was upgraded to Red Flag and was seen in clinic on day 152. On day 215, [redacted] had a confirmed cancer diagnosis T3a with no nodal metastases. There has been a resultant 8-month delay in

obtaining diagnosis and a recommendation of treatment for a prostate cancer.

Causal Factors

1. Referral letters did not have their clinical priority accurately assigned by the GP. Referral letters were not triaged following receipt by the Hospital.

HSCB

Recommendation 1

HSCB should link with the electronic Clinical Communication Gateway (CCG) implementation group to ensure it is updated to include NICE/NICaN clinical referral criteria. These fields should be mandatory.

Recommendation 2

HSCB should consider GP's providing them with assurances that the NICE guidance has been implemented within GP practices.

Recommendation 3

HSCB should review the implementation of NICE NG12 and the processes surrounding occasions when there is failure to implement NICE guidance, to the detriment of patients.

HSCB, Trust and GPs

Recommendation 4

GPs should be encouraged to use the electronic CCG referral system which should be adapted to allow a triaging service to be performed to NICE NG12 and NICaN standards. This will also mean systems should be designed that ensure electronic referral reliably produces correct triaging e.g. use of mandatory entry fields.

TRUST

Recommendation 5

Work should begin in communicating with local GPs, perhaps by a senior clinician in Urology, to formulate decision aids which simplify the process of Red-flag, Urgent or Routine referral. The triage system works best when the initial GP referral is usually correct and the secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence the norm.

Recommendation 6

The Trust should re-examine or re-assure itself that it is feasible for the Consultant of the Week (CoW) to perform both triage of non-red flag referrals and the duties of the CoW.

Recommendation 7

The Trust will develop written policy and guidance for clinicians on the expectations and requirements of the triage process. This guidance will outline the systems and processes required to ensure that all referrals are triaged in an appropriate and timely

manner.

Recommendation 8
The current Informal Default Triage (IDT) process should be abandoned. If replaced, this must be with an escalation process that performs within the triage guidance and does not allow Red-flag patients to wait on a routine waiting list.

Recommendation 9
Monthly audit reports by Service and Consultant will be provided to Assistant Directors on compliance with triage. These audits should be incorporated into Annual Consultant Appraisal programmes. Persistent issues with triage must be escalated as set out in recommendation 10.

Recommendation 10
The Trust must set in place a robust system within its medical management hierarchy for highlighting and dealing with 'difficult colleagues' and 'difficult issues', ensuring that patient safety problems uncovered anywhere in the organisation can make their way upwards to the Medical Director's and Chief Executive's tables. This needs to be open and transparent with patient safety issues taking precedence over seniority, reputation and influence.

CONSULTANT 1

Recommendation 11
Consultant 1 needs to review his chosen 'advanced' method and degree of triage, to align it more completely with that of his Consultant colleagues, thus ensuring all patients are triaged in a timely manner.

Recommendation 12
Consultant 1 needs to review and rationalise, along with his other duties, his Consultant obligation to triage GP referrals promptly and in a fashion that meets the agreed time targets, as agreed in guidance which he himself set out and signed off. As he does this, he should work with the Trust to aid compliance with recommendation 6.

2.0 THE REVIEW TEAM

Dr J R Johnston - Consultant Medical Adviser - Chair

Mr M Haynes - Consultant Urologist

Mrs K Robinson - Booking & Contact Centre Manager

Mrs T Reid - Acute Clinical & Social Care Governance Coordinator

3.0 SAI REVIEW TERMS OF REFERENCE

1. To undertake an initial investigation/review of the care and treatment of patients Patient 15, Patient 13, Patient 12, Patient 14 and Patient 11, in the period after referral to the SHSCT Urology service using

Southern Health and Social Care Trust

3.0 SAI REVIEW TERMS OF REFERENCE

National Patient Safety Agency root cause analysis methodology.

2. To determine whether there were any factors in the health & social care services interventions delivered or omitted to Patient 15, Patient 13, Patient 12 Patient 14 and Patient 11 that resulted in an unnecessary delay in treatment and care.
3. The investigation / Review Team will provide a draft report for the Director of Acute Services. This report will include the outcome of the Team's investigation/review, identifying any lessons learned and setting out their agreed recommendations and actions to be considered by the Trust and others.
4. The Trust will share or disseminate the outcomes of the investigation/review with all relevant parties internally and externally including the service user and relevant family member(s) (where appropriate).

4.0 REVIEW METHODOLOGY

The Review Team will undertake an analysis of the information gathered using RCA tools and may make recommendations in order that sustainable solutions can minimise any recurrence of this type of incident. The Review Team will request, collate, analyse and make recommendations on such information as is relevant under its Terms of Reference in respect of the incident outlined above.

Gather and review all relevant information

- Inpatient notes Craigavon Hospital.
- Information from the Northern Ireland Emergency Care Record (NIECR) and Patient Administration System.
- Information from laboratory systems.
- Information obtained from relevant medical, nursing and management staff.
- Review of Relevant Reports, Procedures, Guidelines.

Information mapping

- Timeline analysis
- Change analysis for problem identification and prioritisation of care delivery problems and service delivery problems as well as identifying contributory factors.

5.0 DESCRIPTION OF INCIDENT/CASE

5.1 Triage of GP referrals - background

The general public expect that, when they engage with their GP complaining of symptoms that are potentially due to a cancer, they will be referred to the appropriate secondary care services promptly and that they will respond, also promptly, to confirm or exclude the diagnosis of cancer.

5.0 DESCRIPTION OF INCIDENT/CASE

The DHSSPSNI **Service Framework for cancer prevention, treatment and care** (Standard 13) of 2011 indicates, "*All people with signs and symptoms that might suggest cancer should be appropriately assessed by their GP and referred promptly on to hospital for further tests if needed*".

Cancer specialists, working in networks, have formulated lists of symptom and sign triggers which can signify the development of a cancer. Using these lists, primary care doctors can refer patients into secondary care; triaging a large number of patients by assigning them to different degrees of urgency (Routine, Urgent and Red-flag). If these are used as designed, this can provide an efficient referral system.

NICE have been instrumental in ensuring uniformity and the validity of these cancer recognition and referral lists of symptoms and signs. They have also formulated guidance regarding how safety nets should be setup to ensure patients are not missed. Local programmes, using this type of guidance, have been established, under the auspices of NICaN and the HSCB, to set up these triage pathways and safety nets.

5.2 Triage of GP referrals – Northern Ireland

NI Referral Guidance for Suspected Cancer (2012)

The Northern Ireland Referral Guidance for Suspected Cancer 2012 is based on the NICE clinical guideline, CG 27 - *Referral guidelines for suspected cancer,* published in June 2005. This has a section on Urological Cancer. It was introduced to GPs by HSCB correspondence (30/12/2012), revealing the new red-flag process and indicating in appendix A that, "*triaging will take place in a timely manner, within 72 hours of receipt of referral or the referral should continue with the GP Prioritisation".*

This is still the only set of referral guidance for suspected urological cancer available online on the NICaN website (last accessed 18/11/2018).

However, the 2005 CG27 guidance has been replaced by NICE Guideline NG12 *Suspected cancer: recognition and referral* published in June 2015. This was endorsed by the Department of Health (NI) with HSC (SQSD) (NICE NG12) 29/15 on the 19th August 2015 which instructed the HSCB / PHA to send out the guidance to the appropriate Family Practitioners. This particular kind of guidance requires the HSCB to circulate regionally endorsed NICE guidelines to Trusts and GPs for implementation. Trusts are expected to review guidance against a base line assessment and provide HSCB with an assurance that the guidance has been implemented. If a Trust is unable to fully implement the guidance within the one-year period without regional co-ordination and/or additional resources, they should provide a formal assurance to HSCB, and this is to be managed as part of the risk management process. This assurance process does not however apply to primary care and GP's.

5.0 DESCRIPTION OF INCIDENT/CASE

NICaN Urology Cancer Clinical Guideline (2016)

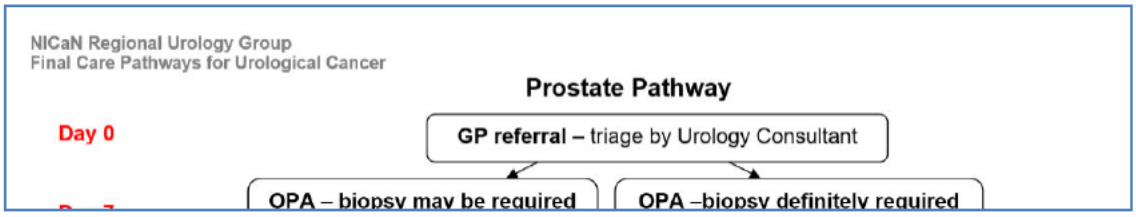
The NICaN Urology Cancer Clinical Guideline document, (version 1.3, March 2016), was produced regionally to support the diagnosis, treatment and management of urological cancer. This version included amendments, to replace the previous red flag guidelines, with those from NICE NG12; the document was signed off on behalf of the NICaN by Consultant Urologist, Cons1.

The Review Team's evaluation of the advantages of NICE NG12 (2015) over the CG27 (2005) guidelines reveals fewer cases would be red-flagged for Urology, as a result of,

- a reduction in number of non-visible haematuria patients; and
- increases in age criteria of 45 years and over.

However, rollout of NG12 by the HSCB does not appear to have happened. The Review Team understands that the reason NG12 has not been implemented lies with ongoing discussions between the HSCB and GPs.

Appendix 2 of the NICaN Urology Cancer Clinical Guideline guidelines highlights the Urology Care pathways. Cons1 was present at the workshop discussing those on 02/10/2008. It clearly indicates that, for the Prostate pathway, the GP referral would be triaged by the Urology Consultant.



5.3 Triage of GP referrals – SHSCT

The process of Urology triage in CAH is based upon the NI Referral Guidance for Suspected Cancer of 2012 as described above i.e. it is based on the 2005 NICE CG27 guidelines and not the more up to date 2012 NG12. In CAH, triage of referrals is performed by the Consultant Urologist of the week.

The SHSCT Urological Cancer multi-disciplinary team (MDT) was led at the time by Consultant 1 (Cons1), who was also a joint chair.

Over a period of decades, within the SHSCT and Craigavon AH, there were occasions when triage was not performed; and this varied between consultants and specialities. Acute Services had a particular problem with this issue. Preliminary discussions by the Review Team revealed that triaging within Acute Services was a, "*very haphazard process going back for approximately 25 years. There were many Consultants who would not triage but Consultant 1 was the most persistent and there were multiple attempts to tackle this issue*".

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5.0 DESCRIPTION OF INCIDENT/CASE

Interview with Associate Medical Director (AMD1)

AMD1 first became aware of waiting list problems with Cons1 in 1996–8 when AMD1 was the lead clinician in outpatients. Cons1's OPD letters were being kept in a ring binder and were not on any waiting list. Once challenged, Cons1 would stop this practice and improve but would then slip back. There were further non-triage meetings with Cons1 when AMD1 was the Clinical Director of Surgery.

Interview with Director of Acute Services (DAS2)

In 2007, DAS2 (while in previous post in CAH) found a waiting list which was 10 years long. They worked on this with the Consultant, Cons1, and cleaned it up; they found no serious patient related issues.

Interview with Director of Acute Services (DAS1)

DAS1 indicated that the Urology Services were under various kinds of pressure during her time as Director. There was a regional transformation project in place for Regional Urology Services under Mr M. Fordham; this generated an element of pressure to modernise and change. Along with this and other issues, including the triage problem, Consultant 1 struggled to adapt to these changes and to comply with the other issues and triaging. DAS1 paints a picture of many issues with Cons1, triaging being only one of many issues but, in her opinion, not the most important issue.

Nevertheless, in April 2010, Consultant 1 (Cons1) was put under pressure to complete his triage list. The surgical Associate Medical Director (AMD1) brought concerns to DAS1. The other Urologists had been 'covering' triaging for Cons1; the Head of Service Surgery had informed AMD1 of this. They met Cons1 the next day. The European Association of Urology meeting was in Spain the following day and Cons1 wished to attend. DAS1 and AMD1 informed Cons1 he would not be attending the meeting unless he triaged all his referrals immediately. Cons1 duly addressed the triage backlog, completing them that evening. From that time on, AMD1 and the Head of Service (HoS1) monitored that Cons 1 was triaging the GP referral letters. However, DAS1 commented that the HoS1 had a difficult job managing Cons1.

Following interview with Head of Service (HoS1)

The Head of Service for Urology (HoS1) indicated that she inherited the problem upon appointment although she was aware that it was a long running issue, going back perhaps 25 years. She highlighted this was an ongoing issue with Cons1. He had the longest backlog and took longest to triage. There were issues with other Consultants who, on occasion, did not triage but Cons1 was the only one, when asked to triage, didn't do it. This came to head in 2010 (referred to above) and again in 2014.

Informal Default Triage (IDT) process

In May 2014, after escalation to HoS1, an Informal Default Triage (IDT) process was put in place by the Trust's booking centre. This process allowed the booking office to allocate

5.0 DESCRIPTION OF INCIDENT/CASE

patients, who had not been triaged in time, to be allocated to a 'waiting list' using the GP triage category. Therefore, this IDT process of putting patients on the waiting list without triage meant that they did not get missed. However, some patients, who should have been triaged as a red flag, waited on the waiting list with their 'incorrect' GP triage category. After much discussion, this detailed process was formally circulated to all specialties on the 6th November 2015 by the Assistant Director of Support Services (ADSS1).

When questioned about this IDT process, the DAS2 was not aware of it even though it started during her time in post i.e. May '14. When asked about its potential problem of leaving incorrectly triaged (by their GP) patients on a waiting list she stated, "*Completely ridiculous, because would allow a cancer patient who should have been red flagged by their GP to go unchallenged by a Consultant triage process i.e. could have to wait for 11 months*".

5.4 Index case

In 2016, the SHSC Trust investigated (RCA ID 52720), in what subsequently became an 'Index case' for the cases in this RCA, the treatment and care of Patient 10. Patient 10 was a patient who had had Ca Colon (2010), breast carcinoma (2013) and then developed renal carcinoma. During review for her Breast Ca in June 2014, a CT Scan revealed that, previously noted, renal cysts had increased in size. Further investigation by a MRI scan was reported in a limited and incomplete fashion; resulting in a 'routine' referral GP letter on 29/10/2014.

During the investigation, the Review Team identified that Patient 10's GP referral letter had not been triaged; the Consultant Urologist with responsibility that week for triage duties was Cons1. This referral therefore waited as a 'new routine' referral till January 2016 to be seen by a Consultant Urologist.

The index case Review Panel agreed 3 main contributing factors led directly to Patient 10s delay in diagnosis. Firstly, the content of the MRI report; secondly a letter following a CT scan did not mention important information and thirdly, the opportunity to upgrade the referral to red flag was lost by the omission of triage; this resulted in a 64-week delay to diagnosis of a suspicious renal mass.

The index case Review Panel concluded in March 2017 that, ".... *a significant number of letters within Urology are not being triaged by the minority of the Team. It is clear that the default triage management process (*vide infra*) continues to be initiated secondary to the omission of Triage by individual members of the urology team and not the entire Urology Team*".

Of the 2 lessons learnt, one indicated that,

> "*Triage of GP referral letters remains a key element in validating appropriate utilisation of specialist services and ensuring patient safety. Triage also serves as an opportunity for early intervention for patients at risk of malignant disease or clinical deterioration.*"

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5.0 DESCRIPTION OF INCIDENT/CASE

This led to a recommendation that,

> *"This SAI has demonstrated that patients will be at an increased risk of harm when the opportunity for early intervention at Triage is omitted. The Review Panel recommend that the Trust reviews the process which enables the clinical triaging and escalation of triage non-compliance in accordance with the Integrated Elective Access Protocol (IEAP).*
>
> *In particular the fundamental issue of triaging GP referral letters remains a challenge within Urology. The Urology operational and medical management teams immediately need to address the issue of un-triaged referrals not being processed in accordance with IEAP."*

The findings of this investigation, chaired by Consultant Urologist 2 (Cons2), were made available in December 2016 and formally signed off on the 15th March 2017. A letter highlighting a number of concerns was sent to the (then) lead for Acute Governance for Acute Services (AGAS1), on the 15th December 2016.

The letter pointed out that the IDT process implied that triage non-compliance was to be expected but that this process did not have a clear escalation plan to include the individual Consultant and, indeed, had not been effective in addressing triage non-compliance. Furthermore, the letter pointed out that, from July 2015 till October 2016, there were 318 non-triaged letters which the Trust could not provide assurance that patients were not being exposed to harm by waiting as a routine or urgent appointment i.e. when they should have been red-flagged.

It is not absolutely clear who wrote this letter as it has no signature, but it appears to have been written by, or on behalf of, Cons2. On the 10th January 2017, Cons2 was requested by the Medical Director (MD3) to share the report with the 2 key Consultants involved in the SAI. One of these was Cons1. Cons2 refused, stating that he was Cons1's colleague and not his manager.

This letter was escalated to the Director of Acute Services (DAS3) and the Assistant Director of Anaesthetics & Surgery. This was further escalated to the Chief Executive of the SHSCT.

Cons1 was written to by AMD1 on the 23rd March 2016, acknowledging his hard work as a Consultant Urologist but pointing out that there were governance and patient safety concerns with regard to untriaged letters dating back over 2 years, and other important issues. Cons1 was asked to respond with a commitment and immediate plan to address these issues.

The Review Panel also determined that there were 7 other patients who were not triaged that week along with Patient 10. They subsequently performed a 'look-back' exercise (number 1) of these referrals. Of the seven referrals, six charts were available and each patient had an appropriate

5.0 DESCRIPTION OF INCIDENT/CASE

management plan. One set of notes were missing and efforts were made to find them.

Cons1 provided his personal review, dated 25/01/2017, of the Index Case to the Chairman of this Review Team. It provides an argued retrospective rationale that a timely triage by himself would not have altered the referral grading. However, it does not provide a sound reason for his actual lack of triage. His report is consistent in arguing his view that he does not have time to perform both Consultant of the Week (CoW) duties and triaging of non-red flag referrals.

5.5 Look back exercise #2

Upon realisation that the 'look-back' exercise #1 had resulted from non-triage over the week beginning the 30/10/2014, further efforts were made to investigate the size of this non-triage issue and to find missing referral letters. Cons1 was contacted and the Head of Service for Urology (HoS1) obtained permission to look for missing GP referral letters in his filing cabinet. Cons1 stated that there were referral letters in a filing cabinet in his office. During interview, he stated that he kept the referrals to ensure they would not be missed or overlooked. The Head of Service for Urology retrieved these referral letters, which numbered over 700 along with the triage lists from the booking centre.

These referrals were then reviewed by the Urology Consultant Team revealing 30 patient referrals should have been red-flagged and four of these patients, following review, were diagnosed with cancer, becoming the subject of this review.

This (RCS 69120) Review Team reviewed the clinical notes from these 4 patients and following discussion, under the Urological guidance of AMD1, detailed the clinical course and made the following conclusions.

Patient 14 03/06/2016 - Personal Information-year-old male referred to Urology Outpatients by GP for assessment and advice with a raised PSA.
The referral was marked Urgent by the GP.
The referral was not triaged on receipt.
09/08/2016 - added to W/L Urgent.
27/01/2017, as part of the internal review #2, the referral was upgraded to R/F and was seen in clinic on day 246. Therefore, this was an incorrect GP referral.
05/04/2017 (D304), following U/S guided biopsy, the patient obtained a confirmed cancer diagnosis and there was a recommendation for treatment of a prostate cancer by surveillance protocol.

Conclusions

Resultant 10-month delay in obtaining diagnosis.
Following Review Team consideration, deemed not to be a clinically significant delay.

Patient 11 28/07/2016 - Personal Information-year-old male referred to Urology Outpatients by GP for assessment and advice, concerning elevated PSA.
The referral was marked Urgent by the GP.

5.0 DESCRIPTION OF INCIDENT/CASE

The referral was not triaged on receipt.
30/09/2016 - added to W/L Urgent.
18/01/2017 - as part of an internal review #2, upgraded to R/F. Therefore, this was an incorrect GP referral.
20/02/2017 (D207) seen at R/F appointment. Sent for MRI and prostate biopsy.
11/04/2017 (D258) - diagnosed with a confirmed low risk prostate cancer and there was a recommendation for treatment of a prostate cancer by surveillance protocol.

Conclusions

Resultant 9-month delay in obtaining diagnosis.
Following Review Team consideration, deemed not to be a clinically significant delay.

Patient 13 28/07/2016 - Personal Inform -year-old male referred to Urology by GP following an episode of haematuria.
The referral was marked Routine by the GP.
The letter was not triaged.
30/09/2016 - Patient 13 was placed on a Routine waiting list.
19/01/2017 - As part of an internal review #2, upgraded to a R/F referral. Therefore, this was an incorrect GP referral.
31/01/2017 (188d) - reviewed at OPD and flexible cystoscopy.
22/02/2017 TURBT/TURP - diagnosed with bladder (locally advanced) and prostate cancer and there was a recommendation of treatment for his bladder cancer.

Conclusions

Resultant 6-month delay in obtaining diagnosis.
Following Review Team consideration, it is probable that the delay is clinically significant; time will tell*.

* The Review Team referred to an expert for advice.
Delay in definitive surgical treatment beyond 12 weeks conferred an increased risk of disease-specific and all-cause mortality among subjects with stage II bladder cancer. He remains disease free as of September 2018.

1. John L. Gore, Julie Lai, Claude M. Setodji, Mark S. Litwin, Christopher S. Saigal, and the Urologic Diseases in America Project. Mortality increases when radical cystectomy is delayed more than 12 weeks. Results from a surveillance, epidemiology, and end results–Medicare analysis. Cancer March 1, 2009.
2. Nader M. Fahmy, Salaheddin Mahmud, Armen G. Aprikian. Delay in the surgical treatment of bladder cancer and survival: Systematic Review of the Literature. *European Urology 50 (2006) 1176–1182.*

Patient 12 08/09/2016 - Personal Inform -year-old male was referred to Urology Outpatients on for assessment and advice on lower tract symptoms and elevated PSA.
The referral was marked Urgent by the GP.
The referral was not triaged on receipt.
27/01/2017 – further GP letter – please upgrade to R/F.
30/01/2017 - as part of the internal review #2, upgraded to R/F.

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5.0 DESCRIPTION OF INCIDENT/CASE

06/02/2017 - seen in clinic on day 152.
11/04/2017 (D215) - confirmed cancer diagnosis T3a with no nodal metastases – high risk and there was a recommendation of treatment for a locally advanced non-metastatic prostate cancer.

Conclusions

Resultant 8-month delay in obtaining diagnosis.
Following Review Team consideration, it is probable that the delay is not clinically significant.

At a later date, towards the end of 2018, another patient came to the attention of the Review Team – Patient 15 This patient could also have been one of those found in Cons1 filing cabinet but appeared at an outpatient clinic before the outworking of the look back exercise #2. A Consultant Urologist realised in the clinic that this was also a Cons1 non-triaged patient who was incorrectly referred by their GP.

Patient 15 30/08/2015 - Personal Inform-year-old male referred to Urology Outpatients by GP for assessment and advice with a raised PSA.
The referral was marked Routine by the GP.
The referral was not triaged on receipt.
29/01/2016 2nd GP referral marked as Suspected Cancer – Red flag; Patient 15 was added to W/L R/F following this referral.
As part of the internal look back #2, the referral was noted.
Patient 15 had already received an appointment and was seen in clinic on day 153. Therefore, 1St GP referral was incorrect; the 2nd was a correct GP referral.
11/02/2016 (D166), following a prostate biopsy, the patient obtained a confirmed cancer diagnosis T3a and there was a recommendation for treatment of a prostate cancer.

Conclusions

Resultant 6-month delay in obtaining diagnosis.
Following Review Team consideration, it is felt that the delay is unlikely to be clinically significant.

7.0 CONCLUSIONS

The Review Team interviewed a number of Trust staff including Directors (past and present), an Assistant Director, Head of Service and an Associate Medical Director as part of the review process. These interviews, along with clinical documents and health records systems, have helped inform the conclusions by providing the evidence and also corroboration where there appeared to be differences of opinion.

The Review Team and everybody interviewed, including Cons1, provided affirmation that a timely, efficient triage system which checked the initial GP referral was very important to patients. Comments made when interviewees were asked about the importance of triage and where the process of triaging a potential cancer patient ranked alongside other issues such as probity, patient experience and performance, were consistent,

"Very significant". Very high up the list in terms of importance".
"It is fundamental people are seen in the appropriate time".
"Very important" ... "Important for the patient".
"Vital" ... "Very significant .. patients are often anxious and depend on the system to work".

Cons1 replied,

"It is a serious issue, very important"..... "Number one ranking in overall scheme of things"

The Review Team established that there were factors in HSC service delivery to the 5 patients under examination that resulted in an unnecessary delay in treatment and care. In 4 patients the delay was thought not to be clinically significant but in 1 Patient 13 there probably was a significant delay.

Consideration of the causative factors to the patients' delays reveal,

- Referral letters did not have the clinical priority accurately assigned by the GP; and
- Referral letters were not triaged following receipt by the Hospital.

7.1 Referral letters did not have the clinical priority accurately assigned by the GP.

Contributory factors

Task Factors (policy and guidelines)
The Review Team reviewed the GP referrals regarding the five patients listed above. They concluded, as judged from the Northern Ireland Cancer Network (NICaN) Referral Guidance for Suspected Cancer (December 2012), that all five patients should have been referred to Urology by the GP's as red flag referrals (suspected cancer) i.e. incorrect triage.

Task Factors (decision aids)
The current decision aid for GPs is the NI Referral Guidance for Suspected Cancer 2012 based on NICE CG 27 *Referral guidelines for suspected cancer* published in June 2005. It is clear that Secondary care, in the form of Consultant Urologists, should triage these GP referrals; by doing so, 11% of GP referrals are changed (from Review Team member). It is also clear that Cons1 would have been in no doubt as to his responsibilities; he was intimately

involved in setting this standard and signed off the NICaN clinical guidelines.

However, it is clear this very important and critical triage safety net, work can be considered onerous and other electronic methods which GPs can use might be more efficient and help to reduce that load.

According the HoS1, most patient referrals by GPs to Trusts for outpatient appointments are now made through the electronic Clinical Communication Gateway (CCG). However, some paper referrals are still received. CCG is a digital referral system for Primary care which can contain referral criteria that meet NICE and NICaN guidance. This would enable appropriate clinical triaging of referrals to be performed as part of the selection of referral reasons and/or symptom description.

Using the electronic CCG pathway, some clinical specialties, such as gynaecology, have worked closely with the Public Health Authority to develop a better GP referral tool e.g. using 'banner guidance' (a specialty specific banner, listing symptoms and signs) which complies with NICE/NICaN guidance. This 'banner guidance' helps by directing clinicians to use the NICE/NICaN referral criteria which allow for timely and appropriate triage of patients to clinically appropriate appointment types. It is possible when red flag symptoms are chosen that an immediate alert could go to the Red Flag booking team, to allow the appointment booking process to begin immediately. However, currently, the referral criteria fields are optional i.e. not mandatory, so opening up the possibility that fields are not completed, leading to error and delay.

NICE NG12
The reference CG27 guidance has been replaced by NICE Guideline NG12 *Suspected cancer: recognition and referral* but, despite being endorsed by the DHSSPSNI and accepted by the Regional Urologists, it has yet to be implemented. Its use as a triage standard should result in fewer red-flagged cases which should ease some of the pressure on waiting lists. Its adoption would take place in primary care and should form the basis of the electronic CCG referral tool.

There was a consistent medical staff view from the Review Team, the AMD1, and indeed Cons1, that GP's have a crucial and important responsibility in getting the referral criteria/urgency category correct. If the GP does not provide enough, or the correct information, the NI Electronic Care Record (NIECR) needs to be checked and that slows the whole triage process down. It was clear that the triage system works best when the initial GP referral is usually correct and the Secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence the norm.

7.2 Referral letters were not triaged following receipt by the hospital.

Contributory factor

Task Factors (policy and guidelines)

The Integrated Elective Access Protocol (IEAP) (DHSSPS, April 2008) defines the roles and responsibilities of staff (in both primary and secondary care) when patients enter an elective care pathway. It states,

> '…*an Executive Director will take lead responsibility for ensuring all aspects of this Protocol are adhered to…. Patients will be treated on the basis of their clinical urgency with urgent patients seen and treated first*'.

The Principles for booking Cancer Pathway patients states,

> "Clinical *teams must ensure triage is undertaken daily, irrespective of leave, in order to initiate booking patients*".

and,

> "*Referrals will be received, registered within one working day and forwarded to Consultants for prioritisation*".

However, the IEAP states,

> *"…if clinical priority is not received from Consultants within 72 hours, processes should be in place to initiate booking of urgent patients according to the GP's classification of urgency".*

Following on from the IEAP of 2008, national and regional policies and guidelines, already referred to above, have been introduced which have outlined the detailed role of the Urology Consultant in triaging referrals that have come in from Primary care e.g.,

- Service Framework for cancer prevention, treatment and care (Standard 13) 2011;
- NI Referral Guidance for Suspected Cancer 2012; and
- NICaN Urology Cancer Clinical Guideline document, (version 1.3, March 2016).

These have provided agreed lists of the critical symptomatology of Urological cancers and the roles and responsibilities of Primary and Secondary care staff in ensuring patients receive prompt recognition and treatment of their cancer.

Review of Adult Urology Services in Northern Ireland

In March 2009, a *Review of Adult Urology Services in Northern Ireland - A modernisation and investment plan* was published. Its External Advisor was Mr Mark Fordham. SHSCT Consultant Urologists were represented on the committee.

Recommendation 4 states, "*Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system".* Consultants indicated that they would routinely upgrade a significant number of routine and urgent referrals (GP) to urgent or red flag. It was noted that the development of agreed referral guidelines/criteria for suspected Urological cancers was a priority piece of work for the recently formed NICaN Group. That work was led by Cons1; see page 6.

Section 3.31 of the report indicates that, "*Consultant Urologists unanimously consider that referral triage should be led by Consultants. With over 40% of referrals being cancer related*

(and with many not red flagged or marked urgent) they believe that they are best placed and skilled to undertake the triage process. They also believe that despite the volume of referrals, this is not a particularly time consuming process."

Contributory factor

Staff factor

It is obvious from reading the documents referred to above that Cons1 has been aware of developments in this field and, indeed has been party to the discussions and signed some of them off. Cons1 was chair of NICaN (Urology) and was involved in drafting the NICaN regional Urology guidance, and therefore was very familiar with the requirement to triage GP referrals.

Despite all of this, and even though Cons1 agreed that this triaging role was, "*very important*", …. it was, "*a very serious matter not to be minimised, very serious"* he stated he would not triage non-red flag referrals.

When asked, *"Does triage still need done?"* Cons1 answered*, "a procedure is needed to highlight when it needs done and who does it".* When further asked, *"Who was involved in SHSCT Urology service in setting up triage"?* Cons1 answered for urological cancer, "*I was the Lead"*.

He felt triage of referral letters was too time consuming and the amount of time spent on triage, in his opinion, rendered inpatient care unsafe. He highlighted that he had previously escalated his concerns about work load to management teams and medical directors.

In relation to triage, Cons1 stated, '*I would love if we had a Trust Urology agreement on the type of triage to be conducted*'. When it was pointed out that, "*Consultant colleagues did triage for you. How did they do it?"* He stated, "*It depends on how you do it"* ..... "*Not all do advanced / enhanced triage, they compromise. It is a spectrum"... "They have not done it in the detail I felt it needed for routine/urgent non-red flag case".*

When questioned further, regarding his way of organising his own work load, Cons1 stated, '*....yes I did it my way – I wasn't cognisant of being unbending, I am very particular*'.

Cons1 highlighted to the Review Team that he currently takes annual leave each Friday and spends the weekend triaging. He stated that it is impossible to be Urologist of the Week and triage referrals appropriately. He stated he still can't do triage and everything else. He stated, '*I do triage entirely in my own time to allow me to do it properly'*.

When asked about using the NIECR - Electronic Referral using the Clinical Communication Gateway (CCG) method, Cons1 stated found the new CCG triage system*, "Very, very good, I wish all information was available on ECR. It is less time consuming. ECR makes it easier to check information".*

The Review Team concluded that there was a serious inconsistency between the guideline

standard that a Consultant should triage GP referrals (which Cons1 helped to construct) along with his stated view of the crucial importance of triage and Cons1's actual practice.

Cons1's chosen method of triage was beyond what is required. His triage is the equivalent of a virtual clinic where he reviews NIECR and books investigations for patients. While the Review Team recognised this was a detailed triage process, they concluded that his prioritisation of work and attention to detail meant that some patients got a higher standard of triage/care, while, crucially, others were not triaged, leading to a potentially critical delay in assessment and treatment for those patients. Cons1 is aware of this.

The Review Team concluded that Cons1's prioritisation of work and attention to detail led to some patients receiving a high standard of care, while others ran the real risk of having a cancer diagnosis delayed till it was dangerously late.

Contributory factor

Work load/scheduling

In 2008, when the IEAP was published, there was a maximum waiting time of 9 weeks for a first Outpatient appointment. On 30th September 2016, there were 2012 patients on the routine Urology outpatient waiting list, with 597 patients showing as waiting 52 weeks and over. The longest waiting time was 554 days (80 weeks). Therefore, if patient referrals are incorrectly referred, or not triaged and continue to use the GP's classification of urgency, there will be a significant wait. Cons1 is aware of this reality.

The Review Team considered the Consultant of the Week (CoW) work load, including ward rounds, clinics, emergency theatre sessions as a contributory factor. Cons1 has consistently argued that he cannot triage non-red flag referrals and carry out the duties of the CoW. He has not indicated who else should carry out the triage duties. However, the Review Team note that the other Consultant Urologists were able to manage this work load and triage referral letters in a timely fashion, with other members of the consultant team also ordering investigations, providing treatment recommendations and adding patients directly to waiting lists, similar to outcomes achieved from Cons1's 'advanced triage'.

Contributory factor

Organisational

The Review Team concluded that the non-triage of Urology referrals by Cons1 has been an ongoing problem in the Trust for many years, possibly decades. While there were pockets of non-compliance by other Consultants, when escalated, compliance improved. However, the Review Team note that Cons1 consistently did not return triage information on referrals thus not allowing the appropriate prioritisation of appointments by clinical need.

Interviews with 2 previous and the current Director of Acute Services, AMD1 and the Head of Surgery Service have highlighted that on many occasions, over a prolonged period, attempts had been made by the Trust's officers to address Cons1's non-compliance with triage. These

attempts encompassed both direct face to face conversations which were often heated, correspondence and, as in 2010, study leave refusal until there was compliance. These interventions all resulted in a familiar pattern of response; temporary improvement in compliance with triage, followed by a return to non-compliance.

In 2014, due to continuing non-compliance, the Trust implemented an 'Informal' Default Triage Process to manage the referrals which were not being triaged and returned to the Booking Centre. The Review Team considered the intention of this process was to prevent any delay in patients being added to the waiting list. However, this meant the 'non-return of triage' was not individually addressed with the non-compliant clinicians. Furthermore, and most importantly, it allowed patients, who should have been red-flagged, to remain on a waiting list until review.

In 2014, the Director of Acute Service 2 (DAS2) discussed non-compliance with Cons1 and agreed that Cons1 would no longer triage referral letters. Cons1 was heavily involved with formulating the NICaN Urology guidelines at the time and was grateful to the extent that he thanked DAS2.This task was delegated to other Urology Consultants for a time. However, Cons1 does not recollect having to formally stop triage. At interview, DAS2 was not aware that he had resumed those duties; she remembered that their Cancer performance figures improved when Cons1 was not triaging.

Escalation within Organisation
At every interview, questions were asked whether Cons1's consistent and prolonged non-compliance with triaging was referred upwards to executive level i.e. the Medical Director and Chief Executive.

Director DAS1 considered that the problem was being managed at Service level, although as it was only one of a series of issues and considered to be a 'minor' one, it did not predominate at higher level meetings with the Medical Director (MD1); to the extent that he may not have been aware of it.

Director DAS2 considered that the problem was dealt with by agreeing with Cons1 to stop triaging. There were other issues that were flagged up to MD2, but she was not able to remember whether MD2 was made aware of the triage problem.

During DAS3's current tenure Executive members certainly knew; at CAH Oversight meeting level and at the time of the look back exercise #2 which ultimately led onto this SAI and RCA process. The Medical Director (MD3) was directly involved in the RCA process and the CEO was aware. At Trust Board level, it is thought that a non-Executive member was asked to examine the situation which would indicate that it had also reached that level.

Overall, the Review Team in considering whether there was a satisfactory escalation of this 'non-triage' issue have concluded that there was no evidence of consistent and proactive escalation of 'non-return of triage' either to the Medical Director or the Chief Executive until the look back exercise #2 basically forced the seriousness of the issue out into the open. Indeed,

they do not appear to have appreciated the importance of triage, certainly from the patient's perspective. The Trust's officers made efforts to address Cons1's non-triage over time but were consistently thwarted by Cons1's refusal to comply. The Trust failed to put systems, processes and fail safes in place to ensure Cons1's consistently triaged patient referrals until 2017.

Systems and processes have now been put in place so that the Head of Service for Urology reviews Cons1's compliance with triage. HoS1 will check all Urology triage on an adhoc basis but, with Cons1, she will check daily when he is the Consultant of the Week. Any non-compliance with returning referrals without triage is addressed immediately. However, this process is heavily dependent on HoS1 who, when she is on leave, often has to recover non-triaged cases upon her return.

8.0 LESSONS LEARNED

1. The clinical urgency category allocated by GPs to 30 patients referred to Urology were incorrect. The referrals using NICaN guidance should have been referred as a Red Flag. Four (plus 1) of these patients were subsequently shown to have cancer.

2. The process of triaging Urology cancer referrals from Primary Care to Secondary Care, under the direction of the HSCB, appears to be less efficient than it could be, bearing in mind that NICE NG12 guidance has not been adopted and electronic referral using CCG is not being used as efficiently as it could.

3. GP's are not mandated to provide HSCB with an assurance that they comply with the most up to date NICE or other guidelines. Therefore, HSCB are unaware of any risks consequent upon the non-compliance with NICE and other guidance within GP practices.

4. GP's are not mandated to refer patients using CCG clinical criteria banners; this can lead to error and delay.

5. There is no Regional or Trust guidance or policy on what is expected of clinicians when triaging referral letters. Triage of patient referrals is obviously viewed as extremely important but does not seem to be at an equivalent level of importance when ranked alongside other clinical governance issues. Despite being an evident problem for decades and requiring considerable time and effort to find a solution, it only really surfaced within the Trust after an Index case forced the situation out into the open.

6. Despite it being absolutely clear to Consultant 1 (based upon his close proximity to the development and signing off of regional guidance) of the consequences of non-triage, he did not routinely triage referral letters. The Review Team consider that Cons1's refusal to triage to a level similar to other clinicians, led to patients not being triaged,

and this resulted in delays in assessment and treatment. This may have harmed one patient.

7. Cons1 confirmed that despite the Trust reminding him of the requirement to triage, he did not consistently triage referrals. He argued that, due to time pressures, he felt he was unable to perform the duties of the Consultant of the Week and his triaging duties. He has highlighted those views to Trust operational and management teams over a number of years.

8. The Trust made efforts to address Cons1's non-triage over time. However, the Trust failed to put systems, processes and fail safes in place to ensure Cons1 consistently triaged patient referrals until 2017. However, this safeguarding process is heavily dependent on the Head of Service checking triage is completed when Cons1 is Consultant of the Week.

9. The Informal Default Triage process allows patients who should be red flagged to remain on a waiting list of routine or urgent cases.

10. From examining the triaging issue over the length of time it has existed, it is obvious that there is an unwillingness or inability within the medical hierarchy to tackle its 'difficult colleague' problem. The reasons behind this probably include not taking ownership of its own problems and poor support from senior medical management perhaps resulting in issues not being referred upwards.

9.0 RECOMMENDATIONS AND ACTION PLANNING

HSCB

Recommendation 1

HSCB should link with the electronic Clinical Communication Gateway (CCG) implementation group to ensure it is updated to include NICE/NICaN clinical referral criteria. These fields should be mandatory.

Recommendation 2

HSCB should consider GP's providing them with assurances that the NICE guidance has been implemented within GP practices.

Recommendation 3

HSCB should review the implementation of NICE NG12 and the processes surrounding occasions when there is failure to implement NICE guidance, to the detriment of patients.

HSCB, Trust and GPs

Recommendation 4

GPs should be encouraged to use the electronic CCG referral system which should be adapted to allow a triaging service to be performed to NICE NG12 and NICaN standards. This will also mean systems should be designed that ensure electronic referral reliably produces correct triaging e.g. use of mandatory entry fields.

TRUST

Recommendation 5

Work should begin in communicating with local GPs, perhaps by a senior clinician in Urology, to formulate decision aids which simplify the process of Red-flag, Urgent or Routine referral. The triage system works best when the initial GP referral is usually correct and the secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence the norm.

Recommendation 6

The Trust should re-examine or re-assure itself that it is feasible for the Consultant of the Week (CoW) to perform both triage of non-red flag referrals and the duties of the CoW.

Recommendation 7

The Trust will develop written policy and guidance for clinicians on the expectations and requirements of the triage process. This guidance will outline the systems and processes required to ensure that all referrals are triaged in an appropriate and timely manner.

Recommendation 8

The current Informal Default Triage (IDT) process should be abandoned. If replaced, this must be with an escalation process that performs within the triage guidance and does not allow Red-flag patients to wait on a routine waiting list.

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9.0 RECOMMENDATIONS AND ACTION PLANNING

Recommendation 9

Monthly audit reports by Service and Consultant will be provided to Assistant Directors on compliance with triage. These audits should be incorporated into Annual Consultant Appraisal programmes. Persistent issues with triage must be escalated as set out in recommendation 10.

Recommendation 10

The Trust must set in place a robust system within its medical management hierarchy for highlighting and dealing with 'difficult colleagues' and 'difficult issues', ensuring that patient safety problems uncovered anywhere in the organisation can make their way upwards to the Medical Director's and Chief Executive's tables. This needs to be open and transparent with patient safety issues taking precedence over seniority, reputation and influence.

CONSULTANT 1

Recommendation 11

Consultant 1 needs to review his chosen 'advanced' method and degree of triage, to align it more completely with that of his Consultant colleagues, thus ensuring all patients are triaged in a timely manner.

Recommendation 12

Consultant 1 needs to review and rationalise, along with his other duties, his Consultant obligation to triage GP referrals promptly and in a fashion that meets the agreed time targets, as agreed in guidance which he himself set out and signed off. As he does this, he should work with the Trust to aid compliance with recommendation 6.

10.0 DISTRIBUTION LIST

In addition to the Review Team, the following.

Mr S Devlin, Chief Executive SHSCT.

Dr Maria O'Kane, Medical Director, SHSCT.

Mrs Melanie McClements Interim Director of Acute Services.

Health & Social Care Board (HSCB).

Chairs of Morbidity & Mortality Groups SHSCT.

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Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:	Personal Information	**HSCB Ref Number:**	**S11471**

SECTION 1

INFORMING THE SERVICE USER[1] / FAMILY / CARER

1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***	✓
	Comment: 5 ***If multiple service users are involved please indicate the number involved***			
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**	✓	**NO**	
	If **YES**, insert **date informed**:19.2.18			
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI			
	a) No contact or Next of Kin details or Unable to contact			
	b) Not applicable as this SAI is not 'patient/service user' related			
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user			
	d) Case involved suspected or actual abuse by family			
	e) Case identified as a result of review exercise			
	f) Case is environmental or infrastructure related with no harm to patient/service user			
	g) Other rationale			
	If you selected c), d), e), f) or g) above please provide further details:			
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**	
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY		
	NO	If **NO**, provide details:		
For completion by HSCB/PHA Personnel Only (Please select as appropriate (✓))				
Content with rationale?	**YES**		**NO**	

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)

5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	✓
	If **YES**, insert date informed:			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:			
	a) Draft review report has been shared and further engagement planned to share final report			
	b) Plan to share final review report at a later date and further engagement planned			✓

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SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*		
	c) Report not shared but contents discussed ***(if you select this option please also complete 'l' below)***	
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (Please select as appropriate (✓))				
Content with rationale?	**YES**		**NO**	

SECTION 2							
INFORMING THE CORONERS OFFICE **(under section 7 of the Coroners Act (Northern Ireland) 1959)** *(complete this section for all death related SAIs)*							
1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**		**NO**				
	If **YES**, insert **date informed**:						
	If **NO**, please provide details:						
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**				
	If **YES**, insert **date report shared**:						
	If **NO**, please provide details:						
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES**		**NO**		**N/A**		**Not Known**
	If **YES**, insert **date informed**:						
	If **NO**, please provide details:						

DATE CHECKLIST COMPLETED	**22.5.2020**

[1] *Service User or their nominated representative*

Patient: Patient 1

H&C: Personal Information redacted by the USI

Diagnosed with locally advanced prostate cancer August 2019. MDM 31st October 2019 recommended ADT and refer for EBRT. Not referred for EBRT and hormone treatment not as per guidance. March 2020 rising PSA and local progression (urinary retention). Re-staged June 2020 and developed metastatic disease

Date/ Time	Summary Of Events	Staff
13/06/19	GP red flag referral for nocturia raised PSA	
14/06/19	Letter received	
17/06/19	Letter– reviewed by consultant plan for MRI scan and appointment arranged for 22 July 2019	AOB
21/06/19	MRI requested for Pelvis- Referred as rising PSA 19.81 on 12 June 2019 Previous MRI June 18 – prostatic enlargement.	
10 /07/19	MRI reported	
22/07/19	Attended OPD appointment in SWAH – advised possible malignancy of prostate, raised PSA. Arranged to have appointment in SWAH of scan of urinary tract in particular in relation to bladder voiding on micturition. Also requested appointment to attend Thorndale Unit in CAH Dictated 13/08/19 typed 03/09/19	
20/08/19	Thorndale Unit for trans biopsy of prostate under local anaesthetic.	Nurse Kate ONeill
29/08/19	MDT	
23/09/19	Attended OPD CAH advised no evidence of prostatic adenocarcinoma in any of the 9 cores taken from the right lateral lobe of the prostate gland. He was found to have Gleason 4+3 adenocarcinoma found in 7 of the 11 cores taken from the right lateral lobe of his prostate gland. The maximum tumour length was 6mm and tumour was considered to occupy approx. 8% of total core tissue volume. There was no evidence of perineural infiltration, lymphovascular infiltration or extracapsular invasion. Advised nature of adenocarcinoma to be high risk category particularly in relation to high PSA 20ng.ml even though he had been taking Finasteride since 2010. For this reason – initiated androgen blockade by prescribing Bicalutamide 150mgs daily in addition to tamoxifen 10mgs daily in order to minimise the risk of gynaecomastia arising as a consequence of androgen blockage. Requested radioisotope bone scan and CT CAP GP requested to prescribe Bicalutamide 50mgs daily. Letter to GP dictated 14/10/19 typed 15/10/19	AOB
14 /10/19	Patient 1 spoke to consultant secretary and subsequently consultant to advise that the combination of Bicalutamide and Tamoxifen had resulted in adverse toxicity which he found difficult to tolerate. Reported fuzzy head concerned unsafe to drive. Therefore discontinued until end of October. Will assess tolerance at clinic appointment on11 November 2019.	

Patient: Patient 1
H&C: Personal Information redacted by USI

11/11/19	Seen at clinic in SWAH - able to tolerate lower dose. Bloods taken PSA. Seen at clinic. Letter states It would be ideal to have optimal biochemical response to androgen blockade or androgen deprivation prior to consideration for radical radiotherapy. If his PSA has not decreased further it may be necessary to take an incremental approach to increased androgen blockade by increasing the dose of Bicalutamide to 50mgs twice a day and hopefully subsequently to taking the higher dose of 150mgs once again. As I suspect that the addition of a LHRH agonist may be more intolerable. Dictated 2/1/19 typed 10/01/2020	
2/1/2020	Phone call from AOB to Patient 1 – PSA dropped to 3.84 Needs repeat bloods in preparation for clinic appointment in January.	
27/1/2020	Seen at OPD appointment Serum PSA down 2.23 by 7th January 2020. Noted to be doing well. Only problem nocturia (twice at night). Plan to increase Bicalutamide 100mgs daily.	
5/3/2020	Serum PSA increased 5.37ng/ml	
11/3/2020	Letter to GP asking to increase dose to Bicalutamide 150mgs daily indefinitely. Plan repeat PSA mid-April. Plan review in SWAH 27th April 2020.	
27/04/2020	Appointment cancelled in view of covid outbreak. PSA check on 14 April – 12.08ng	
1/06/2020	Consultant spoke with Patient 1 advised to commence Leuprorelin 3.75mgs to be administered subcutaneously. To commence 1st week in June and repeat bloods at the same time. Plan for TURP in DHH. Needs to have adenocarcinoma restaged by having radioisotope bone scan.	
17/06/2020	Admitted to DHH for TURP Complicated by urinary sepsis requiring iv antibiotics. Failed trial removal of catheter for repeat TROC in SWAH in two weeks.	
22/06/2020	Discharged from DHH	
	Pathology report Adenocarcinoma – perineural and lymphovascular invasion seen.	
22/6/2020	Letter to GP Noted further elevation of PSA from 27.22ng/ml on 3 June 2020 to 29.5ng/ml on 12 June 2020.	

Patient: Patient 9
H&C: Personal Information redacted by the USI

Initial assessment May 2019. Clinically felt to have a malignant prostate. Commenced on Bicalutamide 50mg OD, TURP arranged (Benign pathology). Reviewed in outpatients in July 2019. Planned for repeat PSA and further review. Emergency Department attendance May 2020 resulting in catheterization. Rectal mas investigated and diagnosed as locally advanced prostate cancer. Commenced on Hormone treatment July 2020 and staging investigations arranged.

Date/ Time	Summary Of Events	Staff
1 May 2019	Attendance at Emergency Department Urinary Problems, severe pain, referred to Urology	
24/5/2019	Outpatient appointment with AOB Recent Urinary Retention on 1 May 2019. Preceding LUTS, Had TROC which failed, URE Normal, PSA 9.45, DRE: T3? TA CP. Plan: Rx Bicalitamide 50 MG's TURP on 12 June 2019	AOB
12/06/19	Admitted for TURP	AOB
13/06/19	Day 1 post TURP NEWS 0 Bloods awaited Needs clexane prescribed • TROC 6am • PRN antimedic	FY1
14/06/19	Day 2 Post TURP TROC today	Urology Registrar
15/06/19	Discharged Review with Mr O'Brien July 2019	FY1
02/07/19	Review OPD with AOB LUTS Hesitancy Unsatisfactory voiding Noturia x 4-5 Dysuria Plan PSA MSSU Rx ciprofloxacin 250 mgs BD x 2 weeks U/S Urinary tract Review September 2019	AOB
08/05/2020	Attended Emergency Department: *Symptoms: running to toilet a lot but unable to pu - in a lot of pain, not passed any urine today, bowel blockage also*	
12/05/2020	Virtual appointment: by Mr O'Brien, wrote to patient and to GP to advise GP to prescribe Bicalutamide 50mgs, in addition to Tamsulosin 400mgs, and that he would be reviewed in Surgical	AOB

Patient: [redacted]
H&C: [redacted]

	Assessment Unit on 18 May 2020 for removal of indwelling urethral catheter	
18/05/20	CAOBHOT – Ambulatory Care Unit CAH Extract from letter: *He had his catheter removed this morning and he attended to the clinic for post voids. Unfortunately at this point he was unable to void and was uncomfortable. He had 500mls in his bladder and therefore we catheterised him again. This is despite him having restarted his Bicalutamide and his Tamsulosin. His PSA recently was 9.5ng/ml and I know from my colleague Mr Elbaroni last week this his DRE felt malignant. I have booked him for a MRI of his prostate. I have discussed with [redacted] his symptoms further as well as he describes tenesmus, PR bleeding for the last 2 weeks, increase in his bowel habit. Given this, I have also written a letter to our colleagues in General Surgery to see if they could follow this up as a Red Flag. I will be in contact with the results.*	Urology registrar
02/07/20	Discussed at Urology MDM 02.07.20. [redacted] has locally advanced prostate cancer at the very least. He needs seen at clinic and commenced on ADT, a bone scan arranged, further MDM discussion and possible referral to Oncology.	
06/07/20	Outpatient clinic with Mr O'Donoghue Extract from letter: *PSA 9.40ng/ml 8th May 2020, MRI prostate 27/05/2020 showed large locally advanced prostate cancer, CT chest, abdomen and pelvis 12/06/2020 showed large rectal mass with small volume groin nodes and no distant metastasis, rectal biopsies 26th June 2020 showed prostatic adenocarcinoma which is high grade.* Plan from appointment was: *We are going to start him on an LHRH analogue and we will discuss him further at the MDT once the scan results come to hand. It is most likely that if he doesn't have metastatic disease he will be referred to oncology*	JOD
27/07/20	Attendance to Emergency Department with urinary retention, ongoing problem with catheter, changed earlier in the day, [redacted] not passing urine since Taken to theatre from ED for open insertion of a suprapubic catheter and admitted to 4S	ED and M Haynes
	Discharged from 4S: Extract from discharge letter: *It was decided this man would need a defunctioning stoma and ? ileal conduit. Stoma nurse reviewed [redacted] re future stoma.* *Surgical team are happy to operate on this man when he feels fit enough, he currently wants to return home to recuperate before undergoing any more operations. Discussed with Mr Epanomeritakis and SpR Mr Convie and he is able to go home*	M Haynes/Mr Epanomeritakis

Patient: Patient 9
H&C: Personal Information redacted by the USI

	for now. I will cc this letter to Mr Haynes Consultant urologist also so that the teams can liase re. whether urology want to also operate at the same time if required and to ensure appropriate follow-up	

Patient: Patient 5
H&C: Personal Information redacted by the USI

This Personal year old man underwent right radical nephrectomy in March 2019 for a large right renal cell carcinoma infiltrative of the renal vein. There was no definite evidence of disease recurrence or progression on CT scanning in June 2019. He was found to have an iron and folate deficient anaemia in October 2019 and a further CT scan was requested for December 2019. This scan was reported on 11 January 2020 and was not followed up until 28 July 2020.

Date/ Time	Summary Of Events	Staff
17/01/2019	**Urology MDM** This Personal year old man has remained on Warfarin since 2012 when he was found to have fast atrial fibrillation and left bundle branch block. DC conversion in 2014 did not succeed in permanent restoration of sinus rhythm. Taking Bisoprolol 7.5 mg daily has maintained controlled atrial fibrillation since. Echocardiography in 2015 confirmed a LVEF of 55%, mild mitral valvular regurgitation, moderate left atrial dilatation and mild right ventricular dilatation. He was discharged from cardiology review in 2015. He presented to the Emergency Department on 12 December 2018 following the onset of visible haematuria. His GFR was 57 ml/min. A CT Chest and CT Urogram were performed on 04 January 2019. The heart was reported to be enlarged. One pretracheal lymph node had a diameter of 12 mm and there was one small intrapulmonary lymph node related to the horizontal fissure. He was found to have a large, right renal tumour mass with a craniocaudal diameter of 15cm. The right renal vein appeared to be distended, and in continuity with the cranial pole of the tumour. MDM Plan: Discussed at Urology MDM 17.01.19. Patient 5 has a large right renal tumour with no definite evidence of metastatic disease. For review by Mr O'Brien on 18 January 2019.	
18/01/2019	**Urology Outpatient Clinic** Letter to patient - It has been agreed that it would certainly be most useful for you to have an MRI scan performed in order to determine whether there is any extensive involvement of major vessels in your abdomen by the tumour arising from your right kidney. You will receive an appointment to attend the MRI department at Craigavon Area Hospital in the near future. I have also requested a radioisotope renogram in order to quantify the function of your left kidney, in order to be able to advise you of the likely remaining kidney function, if you were to have your right kidney removed. You will also receive a letter of appointment to attend the Department of Radiology at Craigavon Area Hospital to have that renogram performed. I have also had the opportunity of reviewing echocardiograms that you have had done of your heart in 2016, and again more	Mr A O'Brien Consultant Urologist

Patient: Patient 5
H&C: Personal Information redacted by the USI

	recently in February 2018. The Department of Cardiology will arrange a further appointment for you to attend to have a further echo performed in the near future. Lastly, I have also shared your history with my colleagues in anaesthesia, and who have kindly agreed to arrange a consultation for you, in order to further assess the risks posed by significant surgery. You will receive that appointment as well. When all of that has been conducted, I will arrange a further review appointment for you when I will discuss with you the views of my colleagues, and when hopefully you will be enabled to arrive at an informed decision regarding your further management.	
05/02/19	**NM Renal DMSA.** There is photopenia at the lower pole of the right kidney corresponding to the known tumour. The left kidney appears unremarkable. Differential function estimated as follows: Left kidney 63%; right kidney 37%.	Dr S Vallely
07/02/19	**MRV Inferior vena cava.** Image quality suboptimal, due to patient movement. Large, 14 cm mass in the right kidney. There is likely tumour in the right renal vein. Over a distance of 1.7 cm, the vein is clear of thrombus before it joins the IVC.	Dr R McConville Consultant Radiologist
08/02/19	**Anaesthetic Review** Letter to referrer – Patient 5 is Personal Inform, with his main health issues to date being cardiac. He has known hypertension (on irbesartan), and atrial fibrillation (maintained on bisoprolol and warfarinised). There is a history of a failed DC cardioversion. Most recent echocardiogram (7th February 2019) shows mild-moderate tricuspid regurgitation, biatrial dilation (with his left atrium severely dilated), preserved systolic function but evidence of diastolic cardiac dysfunction (which would be in keeping with his hypertension). Patient 5 has no respiratory problems, and remains active. He lives independently, and continues to garden, including grass cutting. He would become dyspnoeic on climbing stairs. There is no clear suggestion in his history to suggest overt cardiac defeat. He has had a previous Personal Information redacted by the USI following trauma, and also suffers from arthritis in his right knee. I had hoped to perform CPX testing on him today, however the limited flexion available in his arthritic knee meant we were unable to proceed, and the attempted test was essentially non-diagnostic. He did become fairly dyspnoeic early into cycling,	Dr R McKee Consultant Anaesthetist

Patient: Patient 5
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	however it is difficult to read too much into that, as there was ongoing discomfort from his arthritic knee. Despite his remaining active and independent, such a procedure does have significant associated risk. I have discussed this with him in detail. Major concerns outlined were CVA, MI, development of heart failure requiring ongoing treatment, pneumonia, DVT, PE, and other infective problems. The possibility of his not being as well able to manage independently following surgery has also been raised. I have explained that given the risk profile here, he would need level 2 / HDU care post-operatively. His daughters seemed to grasp the significance of this, however, certainly on discussion today, Patient 5 seemed to be keen to actively consider surgery. I have explained that you would plan to review him following all his investigations and discuss this all in the round, including any other options which may be available.	
14/02/19	**Urology MDM** Patient 5 s imaging indicates a large right renal lesion with right renal vein involvement but no involvement of the IVC. Pre op assessment indicates high risk for mortality and morbidity in the post-operative period. For review with Mr O'Brien to discuss with patient and family if surgery is in his best interest.	
19/02/19	**Urology Outpatient Clinic** Letter to patient - I write to confirm that I have arranged for you to be admitted to our department, on Wednesday 6th March 2019 for right radical nephrectomy that day. You will receive formal notification of your admission before then. You will be expected to arrive at the Elective Admissions Ward, Ward 1 West, at 8am that day. I would be grateful if you would ensure that you arrive any time after 7.30am and no later than 8am, just in case any further blood tests need to be performed prior to surgery. It is critically important that you do not have anything to eat or drink after midnight the night before. I also write to confirm that I have advised that you continue to take Warfarin as usual up until and including Thursday 28th February 2019. You should not take any Warfarin thereafter. I have written to your family doctor, Dr Garland, requesting that the Practice Nurse administer Enoxaparin subcutaneously, 60mg on Monday 4th March 2019 and 40mg on Tuesday 5th March 2019. I have also requested that the Practice Nurse repeat your INR on Tuesday 5th March 2019. When you receive this letter, I would be grateful if you would contact Personal Information redacted by the USI Surgery to arrange those appointments with the Practice Nurse on Monday 4th March and Tuesday 5th March. I look forward to meeting you again following your forthcoming admission.	Mr A O'Brien Consultant Urologist
06/03/19	**Inpatient Admission**	

Patient: Patient 5
H&C: Personal Information redacted by the USI

	Admitted electively for a radical nephrectomy for suspected renal cell carcinoma. He was transferred to ICU post op for inotropic support. He was later transfered to the ward. He developed Enterobacter aerogenes +ve BC. On micro advice he was continued on tazocin + ciprofloxacin. He is to be discharged on a 7 day course of ciprofloxacin. Histology confirmed renal cell carcinoma. He is to be followed up by Mr O'Brien. Discharged 17/03/19.	
14/03/19	**Urology MDM** Discussed at Urology MDM 14.03.19. Patient 5 has a high risk Clear Cell Renal Cell Carcinoma. For review with Mr O'Brien to arrange CT in 3 months.	
29/03/19	**Urology Telephone Consultation** Letter to patient - I am aware that you had not been feeling well during recent months, and I do suspect that your anaemia may have been contributing to that lack of wellbeing. I am aware that you are currently taking iron tablets. I write to advise you that I have also written to Dr Garland, requesting that he issue you a prescription for Folic Acid tablets, 5mgs to be taken once daily, for a period of 3 months. When you receive this letter, I would be grateful if you would collect a prescription from Personal Information redacted by the USI Surgery. I also write to advise you that I have requested the Department of Radiology at South Tyrone Hospital to arrange an appointment for you to have a further CT scan of your chest, abdomen and pelvis performed during December 2019, and I hope to review you with the report in January 2020.	Mr A O'Brien Consultant Urologist
11/06/19	**CT Chest, abdomen and pelvis with contrast.** Comparison with 4 January 2019 and the 4 March 2019. Unchanged 1 cm pretracheal node and multiple other smaller mediastinal nodes. Small (1.7 cm) low density lesion posterior to the left atrium, unchanged and of doubtful clinical significance. Multiple small and unchanged pulmonary nodules. No definite pulmonary metastasis. Multiple small low density lesions within the liver some of which too small to categorise. No convincing change.	Dr M Williams Consultant Radiologist

Patient: Patient 5
H&C: Personal Information redacted by the USI

	Right nephrectomy. No enlarged abdominal or pelvic nodes are seen. There is a little ill-defined soft tissue posterior to the cava and adjacent to surgical clips which is probably postsurgical. Advanced degenerative change at both shoulders. No skeletal metastasis seen. CONCLUSION: No evidence of disease recurrence.	
17/12/19 15:36	**CT Chest, abdomen and pelvis with contrast** Indication: Restaging of recurrent renal cell carcinoma. Right radical nephrectomy March 2019. Technique: Portal venous phase volume scan of the chest, abdomen and pelvis with oral contrast. Comparison is made to the previous CT scan from 11 June 2019. Findings: The lung parenchymal appearances are stable, with no convincing evidence of metastatic disease. A borderline enlarged 10 mm short axis lower pretracheal lymph node is stable. There is no suggestion of active lymphadenopathy elsewhere within the scan range. Sub centimetre low density lesions in the liver remained stable, presumably relating to a simple cysts. The right renal bed is unremarkable, as is the left kidney, adrenal glands, spleen and pancreas. Within the left side of the L1 vertebral body, there is new area of ill-defined sclerosis slightly extending into the pedicle. This was not evident on the previous CT scan, and sclerotic metastasis is within the differential; a dedicated isotope bone scan would be worth considering for further evaluation. Conclusion: Possible sclerotic metastasis in L1 vertebral body.	Dr A Milligan Consultant Radiologist
28/07/20	**Urology Virtual Clinic** Letter to patient - Apologies in the delay in coming back to you with the result of this scan. As you are aware this was performed as follow up following your previous surgery for kidney cancer. Within the abdomen and chest your CT scan is satisfactory and does not show any problems related to your previous kidney cancer. There is however an in determinate area of possible abnormality within one of the bones of your spine which requires further assessment with a follow up CT scan and a further scan called a bone scan. I have requested these from the X-ray Department and you will receive appointments in the near future. In addition to the follow up	Mr M Haynes Consultant Urologist

Patient: Patient 5

H&C: Personal Information redacted by the USI

	scans I would be grateful if you could arrange a blood test with your GP using the enclosed blood test request form for an up to date kidney function blood test and also a prostate blood test.	
06/08/20	CT Bone Scan appointment booked.	

Department of
Health, Social Services and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

www.dhsspsni.gov.uk

INTEGRATED ELECTIVE ACCESS PROTOCOL
30th April 2008

DOCUMENT CONTROL INTEGRATED ELECTIVE ACCESS PROTOCOL			
Authors	Michelle Irvine – Programme Director, Elective Workstream Maria Wright – Associate Director, Outpatients Rosemary Hulatt – Associate Director, Diagnostics		
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Approved By		**Signature**	
Distribution	Trust Chief Executives; Directors of Planning and Performance; Directors of Acute Care; DHSSPS		
Review Date	April 2009		

CONTENTS

ABBREVIATIONS

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

SECTION 1

CONTEXT

1.1 INTRODUCTION

1.1.1 This protocol has been developed to encompass the elective pathway within a hospital environment. The principles can be applied to primary and community settings, however it is recommended that guidance is developed which recognises the specific needs of the care pathway provided in these settings.

1.1.2 The length of time a patient needs to wait for elective treatment is an important quality issue and is a visible public indicator of the efficiency of the hospital services provided by the Trust. The successful management of patients who wait for outpatient assessments, diagnostic investigations and elective inpatient or day case treatment is the responsibility of a number of key individuals within the organisation. General Practitioners, commissioners, hospital medical staff, managers and clerical staff have an important role in ensuring access for patients in line with maximum waiting time guarantees, managing waiting lists effectively, treating patients and delivering a high quality, efficient and responsive service. Ensuring prompt timely and accurate communications with patients is a core responsibility of the hospital and the wider local health community.

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

1.1.4 This protocol will be updated, as a minimum, on an annual basis to ensure that Trusts' polices and procedures remain up to date, and reflect best practice locally and nationally. Trusts will ensure a flexible approach to getting patients treated, which will deliver a quick response to the changing nature of waiting lists, and their successful management.

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

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

1.1.7 There is an imperative to identify capacity constraints that could threaten the delivery of these key access targets and speed up the planning and delivery of extra capacity, where it is needed, to address these constraints. The health community will need to develop a co-ordinated approach to capacity planning taking into account local capacity on a cross Trust basis and independent sector capacity on an on-going partnership basis.

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

1.1.9 The intention is that this protocol will be further developed to consider all aspects of access to a range of quality healthcare at a date and time of the patients' choice.

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

1.1.11 Delivery of this protocol will require a step change in the way Trusts function. Trusts will need to transform themselves and this can only be achieved through a change in the way its staff approach their work on a day-to-day basis. Through this protocol, Trusts will aspire to work with patients and staff to raise expectations basing them not on where we are but on where we need to be.

1.1.12 For the purposes of this protocol, the term inpatient refers to inpatient and day case elective treatment. The term 'PAS' refers to all patient

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

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

1.2 UNDERPINNING PRINCIPLES

1.2.1 Patients will be treated on the basis of their clinical urgency with urgent patients seen and treated first. The definition of clinical urgency will be defined specifically by specialty / procedure / service.

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

1.2.3 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to admit, i.e. if there was a bed available tomorrow in which to admit a patient - they are fit, ready, and able to come in.

1.2.4 Trusts should design processes to ensure that inpatient care is the exception for the majority of elective procedures, not the norm. The principle is about moving care to the most appropriate setting, based on clinical judgement. This means moving day case surgery to outpatient care, and outpatient care to primary care or alternative clinical models where appropriate.

1.2.5 Change No 1 within the publication "10 High Impact Changes for Service Improvement and Delivery"[1] focuses on day surgery and the document provides Trusts with tools and resources to help implement this high impact change.

1.2.6 Trusts will introduce booking systems aimed at making hospital appointments more convenient for patients. Booking systems are chronologically based and will move Trusts onto a system of management and monitoring that is chronologically as opposed to statistically based.

1.2.7 As part of a plan for the implementation of booking, Trusts must ensure their elective admission selection system is managed on a chronological basis within clinical priority with immediate effect. The intention is to provide patients with certainty and choice enabling them to access services that are sensitive to their needs.

1.2.8 This will require changes in working practices. It will also require technological change to information systems to enable provision of quality information to support the booking process.

1.2.9 There is a need to balance the flow of patients from primary care through outpatients and on to booking schedules should they need elective admission. It follows that the level of activity in the Service and Budget Agreements and the level of provision of outpatient and inpatient capacity must be linked. If one changes, all should change.

1.2.10 This "bottom up" approach is based on the belief that services need to be built on firm clinical foundations. Trusts need a clinical vision built up specialty by specialty and department by department through debate and agreement between clinicians across the health community as to the best way to meet patient needs locally.

1.2.11 It is essential that patients who are considered vulnerable for whatever reason have their needs identified at the point of referral.

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

1.2.12 All relevant information must be recorded to ensure that when selecting a vulnerable patient for admission, their needs are identified early and appropriate arrangements made. This information should be recorded in detail in the episodic comment field of PAS relating to the listing. The patient master index comment field should not be used due to confidentiality issues.

1.2.13 Communication with this patient group will recognise their needs and, where appropriate, involve other agencies.

1.2.14 An operational process should be developed by Trusts to ensure that children and vulnerable adults who DNA or CNA their outpatient appointment are followed up by the most appropriate healthcare professional and a clear link to the referring clinician established.

1.2.15 In implementing this protocol the needs of ethnic groups and people with special requirements should be considered at all stages of the patient's pathway.

1.3 OWNERSHIP

1.3.1 Ownership is key to delivering quality of care. Trusts must ensure that all staff are conversant with the Departmental targets and standards and are comfortable with the local health communities' approach to their delivery.

1.3.2 These targets and standards must be seen to be core to the delivery of all aspects of care provision by all levels of staff within the Trust.

1.3.3 This is a major change agenda requiring significant commitment and investment at corporate and individual level. An Executive Director will take lead responsibility for ensuring all aspects of this Protocol are adhered to.

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

1.4 REGIONAL TARGETS

1.4.1 The targets in respect of elective treatments are:

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

1.5 DELIVERY OF TARGETS

1.5.1 The waiting time targets are based on the “worst case” i.e. they reflect the minimum standards with which every Trust must comply.

1.5.2 The expectation is that these targets are factored into plans at Trust Board, divisional, specialty and departmental levels as part of the normal business

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

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

1.6 CAPACITY

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

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

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

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

1.6.4 This information will enable Trusts to evaluate its waiting/booked lists in terms of theatre sessions (time in hours) and length of stay (time in bed days).

1.6.5 Each specialty should understand its elective bed requirements in terms of both inpatients and daycases, setting challenging daycase and LOS targets and agreeing plans to deliver them. In addition, systems must be developed to ensure assessment can be made of available capacity and flexible working arrangements developed accordingly.

1.6.6 Theatre sessions should be seen as corporate resources and used flexibly to ensure the delivery of waiting list and waiting time targets across consultants within the same specialty and specialties within the same Trust. This ties in with the Real Capacity Paper which also requires commissioners to demonstrate that they have used capacity flexibly across Trusts. The expectation is that divisions and/ or specialties will be able to demonstrate that they have optimised the use of existing capacity to maximise the treatment of patients within existing resources.

1.6.7 Trusts will treat patients on an equitable basis across specialties and managers will work together to ensure consistent waiting times for patients of the same clinical priority.

1.6.8 Trusts will set out to resource enough capacity to treat the number and anticipated casemix of patients agreed with commissioners. The Real Capacity Planning exercise will support this process locally.

1.6.9 Divisions/specialties will monitor referrals and additions to lists in terms of their impact on clinic, theatre time, bed requirements and other key resources e.g. ICU facilities, to ensure a balance of patients in the system and a balance between patients and resources.

1.6.10 When the balance in the system is disturbed to the extent that capacity is a constraint, divisional/specialty managers will be expected to produce plans

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

1.6.11 It is important for all services to understand their baseline capacity, the make-up of the cohort of patients waiting to be treated and the likely changes in demand that will impact on their ability to initiate treatment and meet the maximum waiting time guarantees for patients.

1.6.12 Trusts should ensure that robust prospective capacity planning arrangements are in place, with clear escalation procedures to facilitate capacity gaps to be identified and solutions found in a timely manner to support operational booking processes and delivery of the targets.

1.6.13 In summary, the intention is to link capacity to the Service and Budget Agreement i.e. to agree the plan, put in place the resources to achieve the plan, monitor the delivery of the plan and take corrective action in the event of divergence from the plan proactively. The existing arrangements whereby patients are added to waiting lists irrespective of whether Trusts have the capacity to treat them must change.

1.7 BOOKING PRINCIPLES

1.7.1 These booking principles have been developed to support all areas across the elective pathway where appointment systems are used.

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

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

1.7.4 Booking development work within Trusts should be consistent with regional and local targets, which provide a framework for progress towards ensuring successful and consistent booking processes across the health community in Northern Ireland.

1.7.5 All booking processes should be underpinned with the relevant local policies and procedures to provide clarity to operational staff of the day to day requirements and escalation route, for example: management of patients who cancel / DNA their appointment, process for re-booking patients, and monitoring of clinical leave and absence.

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

1.7.7 The definition of a booked appointment is:

a) The patient is given the choice of when to attend.
b) The patient is advised of the total waiting time during the consultation between themselves and the healthcare provider / practitioner or in correspondence from them.
c) The patient is able to choose and confirm their appointment within the timeframe relevant to the clinical urgency of their appointment
d) The range of dates available to a patient may reduce if they need to be seen quickly, e.g. urgent referrals or within 2 weeks if cancer is suspected.
e) The patient may choose to agree a date outside the range of dates offered or defer their decision until later

1.7.8 Booking Process

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

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

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

1.7.11 Principles for booking Cancer Pathway patients

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

1.7.12 Principles for booking Urgent Pathway patients

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

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

1.7.13 Principles for booking Routine Pathway patients

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

1.7.14 Principles for Booking Review Patients

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

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

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

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

SECTION 2

GUIDANCE FOR MANAGEMENT OF ICATS SERVICES

2.1 INTRODUCTION

2.1.1 The administration and management of ICATS referrals and ICATS requests for diagnostics must be consistent, easily understood, patient focused, and responsive to clinical decision-making.

2.1.2 ICATS services are managed in accordance with the Data Definitions and Guidance Document for Monitoring of ICATS Services Sept 2007 **(Appendix 1).**

2.1.3 The level of functionality available on the Electronic Referral Management System to support the administration of patients in an ICATS setting is developmental. Achievement of the standards outlined will be where functionality permits.

2.1.4 Referrals will be managed through a centralised registration process in the nominated Hospital Registration Offices (HRO's) within Trusts to receive, register and process all ICATS referrals. The Trust should ensure that a robust process is in place to ensure that referrals received outside the HRO are date stamped, forwarded to the HRO and registered onto ERMS according to the date received by the Trust.

2.1.5 All new patients should be able to book their appointment in line with the guidance outlined in Booking Principles Section 1.7 The expectation is that follow up patients should also be offered an opportunity to choose the date and time of their appointment.

2.2 KEY PRINCIPLES

2.2.1 Where ICATS is in place for a specialty, all referrals should be registered and scanned onto Electronic Referral Management System (ERMS) within 24 hours of receipt.

2.2.2 Each ICATS must have a triage rota to ensure that every referral is triaged and the appropriate next step is confirmed, according to the clinically agreed

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

2.2.3 The outcome of the triage will be confirmed by letters to the GP and patient within a further two working days of triage (five working days in total from receipt).

2.2.4 ICATS clinical staff will be aware of all exclusions that prevent patients from being assessed or treated within the ICATS setting**.**

2.2.5 Patients of equal clinical priority will be selected for booking in chronological order in order to meet the maximum waiting time guarantee for patients and local access standards.

2.2.6 All patients deemed appropriate will be offered an ICATS appointment within six weeks from the triage date.

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

2.2.8 Staff should be supported by appropriate training programmes.

2.3 CALCULATION OF THE WAITING TIME

2.3.1 The waiting time clock for ICATS starts after the triage decision has been taken that an appointment in ICATS clinic is the appropriate next step.

2.3.2 The ICATS clock stops when the patient attends for first appointment or when the patient has been discharged from ICATS.

2.3.3 Patients who cancel an appointment will have their waiting time clock reset to the date the hospital was informed of the cancellation. Patients who refuse a reasonable offer of an appointment will also have their waiting time clock reset to the date the reasonable offer was refused. To ensure the

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

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

2.3.4 No patient should have his or her appointment cancelled. If the ICATS service cancels a patient's appointment, the patient's waiting time clock will not be reset and the patient should be offered another appointment, ideally at the time of the cancellation, and which is within six weeks of the original appointment date.

2.4 NEW REFERRALS

2.4.1 All ICATS referrals will be registered and scanned onto ERMS within 24 hours of receipt. All referrals forwarded for ICATS triage must be triaged or assessed to make a clear decision on the next step of a referral within three working days of the referral being logged by the HRO onto ERMS.

2.4.2 Within five working days of the referral being recorded onto ERMS, the GP and patient must be issued with written confirmation of the next stage of the patient's treatment.

2.4.3 Where there is insufficient information for the professional to make a decision, they have the option to either return the referral to the referrer requesting the necessary information or contact the referrer in the first instance to access the necessary information. If this cannot be gained, the referral should be returned to the referrer requesting the necessary information and a new referral may be initiated.

2.4.4 Those patients identified for outpatients and diagnostic services following triage will be managed in line with the relevant sections of this IEAP.

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

2.5 BOOKING

2.5.1 All patients requiring an appointment in an ICATS will have the opportunity to agree the date and time of their appointment, in line with the booking principles outlined in Section 1.7.

2.5.2 If a patient requests an appointment beyond the six week ICATS standard the patient will be discharged and told to revisit their GP when they are ready to be seen at the ICATS clinic. This will ensure that all patients waiting for an ICATS appointment are fit and ready to be seen. It is accepted that local discretion may be required where short periods of time are involved, for example, if patients are requesting dates up to a week over their breach date. Trusts should ensure that reasonableness is complied with to facilitate recalculation of the patient's waiting time and to facilitate booking the patient into the date they requested.

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

2.6 REASONABLE OFFERS

2.6.1 All patients must be offered reasonable notice. A reasonable offer is defined as an offer of appointment, irrespective of provider, that gives the patient a minimum of three weeks' notice and two appointments. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date of the second appointment date declined.

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

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

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

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

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

- Where a patient has had an opportunity to agree the date and time of their appointment, they will not normally be offered a second appointment. These patients will be referred back to the care of their referring clinician.

- Under exceptional circumstances a clinician may decide that a patient should be offered a second appointment. The second appointment must be booked.

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

- The patient will be given a second opportunity to book an appointment, which should be within six weeks of the original appointment date.

- If a second appointment is cancelled, the patient will not normally be offered a third opportunity and will be referred back to their referring clinician.

2.7.3 If a patient has been referred back to their referring clinician and the referrer still wishes a patient to be seen in ICATS, a new referral is required.

2.7.4 The Implementation Procedure for the Management of Patients who DNA or Cancel can be found in **Appendix 4.**

2.8 MAXIMUM WAITING TIME GUARANTEE

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

2.9 COMPLIANCE WITH TRUST LEAVE PROTOCOL

2.9.1 It is essential that leave/absence of ICATS practitioners is organised in line with Trusts' notification of leave protocol. It is also necessary for Trusts to have robust policies and procedures that minimise the cancellation/reduction of ICATS clinics.

2.9.2 The protocol should require a minimum of six weeks' notification of intended leave. A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

2.10 CLINIC OUTCOME MANAGEMENT

2.10.1 There are a number of locations within Trusts where patients present for their ICATS consultation. This protocol applies to all ICATS locations. It is the responsibility of the ERMS user managing the attendance to maintain data quality.

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

2.10.3 When the assessment has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on ERMS.

2.11 REVIEW APPOINTMENTS

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

2.11.2 As previously stated, the Booking Centres will be responsible for partially booking all new appointments. Booking Centres will also book review appointments that are required to be more than 6 weeks in the future. ICATS administration staff will make bookings directly with the patient at the clinic for any further appointments needing to occur within 6 weeks.

2.12 TEMPLATE CHANGES

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

2.12.2 Templates will identify the number of slots available for new and follow up appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated to each appointment slot.

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

2.12.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager. The Implementation Procedure for management of Clinic Template Changes can be found in **Appendix 5.**

2.13 VALIDATION

2.13.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. Trusts should ensure that all relevant data fields are completed in ERMS. This should be undertaken as a minimum on a monthly basis and ideally on a weekly basis as waiting times reduce.

2.13.2 The data validation process will apply to both new and follow up appointments. The Implementation Procedure for data validation can be found in **Appendix 6.**

SECTION 3

GUIDANCE FOR MANAGEMENT OF OUTPATIENT SERVICES

3.1 INTRODUCTION

3.1.1 The following protocol is based on nationally recommended good practice guidelines to assist staff with the effective management of outpatient services.

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

3.1.3 There will be dedicated Hospital Registration Offices (HROs) within Trusts to receive, register and process all outpatient referrals. The HROs will be required to register and scan referrals (where appropriate) onto the Electronic Referrals Management System (ERMS) and PAS.

3.1.4 There will be dedicated booking functions within Trusts and all new and review outpatients should have the opportunity to book their appointment. The booking process for non-routine groups of outpatients or those with additional service needs should be designed to identify and incorporate the specific pathway requirements of these patients.

3.2 CALCULATION OF THE WAITING TIME

3.2.1 The starting point for the waiting time of an outpatient new referral is the date the clinician's referral letter is received by Trusts. All referral letters, including faxed, emailed and electronically delivered referrals, will be date stamped on the date received into the organisation.

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

3.2.2 Patients who cancel an appointment will have their waiting time clock reset to the date the hospital was informed of the cancellation. Patients who

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

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

3.3 KEY PRINCIPLES

3.3.1 Referrals into Trusts should be pooled where possible within specialties. Referrals to a specific consultant by a GP should only be accepted where there are specific clinical requirements or stated patient preference. As a minimum, all un-named referrals should be pooled.

3.3.2 All referrals, appointments and waiting lists should be managed according to clinical priorities. Priorities must be identified for each patient on the waiting list, allocated according to urgency of the treatment. Trusts will manage patients in 2 streams, i.e. urgent and routine. Templates should be constructed to ensure enough capacity is available to treat each stream within agreed maximum waiting time guarantees. The Implementation Procedure for Template Redesign can be found in **Appendix 7.**

3.3.3 The regional target for a maximum OP waiting time is outlined in Section 1.4. Maximum waiting times for urgent patients should be agreed locally with clinicians.

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

3.3.5 Patients of equal clinical priority will be selected for booking in strict chronological order. Trusts must ensure that Department waiting and booking targets and standards are met.

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

3.3.7 Trusts should provide training programmes for staff which include all aspects of this IEAP and its Implementation Procedures. It is expected that training will be cascaded at and by each clinical, managerial or administrative tier within Trusts, providing the opportunity where required, for staff to work through operational scenarios.

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

3.4 NEW REFERRALS

3.4.1 All outpatient referrals sent to Trusts will be received at the dedicated HRO's and registered within one working day of receipt. GP priority status must be recorded at registration.

3.4.2 Trusts will work towards a system whereby the location of all letters can be tracked at all times through the referral and appointment system, and that letters sent to be prioritised and which are not returned can be identified.

3.4.3 All referrals must be prioritised and clinical urgency must be clearly identified. Clinicians will be responsible for ensuring that cover is provided for referrals to be read and prioritised during their absence. A designated officer should oversee this and a protocol will be required for each department.

3.4.5 All outpatient referrals letters will be prioritised and returned to the HRO within 3 working days. It will be the responsibility of the health records

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

3.4.6 Where clinics take place, or referrals can be reviewed less frequently than weekly, a process must be put in place and agreed with clinicians whereby GP prioritisation is accepted in order to proceed with booking urgent patients.

3.4.7 Inappropriate and inadequate referrals should be returned to the referral source. A minimum referral criteria dataset has been agreed and is outlined in **Appendix 8**

3.4.8 An Effective Use of Resources Policy is in place for some services and Trusts should ensure that this is adhered to. The policy is included for reference in **Appendix 9.**

3.5 URGENT AND ROUTINE APPOINTMENTS

3.5.1 All consultant led outpatient appointments where the patient attends the Trust should be booked. The key requirements are that the patient is directly involved in negotiating the appointment date and time, and that no appointment is made more than six weeks into the future.

3.5.2 All routine patients must be booked within the maximum waiting time guarantee. Urgent patients must be booked within the maximum wait agreed locally with clinicians, from the date of receipt. It is recognised that there will be occasional exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Trusts should ensure that when accommodating these patients, the appointment process is robust and clinical governance requirements met.

3.5.3 Acknowledgment letters will be sent to routine patients within five days of receipt of the referral. The estimated length of wait, along with information on

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

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

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

3.6 BOOKING

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

3.7 REASONABLE OFFERS

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

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

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

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

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

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

- Where a patient has had an opportunity to agree the date and time of their appointment, they will not normally be offered a second appointment. These patients will be referred back to the care of their referring clinician.

- Under exceptional circumstances a clinician may decide that a patient should be offered a second appointment. The second appointment must be booked.

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

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

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

- The patient will be given a second opportunity to book an appointment, which should be within six weeks of the original appointment date.

- If a second appointment is cancelled, the patient will not normally be offered a third opportunity and will be referred back to their referring clinician.

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

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

3.9 MAXIMUM WAITING TIME GUARANTEE

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

3.10 COMPLIANCE WITH LEAVE PROTOCOL

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

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

3.10.2 It is essential that planned medical and other clinical leave or absence is organised in line with an agreed Trust Human Resources (HR) protocol. Thus it is necessary for Trusts to have robust local HR policies and procedures in place that minimise the cancellation/reduction of outpatient clinics and the work associated with the rebooking of appointments. There should be clear medical and clinical agreement and commitment to this HR policy. Where cancelling and rebooking is unavoidable the procedures used must be equitable, efficient, comply with clinical governance principles and ensure that maximum waiting times for patients are not compromised.

3.10.3 The protocol should require a minimum of six weeks' notification of intended leave, in line with locally agreed HR policies.

3.10.4 A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit. The Implementation Procedure for Compliance with Leave Protocol can be found in **Appendix 10.**

3.11 CLINIC OUTCOME MANAGEMENT

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

3.11.2 All patients will have their attendance registered on PAS upon arrival in the clinic. The patient must verify their demographic details on every visit. The verified information must be cross-checked on PAS and the medical records.

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

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

3.12 REVIEW APPOINTMENTS

3.12.1 All review appointments must be made within the time frame specified by the clinician. If a review appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the consultant. Trusts should actively monitor patients on the review list to ensure that they do not go past their indicative month of treatment and take the necessary action to ensure capacity is available for this cohort.

3.12.2 Review patients who require an appointment within six weeks will negotiate the date and time of the appointment before leaving the department and PAS updated. Patients requiring an appointment outside six weeks will be placed on a review waiting list, with the indicative appointment date recorded, and be booked in line with implementation guidance for review pathway patients.

3.13 CLINIC TEMPLATE CHANGES

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

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

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

3.13.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager. The Implementation Procedure for the management of Clinic Template Changes can be found in **Appendix 5.**

3.14 VALIDATION

3.14.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a weekly basis and continually reviewed as waiting times reduce. This is essential to ensure PTLs are accurate and robust at all times. The Implementation Guidance for Data Validation can be found in **Appendix 6.**

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

3.14.3 For patients in specialties that are not yet booked, they will be contacted to establish whether they will still require their appointment.

3.15 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

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

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

SECTION 4

PROTOCOL GUIDANCE FOR MANAGEMENT OF DIAGNOSTIC SERVICES

4.1 INTRODUCTION

4.1.1 The following protocol is based on nationally recommended good practice guidelines to assist staff with the effective management of diagnostic waiting lists. Where possible, the principles of good practice outlined in the Outpatient and Elective Admissions Section of this document should be adopted in order to ensure consistent standards and processes for patients as they move along the pathway of investigations, assessment and treatment. This section aims to recognise areas where differences may be encountered due to the nature of specific diagnostic services.

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

4.1.3 There will be a centralised registration process within Trusts to receive, register and process all diagnostic referrals. It is expected that this will be in a single location, where possible.

4.1.4 The Trust should work towards introducing choice of the date and time of tests to all patients. The Booking Principles outlined in Section 1 of this document should be considered in the development of this strategy.

4.2 CALCULATION OF THE WAITING TIME

4.2.1 The starting point for the waiting time of a request for a diagnostic test is the date the clinician's request is received into the department, in line with the guidance on Completing Diagnostic Waiting Times Collection (Definitions Document), September 2007. This can be found in **Appendix 14.** All referral letters and requests, including faxed, emailed and electronically delivered referrals, will be date stamped on the date received.

4.2.2 Patients who cancel an appointment will have their waiting time clock reset to the date the service was informed of the cancellation.

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

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

4.3 KEY PRINCIPLES

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

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

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

4.3.4 Staff should be supported by appropriate training programmes.

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

4.4 NEW DIAGNOSTIC REQUESTS

4.4.1 All diagnostic requests sent to Trusts will be received at a single location within the specialty Department. Trusts should explore the setting of one centralised diagnostic registration centre.

4.4.2 All requests will be registered on PAS / relevant IT system within one working day of receipt. Only authorised staff will have the ability to add, change or remove information in the outpatient module of PAS or other diagnostic system.

4.4.3 Trusts will work towards a system whereby the location of all letters can be tracked at all times through the referral and appointment system and that letters sent for prioritisation and not returned can be identified. Trusts should consider the introduction of clinical tracking systems similar to that used in patient chart tracking.

4.4.4 All requests must be prioritised and clinical urgency must be clearly identified. Clinicians will be responsible for ensuring that cover is provided for requests to be read and prioritised during their absence. A designated officer should oversee this and a protocol will be required for each department.

4.4.5 All requests will be prioritised and returned to the central registration point within 3 working days. It will be the responsibility of the health records manager or departmental manager to monitor this performance indicator. Monitoring on a consultant level will take place by consultant on a monthly basis. Following prioritisation, requests must be actioned on PAS / IT system and appropriate correspondence issued to patients within 1 working day.

4.4.6 Where clinics take place, or requests can be reviewed less frequently than weekly, a process must be put in place and agreed with clinicians whereby the GP's priority is accepted in order to proceed with booking urgent patients.

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

4.5 URGENT AND ROUTINE APPOINTMENTS

4.5.1 All requests must be booked within the maximum waiting time guarantee. The key requirement is that the patient is directly involved in negotiating the date and time of the appointment and that no appointment is made more than six weeks in advance.

4.5.2 Urgent requests must be booked within locally agreed maximum waits from the date of receipt. It is recognised that there will be exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Trusts should ensure that when accommodating these patients, the appointment process is robust and clinical governance requirements met.

4.5.3 All routine patients must be booked within the maximum waiting time guarantee. Acknowledgement letters will be issued to routine patients within 5 working days of receipt of request. The estimated wait, along with information on how the patients will be booked should be included on the acknowledgement letter.

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

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

4.6 CHRONOLOGICAL MANAGEMENT

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

4.6.2 It is expected that Trusts will use two prioritisation categories; urgent and routine.

4.7 BOOKING METHODS

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

4.8 REASONABLE OFFERS

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

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

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

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

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

4.9.1 If a patient DNAs their diagnostic test, the following process must be implemented.

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

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

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

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

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

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

4.10 TRANSFERS BETWEEN HOSPITALS

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

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

4.11 COMPLIANCE WITH TRUST LEAVE PROTOCOL

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

4.11.2 It is therefore essential that leave/absence is organised in line with the Trust's Human Resources leave protocol. It is necessary for Trusts to have robust policies and procedures that minimise the cancellation/reduction of diagnostic sessions and the work associated with the rebooking of appointments. Where cancelling and rebooking is unavoidable the procedures used must be equitable and comply with clinical governance principles.

4.11.3 The local absence/leave protocol should require a minimum of six weeks' notification of intended leave, in line with locally agreed policies.

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

4.12 SESSION OUTCOME MANAGEMENT

4.12.1 There are a number of locations within Trusts where patients present for their diagnostic tests. This protocol applies to all diagnostic services. It is the responsibility of the PAS / relevant system user administrating the clinic to maintain data quality.

4.12.2 All patients will have their attendance registered on PAS / IT system upon arrival at the clinic. The patient must verify their demographic details on every visit. The verified information must be cross-checked on PAS / IT system and the medical record.

4.12.3 Changes in the patient's details must be updated on PAS / IT system and the medical record on the date of clinic.

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

4.13.1 DIAGNOSTIC TEST OUTCOME

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

4.14 FOLLOW UP APPOINTMENTS

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

4.14.2 Where follow up appointments are not booked, patients who require a review within six weeks will negotiate the date and time of this appointment before leaving the department and PAS / IT system updated. Patients requiring an appointment outside six weeks will have their appointment managed through a 'hold and treat' system. They will be managed on a review waiting list, with an indicative date of treatment and sent a letter confirming their appointment date six weeks in advance.

4.15 TEMPLATE CHANGES

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

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

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

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

4.16 VALIDATION

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

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

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

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

4.17 PLANNED PATIENTS AND DIAGNOSTICS TESTS CLASSIFIED AS DAY CASES

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

4.18 PLANNED PATIENTS

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

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

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

4.19 HOSPITAL INITIATED CANCELLATIONS

4.19.1 No patent should have his or her admission cancelled. If Trusts cancel a patient's admission, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity, which should must be within the maximum waiting time guarantee.

4.19.2 Trusts should aim to have processes in place to have the new proposed admission date arranged before that patient is informed of the cancellation.

4.19.3 The patient should be informed in writing of the reason for the cancellation and the date of the new admission. The correspondence should include an explanation and an apology on behalf of the Trust.

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

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

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

4.20 PATIENTS LISTED FOR MORE THAN ONE DIAGNOSTIC TEST

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

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

4.20.3 Where a patient requires more than one test carried out on separate occasions by different (or the same) clinician, the patient should be placed on the active waiting list for the first test and on the planned waiting list for any subsequent tests.

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

SECTION 5

GUIDANCE FOR MANAGEMENT OF ALLIED HEALTH PROFESSIONAL (AHP) SERVICES

5.1 INTRODUCTION

5.1.1 Allied Health Professionals work with all age groups and conditions, and are trained in assessing, diagnosing, treating and rehabilitating people with health and social care needs. They work in a range of settings including hospital, community, education, housing, independent and voluntary sectors. This guidance provides an administrative framework to support the management of patients waiting for AHP services.

5.1.2 Although it is written primarily for services provided in Trusts, it is recognised that there are a number of AHPs who provide services for children with physical and learning disabilities within special schools and with special educational needs within mainstream schools. Operational practices in these settings should be in line with the principles of the IEAP and provide consistency and equity for patients. Trusts should collaborate with colleagues within the Department of Education and the relevant schools to harmonise practices and ensure that children are able to access services equitably and within the maximum waiting time guarantees. A robust monitoring process will be required.

5.1.3 For the purposes of this section of the protocol, the generic term ‘clinic’ will be used to reflect AHP activity undertaken in hospital, community or domiciliary settings as it is recognised that AHPs provide patient care in a variety of care locations.

5.2 KEY PRINCIPLES

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

5.2.2 When looking at the experience of the patient it is important to consider the whole of their journey, with both the care and administrative pathways designed to support the patient's needs at each stage. The wait to receive outpatient therapy is likely to be one of many they experience in different parts of the system. It is the responsibility of all those involved to ensure that the patient wastes as little time as possible waiting and is seen by the right person as quickly as possible.

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

5.3 CALCULATION OF THE WAITING TIME

5.3.1 The waiting time clock for an AHP referral commences on the date the referral letter is received by the AHP service within the Trust. All referral letters, including faxed, emailed and electronically received referrals, will be date stamped on the date received.

5.3.2 The waiting time clock stops when the first definitive AHP treatment has commenced or when a decision is made that treatment is not required. Further information on definitions and sample patient pathways is contained in the Data Definitions and Guidance Document for AHP Waiting Times and can be found in **Appendix 12.**

5.3.3 As booking systems are introduced, patients should be made a reasonable offer, where clinically possible. Patients who refuse a reasonable offer of treatment, or fail to attend an AHP appointment, will have their waiting time clock re-set to the date the service was informed of the cancellation (CNAs) or the date the patient failed to attend (DNAs).

5.4 NEW REFERRALS

5.4.1 All AHP referrals will be registered on the relevant information system within 1 working day of receipt.

5.4.2 Trusts should work towards a system whereby all AHP referrals sent to the Trust are received at a dedicated registration function (s). Trusts should ensure that adequate systems are in place to deal with multiple referrals for the same patient regarding the same condition from a number of sources.

5.4.3 All referrals must be triaged or assessed to make a clear decision on the next step of a referral and clinical urgency (urgent or routine) clearly identified and recorded. All referrals will be prioritised and returned to the registration point with 3 working days.

5.4.4 Trusts must ensure that protocols are in place to prevent unnecessary delay from date stamping / logging of referrals to forwarding to the AHP department responsible for referral triage and/or initiation of treatment. It will be the responsibility of the relevant manager to monitor this performance indicator.

5.4.5 A robust system should be in place to ensure that cover is provided for referrals to be read and prioritised during practitioners' absence. A designated officer should oversee this and a protocol will be required for each service.

5.4.6 Where referrals can be reviewed less frequently than weekly, a process must be put in place and agreed with AHPs whereby the referrer's prioritisation is accepted in order to proceed with booking patients.

5.4.7 Following prioritisation, referrals must be updated on the relevant information system and appropriate correspondence issued to patients within 1 working day. Where there is insufficient information for the AHP to make a decision, they should contact the originating referrer in the first instance to access the

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

5.4.8 Trusts will work towards a system whereby the location of all letters can be tracked at all times through the referral and appointment system, and that letters sent to be prioritised and letters which are not returned can be identified.

5.4.9 If at the referral stage the patient / client is identified as being clinically or socially unfit to receive the necessary service the referral should not be accepted (not added to a waiting list) and returned to the originating referrer with a request that they re-refer the patient / client when they are clinically or socially fit to be treated.

5.5 URGENT AND ROUTINE APPOINTMENTS

5.5.1 All routine patients should be appointed within the maximum waiting time guarantee. Urgent patients must be booked within locally agreed maximum waits from the date of receipt. Local booking process should be based upon the principles outlined in Section 1.7.

5.5.2 For routine waiting list patients, an acknowledgement letter will be sent to patients within 5 working days of receipt of the referral, which should provide information to patients on their anticipated length of wait and details of the booking process.

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

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

5.6 CHRONOLOGICAL MANAGEMENT

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

5.7 CAPACITY PLANNING AND ESCALATION

5.7.1 It is important for AHP services to understand their baseline capacity, the make-up of the cohort of patients waiting to be treated and the likely changes in demand that will impact on their ability to initiate treatment and meet the maximum waiting time guarantees for patients.

5.7.2 Trusts should ensure that robust prospective capacity planning arrangements are in place, with clear escalation procedures to facilitate capacity gaps to be identified and solutions found in a timely manner to support operational booking processes and delivery of the targets.

5.8 REASONABLE OFFERS

5.8.1 As booking systems are introduced, patients should be offered reasonable notice, where clinically possible. A reasonable offer is defined as an offer of appointment, irrespective of provider, that gives the patient a minimum of three weeks notice and two appointments. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused. To ensure a verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

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

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

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

5.9 AHP SERVICE INITIATED CANCELLATIONS

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

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

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

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

5.10 MAXIMUM WAITING TIME GUARANTEE

5.10.1 If a patient requests an appointment date that is beyond the maximum waiting time guarantee, the patient will be discharged and advised to revisit their referrer when they are ready to be seen. This will ensure that all patients waiting for an AHP appointment / treatment are fit and ready to be seen.

5.10.2 There will undoubtedly be occasions and instances where local discretion is required and sensitivity should be applied when short periods of time are involved; for example, if patients are requesting dates up to a week over their breach date. Trusts should ensure that reasonableness is complied with to facilitate re-calculation of the patient's waiting time, and to facilitate booking the patient into the date they requested.

5.11 COMPLIANCE WITH LEAVE PROTOCOL

5.11.1 Capacity lost due to cancelled or reduced clinics or visits at short notice has negative consequences for patients and on the Trust's ability to successfully implement robust booking processes. Clinic cancellation and rebooking of appointments is an extremely inefficient way to use such valuable resources.

5.11.2 It is therefore essential that AHP practitioners and other clinical planned leave or absence is organised in line with an agreed Trust Human Resources (HR) protocol. Thus it is necessary for Trusts to have robust local HR policies and procedures in place that minimise the cancellation/reduction of AHP clinics and the work associated with rebooking patient appointments. There should be clear practitioner agreement and commitment to this HR policy. Where cancelling and rebooking is unavoidable the procedures used must be equitable, efficient and comply with clinical governance principles.

5.11.3 The protocol should require a minimum of six weeks' notification of planned leave, in line with locally agreed HR policies.

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

5.12 CLINIC OUTCOME MANAGEMENT

5.12.1 All patients will have their attendance recorded or registered on the relevant information system upon arrival for their appointment. The patient must verify their demographic details on every visit. The verified information must be cross-checked on information system and the patient records. Any changes must be recorded and updated in the patient record on the date of the clinic.

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

5.13 REVIEW APPOINTMENTS

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

5.13.2 Review patients who require an appointment within six weeks will negotiate the date and time of the appointment before leaving the service and PAS / information system updated. Patients requiring an appointment outside six weeks should be managed on a review waiting list, with the indicative date recorded when appointment is required and booked in line with the booking principles outlined.

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

5.14 CLINIC TEMPLATE MANAGEMENT

5.14.1 Clinic templates should be agreed between the practitioner and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement.

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

5.14.3 All requests for template and temporary clinic rule changes will only be accepted in writing to the relevant service manager. A minimum of six weeks notice will be provided for clinic template changes.

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

5.15 ROBUSTNESS OF DATA / VALIDATION

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

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

5.15.3 For patients in AHP services that are not yet booked, they will be contacted to establish whether they will still require their appointment.

SECTION 6 PROTOCOL GUIDANCE FOR MANAGEMENT OF ELECTIVE ADMISSIONS

6.1 INTRODUCTION

6.1.1 The following protocol is based on nationally recommended good practice guidelines to assist staff with the effective management of elective waiting lists.

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

6.2 COMPUTER SYSTEMS

6.2.1 To ensure consistency and the standardisation of reporting with Commissioners and the Department, all waiting lists are to be maintained in the PAS system.

6.2.2 Details of patients must be entered on to the computer system within two working days of the decision to admit being made. Failure to do this will lead to incorrect assessment of waiting list size when the daily / weekly downloads are taken.

6.2.3 As a minimum 3 digit OPCS codes should be included when adding a patient to a waiting list. Trusts should work towards expanding this to 4 digit codes.

6.3 CALCULATION OF THE WAITING TIME

6.3.1 The starting point for the waiting time of an inpatient is the date the consultant agrees with the patient that a procedure will be pursued as an active treatment or diagnostic intervention, and that the patient is medically fit to undergo such a procedure.

6.3.2 The waiting time for each inpatient on the elective admission list is calculated as the time period between the original decision to admit date and the date

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

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

6.4 STRUCTURE OF WAITING LISTS

6.4.1 To aid both the clinical and administrative management of the waiting list, lists should be sub-divided into a limited number of smaller lists, differentiating between active waiting lists, planned lists and suspended patients.

6.4.2 Priorities must be identified for each patient on the active waiting list, allocated according to urgency of the treatment. The current priorities are urgent and routine.

6.5 INPATIENT AND DAY CASE ACTIVE WAITING LISTS

6.5.1 Inpatient care should be the exception in the majority of elective procedures. Trusts should move away from initially asking “is this patient suitable for day case treatment?” towards a default position where they ask “what is the justification for admitting this patient?” The Trust’s systems, processes and physical space should be redesigned and organized on this basis.

6.5.2 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to admit, i.e. if there was a bed available tomorrow in which to admit a patient they are fit, ready, and able to come in.

6.5.3 All decisions to admit will be recorded on PAS within two working days of the decision to admit being taken.

6.5.4 Robust booking and scheduling systems will be developed to support patients having a say in the date and time of their admission. Further guidance will be provided on this.

6.5.5 Where a decision to admit depends on the outcome of diagnostic investigation, patients should not be added to an elective waiting list until the outcome of this investigation is known. There must be clear processes in place to ensure the result of the investigation is timely and in accordance with the clinical urgency required to admit the patient.

6.5.6 The statements above apply to all decisions to admit, irrespective of the decision route, i.e. direct access patients or decisions to directly list patients without outpatient consultation.

6.6 COMPLIANCE WITH TRUST HR LEAVE PROTOCOL

6.6.1 Trusts should have in place a robust protocol for the notification and management of medical and clinical leave and other absence. This protocol should include a proforma for completion by or on behalf of the consultant with a clear process for notifying the theatre scheduler of leave / absence.

6.6.2 The protocol should require a minimum of six weeks' notification of intended leave, in line with locally agreed consultant's contracts.

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

6.7 TO COME IN (TCI) OFFERS OF TREATMENT

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

6.7.2 Patients should be made reasonable offers to come in on the basis of clinical priority. Within clinical priority groups offers should then be made on the basis of the patient's chronological wait.

6.7.3 All patients must be offered reasonable notice. A reasonable offer is defined as an offer of admission, irrespective of provider, that gives the patient a minimum of three weeks' notice and two TCI dates. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date of the refused admission.

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

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

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

6.8 SUSPENDED PATIENTS

6.8.1 A period of suspension is defined as:

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

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

- A maximum period not exceeding 3 months.

6.8.2 At any time a consultant is likely to have a number of patients who are unsuitable for admission for clinical or social reasons. These patients should be suspended from the active waiting list until they are ready for admission. All patients who require a period of suspension will have a personal treatment plan agreed by the consultant with relevant healthcare professionals. One month prior to the end of the suspension period, these plans should be reviewed and actions taken to review patients where required.

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

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

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

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

6.8.7 No patient should be suspended from the waiting list without a review date. All review dates must be 1st of the month to allow sufficient time for the patient to be treated in-month to avoid breaching waiting times targets.

6.8.8 No more than 5% of patients should be suspended from the waiting list at any time. This indicator should be regularly monitored.

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

6.9 PLANNED PATIENTS

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

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

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

6.9.4 Ideally, children should be kept under outpatient review and only listed when they reach an age when they are ready for surgery. However, where a child has been added to a list with explicit clinical instructions that they cannot have surgery until they reach the optimum age, this patient can be classed as planned. The Implementation Procedure for Planned Patients can be found in **Appendix 13.**

6.10 CANCELLATIONS AND DNA'S

6.10.1 Patient Initiated Cancellations

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

6.10.2 Patients who DNA

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

- Where a patient has had an opportunity to agree the date and time of their admission, they will not normally be offered a second admission date.

- Under exceptional circumstances a clinician may decide that a patient should be offered a second admission. The second admission date must be agreed with the patient.

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

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

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

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

6.10.7 Trusts should aim to have processes in place to have the new proposed admission date arranged before the patient is informed of the cancellation.

6.10.8 The patient should be informed in writing of the reason for the cancellation and the date of the new admission. The correspondence should include an explanation and an apology on behalf of the Trust.

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

6.10.10 Where patients are cancelled on the day of surgery as a result of not being fit for surgery / high anaesthetic risk, they will be suspended, pending a clinical review of their condition either by the consultant in outpatients or by their GP. The patient should be fully informed of this process.

6.10.11 Hospital-initiated cancellations will be recorded and reported to the relevant department on a monthly basis.

6.11 PERSONAL TREATMENT PLAN

6.11.1 A personal treatment plan must be put in place when a confirmed TCI date has been cancelled by the hospital, a patient has been suspended or is simply a potential breach. The plan should:

- Be agreed with the patient
- Be recorded in the patient's notes
- Be monitored by the appropriate person responsible for ensuring that the treatment plan is delivered.

6.11.2 The listing clinician will be responsible for implementing the personal treatment plan.

6.12 CHRONOLOGICAL MANAGEMENT

6.12.1 The process of selecting patients for admission and subsequent treatment is a complex activity. It entails balancing the needs and priorities of the patient and the Trust against the available resources of theatre time and staffed beds.

6.12.2 The Booking Principles outlined in Section 1.7 should underpin the development of booking systems to ensure a system of management and monitoring that is chronologically as opposed to statistically based.

6.12.3 It is expected that Trusts will work towards reducing the number of prioritisation categories to urgent and routine.

6.13 PRE-OPERATIVE ASSESSMENT

6.13.1 All patients undergoing an elective procedure (including endoscopy procedures) must undergo a pre-operative assessment. This can be provided using a variety of methods including telephone, postal or face to face assessment. Please refer to the Design and Deliver Guide 2007 for further reference.

6.13.2 Pre operative assessment will include an anaesthetic assessment. It will be the responsibility of the pre-operative assessment team, in accordance with protocols developed by surgeons and anaesthetists, to authorise fitness for surgery.

6.13.3 If a patient is unfit for their operation, their date will be cancelled and decision taken as to the appropriate next action.

6.13.4 Only those patients that are deemed fit for surgery may be offered a firm TCI date.

6.13.5 Pre-operative services should be supported by a robust booking system.

6.14 PATIENTS WHO DNA THEIR PRE OPERATIVE ASSESSMENT

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

6.15 VALIDATION OF WAITING LISTS

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

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

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

6.16 PATIENTS LISTED FOR MORE THAN ONE PROCEDURE

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

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

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

6.17 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

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

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

Department of
Health, Social Services and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

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INTEGRATED ELECTIVE ACCESS PROTOCOL
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CONTENTS

ABBREVIATIONS

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

SECTION 1

CONTEXT

1.1 INTRODUCTION

1.1.1 This protocol has been developed to encompass the elective pathway within a hospital environment. The principles can be applied to primary and community settings, however it is recommended that guidance is developed which recognises the specific needs of the care pathway provided in these settings.

1.1.2 The length of time a patient needs to wait for elective treatment is an important quality issue and is a visible public indicator of the efficiency of the hospital services provided by the Trust. The successful management of patients who wait for outpatient assessments, diagnostic investigations and elective inpatient or day case treatment is the responsibility of a number of key individuals within the organisation. General Practitioners, commissioners, hospital medical staff, managers and clerical staff have an important role in ensuring access for patients in line with maximum waiting time guarantees, managing waiting lists effectively, treating patients and delivering a high quality, efficient and responsive service. Ensuring prompt timely and accurate communications with patients is a core responsibility of the hospital and the wider local health community.

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

1.1.4 This protocol will be updated, as a minimum, on an annual basis to ensure that Trusts' polices and procedures remain up to date, and reflect best practice locally and nationally. Trusts will ensure a flexible approach to getting patients treated, which will deliver a quick response to the changing nature of waiting lists, and their successful management.

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

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

1.1.7 There is an imperative to identify capacity constraints that could threaten the delivery of these key access targets and speed up the planning and delivery of extra capacity, where it is needed, to address these constraints. The health community will need to develop a co-ordinated approach to capacity planning taking into account local capacity on a cross Trust basis and independent sector capacity on an on-going partnership basis.

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

1.1.9 The intention is that this protocol will be further developed to consider all aspects of access to a range of quality healthcare at a date and time of the patients' choice.

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

1.1.11 Delivery of this protocol will require a step change in the way Trusts function. Trusts will need to transform themselves and this can only be achieved through a change in the way its staff approach their work on a day-to-day basis. Through this protocol, Trusts will aspire to work with patients and staff to raise expectations basing them not on where we are but on where we need to be.

1.1.12 For the purposes of this protocol, the term inpatient refers to inpatient and day case elective treatment. The term 'PAS' refers to all patient

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

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

1.2 UNDERPINNING PRINCIPLES

1.2.1 Patients will be treated on the basis of their clinical urgency with urgent patients seen and treated first. The definition of clinical urgency will be defined specifically by specialty / procedure / service.

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

1.2.3 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to admit, i.e. if there was a bed available tomorrow in which to admit a patient - they are fit, ready, and able to come in.

1.2.4 Trusts should design processes to ensure that inpatient care is the exception for the majority of elective procedures, not the norm. The principle is about moving care to the most appropriate setting, based on clinical judgement. This means moving day case surgery to outpatient care, and outpatient care to primary care or alternative clinical models where appropriate.

1.2.5 Change No 1 within the publication "10 High Impact Changes for Service Improvement and Delivery"[1] focuses on day surgery and the document provides Trusts with tools and resources to help implement this high impact change.

1.2.6 Trusts will introduce booking systems aimed at making hospital appointments more convenient for patients. Booking systems are chronologically based and will move Trusts onto a system of management and monitoring that is chronologically as opposed to statistically based.

1.2.7 As part of a plan for the implementation of booking, Trusts must ensure their elective admission selection system is managed on a chronological basis within clinical priority with immediate effect. The intention is to provide patients with certainty and choice enabling them to access services that are sensitive to their needs.

1.2.8 This will require changes in working practices. It will also require technological change to information systems to enable provision of quality information to support the booking process.

1.2.9 There is a need to balance the flow of patients from primary care through outpatients and on to booking schedules should they need elective admission. It follows that the level of activity in the Service and Budget Agreements and the level of provision of outpatient and inpatient capacity must be linked. If one changes, all should change.

1.2.10 This "bottom up" approach is based on the belief that services need to be built on firm clinical foundations. Trusts need a clinical vision built up specialty by specialty and department by department through debate and agreement between clinicians across the health community as to the best way to meet patient needs locally.

1.2.11 It is essential that patients who are considered vulnerable for whatever reason have their needs identified at the point of referral.

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

1.2.12 All relevant information must be recorded to ensure that when selecting a vulnerable patient for admission, their needs are identified early and appropriate arrangements made. This information should be recorded in detail in the episodic comment field of PAS relating to the listing. The patient master index comment field should not be used due to confidentiality issues.

1.2.13 Communication with this patient group will recognise their needs and, where appropriate, involve other agencies.

1.2.14 An operational process should be developed by Trusts to ensure that children and vulnerable adults who DNA or CNA their outpatient appointment are followed up by the most appropriate healthcare professional and a clear link to the referring clinician established.

1.2.15 In implementing this protocol the needs of ethnic groups and people with special requirements should be considered at all stages of the patient's pathway.

1.3 OWNERSHIP

1.3.1 Ownership is key to delivering quality of care. Trusts must ensure that all staff are conversant with the Departmental targets and standards and are comfortable with the local health communities' approach to their delivery.

1.3.2 These targets and standards must be seen to be core to the delivery of all aspects of care provision by all levels of staff within the Trust.

1.3.3 This is a major change agenda requiring significant commitment and investment at corporate and individual level. An Executive Director will take lead responsibility for ensuring all aspects of this Protocol are adhered to.

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

1.4 REGIONAL TARGETS

1.4.1 The targets in respect of elective treatments are:

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

1.5 DELIVERY OF TARGETS

1.5.1 The waiting time targets are based on the “worst case” i.e. they reflect the minimum standards with which every Trust must comply.

1.5.2 The expectation is that these targets are factored into plans at Trust Board, divisional, specialty and departmental levels as part of the normal business

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

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

1.6 CAPACITY

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

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

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

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

1.6.4 This information will enable Trusts to evaluate its waiting/booked lists in terms of theatre sessions (time in hours) and length of stay (time in bed days).

1.6.5 Each specialty should understand its elective bed requirements in terms of both inpatients and daycases, setting challenging daycase and LOS targets and agreeing plans to deliver them. In addition, systems must be developed to ensure assessment can be made of available capacity and flexible working arrangements developed accordingly.

1.6.6 Theatre sessions should be seen as corporate resources and used flexibly to ensure the delivery of waiting list and waiting time targets across consultants within the same specialty and specialties within the same Trust. This ties in with the Real Capacity Paper which also requires commissioners to demonstrate that they have used capacity flexibly across Trusts. The expectation is that divisions and/ or specialties will be able to demonstrate that they have optimised the use of existing capacity to maximise the treatment of patients within existing resources.

1.6.7 Trusts will treat patients on an equitable basis across specialties and managers will work together to ensure consistent waiting times for patients of the same clinical priority.

1.6.8 Trusts will set out to resource enough capacity to treat the number and anticipated casemix of patients agreed with commissioners. The Real Capacity Planning exercise will support this process locally.

1.6.9 Divisions/specialties will monitor referrals and additions to lists in terms of their impact on clinic, theatre time, bed requirements and other key resources e.g. ICU facilities, to ensure a balance of patients in the system and a balance between patients and resources.

1.6.10 When the balance in the system is disturbed to the extent that capacity is a constraint, divisional/specialty managers will be expected to produce plans

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

1.6.11 It is important for all services to understand their baseline capacity, the make-up of the cohort of patients waiting to be treated and the likely changes in demand that will impact on their ability to initiate treatment and meet the maximum waiting time guarantees for patients.

1.6.12 Trusts should ensure that robust prospective capacity planning arrangements are in place, with clear escalation procedures to facilitate capacity gaps to be identified and solutions found in a timely manner to support operational booking processes and delivery of the targets.

1.6.13 In summary, the intention is to link capacity to the Service and Budget Agreement i.e. to agree the plan, put in place the resources to achieve the plan, monitor the delivery of the plan and take corrective action in the event of divergence from the plan proactively. The existing arrangements whereby patients are added to waiting lists irrespective of whether Trusts have the capacity to treat them must change.

1.7 BOOKING PRINCIPLES

1.7.1 These booking principles have been developed to support all areas across the elective pathway where appointment systems are used.

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

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

1.7.4 Booking development work within Trusts should be consistent with regional and local targets, which provide a framework for progress towards ensuring successful and consistent booking processes across the health community in Northern Ireland.

1.7.5 All booking processes should be underpinned with the relevant local policies and procedures to provide clarity to operational staff of the day to day requirements and escalation route, for example: management of patients who cancel / DNA their appointment, process for re-booking patients, and monitoring of clinical leave and absence.

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

1.7.7 The definition of a booked appointment is:

a) The patient is given the choice of when to attend.
b) The patient is advised of the total waiting time during the consultation between themselves and the healthcare provider / practitioner or in correspondence from them.
c) The patient is able to choose and confirm their appointment within the timeframe relevant to the clinical urgency of their appointment
d) The range of dates available to a patient may reduce if they need to be seen quickly, e.g. urgent referrals or within 2 weeks if cancer is suspected.
e) The patient may choose to agree a date outside the range of dates offered or defer their decision until later

1.7.8 Booking Process

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

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

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

1.7.11 Principles for booking Cancer Pathway patients

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

1.7.12 Principles for booking Urgent Pathway patients

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

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

1.7.13 Principles for booking Routine Pathway patients

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

1.7.14 Principles for Booking Review Patients

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

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

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

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

SECTION 2

GUIDANCE FOR MANAGEMENT OF ICATS SERVICES

2.1 INTRODUCTION

2.1.1 The administration and management of ICATS referrals and ICATS requests for diagnostics must be consistent, easily understood, patient focused, and responsive to clinical decision-making.

2.1.2 ICATS services are managed in accordance with the Data Definitions and Guidance Document for Monitoring of ICATS Services Sept 2007 **(Appendix 1).**

2.1.3 The level of functionality available on the Electronic Referral Management System to support the administration of patients in an ICATS setting is developmental. Achievement of the standards outlined will be where functionality permits.

2.1.4 Referrals will be managed through a centralised registration process in the nominated Hospital Registration Offices (HRO's) within Trusts to receive, register and process all ICATS referrals. The Trust should ensure that a robust process is in place to ensure that referrals received outside the HRO are date stamped, forwarded to the HRO and registered onto ERMS according to the date received by the Trust.

2.1.5 All new patients should be able to book their appointment in line with the guidance outlined in Booking Principles Section 1.7 The expectation is that follow up patients should also be offered an opportunity to choose the date and time of their appointment.

2.2 KEY PRINCIPLES

2.2.1 Where ICATS is in place for a specialty, all referrals should be registered and scanned onto Electronic Referral Management System (ERMS) within 24 hours of receipt.

2.2.2 Each ICATS must have a triage rota to ensure that every referral is triaged and the appropriate next step is confirmed, according to the clinically agreed

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

2.2.3 The outcome of the triage will be confirmed by letters to the GP and patient within a further two working days of triage (five working days in total from receipt).

2.2.4 ICATS clinical staff will be aware of all exclusions that prevent patients from being assessed or treated within the ICATS setting**.**

2.2.5 Patients of equal clinical priority will be selected for booking in chronological order in order to meet the maximum waiting time guarantee for patients and local access standards.

2.2.6 All patients deemed appropriate will be offered an ICATS appointment within six weeks from the triage date.

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

2.2.8 Staff should be supported by appropriate training programmes.

2.3 CALCULATION OF THE WAITING TIME

2.3.1 The waiting time clock for ICATS starts after the triage decision has been taken that an appointment in ICATS clinic is the appropriate next step.

2.3.2 The ICATS clock stops when the patient attends for first appointment or when the patient has been discharged from ICATS.

2.3.3 Patients who cancel an appointment will have their waiting time clock reset to the date the hospital was informed of the cancellation. Patients who refuse a reasonable offer of an appointment will also have their waiting time clock reset to the date the reasonable offer was refused. To ensure the

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

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

2.3.4 No patient should have his or her appointment cancelled. If the ICATS service cancels a patient's appointment, the patient's waiting time clock will not be reset and the patient should be offered another appointment, ideally at the time of the cancellation, and which is within six weeks of the original appointment date.

2.4 NEW REFERRALS

2.4.1 All ICATS referrals will be registered and scanned onto ERMS within 24 hours of receipt. All referrals forwarded for ICATS triage must be triaged or assessed to make a clear decision on the next step of a referral within three working days of the referral being logged by the HRO onto ERMS.

2.4.2 Within five working days of the referral being recorded onto ERMS, the GP and patient must be issued with written confirmation of the next stage of the patient's treatment.

2.4.3 Where there is insufficient information for the professional to make a decision, they have the option to either return the referral to the referrer requesting the necessary information or contact the referrer in the first instance to access the necessary information. If this cannot be gained, the referral should be returned to the referrer requesting the necessary information and a new referral may be initiated.

2.4.4 Those patients identified for outpatients and diagnostic services following triage will be managed in line with the relevant sections of this IEAP.

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

2.5 BOOKING

2.5.1 All patients requiring an appointment in an ICATS will have the opportunity to agree the date and time of their appointment, in line with the booking principles outlined in Section 1.7.

2.5.2 If a patient requests an appointment beyond the six week ICATS standard the patient will be discharged and told to revisit their GP when they are ready to be seen at the ICATS clinic. This will ensure that all patients waiting for an ICATS appointment are fit and ready to be seen. It is accepted that local discretion may be required where short periods of time are involved, for example, if patients are requesting dates up to a week over their breach date. Trusts should ensure that reasonableness is complied with to facilitate recalculation of the patient's waiting time and to facilitate booking the patient into the date they requested.

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

2.6 REASONABLE OFFERS

2.6.1 All patients must be offered reasonable notice. A reasonable offer is defined as an offer of appointment, irrespective of provider, that gives the patient a minimum of three weeks' notice and two appointments. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date of the second appointment date declined.

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

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

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

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

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

- Where a patient has had an opportunity to agree the date and time of their appointment, they will not normally be offered a second appointment. These patients will be referred back to the care of their referring clinician.

- Under exceptional circumstances a clinician may decide that a patient should be offered a second appointment. The second appointment must be booked.

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

- The patient will be given a second opportunity to book an appointment, which should be within six weeks of the original appointment date.

- If a second appointment is cancelled, the patient will not normally be offered a third opportunity and will be referred back to their referring clinician.

2.7.3 If a patient has been referred back to their referring clinician and the referrer still wishes a patient to be seen in ICATS, a new referral is required.

2.7.4 The Implementation Procedure for the Management of Patients who DNA or Cancel can be found in **Appendix 4.**

2.8 MAXIMUM WAITING TIME GUARANTEE

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

2.9 COMPLIANCE WITH TRUST LEAVE PROTOCOL

2.9.1 It is essential that leave/absence of ICATS practitioners is organised in line with Trusts' notification of leave protocol. It is also necessary for Trusts to have robust policies and procedures that minimise the cancellation/reduction of ICATS clinics.

2.9.2 The protocol should require a minimum of six weeks' notification of intended leave. A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

2.10 CLINIC OUTCOME MANAGEMENT

2.10.1 There are a number of locations within Trusts where patients present for their ICATS consultation. This protocol applies to all ICATS locations. It is the responsibility of the ERMS user managing the attendance to maintain data quality.

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

2.10.3 When the assessment has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on ERMS.

2.11 REVIEW APPOINTMENTS

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

2.11.2 As previously stated, the Booking Centres will be responsible for partially booking all new appointments. Booking Centres will also book review appointments that are required to be more than 6 weeks in the future. ICATS administration staff will make bookings directly with the patient at the clinic for any further appointments needing to occur within 6 weeks.

2.12 TEMPLATE CHANGES

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

2.12.2 Templates will identify the number of slots available for new and follow up appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated to each appointment slot.

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

2.12.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager. The Implementation Procedure for management of Clinic Template Changes can be found in **Appendix 5.**

2.13 VALIDATION

2.13.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. Trusts should ensure that all relevant data fields are completed in ERMS. This should be undertaken as a minimum on a monthly basis and ideally on a weekly basis as waiting times reduce.

2.13.2 The data validation process will apply to both new and follow up appointments. The Implementation Procedure for data validation can be found in **Appendix 6.**

SECTION 3

GUIDANCE FOR MANAGEMENT OF OUTPATIENT SERVICES

3.1 INTRODUCTION

3.1.1 The following protocol is based on nationally recommended good practice guidelines to assist staff with the effective management of outpatient services.

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

3.1.3 There will be dedicated Hospital Registration Offices (HROs) within Trusts to receive, register and process all outpatient referrals. The HROs will be required to register and scan referrals (where appropriate) onto the Electronic Referrals Management System (ERMS) and PAS.

3.1.4 There will be dedicated booking functions within Trusts and all new and review outpatients should have the opportunity to book their appointment. The booking process for non-routine groups of outpatients or those with additional service needs should be designed to identify and incorporate the specific pathway requirements of these patients.

3.2 CALCULATION OF THE WAITING TIME

3.2.1 The starting point for the waiting time of an outpatient new referral is the date the clinician's referral letter is received by Trusts. All referral letters, including faxed, emailed and electronically delivered referrals, will be date stamped on the date received into the organisation.

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

3.2.2 Patients who cancel an appointment will have their waiting time clock reset to the date the hospital was informed of the cancellation. Patients who

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

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

3.3 KEY PRINCIPLES

3.3.1 Referrals into Trusts should be pooled where possible within specialties. Referrals to a specific consultant by a GP should only be accepted where there are specific clinical requirements or stated patient preference. As a minimum, all un-named referrals should be pooled.

3.3.2 All referrals, appointments and waiting lists should be managed according to clinical priorities. Priorities must be identified for each patient on the waiting list, allocated according to urgency of the treatment. Trusts will manage patients in 2 streams, i.e. urgent and routine. Templates should be constructed to ensure enough capacity is available to treat each stream within agreed maximum waiting time guarantees. The Implementation Procedure for Template Redesign can be found in **Appendix 7.**

3.3.3 The regional target for a maximum OP waiting time is outlined in Section 1.4. Maximum waiting times for urgent patients should be agreed locally with clinicians.

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

3.3.5 Patients of equal clinical priority will be selected for booking in strict chronological order. Trusts must ensure that Department waiting and booking targets and standards are met.

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

3.3.7 Trusts should provide training programmes for staff which include all aspects of this IEAP and its Implementation Procedures. It is expected that training will be cascaded at and by each clinical, managerial or administrative tier within Trusts, providing the opportunity where required, for staff to work through operational scenarios.

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

3.4 NEW REFERRALS

3.4.1 All outpatient referrals sent to Trusts will be received at the dedicated HRO's and registered within one working day of receipt. GP priority status must be recorded at registration.

3.4.2 Trusts will work towards a system whereby the location of all letters can be tracked at all times through the referral and appointment system, and that letters sent to be prioritised and which are not returned can be identified.

3.4.3 All referrals must be prioritised and clinical urgency must be clearly identified. Clinicians will be responsible for ensuring that cover is provided for referrals to be read and prioritised during their absence. A designated officer should oversee this and a protocol will be required for each department.

3.4.5 All outpatient referrals letters will be prioritised and returned to the HRO within 3 working days. It will be the responsibility of the health records

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

3.4.6 Where clinics take place, or referrals can be reviewed less frequently than weekly, a process must be put in place and agreed with clinicians whereby GP prioritisation is accepted in order to proceed with booking urgent patients.

3.4.7 Inappropriate and inadequate referrals should be returned to the referral source. A minimum referral criteria dataset has been agreed and is outlined in **Appendix 8**

3.4.8 An Effective Use of Resources Policy is in place for some services and Trusts should ensure that this is adhered to. The policy is included for reference in **Appendix 9.**

3.5 URGENT AND ROUTINE APPOINTMENTS

3.5.1 All consultant led outpatient appointments where the patient attends the Trust should be booked. The key requirements are that the patient is directly involved in negotiating the appointment date and time, and that no appointment is made more than six weeks into the future.

3.5.2 All routine patients must be booked within the maximum waiting time guarantee. Urgent patients must be booked within the maximum wait agreed locally with clinicians, from the date of receipt. It is recognised that there will be occasional exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Trusts should ensure that when accommodating these patients, the appointment process is robust and clinical governance requirements met.

3.5.3 Acknowledgment letters will be sent to routine patients within five days of receipt of the referral. The estimated length of wait, along with information on

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

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

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

3.6 BOOKING

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

3.7 REASONABLE OFFERS

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

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

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

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

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

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

- Where a patient has had an opportunity to agree the date and time of their appointment, they will not normally be offered a second appointment. These patients will be referred back to the care of their referring clinician.

- Under exceptional circumstances a clinician may decide that a patient should be offered a second appointment. The second appointment must be booked.

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

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

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

- The patient will be given a second opportunity to book an appointment, which should be within six weeks of the original appointment date.

- If a second appointment is cancelled, the patient will not normally be offered a third opportunity and will be referred back to their referring clinician.

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

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

3.9 MAXIMUM WAITING TIME GUARANTEE

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

3.10 COMPLIANCE WITH LEAVE PROTOCOL

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

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

3.10.2 It is essential that planned medical and other clinical leave or absence is organised in line with an agreed Trust Human Resources (HR) protocol. Thus it is necessary for Trusts to have robust local HR policies and procedures in place that minimise the cancellation/reduction of outpatient clinics and the work associated with the rebooking of appointments. There should be clear medical and clinical agreement and commitment to this HR policy. Where cancelling and rebooking is unavoidable the procedures used must be equitable, efficient, comply with clinical governance principles and ensure that maximum waiting times for patients are not compromised.

3.10.3 The protocol should require a minimum of six weeks' notification of intended leave, in line with locally agreed HR policies.

3.10.4 A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit. The Implementation Procedure for Compliance with Leave Protocol can be found in **Appendix 10.**

3.11 CLINIC OUTCOME MANAGEMENT

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

3.11.2 All patients will have their attendance registered on PAS upon arrival in the clinic. The patient must verify their demographic details on every visit. The verified information must be cross-checked on PAS and the medical records.

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

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

3.12 REVIEW APPOINTMENTS

3.12.1 All review appointments must be made within the time frame specified by the clinician. If a review appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the consultant. Trusts should actively monitor patients on the review list to ensure that they do not go past their indicative month of treatment and take the necessary action to ensure capacity is available for this cohort.

3.12.2 Review patients who require an appointment within six weeks will negotiate the date and time of the appointment before leaving the department and PAS updated. Patients requiring an appointment outside six weeks will be placed on a review waiting list, with the indicative appointment date recorded, and be booked in line with implementation guidance for review pathway patients.

3.13 CLINIC TEMPLATE CHANGES

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

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

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

3.13.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager. The Implementation Procedure for the management of Clinic Template Changes can be found in **Appendix 5.**

3.14 VALIDATION

3.14.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a weekly basis and continually reviewed as waiting times reduce. This is essential to ensure PTLs are accurate and robust at all times. The Implementation Guidance for Data Validation can be found in **Appendix 6.**

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

3.14.3 For patients in specialties that are not yet booked, they will be contacted to establish whether they will still require their appointment.

3.15 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

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

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

SECTION 4

PROTOCOL GUIDANCE FOR MANAGEMENT OF DIAGNOSTIC SERVICES

4.1 INTRODUCTION

4.1.1 The following protocol is based on nationally recommended good practice guidelines to assist staff with the effective management of diagnostic waiting lists. Where possible, the principles of good practice outlined in the Outpatient and Elective Admissions Section of this document should be adopted in order to ensure consistent standards and processes for patients as they move along the pathway of investigations, assessment and treatment. This section aims to recognise areas where differences may be encountered due to the nature of specific diagnostic services.

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

4.1.3 There will be a centralised registration process within Trusts to receive, register and process all diagnostic referrals. It is expected that this will be in a single location, where possible.

4.1.4 The Trust should work towards introducing choice of the date and time of tests to all patients. The Booking Principles outlined in Section 1 of this document should be considered in the development of this strategy.

4.2 CALCULATION OF THE WAITING TIME

4.2.1 The starting point for the waiting time of a request for a diagnostic test is the date the clinician's request is received into the department, in line with the guidance on Completing Diagnostic Waiting Times Collection (Definitions Document), September 2007. This can be found in **Appendix 14.** All referral letters and requests, including faxed, emailed and electronically delivered referrals, will be date stamped on the date received.

4.2.2 Patients who cancel an appointment will have their waiting time clock reset to the date the service was informed of the cancellation.

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

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

4.3 KEY PRINCIPLES

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

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

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

4.3.4 Staff should be supported by appropriate training programmes.

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

4.4 NEW DIAGNOSTIC REQUESTS

4.4.1 All diagnostic requests sent to Trusts will be received at a single location within the specialty Department. Trusts should explore the setting of one centralised diagnostic registration centre.

4.4.2 All requests will be registered on PAS / relevant IT system within one working day of receipt. Only authorised staff will have the ability to add, change or remove information in the outpatient module of PAS or other diagnostic system.

4.4.3 Trusts will work towards a system whereby the location of all letters can be tracked at all times through the referral and appointment system and that letters sent for prioritisation and not returned can be identified. Trusts should consider the introduction of clinical tracking systems similar to that used in patient chart tracking.

4.4.4 All requests must be prioritised and clinical urgency must be clearly identified. Clinicians will be responsible for ensuring that cover is provided for requests to be read and prioritised during their absence. A designated officer should oversee this and a protocol will be required for each department.

4.4.5 All requests will be prioritised and returned to the central registration point within 3 working days. It will be the responsibility of the health records manager or departmental manager to monitor this performance indicator. Monitoring on a consultant level will take place by consultant on a monthly basis. Following prioritisation, requests must be actioned on PAS / IT system and appropriate correspondence issued to patients within 1 working day.

4.4.6 Where clinics take place, or requests can be reviewed less frequently than weekly, a process must be put in place and agreed with clinicians whereby the GP's priority is accepted in order to proceed with booking urgent patients.

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

4.5 URGENT AND ROUTINE APPOINTMENTS

4.5.1 All requests must be booked within the maximum waiting time guarantee. The key requirement is that the patient is directly involved in negotiating the date and time of the appointment and that no appointment is made more than six weeks in advance.

4.5.2 Urgent requests must be booked within locally agreed maximum waits from the date of receipt. It is recognised that there will be exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Trusts should ensure that when accommodating these patients, the appointment process is robust and clinical governance requirements met.

4.5.3 All routine patients must be booked within the maximum waiting time guarantee. Acknowledgement letters will be issued to routine patients within 5 working days of receipt of request. The estimated wait, along with information on how the patients will be booked should be included on the acknowledgement letter.

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

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

4.6 CHRONOLOGICAL MANAGEMENT

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

4.6.2 It is expected that Trusts will use two prioritisation categories; urgent and routine.

4.7 BOOKING METHODS

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

4.8 REASONABLE OFFERS

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

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

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

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

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

4.9.1 If a patient DNAs their diagnostic test, the following process must be implemented.

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

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

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

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

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

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

4.10 TRANSFERS BETWEEN HOSPITALS

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

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

4.11 COMPLIANCE WITH TRUST LEAVE PROTOCOL

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

4.11.2 It is therefore essential that leave/absence is organised in line with the Trust's Human Resources leave protocol. It is necessary for Trusts to have robust policies and procedures that minimise the cancellation/reduction of diagnostic sessions and the work associated with the rebooking of appointments. Where cancelling and rebooking is unavoidable the procedures used must be equitable and comply with clinical governance principles.

4.11.3 The local absence/leave protocol should require a minimum of six weeks' notification of intended leave, in line with locally agreed policies.

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

4.12 SESSION OUTCOME MANAGEMENT

4.12.1 There are a number of locations within Trusts where patients present for their diagnostic tests. This protocol applies to all diagnostic services. It is the responsibility of the PAS / relevant system user administrating the clinic to maintain data quality.

4.12.2 All patients will have their attendance registered on PAS / IT system upon arrival at the clinic. The patient must verify their demographic details on every visit. The verified information must be cross-checked on PAS / IT system and the medical record.

4.12.3 Changes in the patient's details must be updated on PAS / IT system and the medical record on the date of clinic.

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

4.13.1 DIAGNOSTIC TEST OUTCOME

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

4.14 FOLLOW UP APPOINTMENTS

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

4.14.2 Where follow up appointments are not booked, patients who require a review within six weeks will negotiate the date and time of this appointment before leaving the department and PAS / IT system updated. Patients requiring an appointment outside six weeks will have their appointment managed through a 'hold and treat' system. They will be managed on a review waiting list, with an indicative date of treatment and sent a letter confirming their appointment date six weeks in advance.

4.15 TEMPLATE CHANGES

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

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

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

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

4.16 VALIDATION

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

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

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

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

4.17 PLANNED PATIENTS AND DIAGNOSTICS TESTS CLASSIFIED AS DAY CASES

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

4.18 PLANNED PATIENTS

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

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

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

4.19 HOSPITAL INITIATED CANCELLATIONS

4.19.1 No patent should have his or her admission cancelled. If Trusts cancel a patient's admission, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity, which should must be within the maximum waiting time guarantee.

4.19.2 Trusts should aim to have processes in place to have the new proposed admission date arranged before that patient is informed of the cancellation.

4.19.3 The patient should be informed in writing of the reason for the cancellation and the date of the new admission. The correspondence should include an explanation and an apology on behalf of the Trust.

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

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

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

4.20 PATIENTS LISTED FOR MORE THAN ONE DIAGNOSTIC TEST

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

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

4.20.3 Where a patient requires more than one test carried out on separate occasions by different (or the same) clinician, the patient should be placed on the active waiting list for the first test and on the planned waiting list for any subsequent tests.

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

SECTION 5

GUIDANCE FOR MANAGEMENT OF ALLIED HEALTH PROFESSIONAL (AHP) SERVICES