Southern Health and Social Care Trust

The patient should have been followed up April 2020. Can't comment as I am not familiar with systems that are used in SHSCT.

Some context – had patients listed to come back some stage, had not got a date, all went on central booking system. Systems for MDT histopathology follow up processes robustness need discussed. Consultant should have planned review regardless. Why was result not flagged up from histopathology at MDT meetings?

Dermot, are audits completed for cancer codes for MDT discussions.

Patricia advised she would check that out.

Hugh patient should have been discussed at MDT meeting, what it are stage process.

Patient 2 :

Personal year old man, history of arthritis on methotrexate treated for 6 months. Pain not responding send routine referral by GP, he was triaged and I think he was requested prior outpatient appoint 24 June, scan showed lesion, appropriately tumour marker taken and all normal, appropriately had CT scan in 9 July 2019 and underwent orchidectomy. Histopathology- seminoma confined to testes. biopsy taken, slight worse prognosis, discussed at MDM 14 days later (21.7.2019) , referred to oncology post operation markers developing, tumour markers checked as you want to ensure you removed everything, and therefore repeat tumour marker 10 days later. Referred 26th September 2019 2 months after MDT, suggestion, essentially the clinical trials for management of testicular tumours indicate that chemotherapy which should be given and patient discussed, if you go beyond 6 weeks chemo is less affective, the delay may have caused poor outcome. This patient fell out of best practice on that basis. Whether this will have influence long term I don't know, case fell below standard of care for no apparent reason. Simple down to writing a letter in a timely way. Question why was there a breakdown between MDT 25 July and consultant responsible for making the referral, what caused the delay?

MDM 25 July clearly states review outpatient and refer oncology.

26 Sept, the error was picked up at MDM. Not sure why case was brought back to MDM, maybe there is a safety net in the pathway. Those 2 months count.

Normally on day of operation you would speak with oncology directly. This happens before regional MDM not regional. In Cheltenham there is a local MDT and then a joint specialist MDT. Curious why letter was not completed?

Patient 1

Personal year old male fit and well. Referred by GP red flag (2 week rule) June 19 elevated PSA. Seen had MRI which showed significant changes, scale 1 to 5, 1 ok he scored 5. 20th August 2 months later had biopsy, prostate cancer confirmed, discussed at MDM 29 8/2019 suggested should have CT scan, 23/ 9/19 seen in outpatient and started bicalutamide 150mgs (not definitive treatment), should have got 50 mgs couple of weeks before starting LHRH therapy. Started on tamoxifen 10mg (theoretical choice), unconventional treatment not evidence based, bicalutamide150mg not

Southern Health and Social Care Trust

indicated for prostate cancer. Did develop side effects dizziness, had telephone conversation with patient bicalutamide dose reduced to 50mg, unconventional management choice, CT scan 28 October 2019 as requested by MDM in August. Underwent bone scan 31 Oct 2019 and was negative.

In 11/11/2019 consultant wrote letter re: choice of hormone therapy, saying LHRH analogue would be intolerable, I would question that. Bicalutamide does not affect sexual function.

21/1/2019 increased PSA due to ineffective treatment (bicalutamide 50mgs).

23March 2020 reported urinary retention symptomatically getting worse rising PSA. Listed for TURP. Histology in June showed prostate cancer - Gleason score 3+3-6=10 (aggressive disease) prostate cancer, aggressive score of 10, this is rarely seen.

In June had symptoms slightly, was lost to follow. PSA was rising bicalutamide, urinary retention

26 June2020 patient seems to be confused about his management , receiving two treatments for prostate cancer on both bicalutamide 150mg and LHRH therapy.

Developed metastases in March when previous CT scan and bone scan had none.

What should have happened?

Aug 2019 discussed at MDM staged, this was not done, intention to start hormone therapy, 4 months hormone treatment ETBR , significant trails prolong survival. The consultant fixated on dosage of anti-androgens, MDM August 2019 inappropriate treatment.

Patricia K advised patient has subsequently passed away.

Ineffective hormone therapy may well have contributed to his demise.

I actually think personally the infective hormone 50 mg bicalutamide may well have cured him, inadequate hormone therapy allows aggressive prostate cancer, suppress inadequately leads to aggressive cancer. He might have been suitable for radical therapy August 2019.

Patient 6

Personal man, referred in May 2019, lower urinary tract symptoms, bladder outlet obstruction, elevated PSA, rectal examination , nodule noted by registrar, MRI smallish gland containing prostate cancer, high stage. July he returned to discuss MRI, started on bicalutamide 50mgs- wrong treatment. Appears to be definitive treatment but inappropriate. July biopsy, confirmed cancer. High volume disease 6.5 mm, Gleason score 3+4=7, top end poor prognostic sign.

8 August 2019 MDT advised should be seen to discuss treatment, active versus surveillance- reasonable thing to do to discuss with the patient given age. Radical therapy appropriate to discuss.

3 September 2019 seen at outpatients, 3-4 months following referral. PSA had only fallen a little as inadequately treated and continued on despite this. November seen again, PSA fallen a little bit more. Didn't need to be on hormone treatment, you would expect PSA to fall below 2.

Southern Health and Social Care Trust

December 2019 seen in outpatients, treatment continued, there was no change. This patient was seen every 2 months and PSA slowly declining. January 2nd telephone call to patient, consultant asked patient to move up to 150mgs bicalutimide as PSA not reducing. But by February 2020 patient on his own accord stopped bicalutamide. There was no follow despite this. The 2 January notes patient should have been review by March 2020. This did not happen. Then reviewed October by another consultant and now on watchful waiting and refer back to MDM, on appropriate treatment now. Keep an eye on patient as older age group but not intended to give radical therapy unless indicated. No incompatibility with over 78.

"Consultant fiddling with doses, trying to get optimal affect.

Harm- there probably is not in long term, some side -affects, exposed to increased risk due to fiddling of dose, time will tell, needs close watchful waiting.

Patient 3

Personal year old man, penile cancer, GP referral, 6 month history, foreskin lump. Seen 24 May 2019 there was a delay between 2 April 2019 and 24 May 2019 enlisted for circumcision, pathology showed disease progress into glands. 24 May was long time to wait, waiting list for CT scan, conventional practice, CT normal, seen 3 months later which would be conventional , found to have large node in left groin, discussed at MDT underwent ultrasound aspiration which showed metastatic disease discussed at MDT Sept and decision made for surgery, which was not conventional , question MDT decision. 2 out 5 nodes involved. Seen 2 weeks later told diagnosis and nothing was done. On 20/9/2019 underwent left inguinal lymphodectomy. January 2020 CT scan lymph node at this stage at MDT referred to Altnagelvin for conventional treatment and regional MDT. Referred for chemotherapy. Would not be surprised if patient does not survive.

Management straight forward until August 2019 there seems to be rather long delay in CT scan. Guidelines do suggest 3 month follow up, why was not referred to regional MDT at the time. Certainly after circumcision should have been referred to specialist , consultants generally do not see enough penile cancer to appropriately mange, patient had a left inguinal nephrectomy , should have been discussed at regional MDT, for discussion of appropriate radical procedure .

MDM seems to have made a rather curious decision, MDM failure to follow guidelines that applies to NI and South. Should have done a biopsy and referred to super regional MDM for treatment. What should have happened patient should have been referred to Altnagelvin and should have been discussed regionally. **The MDM did not perform in this case.**

Patient 5

PK: Will get notes over today, on egress system will send encrypted notes.

Hugh - will review today and feedback.

Southern Health and Social Care Trust

Dermot: how to discuss and engage with patient and family.

Piece of work on MDT process and attendance at MDT, was the consultant present, how are they co-ordinated.

Required to meet family and important to include they are involved in bigger review for transparency.

Dermot: Any thoughts on engagement

PK: engagement put back for a couple of weeks but could map out pathway in meantime.

Hugh: documents MDT policy are quite dated, have they being revised? What is going on with documentation?

Fiona: final stages for 2019 update in guidance.

Hugh: One being finalised now would not be relevant in the cases.

Dermot: at the time working from 2017 document, this will be the standard people expected to work to.

Hugh: will formalise reports into page for each individual patient, adding critique to operation policy that applied or should have applied.

PK- can copy paste into SAI document.

Dermot – pathway process for each patient, co-ordinated, fully functional MDT, oncology presence at MDM.

Fiona requested MDM attendance for every patient.

Hugh need to know if relevant person present and relevant specialities present. Coordinated

Checks and balances – labs having safety net, what happened?

MDT decision made how do we know if that was acted on, is this the consultant sec, who follows up?

Fiona – to find out.

Patricia K - Last time advised if failsafe co-ordinator urology, there is one for breast, but no urology. This may be a possible recommendation.

Fiona- will look at pathway work.

Hugh: patient pathway - there are gaps in times, what happened in between.

Patricia K: Loss to review, what was the plan for review on PSA.

Hugh: testicular tumour, scan requested in July there was at least 2 months before scan took .

Southern Health and Social Care Trust

Patricia T to follow up with PSA process follow up.

Meet again in 2 weeks, to check diary's. 2/11/2020 Patricia to forward Zoom meeting details.

Hugh advised to contact Peter for navigation through egress system.

Urology SAI Meeting

Meeting 02/11/2019

Dr Dermot Hughes – Retired Medical Director (Leadership Centre)
Urology Surgeon – Mr Hugh Gilbert – Retired Consultant Urologist England
Mrs Fiona Reddick – Head of Clinical Cancer Services
Mrs Patricia Thompson – Specialist Nurse Urology
Mrs Patricia Kingsnorth – Acting Acute Clinical Social Care Governance Coordinator

Patient 5 - daughter has contacted Patricia to advise Patient 5 does not want to engage in family discussion.
Patient 1 - Personal Information redacted by the USI, as dad was given 18 months sadly passed away 2 months later. WOULD LIKE TO MEET

Patient 4 s family would like to meet,
Patricia –Patricia checking notes – checking PAS – confirmed.

PK – Asked for terms of reference to be checked by everyone.
.
PK 1 Recompleted for overarching report, need to confirm all are happy with wording.
PK advised Hugh someone leaked review to local press.
Department of Health responded- SAI ongoing. PK advised at the stage Zoom to Zoom meetings with family members to happen in order to take their views on board. Hoping to meet all family's over the next 2 weeks.

Hugh – advised he has formalised each case, his version of events, case review. Hugh advised he has provided commentary and couple of questions for each case , if you need me to participate in family meeting happy to do so.

Dermot- TOR need to clear and precise. question MDT meetings were recommendations followed?

Hugh - qualitative thing questions batched together, some fundamental questions. MDT thinking when set up 2002 was intended to precisely stop this sort of behaviour, seems to significant opportunities for people to stand up and say you can't do this , this was not done. Why? Question how are results flagged up to people? Consult take on more administration role, secretaries moved shifted, difficulty keeping tabs on CT scan if infrastructure does not support it. Just do not leave them you must ensure they get to right place.

Dermot Infrastructure different across NI is different. Breast cancer better resourced; there are different levels of investment with urology cancer.

Hugh- 10 -12 years, breast cancer was draining all resources, however it was extremely well set up, rigid how they handle them

Urology there are different types of cancer , there are complexities, 5 cancers, introduction of MDT, should require a key worker for each patient. This would take

a lot of investment. There is significant miss management of patients, others need to look at themselves, should look for more investment, are these patients more less deserving that other cancer patients ?

Dermot- if you take the professional out and you don't have systems in place it will evitable happen again.

Hugh - Where checks and balance not in place at MDT- potential root cause of the problems, maybe if checks were in place , this type of behaviour would have being weeded out, not sure what personalities were.

PK asked Hugh to share analysis of each case.

Patient 3 [redacted]

Patient diagnosed with penile cancer- timeline established- in essence commentary. Gentleman badly served should have being staged before or after operation circumcision, should have had lymph dissection both groins, T1 disease, that omission would have reduced 5 year survival rate , 45 % chance of survival.

Concerns – 5 nodes were harvested, in my experience it should have been double that number. The consent form was inadequate, lymph node why ? Potential complication not highlighted.
MDT team not following normal guidelines, used in Bristol EAU guidelines they are comprehensive, free to everyone to access, problem is that there was good recording, however there is no list of who was present at the meeting, Chair only identified, therefore don't know who made decision, timing and steps for treatment were very long in this case.
Penile cancer get on with treatment as fast as you can. There is currently regional Penile cancer MDT why was this patient not referred directly at time of diagnosis, why did this not happen. Reference centre linked to hospital Manchester, no discussion about this and this should be mandatory.
Very badly served, metastatic disease, 5 years, proper treatment 90% chance of survival.

Dermot – can get names of those attended MDT for each case.

Hugh- don't want to point finger, but if I had seen this case I would say you most refer to superregional MDT reference centre,

Dermot- this is a straight forward process- rare cancer – refer to regional MDT

Hugh- The MDM concurred leave patient for 3/12 the lymph primary tumour and survived 5 year chance.

Fiona- advised she would check attendances at MDT and will send through.

Dermot – need this done for every MDT meeting for every patient- who made decision and correct cohort of professions were present at the meeting.

Hugh – I will I send through documents- every time MDT I have highlighted in bold- date for MDM and good if we could populate attendee with this.

Patient 6 – Again patient was given an inappropriate dose even before histology was obtained, turned out to have cancer. MDT recommended going on to active surveillance or curative treatment. Clinician treated UTI symptoms, PSA came down slowly, would normally aim PSA to come down quickly, PSA stalled 150mg unlicensed treatment/dose, dose use to be allowed as single agent, due to excess cardiovascular deaths this was discontinued.
There was inappropriate use of bicalutamide , what rational was given for this treatment, comparison to MDT either over treated or undertreated, clinician deciding to go against MDT recommendations, this raises questions about audit results for MDT follow up. fairly damning, failed to keep up with professional standards , using therapy that is essentially banned.

Patient 9
Urinary retention unmistakably flags prostate cancer- standard treatment MRI for t4 disease arguable, inappropriate treatment patient given low dose, TURP showed ulceration dismembered urethra, should have had biopsy from rectum, clinician fixated on dose- did not consider prostate cancer – did after delay- consider prostate cancer- requested biopsy's but nothing happened for months – what happened between Aug 19- May 2020 –appears lost to follow up. Patient comes back with urinary retention- he stopped bicalutamide on his own record, clinician spoke to patient on phone and clinician restarted on wrong treatment, patient comes back with red flag symptoms – rectal bleeding, registrar – poorly differentiated worse prostate cancer, symptoms, MDM discussion and proper hormone therapy recommended , can confirm this happened , patient had colostomy.

Inappropriate use of bicalutamide –
50mg of bicalutamide allows hormone react to cancer

Very poorly differentiated caner, is 50mg responsible for that differentiated cancer – Hugh advised he should be able to answer that question next time we meet , will speak to professor of urology and see what he thinks, do what a district general would do.
Inappropriate treatment – accelerated cancer, patient had metastases from the outset and could have being offered radical therapy- 90% 5 year survival, lost that opportunity as given wrong treatment and lost to follow up.

Conclusion could have enjoyed good quality of life if treated appropriately

Dermot - oncology got to MDT at end of treatment

Hugh - yes MDT on 02/07/2020 6/08/2020. First time bone scan and treatment offered by then pelvis had fallen and urethral fissure .You would see this type one in every 2-3 years, radiotherapy hormone sensitive prostate cancer, normally you would refer to oncology – and other options for management of disease considered.

Wrong- blocking progressive cancer, other treatment s should have being considered for radical therapy at the outset.

Outset patient had retention –examined – has prostate cancer – elevated PSA – digital rectal examination clear- acknowledged by AOB, TURP did not specify prostate cancer, but there were enough flags to warrant consideration, we missed something, biopsy through TURP via rectum would have being appropriate.

Dermot- raises question about MDT- clinical suspicion of cancer,

Hugh – think legitimate PSA over 100 want to get on with treatment, reasonable standard practice, rectal examination and PSA under 10 arguable, some occasions high PSA you may decide not to do biopsy, clear. However in this case biopsy was necessary and then inadequate treatment,

Patient 8

Straight forward, histology less than 5%- PSA remains low, straight forward failure of follow up, why did result not come across someone desk, coincidental – majority of cancer differentiated , this should be managed 'watchful waiting', delay in 7 months, why was case not discussed at MDT, why did definite diagnosis escape the system. Did present 2014-, is 5 years fairly standard waiting time as implied in AOB letter.

Dermot – was it a routine referral- everything went through , seen by registrar – appropriate tests requested, 2016 Letter for GP noted waiting for 2 years, record of urine flow rate was done, letter from AOB regret for delay. Relisted for TURP, original listing in notes, why was he lost? . Waiting 5 + years for surgery

Dermot- structural problems in NI Urology, and other departments for example waiting lists for hip operations, there are lots of people on waiting lists getting ill, getting addicted to pain killers. Not sure of urology waiting lists.

Hugh appropriate documentation put through should have been added to list. Pending list follow up on patients, these patients are in queue but there was no date for follow up. Hugh advised he spends his time going through these lists as it is the clinician responsibility to look after their own waiting list, if clinician does not have capacity to get patient s in

Patient was put on review list for AOB, however the result was never followed up and not added to list until August.

Hugh- operation and most TURP procedures have telephone follow up. There is a follow up process to report back to patient–report back to MDM - this has not worked in this case.

Dermot- MDM safety net – case was not discussed.

Hugh most MDT list are generated through pathology, problems with this gentleman TURP biopsy did not identify cancer, there is no perfect system, unless you discuss everyone, not possible to discuss every case at MDT..

MDM there could be 25-30 cases per MDT, that is a lot of work.

Hugh – we need to try to organise processes, how patients get to MDM

no harm done.

Patient 1

Urinary tract symptoms .Finasteride with harvest PSA, referral triaged appropriately – MRI – high likely Prostate cancer, , clear indication of prostate cancer, intermediate risk, could argue high risk, needed further staging CT and bone scan, number of occasions 2 or 3 consultations, no letter for 1-2 consultations, but 3rd letter confirms everything, MDM recommended staging at moment no metastases and to consider radio therapy, hormone treatment, reviewed and stated on bicalutamide . again inappropriate treatment, not licenced. Huge delays, more than you would expect, side effects and clinician reduced bicalutamide inappropriately. MDM referred to externally, therapy. PSA fallen to 3.8 referral to oncology was considered but not done, Conscious treatment carries side effects but until you try on each treatment you can't determine what side effects.

MDM discussion but clinician ignored advice and increased bicalutamide 100 then 150 even though the patient had problems with that does before. Patient presented urinary retention – PSA up – red flag, histology result was very poorly, as bad as prostate cancer can get. Letter was vague rather than addressing Prostate cancer – referral trial catheter, unable to put following TURP- June Metastases

Outset no metastases- high degree success rate- given inappropriate treatment- differentiated prostate cancer, there are some treatments available and should have being referred on for this. T

MDM compliance with recommendation. Inappropriate treatment unnecessary treatment, this mam life shortened by wrong treatment, actively obstructing treatment and advancing his disease.

Hugh – normally in cases there are shades of grey- just don't get clinician point of view, you need to walk in their shoes, Prescribing is contrary to recommendations, you just don't do it.

Patient 2 -

Really good pick up form clinically point of view, longstanding scrotal symptoms, stopped methotrexate, has arthritis, this guy was in trouble, series of events, referral letter goes to wrong place, rheumatology then to urology eventually then picked up. USS very equivocal on findings, AOB was straight onto it, standard practice followed, tests and CT done etc all appropriately, Evidence of metastases disease, long time goes by before orchiectomy, there are risk factors- greater than 4 cms, tumour markers within normal limits, slightly raised. Inappropriate delay in chemo as a result may not get such a good response.

Missing letter from AOB regional MDT- should have gone, orchiectomy and by time histopathology came back, 25 July MDM discussion - letter did not go until 2/12 later, time window of treatment had gone by, 6/52 for orchiectomy, 12 weeks gone by at this stage. One option may be surveillance, discussion with oncology combined chemotherapy single dose, difficult to know if patient will be affected, testicular cancer, clinical trials, when someone deviated outside normal practice don't know what risks and benefits are. Chance of reoccurrence 15% as appose to 5% but evidence used not comparable.

Probably will not make real difference.

Referral to MDM from onset, across specialities, would have helped. Again MDM right in advice but was not acted on, decision was parked, and he has suboptimal treatment.

Patient 7

GP referral 2016 mass- investigation raised GTT, Mass on USS, requested CT scan. MDM shortly after for surveillance. Patient then suffered a bit going from pillar to post, there was no continuity of care, gentleman was seen by other locum consultants, different form of imaging, MRI scan does not correspond with CT, lesion looks smaller on MRI. Does return back to CT scan, nodule had resolved, further CT scan in 2018 small increase 2.8 cms, there was clear written intention small renal masses. MDM? , for partial nephrectomy, NOT done – it should have being done, tumour was centrally placed , should have removed kidney to ensure removal of all caner. Would contest decision for partial nephrectomy, should have being discussed at MDM- thi did not happen , patient undecided on treatment . 2019 increased in size. Treatment radical nephrectomy- entirely appropriate, continued under surveillance - growing in size, was not referred to small masses MDM, did not go for radical nephrectomy, reviewed 6/12 later and lesion had

definitely increased in size, not seen by radiology to discuss options, certainly needed nephrectomy. Patient was due to be seen by cardiology and wife explained cardio surgery , echo was completed. Aug 2020 seen by locum consultant who looked at wrong images and advised cancer has not changed when in fact it has. Thankfully patient was reviewed shortly afterwards, thought cancer had not changed but would check with MDM. Although made mistake did so in failsafe way as took patient back to mdm for discussion and the correct images were viewed and the patient was listed for nephrectomy. AOB failed to act on scan 2018/2019, difficult to predict, chances of long term harm remains low, but time will tell.

Dermot thanked Hugh for all his work

[redacted] - Not previously discussed

Acute painful retention- common, guess there is protocol in place. Trail of catheter and listed to come in for TURP , pre-assessment 5 months later, anaemic should be ringing alarm bells, given iron infusion and admitted for TURP , operation endoscopic appearances of adenocarcinoma. Looking at it is not a way to diagnose, there is no record of Digital rectal exam, 90% of resected tissues – evidenced big tumour, but still no rectal examination. Discussed a month later at MDM, noted not to have mets on staging, recommended start hormone therapy. August - MDM july right treatment recommenced, patient commenced self-catheterisation , not clear who started this. Reasonable treatment, needs to have disease staged, started curious dose, telephone call reported symptoms not better, flexible cystoscopy, patient not keen on this , contacted does not want to go ahead, alternatively USS done, not draining bladder , another big red flag, cancer blocking urethral . AOB had fixation with subtle signs , goes for details but misses bigger picture, prostate cancer disease progressing despite treatment, seems to have tunnel vision and was concentrating hard on symptoms, forgot the symptoms are due to prostate cancer, flexible cystoscopy, there is evidence in images, interim bone scan, shows abnormality t11, single abnormality- there is osteopenia, presence of poorly differentiated disease, not going to behave like normal , this guy was anaemic, hb 86 suggestive malignant filtration, MRI should have being mandatory. Plan review later and then MRI. Don't understand why MRI was not requested.

Nov / Dec /Jan nothing happens. Patient presents with impaired renal function and bilateral hydro nephrosis , due to prostate cancer progression, preferably goes to theatre, difficult procedure- drain kidney and bypass obstruction, some stage alternative treatment, stenting fails. January 29 referred by AOB , he is on bicalutamide 150mg. You know he is on wrong treatment, when do staff stand up-

and say. To me I don't know politics, easier for me to criticise this was a missed opportunity to put hands up and say.

Dermot- this person had one presentation at MDM difficult course without further discussion at MDM

Hugh- clearly not on appropriate treatment that was recommended at MDT .

Dermot – need to look at processes, need safe place to have difficult conversation about concerns

Hugh – don't know how department works, hope it is a happy ship, person outlined and can't raise concerns, difficult to question colleagues, very tough and easy.

Dermot – require clear rules and forums and work is quality assured. And bring cases back to MDM for discussion.

Hugh- Follow on after wards curious- nephrostomy- don't know he expected it to allow flow through urethral opened up, wife phoned to say had to have urostomy uncapped. March shortly after he admitted for uncapping – take LHR agonist – blocker. Its an **antiandrogen** – agent stands on works by abiding lhr8 antagonist not- good drug brings testosterone down, good for spinal cord compression, stops testosterone dead in tracts, dose inaccurate given a maintenance dose – dose modified in an unexplainable way - patient died 4/12 later, last record telephone 1march -22 July. There is no communication.

Digital rectal examine missing, If done nature discovered and started on appropriate hormone therapy, on inappropriate drug, brought out poorly differentiate cancer, Hormone sensitive cancer that first keeps the other under control , you can release hormone if you don't control them .

Hugh I will write down information and forward

Should have being referred to oncologist. Possible metastases diagnose would not have changed anything if given appropriate treatment, long time people raising alarm, His anaemia should have raised flags, Should have had a bone scan, if you look carefully , super scan all radiation goes to metastases, wonder if he had widespread metastases but did not show up in super can,

Was not discussed at MDM, allowed to progress, should have being given opportunity for all treatment, put on wrong treatment and prostate cancer allowed to progress.

Dermot- aggressive prostate cancer without input of oncology questionable.

Hugh- Yes I agree- chemotherapy 2nd generation and 3rd generation antians- oncology takes over, generally manages by oncology. AOB given inappropriate doses

Patient 5 - elderly gentleman fit – Personal Information redacted by - still able to tend to own garden and heavy work, haematuria referred to urology service fairly promptly- CT confirmed renal mass with possible vein involvement- MDM discussed, description of nodule nothing that would say looked like renal cancer.

Seen at outpatients vein gram- investigation of choice, egfr low – checked ensure other kidney will provide good renal function , cardiac problems- although active had cardiovascular disease, AOB ask for anaesthetic opinion- mortality 15 morbidity 80., anaesthetist saying high risk- noted. Patient family decided to go ahead to surgery. Bridging anticoagulation, inotropic support .

Fiona to forward MDM attendance to PK. And PK put on eGress.

Patricia to send her information on.

Post op report- support inotrope, urobacteria – sent home- MDM met while inpatient recommended CT 3/12 discharge, telephone call post op- effectively couple units of blood - curiously did not go for 3/12 and advised 9/12. CT done in 3/12 anyway and there was no change. 9/12 still had scan at 9/12. At this point really impressive management – high risk case, patient cancelled and very well investigated, no stone unturned prior to operation. Reason brought up, done last year showed possible scrotum metastases, asymptomatic, was not relayed to patient and should have had a bone scan, very arguable, not only going to be offered immune therapy, antibodies therapy option, not discussed with patient, long term question who results are flagged, audited and communicated to.

All cases discussed

21 points for consideration – 3 areas- needs examined.

Frist group in relation to individual clinician - MDT and regional – communication P&G, what happens when something goes wrong, challenge, audits are done, should have 1 done yearly, breast cancer made available – key worker for patients

Group B – INVESTIGATION inappropriate- wrong and potentially dangerous treatment, considerable delays- is this an individual problem or systemic problem ?, waiting times.

Administration of pathway, clinician making decision- follow up of appointments- are there other mechanisms that should be used, difficulty as individual to follow all requests, is individual responsibility. Hugh has had to this himself, write them all down and tick off as they are done. not acceptable there is no safety net. I think this is a wider issue not just an individual.

Dermot- don't trust the system.

Hugh personnel experience- inappropriate that I have to do that but I don't trust the system, I have email box, not unique issues happen , department of health to answer .

AOB practice less than ideal, difficult to see how this would practice allowed in a system well managed.

Hugh – whole idea team set up MDT to avoid this problem. That is what it boils down to.

PK – Asked Hugh if he had access to encryption-to send information. Anonymised patients, normally it would be encrypted.

Hugh -Never had to do that before.

PK- look at TOR SAI TOR sent up on each of 9 cases, PHA want overarching document. Check wording, Breach to press, do we keep recommendation same or more anonymised.

Dermot – initial review of consultant- however how did this happen in multiple disciplinary setting. Happen with rec 1.

TOR will be shared with family involved.

Fiona send through information,

Next coulpe of weeks Dermot and Patricia to meet with family. Patient 3 extremely complimentary for AOB, referred to services in Derry, more to do with processes.

Dermot may not be in full view of facts, was not on right pathway,

PK spoke with all gentlemen, will make it easy, family are different. Patient 7 adamant it was junior doctor that made decision, may end up with questions.

Give 2 -3 weeks to meet with family and then meet again, Share notes of family meeting. On to eGress.

PK meet again in one months' time- 30 November same time 09;30 via

Zoom- All agreed. Any other questions?

Hugh queried indemnity- working outside college- if legal action occurs ensure he is covered- PK to get back.

Meeting ended

Southern Health and Social Care Trust

Acute Governance
Urology SAI review team meeting
Monday 30 November 2020 Zoom

PRESENT: **Mr Dermot Hughes (Chair)**
Mrs Patricia Kingsnorth Acute Clinical Governance Co-Ordinator
Mr Hugh Gilbert External Consultant Urologist
Mrs Patricia Thompson Clinical Nurse Specialist
Mrs Carly Connolly Clinical Governance Manager

Mr Gilbert advised he was approached by RIM to find someone to complete the same work.

Dr Hughes advised Mr Gilbert there were some developments last week, Tuesday the Health Minister announced there would be an Independent inquiry in to the consultant. Dr Hughes advised the SHSCT did not have much input into the decision it was the department of health's decision. This is on the back of 2 other ongoing enquires in Northern Ireland, one is a neurology inquiry which Dr Hughes is involved in. Dr Hughes advised it is not of the same magnitude and involves approximately 3000 patients. The question was asked where does that leave this SAI and SHSCT have been advised to continue with the SAI as it is a learning process

Dr Gilbert advised that was fine, he was in contact with Martina Corrigan to get involved to help Mr Haynes to review notes. Dr Gilbert advised he is happy to continue on with the SAI review.

Patricia Kingsnorth advised Dr Gilbert he was needed to complete the SAI review and could not afford to lose him at this stage.

Dr Hughes advised we are going through a completion process. Dr Hughes advised himself and Patricia had met with all the families and said the families were all exceptionally dignified considering the circumstances. Two families have lost their loved one and 2 are in the palliative phase of care.

Mr Gilbert said he could only imagine it being horrible having to explain to the families and relatives.

Dr Hughes advised they reassured all the families work would be complete and that the review team consisted of an external expert urologist.

Patricia Kingsnorth said it was important they keep the momentum going with the 9 cases.

Governance Office, Ground Floor, The Maples
Craigavon Area Hospital
Tel: Personal Information redacted by USI
E-mail acute.governance@southerntrust.hscni.net

Dr Hughes advised an interview with the index consultant would be required and that it was important the review was near complete at that stage and information gathered to prevent delays. Dr Hughes advised the report needs to focus on national and regional guidelines and address why they were not followed in these cases, were patients informed their treatment did not meet national / regional guidelines and if they gave consent for treatment outside these guidelines. Dr Hughes advised the review needs to address the MDT infrastructure, the cohort of attendance at MDT meetings, keyworker / specialist nurse availability, patients did not have access to this service and this was a major deficit in their care.

Mr Gilbert advised in his area they had difficulties with keyworker reliability 5-6 years ago, no longer an issue. Dr Gilbert asked why this was not offered.

Dr Hughes advised he was medical director for 4 years and advised keyworker in breast lung and urology cancer were essential in the communication process of treatment.

Dr Gilbert advised all patients should have had a key worker to offer independent advice, there are clearly administration problems in care but that that does not take away from the fact patients did not follow the right pathway.

Dr Hughes advised there was a standard for peer review guidance was signed off by the Trust in 2016, index consultant was involved in this. Report needs to address the national and local guidelines and compare to what exactly was delivered. Patients /families were not informed treatment was not standard care.

Mr Gilbert advised there were no safeguards put in place.

Patricia Kingsnorth advised she completed the timeline for each individual case. Starting with [redacted].

Dr Hughes talked about MDT meetings, advising none had full cohort attending, there was no oncology input, there was good attendance from urology. The advice at MDT was not carried out, what was carried out was against what the Trust had agreed. There is a standard pathway this should be discussed with the patient, patients were not aware the treatment was not the standard treatment.

Mr Gilbert advised it is important they bring the patient back to MDT to discuss other treatments are satisfactory and important to get oncologist opinion.

Dr Hughes advised families advised the index consultant would have generated a phone call following inpatient stay, families advised they could not access community care when their loved ones were dying, palliative or

district nursing was not available. During inpatient stay families were not able to visit , sister had to sneak them in, in one case daughter [Irrelevant information redacted by the USI]

Mr Gilbert advised not everything is black and white, it sounds dreadful and to think metastases may not have occurred if treatment offered was not outside conventional course.

Dr Hughes advised there are questions regarding MDT, MDT should be a safety net to avoid this.

Mr Gilbert speculated that if there is a group of urologists and I try to think what would I have done, pretty sure I would have said something.

Dr Hughes advised he has asked for business minutes of meetings he has received one so far, there were 2 good audits completed, one completed by trainee on bladder cancer pathway. Audits should provide assurance Dr Hughes advised he was waiting on subsequent work for prostate.

Patricia Kingsnorth advised they need to address the causative factors and contributing factors in the report.

Dr Hughes advised daughter was upset, she appeared sensible and feels here father was not involved in the decision making process he was not informed treatment was not standard recommended treatment and therefore questions was consent gained. Dr Hughes advised conversations regarding treatment in care should be documented and then discussed at MDT peer review.

Mr Gilbert asked how was MDT functioning, how did this happen. Mr Gilbert advised he would go through each individual case and word in a language that could be easily understood.

Dr Hughes advised he was looking into attendance at all MDT meetings , cohort attending each, the review numbers etc.

Mr Gilbert asked about nursing input to MDT and care.

Dr Hughes advised none of the patients had a specialist nurse, peer review, pathways national and standard guidelines were not met.

Mr Gilbert advised it was a fundamental problem that no oncologist was available to provide opinion, they would usually be forthright with what should happen and should not.

Dr Hughes advised he will speak with the lead oncologist as he is not convinced they were unaware. This needs to be clarified, it is a sin of omission not to raise concerns.

Mr Gilbert advised index consultant was ploughing his furrow and therefore concerns were maybe unknown if he kept all to himself.

Dr Hughes advised having spoken with families they all seem to have had a good experience and relationship with the consultant and were surprised when told.

Mr Gilbert advised GMC advice is to provide good medical practice and not that you have to be nice you have to do good at what you do.

Mr Gilbert advised he would look over the cases and provide description and get back. Mr Gilbert advised we need to be clear of what should have happened i.e standard care and what actually happened.

Dr Hughes agreed important to address national and regional guidelines and pathways, look at consultants attendance at meeting and signed of pathways, what was delivered against the agreed pathway.

Mr Gilbert advised he should have all done the end of the following day.

Patricia Kingsnorth asked Patricia Thompson why there was no follow up on some of the cases, Patient 5 and Patient 9 were both to be followed up at outpatients, they did not receive an appointment. Patient 9 was seen in August and then not seen again until he attended ED .

Patricia Thompson advised he was reviewed in July 2019 by consultant, the plan was for USS and review following this. Letter dated 7th July to GP outlines details of 3 episodes. He was put on PIS for a protective review meaning his secretary would book this as the waiting lists were full. The USS was not followed up and therefore he was not reviewed. The USS should have been flagged to the consultant. The USS was done on the 2/8/2019 and the result would have been available that day. In May 2020 he attended ED with urinary retention. There was a note on secretary for secretary to the appointment.

Dr Hughes asked but how would she know the patient was for protected review.

Patricia Thompson advised the secretary types the letter and should then put patient on the waiting list. Patient had USS but this was not followed up and this is why he never received an appointment.

Patricia Kingsnorth advised she would look at the letters. This was the same for Patient 5 .

Dr Hughes advised he thought they were overthinking , patients get lost in hospital system , very clear medical ??

Governance Office, Ground Floor, The Maples
Craigavon Area Hospital
Tel: Personal Information redacted by the USI
E-mail acute.governance@southerntrust.hscni.net

Patricia Thompson advised [redacted] was on the waiting list for review in December 2019 and again was not followed up , he was not a protected review.

Dr Hughes advised [redacted] care was absolutely dreadful.

Patricia Kingsnorth thanked Patricia Thompson for input.

Dr Hughes advised when patients deteriorate they should be brought back to MDT for further discussion, it may be simple treatment. There seems to be a resistance to bring patients back. 4/9 palliative phase or died. They would have benefited from MDT input.

Patricia Thompson advised that she is only new to post and the consultant retired before she begin. Patricia advised that the general consensus was that the consultant personally did not like key worker involvement.

Dr Hughes asked if key workers were available. If they are available and kept out of the patients care is worse. It would have been wonderful for these patients to have had a key worker. If resources were there and they cannot avail of it paints a different picture. Most people do not understand what is happening , keyworker is more approachable and allows them to have a meaningful discussion. These patients were not given that opportunity.

Patricia Kingsnorth asked did most consultants use the specialist nurse/ keyworker?

Patricia Thompson advised her impression from hearing from others was that he did not like keyworker.

Dr Hughes advised specialist pay an important part in patients care and is astounded by this. Important patients get encompassing care and that SHSCT did not provide that when resources are there.

Patricia advised they will meet again next week.

Dr Hughes advised the report needs to consider the national regional standards, keyworker involved etc. Dr Hughes advised families were very dignified at meeting.

Patricia Kingsnorth agreed they were dignified, there was one family who expressed anger but advised they were scared and their dad has now had his surgery.

Dr Hughes agreed that was the best option for them as this was their concern. Dr Hughes asked Patricia Thompson that he hoped she did not find it too upsetting.

Patricia Thompson advised she found Mr [redacted] case quite upsetting .

Governance Office, Ground Floor, The Maples
Craigavon Area Hospital
Tel [redacted]
E-mail acute.governance@southerntrust.hscni.net

Patricia Kingsnorth advised the family just want the truth.

Dr Hughes said they had brought a photograph of [redacted], he was obviously a member of the farming community, he [redacted] Dr Hughes advised we need to check what name they would like in the report as he thought the daughter had asked for [redacted].

Patricia Kingsnorth said she would check.

Dr Hughes advised [redacted] probably does not have long left and [redacted] is in final phase also.

Patricia advised she received a phone call from the family they were concerned the enquiry was going to affect his care . Patricia reassured them it would not.

Patricia Thompson advised the announcement was a shock to her colleagues, they were aware there would be an announcement at some time.

Dr Hughes advised he was shocked it would be an independent enquiry, does not compare to neurology enquiry. It is important that everything must be evidence based.

Patricia Thompson advised it is probably better she was not involved with the consultant.

Dr Hughes agreed and advised he has informed patients and family that Patricia was a newly specialist nurse appointed to the Trust and has not worked with the consultant.

Patricia Thompson advised came from a Trust were there was good MDT team work which involved keyworker.

Dr Hughes thanked Patricia for her input.

Meeting ended

Level 3 SAI review

New Urology review meeting

Date and time: Monday 7th December 2020 0930
Venue: - via Zoom and telephone
Patricia apologised as she was unable to commence meeting via zoom due to technical difficulties. Meeting commenced via telephone initially and progressed to Zoom meeting at 10:05

Attendees:
External Chair – Dr Dermot Hughes.
Mrs Fiona Reddick – Head of Cancer Services
Ms Patricia Thompson – Clinical Nurse Specialist – Urology
Mrs Patricia Kingsnorth – Acting Acute Clinical Governance Coordinator
Notes taker – Mrs Joanne Bell.

Patricia Kingsnorth welcomed everyone to the meeting. Unable to contact Dr Gilbert to advise of technical problems.

Dr Hughes- The main issue for the nine people we have met was that none of them had access to a cancer nurse specialist (CNS) key worker. There was a lack of access to and uncoordinated care in the community. Dr Hughes requested clarity and access to information relating to:

- CNS key worker availability for cancer patients within SHSCT across all sites

- Confirmation if all other Consultants in SHSCT use a CNS?

- Was it a conscious decision for this one professional in question not to use a CNS and did they use the CNS role for diagnostics only but not for support?

- Did the peer review report 2017 detail the availability of CNS in their findings?

- At any stage did anyone highlight their concern of a lack of CNS availability?

- The annual reports for 2018 and 2019

- Need confirmation to determine why these patients had no access to palliative care consultants and nurses to support them

Patricia Thompson -advised that prior to her commencement August 2020, there were two CNS available on one site – CAH. There was one CNS for Urology and one CNS for Macmillan Services.
The usual process involves patients meeting their consultant and CNS at the clinic together. Or the consultant refers the patient on to the CNS. The patient details are shared in order for the CNS to make contact. Consultant urologists want their CNS with them. The professional in question did not like the word key worker but had allocated 1.5 hours for a 1:1 appointment per patient for e.g. breaking bad news

clinic

Fiona Reddick -confirmed CNS availability was in place and there are key performance indicators to support this. Fiona highlighted that the CNS staff should sit under her remit but do not which is unique to SHSCT. Fiona emphasised it was very difficult to progress any regional issues with no managerial responsibility for these staff. There is evidence of cancer patients experience in 2015 and 2018 and local patient surveys but the numbers were small. A Band 7 CNS is present with Consultants and the patient at hot clinics for breaking bad news, receiving pathology results. If not available a B6 present at all times to provide cover. All of the other Consultants practice MDT and the CNS resource has increased from 2 to 5 WTE CNS from then.

Dr Hughes detailed that without the support of a CNS there was real barriers for these patients getting access to the care they needed. Dr Hughes recognised the increased resource from then but these 9 patients had complex deteriorating issues and were left relatively unsupported regarding a link with community services, dealings with GP and visits to ED only to be advised another service was available for them which they were not informed of nor had access to. Dr Hughes emphasised the importance of re-discussion at MDT when their journey was not going right. There is a need to look at the Governance issues here and the support required for annual meetings to discuss issues and agree an action plan for an annual report. There is also a need to support those professionals who were and have been doing the right thing.

Fiona Reddick advised that visit in 2017 a regional group was set up to look at urology services .Martina Thompson, Head of Service for Urology was working on this. Fiona will request this is shared. Fiona advised it is responsibility of MDT chair to collate the annual report. The 2019 report just completed and signed off but Fiona will follow up with Dr A Glackin to confirm if there was opportunity for business meetings in 2018. Fiona advised they are not fully funded for MDT and will share the detail of the resource shortage.
Patricia Thompson – confirmed all other Consultants bring back their patients who are not doing well for rediscussion.at MDT. Fiona also discussed the value of advanced care planning and how it would have been useful in assisting the patient's journey.

Patricia Kingsnorth requested clarity if CNS and key worker role differs within urology? And also an assurance of the detail of the care received by other patients. The draft timelines have been shared and Patricia requested these are reviewed with comments for each case providing a clear steer and clarity around the services accessible so that this may be reflected accurately within the report.

Patricia Thompson confirmed the CNS role should incorporate key worker roles and responsibilities. There should also be cross cover between the CNS during periods of leave/absence. Whilst in her previous post the CNS was not present the consultant always shared the CNS details and telephone number with patient. The CNS was informed of new patients and the patient details shared so that follow up contact was made. Dr Hughes indicated this also provides an additional safety net preventing things being missed. Dr Hughes advised his report which will complete in

one month will be focused on the named patients, the care they received and what care they should have received.

Next meeting **Monday 14Th December 2020 2-4pm via zoom**

Southern Health and Social Care Trust

Acute Governance
Urology SAI

Monday 14/12/2020

PRESENT: **Dr Dermot Hughes (Chair)**
Mr Hugh Gilbert (Urology Consultant)
Fiona Reddick Head of Cancer Services
Mrs Patricia Kingsnorth Clinical Governance Co-ordinator

Apologies: Patricia Thompson

Mrs Kingsnorth thanked Mr Gilbert for reviewing [redacted] **notes and providing feedback.**

Mr Gilbert advised he would need to view the images as there appears to be some confusion over the measurement but overall would not have made a difference and appears to be no concerns.

Mrs Kingsnorth advised she would get the images and forward on to Mr Gilbert.

Mrs Kingsnorth advised that herself and Dermot met on Friday to go through the wording of the reports and just a few amendments were made.

Dr Hughes advised the lead for MDT raised issues but there were no notes made from the meetings held and there was no escalation outside MDT. There was a peer review in 2017 and signed off by the Trust. Additional speciality nurses / keyworkers were provided to all consultants, all consultants had access to a specialist nurse/ keyworker, the index consultant did not use a key worker or specialist nurse.

Mr Gilbert advised there was no reference of specialist nurse in any of the notes.

Dr Hughes advised this issue would be included in the review as contributing factor. Dr Hughes advised the role of the specialist nurse / keyworker as an important safety net in patient care. It allowed patients to have a more in depth discussion about treatment and care and pathway they were following. Patients attended ED when they became unwell, ED could not help. Access to a key worker would have provided support and advice. They did not have access to one.

Mr Gilbert agreed a key worker was a necessary professional in patient care to inadvertently avoid mistakes and provide continuity of care. Mr Gilbert advised MDT should also have had oncology input as they are also an important member of the MDT team.

Governance Office, Ground Floor, The Maples
Craigavon Area Hospital
Tel: [redacted]
E-mail acute.governance@southerntrust.hscni.net

Mr Gilbert advised MDT meetings would have many strong characters present , this could potentially lead to a dominated environment. Colleagues may not have had confidence to speak up and question actions or decisions made. This is a question that needs to be asked, why decisions were not challenged at MDT. Mr Gilbert advised had an oncologist been present concerns would have been raised and decisions challenged.

Dr Hughes agreed oncology was ill served at MDT meetings, 11 % of meeting were attended by oncology, 3 oncologists potentially sharing out 11% of cases. This would not have made a meaningful change in dynamics.

Mr Gilbert advised the question needs to be asked why no one challenged decisions, is it a culture issue within the Trust. Mr Gilbert advised it can be incredibly difficult to speak up and this needs looked into, it is a concern.

Dr Hughes advised staff should be provided with a safe space to challenge and be challenged without a hierarchy. Dr Hughes asked the question should the keyworker be an advocate for the patient. Dr Hughes questioned should the review compare urology care against other services.

Mr Gilbert advised breast cancer would be a good bench mark for comparison, breast cancer has had good investment.

Dr Hughes agreed breast cancer would be the best noting it has a very good functional screening programme. Urology service has had resources increased but still does not meet the same standard of resources as breast cancer services.

Mr Gilbert agreed with this however noted the 2016/2017 annual report suggested keyworker resources for urology cancer patients. Mr Gilbert advised AOB seemed to consider himself as the keyworker. Years ago consultants would have been forced into that however there was keyworkers available.

Dermot advised the peer review stated everyone had access to a keyworker. Patients in the review have had a differential quality and experience of care.

Mr Gilbert advised the consultant was rep for NI whole group until 2016. He was present when guidelines were published in relation to cancer referrals. The patient with penile cancer should have been referred immediately and this did not happen.

Dr Hughes advised he was told the consultant was chair of the regional group but needs to get this confirmed from the NICAN regional group.

Mrs Reddick advised he did hold a position as chair but not entirely sure of when.

Mrs Kingsnorth asked Mr Reddick to get details of this.

Dr Hughes advised the review would need to find out from NICAN if the consultant was involved in regional protocols and not adhering to them himself. Need to obtain NICAN guidance.

Governance Office, Ground Floor, The Maples
Craigavon Area Hospital
Tel: Personal Information redacted by the USI
E-mail acute.governance@southerntrust.hscni.net

Mrs Kingsnorth advised she would forward this to Mr Gilbert to review.

Dr Hughes advised this is a public document and can be emailed through. Dr Hughes advised the NI regional and national guidelines were important to the review and furthermore it was additionally important if the chair of group was not adhering to the guidelines.

Mr Gilbert advised he has gone through a number of the SAI reports and made corrections, he would send these back to Mrs Kingsnorth.
There are a number of outstanding issues to be addressed with in the reports for example MDT attendance, key MDT decisions made, who made decisions, what was the recommendations and then what was the variation .

Dr Hughes advised would need to review guidance, recommendations and what actually happened.

Mr Gilbert advised they need to look at who was MDT, the decision made by MDT, was this followed, if not why not. What was it about the patient that made the consultant deviate from national regional guidelines/ MDT recommendations.

Dr Hughes advised it would be good to ask the consultant but would need to have questions planned to avoid a wide range open debate.

Mrs Kingsnorth advised the consultant can be contacted via his solicitor, we can forward specific questions.

Dr Hughes advised would need to address national standard and variance in care provided.

Mr Gilbert advised he would go through the remainder of the reports and will forward on asap.

Governance Office, Ground Floor, The Maples
Craigavon Area Hospital
Tel: Personal Information redacted by the USI
E-mail acute.governance@southerntrust.hscni.net

Directorate of Acute Services

Notes of a meeting held on Monday 4th of January 2021 to discuss the Complaint regarding Mr O'Brien

Present: Patricia Kingsnorth
Fiona Reddick
Patricia Thompson
Hugh Gilbert
Dermot Hughes

In Attendance: Peter Rodgers

Meeting Began with Introductions as usual,

Mr Hugh Gilbert Clarifies he has most recent reports done and he shall forward them onto Mrs Patricia Kingsnorth. PK agrees that once she receives most recent data she shall collate data and then return them to HG for a final draft of applicable data.

PK acknowledges that Mr O'Brein's solicitor has requested the specific questions that will be asked during their meeting.

Mr Dermot Hughes Advises that questions should be specific and to the point, to ensure clarity of answer requested.

Patient 2

Team Begin to Discuss Patient 2,

Questions Raised:- why was Patient 2 not referred on as per the MDM 25/07/2019 and recommended he was referred onto oncology and seen on 23rd of august

MDM said Patient 2 should have been referred a month prior however the referral did not happen until 25 September and discussed on the 26th

Review team question, why was there an absence of a key worker/ specialist nurse, was Mr O'Brien intentionally excluding key workers in his practice and why this happened.

Review team then acknowledge that throughout all nine cases there are no mention of key workers.

HG curious as to why each stage/ progression for investigation or treatment took up to a month when in reality it should have taken 2 weeks and review team questioned whether this was due to the absence of a key worker that this was overlooked.

HG also expressed concern that Mr O'Brien was intentionally excluding other health professionals from his patients care

Also curious as to what policy is as per MDM for testicular cases, Does the MDM allow for sufficient patient tracking.

Questions posed to ask Mr O'Brien:-

Why did it take so long and why was there no key worker?

Why didn't Mr O'Brien follow NI diagnostic pathway?

[redacted]

Team Continue on discussion of [redacted] case

Comes to light that [redacted] may have been told by a different clinician that his tumour should have been excised sooner

HG acknowledges that the lesion was in a difficult position to proceed without invasive procedures if it had of been in a different position Dr's may have recommended a different procedure

HG raises question why wasn't guidance followed which would suggest this patient was discussed at small kidney mass MDM

Mr Obrien Missed a scan was this due to lack of a key worker/ specialist nurse, considering the difficulty of the case why wasn't a specialist's opinion involved from the outset.

Team acknowledge this case was brought back again and again to MDM and question why the MDM did not question the decision to not seek advice. Also questioned why regional policy was not followed.

PK also raises that [redacted] had 3 locum consultants however Mr O'Brien was primary consultant, with this he had primary responsibility who had the likes of MDM support and why wasn't it consulted.

Team Acknowledges Mr O'Brien had ample oppurtunities to refer [redacted], and question why he decided to vary from established guideline practice.

Patient 1

Team Begin to discuss Mr Personal Information redacted by the case

HG raises that Patient should have been referred to clinical Oncologist

Also acknowledges that the patient was given an unconventional hormone therapy where dosage differed.

Question again raised, why Mr O'Brien deviated from guidelines and still no key worker present.

HG voices how as the patient was on inadequate hormone therapy it may have supressed hormone related cancer however this would not have affected non hormone related cancer this was surmised as prostate cancer having the ability to be made up of a multitude of cancers. HG perceived the treatment provided could have accelerated the cancers progression.

Team curious again, converse as to why no key worker/ nurse was utilised when this was this support was available. Taking into consideration how Mr O'Brien worked in isolation reiterating was there a reason for excluding members of the MDT.

Patricia Thompson does acknowledge this fact and the reluctance of key worker use. Brought to Review team's attention that Patient 1 had phoned unit to enquire about medication, this led to the key worker discovering a number of scans not organised.

The team questioned again the lack of utilisation on Mr O'Brien's part of a key worker could have been detrimental to patient care.

Patient 5

Team Begins Discussion Of Patient 5 Case

HG Vocalises how he perceives management was correct with patient being given clear instructions etc, until a post-operative CT scan shown another lesion that was missed.

Once Patient had seen another consultant along with daughter metastasis was noted team questioned why finding of scan was not acted upon. Which in turn raised the question the lack of utilisation of key workers/ specialist nurses and exclusion of others from Mr O'Brien's work was detrimental to patient care.

HG Iterates how a delay in Hormone intervention would also be detrimental to patient health/care. Patient's age was discussed and how hormone intervention could be influential on life expectancy.

Team quickly revisit how a key worker would have been imperative to adequate patient care.

Patient 4

Team Begin Discussion of Patient 4 Case

Team understand how Patient 4 was discussed at the MDM who suggested standard treatment

Team looking over notes discover that Mr O'Brien had decided on 50mg per day of medication which is not licensed.

Continued discussion of Patient 4 timeline, showing bone scan wasn't abnormal with excess uptake in one area. Radiologist suggested MRI however this was not requested. Team discuss the ramifications that a lack of a key worker played in the inadequacies of patient care.

A Non Re-Referral to MDT as disease progress and MDM recommendations not followed discussed with disregard for use of drug dosage.

PK questions whether redeployment of key workers may have proven a factor in patient care. PT iterates that CNS were kept in Thorndale unit were as Fiona Reddick believes they may have been. PT acknowledges she herself was given time during Covid redeployments to get in touch with patients from her own experience.

PK Suggested that this be clarified

HG says that patients may have been unaware they had access to key workers due to previous experience with Mr O'Brien.

Patient 6

Team begin discussion of Patient 6 timeline and case, it is discussed how Mr O'Brien did not adhere to androgen therapy, and that Patient 6 did not have a clear understanding of what was happening throughout his care.

Brought up again amongst team how lack of key workers severely impacted patient care and how this could have drastically changed patient's experience.

HG voiced that there was no critic on starting tamoxifen, DH however acknowledged that Patient 6 still was not treated to guidelines and again how no key workers were involved.

Patient 3

Team Begin discussion of Patient 3 and his case.

The team note that although Patient 3 was diagnosed with penile cancer he was not referred on.

HG disbelief towards treatment. Does not understand why MDM would condone treatment provided after diagnoses.

Believes Excision biopsy should have been referred to MDM, HG iterated how there are rarely experts in penile cancer due to the rarity as such Mr O'Brien should have consulted more with MDM. Also noted is that Mr Obrien should have taken more appropriate measures for early intervention after biopsy.

Team discuss how this patient should have been referred and discuss how Mr O'Brien was at fault for not referring further.

Patient 9

Team begin discussion of Patient 9 timeline and case.

Noted how the delays in investigations was subpar for patient care and how Mr O'Brien again did not follow regional guidelines.

HG voiced concern about how Patient 9 was on inappropriate hormone therapy considering he initially presented in retention.

Team discuss how Patient 9 was not brought to MDM as he was not being treated for cancer. Iterating how a lack of investigation led to an incorrect treatment. An MRI was not provided for Patient 9 until much later that the team said could again be due to lack of key worker.

Team discussed that if Mr O'Brien was positive that he was treating [redacted] Patient 9 for prostate cancer why was he not referred to the MDM. Discussed that appropriate diagnostic and staging not used also correct cancer guidelines were not followed. This resulted in a lost opportunity for treatment with curative intent for the patient.

Patient 8

Team Discuss Patient 8 Case and timeline

Understand that Patient 8 Cancer was a coincidental find, however no follow up investigation provided. Regarding Mr O'Briens knowledge of the patients result he failed to inform the patient, Team curious again whether this was due to lack of a key worker.

Team discussed was this possibly due to Covid, as well as a lack of safety net for pathology to go on to MDT.

PK & DH iterate that guidelines that Mr O'Brien was to follow are not current guidelines and to consult those during further investigation.

HG raised question regarding all cases as to why Mr O'Brien did not use the opportunity to consult those who may have had more exposure or expertise in the cases he was dealing with

FR Voices how it is imperative to have good communication amongst MDT which Mr O'Brien neglected.

Team voice their concerns as to the standard that had been stated and standard that SHSCT had signed up for as opposed to the standard of care Mr O'Brien provided to his patients.

DH, PK curious as to why no key worker had not been noted in previous SAI this was thought to be because it was not a solely cancer SAI.

HG voiced concern regarding how a MDT may feel compromised in "raising their hand" if something is out of guidelines due to a senior member of staff as well as the MDM condoning treatment.

HG also clarifies he is in the midst of chasing more information regarding hormone therapy with a man who has more expertise in the field this data will then be shared with PK.

Another meeting arranged for 18/01/2021 at 0930

Southern Health and Social Care Trust

Acute Governance
UROLOGY
18 January 2021 @ 9.30am

PRESENT: **Dr D Hughes**
Patricia Kingsnorth
Fiona Reddick
Roisin Farrell

Dr Hughes advised he had now met all the families. He met with the family of [redacted] who was very concerned with his care. Dr Hughes advised [redacted] had a large tumour but had reasonable care. Follow up scan was missed. [redacted] has prostate cancer and the missed follow up scan was an issue. He advised [redacted] attended ED and there was no PSA done and he believes if a PSA was done by either ED or GP this may have changed the course of treatment. Need to check why a PSA wasn't done as there was opportunities to do one. Dr Hughes advised the family have sent in a 5 page timeline. He believes the family feels all is bad but Dr Hughes feels this is not the case. He advised where there are issues this will be acknowledged but where there is none this will be said. The family have asked staff to follow up scan results.
Patricia checked and they were followed up and were reported by radiologists. Imran agreed to recheck.
Fiona agreed to provide timeline for radiology on [redacted].

Dr Hughes advised oncology was surgical and if radiologists were at the review this will confirm the follow up. He added he has reviewed most of the patient's information. He is looking at: Presenting complaint, diagnosis, MDT, Nursing support, Referrals, Compliance to guidelines, Referral back to MDT and onward referrals. This will be the bench mark for all 9 cases. He advised the medical director has concerns not taking patients back to MDT when patients are clearly dying.
Dr Hughes advised it's not done through SAI review but through the royal college review. It is generally done on each individual. He advised it is not generally done by a specialist in that field.
Patricia said when it comes to MDT they need an insight. She asked Fiona if she could provide a clearer insight.
Dr Hughes wants to complete individual review first. He has spoken to Tony Glackin and Joe Sullivan. Joe advised he had sent referrals to the prescribing clinician.
Dr Hughes has also spoken to AMD, the Lead and Barry in Cancer services; he advised none of them were aware. Dr Hughes believes if they were to be giving assurances through the CX they need to be doing audits in 25% of the cases.
Fiona suggested audits need to come down through the specialities. Dr Hughes suggested these are usually done by junior doctors or specialist nurses for their own learning.
He suggested patients don't get a 62 day review.
Fiona to check if any of the 9 patients were on their pathway and if they were on the breach report. She advised there are several breaches within urology.

Governance Office, Ground Floor, The Maples
Craigavon Area Hospital
Tel: [redacted]
E-mail acute.governance@southerntrust.hscni.net

Dr Hughes is aware of this, he advised best practice was 31/62 day agreed target as this was part of the pathway. The issue is if system is working. Dr Hughes feels AO'B didn't work within the process and sometimes worked on his own which is hard.
GP referral 1st month, treatment 2nd month (31/62), he doesn't think this was the thinking of AO'B.
He said after talking to families they are left not knowing.
Dr Hughes is to meet with Martina, Ronan and Mark.
Dr Hughes said AO'B care was very personable. He would like to know if staff were in the position to know or didn't know, if not - why.
He said as part of the learning he will ask staff how they can work together. He feels there is an inappropriate hierarchy within consultants which is wrong. Fiona advised that's what MDT is about.
Dr Hughes feels no nursing care involvement is a huge deficit. He said its bad not treating patients under the guidelines but not to tell the patient they are being treated off the guidelines. He added you can't expect patients to know as this is generally their first cancer. He also added they need to be aware language is not inflammatory.
Patricia advised she had sent out questions along with redacted notes for all patients to AO'B solicitor with a timeframe of 29 January 2021 for response.
Dr Hughes advised they had asked 2-3 questions per case. He said he had already got an external opinion. He said he would be meeting with families again in February and feels this may be tough for some families who found AO'B very personable.
Dr Hughes said AO'B had excluded key workers and had issues picking up scans.

Patient 9 Patricia asked Fiona to liaise with palliative of care nurse for an update on Patient 9 .
Fiona to contact community nursing team caring for status of Patient 9 . She advised it has been a difficult time for community nursing team as they have to be mindful of conversations.
Patricia contacted the family a couple of weeks ago and at that stage Patient 9 was very low and family didn't want to engage. She advised she is trying to keep in contact with families especially if something is going to press she would like to tell the families first to prevent more stress.

Dr Hughes advised he was made aware of a AO'B support group. It was the Patient 5 family that took it to his attention at the meeting. He is considering whether to put it in the report. He advised families have been dignified at dealing with the trauma.
Patricia believes it is particularly stressing for families and this is why they come forward as they saw GP names in the group.

Further meeting Monday 25 January at 9.30am

Governance Office, Ground Floor, The Maples
Craigavon Area Hospital
Tel: Personal Information redacted by the USI
E-mail acute.governance@southerntrust.hscni.net

Governance Office, Ground Floor, The Maples
Craigavon Area Hospital
Tel: Personal Information redacted by the USI
E-mail acute.governance@southerntrust.hscni.net

Southern Health and Social Care Trust

Acute Governance
UROLOGY
25 January 2021 @ 9.30am

PRESENT: **Dr D Hughes**
Mr Hugh Gilbert
Patricia Kingsnorth
Fiona Reddick
Patricia Thompson
Roisin Farrell

Mr Gilbert advised just because oncology isn't at the MDT medics can write to the oncologist. In MrO'B case he did wrong.
Patricia Kingsnorth believes it was MrO'B's behaviour.

Dr Hughes believes MDT was aware of the maverick behaviour and didn't want to address the issues and people came to harm. He was very surprised at the lack of information the medical director had, she was unaware.

Mr Gilbert suggested the medical director would only have known if she was told but believes it was kept within MDT.

Dr Hughes said he would include the role of MDT in the overarching report. He suggested MDT was a service delivery and the information needed have a way of delivering the information.

Mr Gilbert suggested the principal of the MDT is to get rid of this behaviour and make sure every patient has the right and meaningful optimal care. To make sure they are put on the right pathways despite MrO'B behaviour.

Patient 1

Dr Hughes said there was a peer review in 2017. On reviewing recommendations MrO'B didn't adhere to the recommendations in this case. In Patient 1 timeline Dr Hughes question if he give informed consent as Patient 1 wasn't aware. Patient 1 didn't have a cancer nurse specialist. Dr 1 excluded nurses from his care. Dr Hughes found it bizarre the trust lobbying for extra resources but didn't utilise the nurses. Care didn't follow regional guidelines. He added this report was in draft for staff to review.

Mr Gilbert advised he had spoken to professionals. He said low dose was an option but nothing was written down. He feels it was an experiment and wouldn't get ethical approval.

Dr Hughes suggested evidence doesn't exist.

Patricia Kingsnorth asked if there is any evidence to prove it can make it worse.

Mr Gilbert advised BPH andegen blockade drug is used to reduce the chances of developing prostate cancer. This was stopped after 2 years.

Governance Office, Ground Floor, The Maples
Craigavon Area Hospital
Tel: Personal Information redacted by the USI
E-mail acute.governance@southerntrust.hscni.net

He added when a man develops prostate cancer they don't get cured. He said when inadequately treating cancer this becomes worrying if suppressed completely – Finasteride study.

Dr Hughes suggested by ignoring the resolved decision of MDT the patient was being denied regional best practice. He feels MrO'B felt MDT was more an advisory body.

Mr Gilbert said oncologist he spoke to advised every cancer patient should be given full and frank discussions and follow guidelines.

Patricia Kingsnorth suggested the public think that is what they are getting when they are referred to MDT.

Dr Hughes feels MDT was a redundant role.

Patient 5

Dr Hughes advised he had met the family of Patient 5.
He advised the family initially didn't want to be involved in the review as Patient 5 was happy with the care he received. He had metastatic cancer. Family are unhappy with the care Patient 5 received when he attended ED. There was no PSA test done. Dr Hughes suggested they need an opinion around pre urology pathway. He advised Patient 5 was referred as non-urgent. The family contacted MrO'B to his private practice. Mr O'B took him in after the ED appointment to his CAH clinic. Family asked if he could have had an earlier diagnosis of his retention haematuria.

Mr Gilbert said ED would probably not do a PSA test. He also said the routine referral was inappropriate Patient 5 should have a follow up within a couple of weeks. He question if this was systemic in the trust or just the individual.

Patricia Kingsnorth asked if the haematuria was bleeding.

Mr Gilbert said if haematuria or not retention was an early referral. He said MrO'B had taken him in early which is normal practice, he should have examination done. If Patient 5 was seen 2 weeks after this may have been too early for PSA but Mr Gilbert would have done it anyway. Mr Gilbert suggested this should have happened within urology but suggested MrO'B may have been distracted with the renal mass and abnormality CT scan. Bone mastitis unusual. He questioned if it was presented to MDT. Coincidental findings Patient 5 may then have been took back for PSA. If presented to ED.
Mr Gilbert feels the key problems are 1. Patient 5 shouldn't have been routine referral, family right to get appointment. 2. If he was effectively assessed at appointment – Mr Gilbert feels he wasn't.

Dr Hughes advised the family has submitted questions. Delay of 8 months from reporting of CT to treatment. He advised Patient 5 on treatment now and doing fine.

Mr Gilbert suggested the CT done December reported in January and seen in August.

Patricia Kingsnorth said consultant radiologist had reviewed previous scans, no changes on previous scans in March and June. Nobody reviewed CT scan until July. MrO'B saw the scan and then Mr Haynes.

Dr Hughes said Patient 5 didn't have access to a specialist nurse, but confirmed he has one now.

Mr Gilbert said if a cancer nurse had been in place they would have drawn attention of the scan. One of the important skills specialist nurses has they a meticulous in tracking patients.

Dr Hughes said there are specialist nurses for all other patients in urology except MrO'B.

Mr Gilbert queried if Patient 5 had come to any harm and believes he didn't. He believes if TMcC had started hormone treatment sooner it would not have affected his survival. In spinal cord guidelines start sooner rather than later. Don't know if come to any harm.

Dr Hughes believes the family are affected psychologically.

Mr Gilbert doesn't feel Patient 5 came to any harm with the miss diagnosis but can say it hasn't affected the family psychologically.

Patient 2

There was delay in the referral to oncology.
Dr Hughes advised no specialist nurse given at the time. Non action. MDT referral took up at second MDT and spoke to regional MDT. Letter sent to patient from Belfast Trust. Patient 2 went for chemotherapy.
Psychologically all at one with himself, has other medical issues. Care reasonable. Inaction of MDT recommendations. Dr Hughes suggested he may ask MrO'B why.

Mr Gilbert asked if most MDT processes automatic – need presented to regional MDT.

Patricia Kingsnorth said she did ask the solicitor for MrO'B to comment but no comment as yet but MrO'B has had a recent bereavement.

Dr Hughes said he hadn't asked on individual cases he wants to ask specific questions.

Patricia Kingsnorth suggested they may not get a response back.

Dr Hughes said they can go back but they need to respect the bereavement.

Patient 7

Has a small regal mass. For straight forward pathology. Seen several times by medics. MDT did not ask MrO'B why it was not discussed at renal meeting. There was no MDT meeting recorded. Did have radiological input. There were a lot of appointments missed and not done in a timely manner. No specialist nurse allocated, leading to no support.

Mr Gilbert highlighted the important point of having no cancer nurse. He advises their input is invaluable. They would have tracked the patient's development. He suggested there may have been 40 – 60 referrals to MDT. He can understand there was no referral to the regional MDT.

Dr Hughes advised another consultant took over the care and wrote to complain to the GP about the locum not attending the MDT. Dr Hughes said he was going to discuss the letter with the consultant.

Mr Gilbert found it bizarre and unfair what the consultant did towards the locum. He believes all at MDT knew the behaviour by MrO'B was wrong but were not willing to raise the alarm. He suggested they should have spoken to the assistant medical director or the director.

Dr Hughes advised he will add this to the overarching report, he feels they need to capture the role of MDT and none adherence of MDT for patients care.

Mr Gilbert it's exclusive of those who could support patients and cancer specialist nurses.

Patricia Kingsnorth asked for clarification if specialist nurses attended the locum appointments.

Patricia Thompson specialist nurses were excluded by MrO'B. She thinks there was a specialist nurse with Patient 7 .

Dr Hughes said he would ask MrO'B about specialist nurses. He said specialist nurses are there to give aspects of care not given by consultants.

Patient 9

Patricia Kingsnorth said they need more on findings from Mr Gilbert regarding hormone treatment not pursued after biopsy.
The need for referral to MDT. Enough evidence to start treatment.

Mr Gilbert said an enlarged prostrate is not necessarily for blockage. It may be abnormal. May have an elevated PSA. He said a scan was needed and a needle biopsy. A needle biopsy would have shown prostate cancer. Patient was continued on inappropriate treatment. It would have been in the best interest to have TURP prior to radiotherapy, but would have needed definite diagnosis. Potentially normal life expectancy may have been lost. He suggested anyone can write to oncology.

Dr Hughes said he would add to the overarching report.

Mr Gilbert suggested it was straight forward there was clear evidence of prostate cancer. Needle biopsy would have given the opportunity for treatment. When he was referred back it was beyond control.

Dr Hughes said it was only picked up when referred for renal mass. First MDT was lower GI.

Patient 3

Mr Gilbert said there should have the opportunity to send to regional MDT. This case should have been managed by experts in penile cancer. Seen between 10 – 20 penile cancer patients. This shouldn't have been done in a local hospital.

Dr Hughes said case seen at MDT. He advised he had met with the medical director and her preferred option should have been through the regional pathway. He believes this is an issue within Northern Ireland.

Dr Hughes said in this case it was discussed several times at MDT but all MDT weren't following regional best practice. In other cases it was an individual.

Mr Gilbert said in this case there was a failure to make the appropriate referral.

Mr Gilbert agreed to review 4 cases by Wednesday AM. Patricia Kingsnorth to send through other reports.

Dr Hughes will arrange meeting with staff. He said the manager of surgical services was aware of the behaviour but not aware of staff not adhering to MDT and excluding staff. MrO'B was subject to another SAI and professional care. He suggested they should have found facts not guilt and said it was a protracted issue. He had spoken to Joe in Belfast who has been aware for 17 years of his professional practice.

Mr Gilbert suggested the need to intervene in either a supportive or police like way. He found this concerning.

Dr Hughes believed the staff had an attitude it's someone else's problem. The Southern Trust gave assurance without evidence.

Mr Gilbert said self-certification through peer review is not doing you an injustice if not doing fine. He said this is not only a problem with clinicians, doing a review an issue with the system, needing a broader discussion. Peer review regarding specialist nurses and a high volume of cases.

Next meeting 8 February 2021 at 9.30am

Fiona Reddick to check if patient in 62 or 31 day.

Governance Office, Ground Floor, The Maples
Craigavon Area Hospital
Tel: Personal Information redacted by the USI
E-mail acute.governance@southerntrust.hscni.net

Southern Health and Social Care Trust

Acute Governance
UROLOGY
8 February 2021 @ 9.30am

PRESENT: **Dr D Hughes**
Mr Hugh Gilbert
Patricia Kingsnorth
Fiona Reddick
Fiona Sloan
Patricia Thompson
Roisin Farrell, Note taker

Mr Gilbert advised he had sent the reports back to Patricia Kingsnorth. He advised he had put all in blue and his points were in red, he offered to put them in the correct format.

Dr Hughes is happy with Mr Gilbert's format and said he would marry both reports. He suggested it would be helpful to add expected pathway. He advised he had started the overarching report. He is looking at the findings and onward referrals for best practice. He knows what happened, but needs to highlight why it happened. He is not sure everybody realises patients were not getting the right treatment or support.

Mr Gilbert doesn't understand why colleagues didn't question why patients were not on right pathway in the MDT.

Dr Hughes doesn't know why there were no referrals to the specialist nurses. He thinks they may not have known the extent of the non-referrals. He may get clarification at the meeting on the 18th February. He advised he is meeting with the families on 18, 19 & 25 February. He believes some of the families are vulnerable. He said patients with the least deficit are most angry.

Patricia Kingsnorth believes families don't understand and it's the not knowing.

Dr Hughes said Patient 8 had a missed prostrate and Patient 7 issue with treatment.
He said it is unlikely he will be able to give families draft reports before 28 February.
He added they have received questions from MrO'B solicitor.

Mr Gilbert is not sure what the solicitors are asking.

Dr Hughes advised the lead, chair of the committee are drawing up guidelines.

Mr Gilbert suggested it was the lack of control of MrO'B practice.

Patricia Kingsnorth asked Mr Gilbert to stay on after the meeting.
She introduced Fiona Sloan and advised she was going to be the link for the urology patients. Fiona Sloan would be attending the meetings with Dr Hughes, Patricia

Governance Office, Ground Floor, The Maples
Craigavon Area Hospital
Tel: Personal Information redacted by the USI
E-mail acute.governance@southerntrust.hscni.net

Kingsnorth and the families. Patricia Kingsnorth said once the internal review concluded she would be taking a back step.
Patricia Kingsnorth read the "outline of summary" from the draft report.
Mr Gilbert advised there were corrections in the text.

Patricia Kingsnorth read the "description of incident" from the draft report. She read out the findings and conclusion. Patricia asked if anyone had comments to make.
Mr Gilbert advised he had only deleted his own comments.

Patricia Kingsnorth shared the draft report on the computer. She asked if staff had any comments. None.

Mr Gilbert referred to the red type in the report he returned to Patricia Kingsnorth and advised he had made various changes to the findings. He advised he had taken every point from the case and collated them into a format for the report, anything open to interpretation he took out.

Dr Hughes suggested putting the red text in as the findings.

Mr Gilbert said he was trying to put the report into a logical sequence.

Dr Hughes said they were setting a high bar and which would be unequivocal. He said they may add references to local guidelines to set into a Northern Ireland context.
Dr Hughes asked Mr Gilbert if he would do the same process for the rest of the reports.
Mr Gilbert happy to do.

Dr Hughes advised issues still outstanding. He asked if any patients were on the 31 day pathway.

Fiona Reddick advised she had gone through each case. Some were on 31, were incidental findings, 62 were referrals from GP. She confirmed she would check if treatment started in a timely manner and will send information through after the meeting.

Mr Gilbert referred to the testicular case – he believes it was totally inappropriate gaming around 31 and 62 day policy.

Fiona Reddick agreed with Mr Gilbert and advised how some of these are recorded and some are not on the correct treatment.

Dr Hughes questioned in terms of prostate cancer, received incorrect treatment how they met the timeframe.

Dr Hughes flagged the appropriateness of getting the right care.

Patient 2 :
Patricia Kingsnorth asked Mr Gilbert if he wanted to add to the report.

Mr Gilbert didn't want to add to the report.

Dr Hughes advised he will reedit the reports and send out to the review team. He advised the finding will be broken down. He added he needs to include why it happened.

Patricia Kingsnorth agreed to send out the reports and asked the team to review and provide her with any comments.

Dr Hughes said he cannot always say "why" but can say what is expected. But it needs to be escalated to the governance pathway. He added he would appreciate views for the overarching report. He believes the core issued is the recommendations from MDT and the outcomes from the MDT.

Mr Gilbert on phone couldn't make out what he was saying.

Dr Hughes said MDT is none quorate, senior staff didn't challenge the behaviour.

Mr Gilbert suggested as it was portrayed as direct criticism.
Dr Hughes said patients didn't get multidisciplinary care because the doctor decided not.

Fiona Reddick said it was a very important point from Mr Gilbert. She said decisions made weren't quorate as oncologists were not there, no decisions made.

Dr Hughes said oncologist were aware from 17 years, but not locums. But believed the bottom line MDT provided the recommendations but there weren't followed up. Dr Hughes said he would draft the reports and forward them to the review team this week.

Patricia Thompson said from reading the report she felt there was nothing to add apart for the lack of support for the patients.

Meeting closed.

Next meeting 15 February 2021 @ 2pm

Governance Office, Ground Floor, The Maples
Craigavon Area Hospital
Tel: Personal Information redacted by the USI
E-mail acute.governance@southerntrust.hscni.net

Southern Health and Social Care Trust

Acute Governance
UROLOGY
15 February 2021 @ 2pm

PRESENT: **Dr D Hughes**
Mr Hugh Gilbert
Patricia Kingsnorth
Fiona Sloan
Patricia Thompson
Roisin Farrell, Note taker

Fiona Reddick – Sent her apologies.

Patricia Kingsnorth sent the review team a copy of the draft report.

Dr Hughes advised he had formatted the report and had taken Mr Gilberts comments and added them as bullet points. He advised he has started the overarching report and has started comments of the patient's journey. He said he had also started the governance pathway. He added the more they speak to staff he believes it was known at MDT and oncology. He has spoken to the AD for cancer and he wasn't aware. He said they raised concerns regarding the attendance at the MDT by oncology and radiology. He added there was an audit done but not in the areas they knew there were concerns. With regards to the MT case, it was missed for 8 months but was said to have achieve his target. Patient 9 case was delayed for 15 months and it was said it would have met the 31 day. Another cancer patient was on the wrong track of treatment.

Mr Gilbert advised he was a big fan of targets. He feels performances are used to support organisations.

Dr Hughes said there should be an exceptional audit for learning. He advised he will be attending the MDT meeting on Thursday 18 February. He feels they should be advised before putting into the report. He said the MDT chair is rotated on a weekly basis.

Mr Gilbert said for the equivalent in England the chair would be the first consultant there. But every patient would be discussed and after the meeting the chair would liaise with admin to make sure all was processed.

Dr Hughes believes there is no continuity, he does not know if there is a job description for the chair. He feels there was an opportunity to identify concerns, concerns were known but not escalated.

Patricia Kingsnorth received an email from Barry Conway to advise her there was no job description for the chair of MDT, it is part of their job.
Dr Hughes said that usually the chair is funded. He suggested if it is not funded and no learning coming from it.

Governance Office, Ground Floor, The Maples
Craigavon Area Hospital
Tel Personal information redacted by the USI
E-mail acute.governance@southerntrust.hscni.net

Patricia Kingsnorth asked if the review wanted to discuss early recommendations as they were meeting with the families next week.

Dr Hughes said the first stage when meeting the families is to go through the draft report verbally. He wants learning from their individual cases. The issues were not following MDT. Working in isolation even when the support was there. He said they may be asked how it happened; he said nurses were not allowed to attend.

Mr Gilbert said for families they are interested in their loved ones, naturally in due course they will ask why it happened.

Dr Hughes suggested first they met the families to advise them of the review, secondly to verbally give them the report and then thirdly to provide them with the written report and with feedback from the family to be included in the report.

Mr Gilbert suggested they can only say they were unsure why it happened but will try to put in place a system to prevent it happening again.

Dr Hughes said they had arranged 1 hour with each family. He said he would be telling the family these are the problems but would be coming up with robust recommendations to try to prevent it happening again. He feels the families will have a lot to take in.

Mr Gilbert agreed, families will only hear their loved ones weren't properly treated.

Patricia Kingsnorth said families are aware especially from their loved ones have died.

Dr Hughes said families will be reacting to what they are faced with.

Mr Gilbert feels families may say "they would say that". He offered to support staff at the meeting if needed.

Dr Hughes thanked Mr Gilbert. He said he would give the draft report to the families when they received feedback from MrO'B solicitor. He advised the draft report needs completed by 28 February for submission to HSCB.

Mr Gilbert believes there are more than enough cases to have the review.

Dr Hughes said he can tell families the start list of inactions. He said resources were available.

Mr Gilbert said all patients deserve full multi-disciplinary discussions on their cases and said this didn't happen. He agreed resources were there.

Dr Hughes believes MrO'B took the wrong decisions. MDT was there to advise on patient care and to protect the consultant.

Patricia Kingsnorth advised there was an article in the Irish News at the weekend from an MLA stating the Southern Trust was victimising and picking on MrO'B and had took the concerns to the Health Minister.

Dr Hughes said the report is not about MrO'B but the care 9 patients received, and have bench marked it against the care of other patients.

Mr Gilbert said MrO'B was not being victimised, he added MLA's represent their constituents the Southern Trust is there to represent patients care. He added his opinion in the report is backed up by his peers. He added there is flexibility in medicine.

Dr Hughes said the care patients received was outside the recommendations of NICE and NICAN and MDT. He also added there was a support group for MrO'B on Facebook.

Patricia Kingsnorth feels they are taking the right approach and said the care falls short of the guidelines.

Dr Hughes said MrO'B ignored recommendations of his own peers and input from professional colleagues and did not refer on to other professional colleagues. This ran from 2016 – 2020.

Patricia Kingsnorth advised patients from other consultants were referred on.

Dr Hughes 8 or of the 9 recommendations from MDT was right but not acted on.

Patricia Kingsnorth asked if the review team needed to find out if there was deficit from other consultants.

Dr Hughes feels moving from reviewing 9 patients care to reviewing larger amount would not be appropriate.

Patricia Kingsnorth asked if it would be appropriate to review cases.

Dr Hughes suggested maybe a review of 50 cases.

Mr Gilbert reconnected via telephone.
Didn't think it would be helpful and it may look like they were picking on MrO'B.

Dr Hughes said he had asked staff if they use specialist nurses. He will ask at MDT if recommendation are made, do they adhere to this and if not why not. What do they do?

Patricia Kingsnorth advised she had received confirmation from Mr Mark Haynes there was no job description.

Dr Hughes advised with no clarity or payment for this role they may not be able to action as a chair but would be able to raise their concerns via datix.

Patricia Kingsnorth asked if the review team needed any further information.

Dr Hughes advised they needed clarity around the knowledge of who was using nurse specialists, HOS Martina Corrigan was aware and escalated it to AD Heather Trouton. The director and associate director of cancer services were not aware.

Patricia Kingsnorth suggested there was a tolerance of MrO'B's work.

Dr Hughes suggested the management of MrO'B was on needs of the profession and not the needs of the patient.

Patricia Thompson read the reports.
Patient 4 - Regarding the induction dose. She advised MrO'B documented patient got dose on ward.
Patient 1 – She advised there was an appointment in SWAH and believes a number could have been given to the patient.

Dr Hughes said these were very good points. He suggested even if specialist nurse was not allowed in the appointment with MrO'B, he questioned why they didn't share a number.

Patricia Kingsnorth asked Patricia Thompson to check with SWAH if outpatient staff is aware of the specialist nurses.

Dr Hughes said even patients seen in the Southern Trust not given contact details of specialist nurses.

Patricia Thompson asked if patients admitted to wards, staff there should have contacted specialist nurses.

Patricia Kingsnorth is aware of specialist nurses for stoma being contacted.

Dr Hughes thinks it's important to drill down, he doesn't want to portray if this is not the case.

Patricia Thompson to follow up.

Mr Gilbert said with Patient 4 getting his induction does on ward the report will need to be changed to reflect this, he thought Patient 4 had got a lower dose at outpatients.

Patricia Kingsnorth and Patricia Thompson to liaise to review and confirm in notes.

Dr Hughes advised he would work on the recommendations and was attending the MDT meeting on 22 February at 9.20am.

Patient 6 – Patricia Kingsnorth advised Patient 6 made contact to say he would wait to get the report.
Patient 8 – a solicitor's letter was received on his behalf, but she was still liaising with him for meetings.

Mr Gilbert advised he had asked his peers about PSA and was advised this is not done by ED, they would refer the patient to the specialist. He believes ED did what they needed to do. He advised if patient had SPA done during an acute episode this may not have given the right report.

Dr Hughes advised there was a DRE at ED.

Patient 5 – Patricia Kingsnorth asked if age was an issue. He was Personal Information redacted by the USI years old. Mr Gilbert believes not in this scenario, it's a question of doing PSA in patients over 80 as they may not be fit for radical treatment. He believes it is reasonable to do PSA or bone scan. MrO'B did bone scan later after PSA. He feels they should do PSA test. An independent review for treatment of metastatic cancer, give hormone treatment sooner than later. Early to prevent fractured legs. Will not improve his survival rate.

Mr Gilbert does not believe the [redacted] has suffered, he may have benefited from not been on hormone therapy.

Dr Hughes advised the family of [redacted] said their father was tired.

Mr Gilbert advised this would be down to the hormone therapy. On balance there needs to be continued surveillance not only from Dr 1 (MrO'B) but input from specialist nurses, this patient was denied this continuity of care.

Meeting concluded.

Governance Office, Ground Floor, The Maples
Craigavon Area Hospital
Tel: [redacted]
E-mail acute.governance@southerntrust.hscni.net

Southern Health and Social Care Trust

Acute Governance
UROLOGY
22 February 2021 @ 9.30am

PRESENT: **Dr D Hughes**
Mr Hugh Gilbert
Patricia Kingsnorth
Patricia Thompson
Fiona Sloan
Roisin Farrell – Note Taker

Dr Hughes provided feedback about the meetings with the families involved with the exception of Patient 6, he has declined further communication and has requested a copy of the report. He described the meetings as quite difficult.

Patient 7 – the family have reflected from the previous meeting and are happy with the care Patient 7 received. Their concerns are around governance and want assurance around the care of other patients.

Patient 5 – family reflected from previous meeting. They thought the care for their father's tumour was good. They queried the PSA and the role of the urologist. The advised their father is doing better. Dr Hughes advised the family he had got the scan reviewed retrospectively and there were no issues. They were seeking assurance on the scan. They asked if his cancer had been detected earlier would it have made a difference.

Mr Gilbert was certain with hindsight his outcome was not affected.

Dr Hughes said they asked would he have had the same degree of metastasis if seen earlier.

Mr Gilbert advised this was an unanswerable question, still feels he would have the same longevity. He does feel it may have progressed and Patient 5 may have more metastasis.

Patient 2 – Dr Hughes advised Patient 2 has considerable arthritis. He had concerns around governance. Dr Hughes referred to the MDT follow up of 31 & 62 day. He described the tracking as a 3 leg stool when you take on away it all falls.
He told Patient 2 about the SAI review in 2016. He advised it had gone on for 4 years which caused a delay in recommendations. The main concern is the pathway. If the patient or family knows what is going to happen they would follow up.

Patient 8 – Dr Hughes advised from cancer point of view Patient 8 is doing well. He does have consequences of TURP's.

Patricia Kingsnorth asked if the 5 year delay would symptoms been less troublesome.

Governance Office, Ground Floor, The Maples
Craigavon Area Hospital
Tel: Personal Information redacted by the USI
E-mail acute.governance@southerntrust.hscni.net

Mr Gilbert said if symptoms bad enough to warrant surgery he feels yes. In his own opinion the 5 year delayed surgery would have made symptoms worse.

Patient 1 Daughter – Dr Hughes advise family not in a good place.
Their concerns were they were unaware Patient 1 was given in appropriate treatment and hadn't been on the proper pathway. Patient 1 Daughter recalled MrO'B contacting them after Patient 1's death and advised the biopsy didn't reflect the cancer.
Dr Hughes feels it was one of those self-serving statement he has heard before.

Mr Gilbert feels it was a good biopsy and should have been referred on.
Dr Hughes said he would reflect all the patient/families concerns in the reports. He advised of a local politician coming out in support of MrO'B and that families feel hurt.

Mr Gilbert believes politicians are putting themselves in the firing line and should wait for the results of the enquiry.

Patient 9 – Dr Hughes spoke to the family at length. Patient 9 has 5 children who asked to attend the meeting. Dr Hughes felt Patient 9 had told the family but believed the family were quite shocked at what they were being told. It was a difficult meeting. He was asked if this was not 1 person but a lot how did this happen. Dr Hughes believes one of the issues us how did this happen.

Patient 4 – Dr Hughes advised the family were unaware there was no input from oncology or palliative care. Family also concerned how did it happen, how did no one know it was going on.

Mr Gilbert has concerns regarding consent.

Dr Hughes advised patients were not aware they were not being treated normally.

Dr Hughes advised he had met with MDT. He described it as "quite silent conversation". He advised some urologists trained in UK mainland and they questioned the Southern Trust processes. One consultant suggested the team go back to the guidelines. He advised the patient had flutamide treatment. Dr Hughes feels urologists are concerned about themselves. He explained he had gone back to the Medical Director to give an update. Dr Hughes queried why recommendations not been taken forward. He also discussed resources.

Mr Gilbert believes there are issues around MDT, not properly structured. Issues with members attending but there is a separate issues with the inappropriate treatment. He suggested asking MDT if this is the treatment MDT agreed.

Dr Hughes advised there are issues they are aware of. He spoke to the AD & AMD of CCS, they were not aware.

Mr Gilbert suggested people did raise concerns.

Dr Hughes said they were aware if the absence of oncology and radiology but not aware of the internal issues.

Dr Hughes advised he would draft the findings and learning. He believes there are issues they are not aware of, onward referrals to palliative care. The recommendations need to be a retrospective review. It's concerning especially when patients are not being brought back to MDT.

Governance Office, Ground Floor, The Maples
Craigavon Area Hospital
Tel: Personal Information redacted by the USI
E-mail acute.governance@southerntrust.hscni.net

He said the review team need assurance it is not systemic.

Mr Gilbert advised he is the part time urology lead for IRM and believes that is the reason he is doing this review as the Southern Trust approached IRM. He advised there are 2 processes going on. The Trust is going back to review and has asked for guidelines. Asked to do structure guidelines review. He asked if anyone was aware.

Dr Hughes is aware and asked not to be told about this, and he believes families will welcome this especially as it is an issue in Northern Ireland with urology.

Patricia Kingsnorth advised she had received some correspondence from MrO'B in respect of Patient 1 & Patient 9, the review team should have response by the end of this week or start of next week; she advised she would share correspondence with MR Gilbert.

Mr Gilbert happy to look at responses being provided by MrO'B.

Dr Hughes feels issues are black and white but raise significant concerns.

Mr Gilbert feels it concerning the chair of MDT asked the review team to read guidelines. He added the chair referred to MrO'B 13 times and never once mentioned the patients.

Dr Hughes advised he had added lessons learnt into the report, but advised some may be recommendations. Dr Hughes read from the lessons learnt in report. He feels there are mechanisms in place. He also advised the chair of MDT has no job description and should be. Dr Hughes does think MDT has an understanding.

Dr Hughes advised there are themes for recommendations - Need robust governance structure, he feels there is an issue in culture.

Mr Gilbert feels staff knew about issues.

Dr Hughes feels they need to capture this in the report.

Patricia Kingsnorth feels the feedback from staff was "oh that's just Aidan".

Dr Hughes feels it was professional centred care and not patient centred care. staff have more concerns regarding professional.

Mr Gilbert questioned professional. He advised working in an unprofessional way, MrO'B will feel the consequences. He doesn't understand anyone in a professional way can harm patients. He appreciates MrO'B is a caring person.

Patricia Kingsnorth said it is hard to understand as she would have the knowledge, but to provide treatment so far off base and make patients feel protective, which is concerning.

Mr Gilbert said you need good clinical practice and quoted "you don't need to be a nice doctor to be a good doctor".

Dr Hughes feels MrO'B is very personable. He said when trying to understand "why" he can't. He feels non-referrals verging into cruelty.

Mr Gilbert advised the duty of a clinician is to ensure patients get best treatment. He added the penile patient should have been referred. He is not sure how MDT works in Northern Ireland but knows patients are entitled to best treatment and if not being done this needs to be highlighted.
He referred to Patient 7 – feels if an initial plan had been in place there would have been less confusion.

Dr Hughes expectations of MDT should have been driven by doctors.

Patricia Kingsnorth asked Patricia Thompson if any feedback from MDT regarding specialist nurses.

Patricia Thompson advised the specialist nurses were concerned it would be a question answer. She advised specialist nurses felt concerned at MDT but by the end felt more reassured. She advised they were happy to meet today.

Dr Hughes advised he was happy to meet with specialist nurses.

Patricia Kingsnorth advised they had tried to set up 2 meetings in January and advised the specialist nurses were not being ignored.

Dr Hughes asked if staff had any other thoughts.

Fiona Sloan asked about the review back in 2017, she asked did this not raise alarm bells with MrO'B, was there no protection plan.

Dr Hughes advised the review was around red flag referrals. The review team had made multiple recommendations.

Patricia Kingsnorth advised there were concerns raised as far as SMT. Notes left at home, referrals kept in drawers. Did review 5 patients may have suffered. Significant defect of care, learning focused on triage letters. The issues were with admin. There was no concerns regarding practice or nobody raised any concerns.

Dr Hughes confirmed issues were referrals and advised nobody asked at an early stage regarding pathway, this was a missed opportunity.

Fiona Sloan suggested it was a risk management – admin.

Dr Hughes is concerned with what is on Facebook, referring to admin. He explained it is about patient care. The trust didn't take the opportunity to ask about patient pathway.

Fiona Sloan said it is alarming it was missed.

Mr Gilbert believes the issue is with governance it is not robust enough.

Patricia Kingsnorth advised she sent the reports to Mr Gilbert and asked him to review and add ant recommendations in red for the individual cases.

Mr Gilbert advised each family should have the precise learning for their loved ones.

Patricia Kingsnorth asked Patricia Thompson to review the cases. Patricia Kingsnorth will provide Mr Gilbert the kardex.

Governance Office, Ground Floor, The Maples
Craigavon Area Hospital
Tel: Personal Information redacted by the USI
E-mail acute.governance@southerntrust.hscni.net

Mr Gilbert feels there may be an issue with regards to what is documented and word of mouth.

Patricia Kingsnorth advised reports needed completed by Friday. Need response fairly quickly. Fiona Reddick is on annual leave.

Mr Gilbert will work on reports tomorrow 23/02/2021.

Dr Hughes relayed to Mr Gilbert that the families are immeasurably grateful for his input.

Patricia Kingsnorth said the families appreciated his honesty.

Next Meeting Friday 26 February @ 2.30pm.

Governance Office, Ground Floor, The Maples
Craigavon Area Hospital
Tel: Personal Information redacted by the USI
E-mail acute.governance@southerntrust.hscni.net

Southern Health and Social Care Trust

Acute Governance
NAME SAI review team
WHERE via zoom
DATE 26 FEBRUARY 2021

PRESENT: Dr Dermot Hughes

Mrs Patricia Kingsnorth
Mrs Fiona Sloan
Mr Hugh Gilbert
Mrs Patricia Thompson

Mrs Kingsnorth thanked everyone for attending the meeting.
Mrs Kingsnorth advised there are changes to be made to the report.

Discussions were had about were apology would be best placed in the report.

Dr Hughes advised SHSCT have ownership, apology would be best placed at the beginning. All present agreed.

Mrs Sloan advised she spoke with [Patient 1] family and they have asked for the report to reflect their father's personal experience. Fiona asked were would that be best placed in the report.

Dr Hughes advised could be added to the overarching report. It would be fair to include the family words and capture their own experiences in the overarching report.

Mrs Sloan advised family happy not to meet again if there was nothing new to be added to the report.

Mrs Kingsnorth queried [Patient 7] follow up appointment following CT , he never received a follow up appointment. Patricia will check with Martina HOS.

Mrs Kingsnorth advised the start will set the tone of the family report with apology.

All agreed to put apology at the beginning of the report.

Mr Gilbert advised there was a deficit with all cases, some lesser extent than others. This is unequivocal SHSCT and not just one person or group of people.

Mrs Kingsnorth advised the conclusions will address the lessons learnt, thanking families for their contribution acknowledging the stress it caused.

Governance Office, Ground Floor, The Maples
Craigavon Area Hospital
Tel: [Personal Information redacted by the USI]
E-mail acute.governance@southerntrust.hscni.net

Lessons learnt are all learning points for the Trust.

Mr Gilbert advised they are appropriate recommendations and more importantly provides families with assurance.

Patricia advised it is important recommendations are good and SMART. (specific, measurable, attainable relevant and timely).

Rec 1 & 2 read out – Hugh advised patients should have understanding of all treatment options and risks. Agreed.

Rec 3 read out – agreed

Rec 4 – read out and agreed

Rec 5- read out – minor changes to wording.

Rec 6 read out – agreed

Discussions were had about patient not brought back for further discussion at MDT and no CNS offered . There are system problems.

Dr Hughes advised CNS is not just a safety net but an advocate for the patient, they were not given this opportunity, this was a major deficit to patient care. This needs to be a separate statement.

Mrs Kingsnorth advised CNS should be at MDT , nurses to ask for patients to be brought back at MDT.

Mrs Thompson advised CNS currently can ask for patients to be brought back to MDT.

Discussion were had about MDT, Mrs Kingsnorth asked are lists automatic or do consultant bring their own case load. Mr Gilbert advised he does not believe people were completely unaware, hard to keep a secret of such in the working place.

Dr Hughes advised if people did not know, they should have known, it is the responsibility of senior management to know what is going on.
Dr Hughes advised the system does not work, there needs to be a person appointed to Governance such issues.

Mrs Thompson advised sits under wrong division,

Mrs Kingsnorth asked were SMT are aware of this, aware of bicalutamide?

Dr Hughes advised there is no system in place to detect errors.

Dr Gilbert agreed – system not in place, audits should be done to spot outliers, structure should be there to make anyone aware of issues, if no structures therefore issues are unknown. It is senior managements job to ensure such structures exist.

Governance Office, Ground Floor, The Maples
Craigavon Area Hospital
Tel: Personal Information redacted by the USI
E-mail acute.governance@southerntrust.hscni.net

Dr Hughes advised peer review- data was weak, audits were not rigorous enough , AMD should have overseen this. There was one meeting then Covid halted this.

Mrs Kingsnorth asked was report too critical of SMT.

Dr Hughes advised the Trust needs a system in place

Mrs Kingsnorth asked was all this down to one person.

Mr Gilbert advised a clear job description would allow better understanding of all roles and responsibilities. The current system in place does not support the clinical lead in their governance role. This needs addressed. Mr Gilbert advised ultimately it is the responsibility of all.

Recommendations agreed.

Reports were read out, minor changes to be made. Mrs Kingsnorth to make the agreed changes and share on egress and with the team.

Patient 7 **- - mechanism to check staging scans were actioned.**

Patient 5 **- confirmed ED did actually refer red flag.**

Patient 1 **- no CNS – could have flagged patient. Agreed many deficits in patient care. Lessons learned deviation from MDT recommendation. Findings to help protect other patients.**
Recommendation to address this-

Patient 6 **- keep conclusion , recommendation agreed.**

Patient 8 **– routine failsafe mechanism required to prevent from happening again.**

Patient 3 **– all happy with report.**

Patient 9 **- a paragraph added to express condolences.**

Patricia advised draft copy to HSCB, Fiona will phone families to advised reports going out. Still need to update overarching report.

Mrs Kingsnorth advised there has been no correspondence from Mr OB's solicitors.
HSCB will be advised there may be changes, staff to check for factual accuracy.

The meeting ended.

Governance Office, Ground Floor, The Maples
Craigavon Area Hospital
Tel Personal information redacted by the USI
E-mail acute.governance@southerntrust.hscni.net

Southern Health and Social Care Trust

Acute Governance
NAME :Urology SAI
WHERE: Mrs Patricia Kingsnorth Zoom
DATE: 12/04/2021

PRESENT:

Dr Dermot Hughes

Mrs Patricia Kingsnorth

Mr Hugh Gilbert

Mrs Patricia Thompson

Mrs Fiona Sloan

Minutes of previous meeting read out by Carly Connolly. Few amendments to be made. Carly to amend and share with all for approval.

Mrs Kingsnorth explained the process to date. Mrs Kingsnorth advised they have met with 2 of the families [redacted] and [redacted] with further plans to meet with [redacted] on Wednesday.

Mrs Kingsnorth advised [redacted] family have advised they have no comment to make with regards to the report. [redacted] daughter [redacted] has come back with comments and they will be discussed at the meeting. [redacted] daughter [redacted] has advised the recommendations do not reflect their fathers care. [redacted] advises he was not offered surgery and had he would have agreed to have this earlier, this option was never presented to him until October 2020.

Mr Gilbert advised information was taken from clinical notes which may not represent exactly what was said.

Mrs Kingsnorth advised the families understand the report was based on what was written in patient notes. Mrs Kingsnorth advised [redacted] opinion was that the discussion was never had about surgery until he attended his outpatient appointment in Oct 2020.

Mr Gilbert advised this was an important piece of evidence and important people are aware there are 2 versions of the truth.

Mr Hughes agreed the timeline/ analysis was taken from patient notes.

Mrs Kingsnorth advised [redacted] has sadly passed away and that she has been unable to get in touch with his family.

Mrs Kingsnorth advised there are 3 families in total to be contacted. [redacted] who has expressed his wish not to be contacted. [redacted] has contacted his solicitor and litigation will respond. Mrs Sloan will make contact with [redacted] family.

Mrs Kingsnorth advised comments have been received from the Cancer team, AMD for cancer services, clinical lead for cancer services, AD for cancer services.

Governance Office, Ground Floor, The Maples
Craigavon Area Hospital
Tel: [redacted]
E-mail acute.governance@southerntrust.hscni.net

Dr Hughes read out the response from the Cancer team and his response to each individual comment and rationale for each.

Comments discussed and agreed by all present.

Dr Hughes explained Clinical nurse specialists have highlighted they were never given an opportunity to be involved in patients care and would like this to be reflective in the report.

Mrs Kingsnorth shared [redacted] daughter [redacted] response to the report. The family felt abandoned by the Health service. [redacted] had his catheter in for a long period of time and this had a severe impact on his mental health. Family did try to contact the consultant in charge for removal but received no response. He had no CNS and therefore no other point of contact.

Agreed this impact can be added to family narrative of the report.

Hugh advised this issue is a deficit all over the UK and not just this particular patient. Waiting lists for catheter removal are extensive, capacity issues for TURP. There are many men waiting for this procedure and who have had long term catheters in place as a consequence. This is not the fault/ capability issue of one individual but rather capacity issuesacross the UK.

Dr Hughes highlighted [redacted] had no key worker and appreciates this may be a capacity issue. However, if CNS details had been provided this would have offered some support and lessened anxiety for the patient.

Mrs Thompson advised a key worker could have done a trial removal of catheter had one been appointed to [redacted].

Mrs Sloan advised [redacted] advised there was no support from community, the family felt unsupported, there were no contact details given and this was the main issue.

Mrs Thompson agreed a key worker for point of contact is a major loss and therefore can have psychological impact on patients.

Dr Hughes advised the report should address what should have happened, what care should have been provided to [redacted].

Mrs Kingsnorth advised she would link in with Mrs Thompson to conclude a form of words to reflect this.

Mrs Kingsnorth shared the clinical nurse comments.

Dr Hughes read out nurses comments and explained his response and rationale for same. All in agreement with responses provided. All agreed to change wording in report to highlight nurses were not given an opportunity to be part of patients care and are not the ultimate failsafe in patient pathway journey.

Mrs Kingsnorth asked Mrs Thompson if caseloads were shared, asking the question what happens when CNS is off on leave.

Patricia Thompson advised they are currently setting up new job plans, if on leave nurses will pass case load on to another colleagues.

Mrs Kingsnorth advised she would review reports and reword as agreed today in relation to CNS roles and responsibilities . Mrs Sloan will link in with [redacted] family.

Governance Office, Ground Floor, The Maples
Craigavon Area Hospital
Tel: [redacted]
E-mail acute.governance@southerntrust.hscni.net

Mrs Kingsnorth advised there has been no response from Doctor 1's Solicitor at this point. He was given to the 31/03/2021 to respond. Mrs Kingsnorth asked if everyone was happy for final report to submitted following today's agreed amendments.

Dr Hughes advised he would have welcomed a statement/ feedback from doctor 1, families would have welcomed this.

Mrs Kingsnorth highlighted it is now nearly 2 weeks past 31/03/2021 .

Dr Hughes advised we know what happened however we still don't understand why care varied from guidance/ MDT plan.

Mrs Kingsnorth advised she would make amendments , share and team would meet again.

Mrs Kingsnorth advised a group has been set up to work through recommendations. The report will be shared with HSCB and DOH. Families are aware DOH may wish to meet with them.

Next meeting : Monday 19th April 2021 @ 10am.

Governance Office, Ground Floor, The Maples
Craigavon Area Hospital
Tel: Personal Information redacted by the USI
E-mail acute.governance@southerntrust.hscni.net

Acute Action Plan

Reference:	**61920**
Submission Date for Assurance Response / Action Plan to Medical Director:	**19 July 2021**
Update Position *(date provided)*	
Operational Directors	**Melanie McClements Director of Acute Services**
Leads	**Dr Rose McCullagh Associate Medical Director Primary Care** **Ronan Carroll Assistant Director of Acute Services SEC** **Dr Maria O'Kane Medical Director**

Action Plan Urology 69120

Reference number	Recommendations	Designated responsible person	Action required	Date for completion/ timescale	Date recommendation completed with evidence
1	HSCB should link with the electronic Clinical Communication Gateway (CCG) implementation group to ensure it is updated to include NICE/NICaN clinical referral criteria. These fields should be mandatory.	HSCB/ SHSCT	The Trust to liaise with the integrated care team in the board to discuss the NICE/ NICAN clinical referral criteria		
2	HSCB should consider GP's providing them with assurances that the NICE guidance has been implemented within GP practices	HSCB	The trust is taking forward discussion with the HSCB re: the implementation of nice guidance.		
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.	SHSCT/ HSCB	NG 12 in relation to Haematuria has been agreed by NICAN. The Remaining recommendations form NG!" will be fully implement by July 2021 and will be	NG 12 Guideline in relation to haematuria is completed by SHSCT and will be completed by July 2021	

				regionally.	
4	GPs should be encouraged to use the electronic CCG referral system which should be adapted to allow a triaging service to be performed to NICE NG12 and NICaN standards. This will also mean systems should be designed that ensure electronic referral reliably produces correct triaging e.g. use of mandatory entry fields.	HSCB	The Southern trust will liaise with the lead for the communication gateway		
5	**TRUST** 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.	AD surgical/ AMD Primary Care	The urology service hold the view that to enable the referral process to be efficient and effective, the CCG form requires to have mandatory fields which require it to be completed prior to referral from Primary Care.		**COMPLETE** NiCan pathway. Bladder Cancer Pathway March 2020 Revised Prostate Diagnostic Pathway D Female Lower Urinary Tract Sympto Female Urinary Tract Infection.docx

					Male Lower Urinary Tract Symptoms.docx male urinary tract infections.docx
6	The Trust should re-examine or re-assure itself that it is feasible for the Consultant of the Week (CoW) to perform both triage of non-red flag referrals and the duties of the CoW.	AD Surgery/ AMD Surgery	Time needs to be made available in consultant job plans to undertake the task of triaging referral letters. Discussions are ongoing with MD and AD	August 2021 Ongoing discussions with AMD/CD & Urology Team and Zicardian on how this is recorded	
7	The Trust will develop written policy and guidance for clinicians on the expectations and requirements of the triage process. This guidance will outline the systems and processes required to ensure that all referrals are triaged in an appropriate and timely manner.	AD surgery	Currently the IEAP protocol is followed The current regional protocol is being updated.	Jan 2021	**COMPLETE** Integrated Elective Access Protocol - Apr

					 Integrated Elective Access Protocol Draft  FW IEAP referral.msg  Booking Centre SOP manual.doc  TRIAGE PROCESS 2. lmca.docx
8	The current Informal Default Triage (IDT) process should be abandoned. If replaced, this must be with an escalation process that performs within the triage guidance and does not allow Red-flag patients to wait on a routine waiting list.	AD Surgery		Nov 2020	**COMPLETE**
9	Monthly audit reports by Service and Consultant will be provided to Assistant Directors on compliance with triage. These audits should be incorporated into Annual Consultant Appraisal programmes. Persistent issues with triage must be escalated as set out in recommendation 10.	AD surgery	Reports will be sent to AD and AMD/ CD	Nov 2020	**COMPLETE**
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	MD		June 2021	The Trust has progressed a number of workstreams within medical management structures to strengthen systems for identifying and dealing with disruptive colleagues.

	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.				**Medical Leadership Review 2020/21** A review of the Trust medical leadership structure was conducted in 2020/21. As a result the Trust has commenced redeveloping the medical leadership structures which includes the introduction of Divisional Medical Director (DivMDs) roles which have additional clear responsibilities for providing clinical and social care governance assurance to the Medical Director and Chief Executive on all patient safety related activity in their division. The role includes monitoring multi-source feedback including: • Adverse Incidents / Serious Adverse Incidents/ Datix • Complaints • Litigation / Coronial Information • Mortality and Morbidity • Medicines Reconciliation • Professional Medical Governance • Staffing and Staff Management • Professional Performance Management • Appraisal and Revalidation • Patient Safety indicators • Risk Management / Mitigation and Reduction • Ensuring Delivery of Effective Evidence-Based Care These roles are being supplemented via the appointment of additional clinical director roles within divisions. (4 sample DivMD job descriptions attached below) during Quarter 2 2021/22.

					 DivMD JD IMWH (FINAL).docx  DivMD JD OPCC(FINAL).docx  DivMD JD SEC (FINAL).docx  DivMD JD EDUCC(FINAL).docx **Scrutiny of Adverse Incident Reports** The Trust has implemented a system for proactively sharing adverse Incident reports that feature medical staff recorded via the Trust Datix system with AMDs / (soon to be DivMDs) on a quarterly basis to quality assure and identify if there are any issues that require immediate or additional actions to be taken. Assurance on actions required / taken is sought by the Medical Director via monthly AMD meetings. **Doctors and Dentists Oversight Group** In 2020 the Trust established a Doctors' and Dentists' Oversight Group (DDOG) which is responsible for ensuring concerns, both professional and clinical are considered and appropriate actions taken to ensure patient safety are maintained across all Trust services. The DDOG is chaired by the Medical Director and attended by AMDs (soon to be DivMDs) / Deputy Medical Director for Workforce and Education and senior Medical Human Resources staff. The purpose is to have a regular formal meeting to give clinical managers the time and space to discuss established concerns and update on how they are being managed. It also allows

					managers to highlight possible concerns to encourage a consistent and appropriate response across the organisation with a strong focus on patient safety. **Trainee Assurance Mechanisms** Since 2020 the Trust induction arrangements for Medical Trainees include bespoke training in response to incidents / concerns raised that are recent and relevant. The Trust has developed 1 year Educational and Simulation Fellow Posts for senior trainees to assist the Deputy Medical Director in developing and delivering this evidence based training. In addition to this Learning from Coroner's cases, Medicolegal cases, complaints , Datix and Adverse Events is used to shape and inform the Trainees' educational programme at Trust and Divisional levels. Trainees can raise concerns / feedback with any aspect of their experiences in the Trust anonymously via the Trust SouthernDocs web portal. The Deputy Medical Director for workforce and Education has developed Quality Improvement programmes for doctors at all levels within the Trust to improve confidence in addressing areas of concern, including a Navigator Programme for those transitioning from trainee to Consultant and SAS grade particularly those new to Southern Trust. **Management of Concerns** ***Management of Concerns Guidance Documents*** The Southern Trust has developed local guidelines for how to manage concerns involving substantively employed doctors and

					separate guidelines relating to Agency Locum doctors. The Managing concerns about Agency locum doctors guidance was developed in collaboration with the Employment Liaison Advisor from the General Medical Council and to their knowledge it is the first of its kind across the UK. The Trust has also developed a Guidance document for assessing concerns and making judgements regarding risk for clinical managers.    SHSCTHandlingconce rnsaboutAgencylocur SHSCT-Guidelinesfor HandlingConcernsabc SHSCT-AssessingCon cerningandJudgingRis ***GMC Liaison*** There are regular meetings between the Medical Director and the Employment Liaison Officer of the General Medical Council (& Head of Medical HR) to discuss ongoing GMC cases, and any possible current concerns with doctors (including all locum doctors) so that consideration can be given to thresholds for possible referrals to the GMC Regulatory Body. ***Online Information and Information Sharing*** The Southern Trust has developed an easy online portal to allow clinical managers to share information directly to the Medical Directors office. This online form is sent to the Medical Director and a generic email account – *medicaldirector.concerns@southerntrust.hscni.net.*

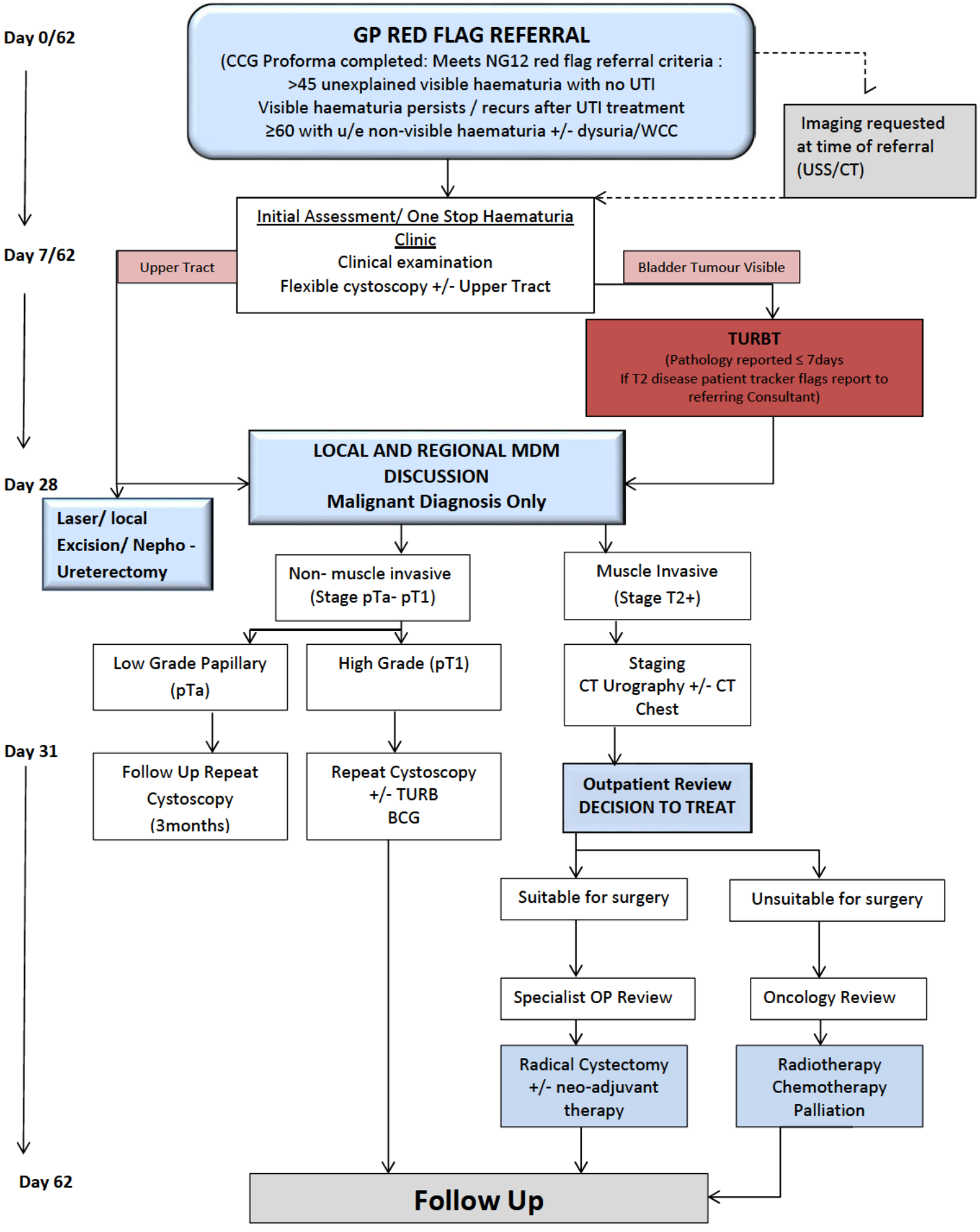
					Training Sessions The Southern Trust arranges and runs training sessions (the most recent of which took place in March 2020) arranged with our clinical leads to take them through how to manage concerns about doctors (both employed doctors and locum doctors). This training was facilitated recently by NHS Resolution (formerly NCAS). ***Support for Doctors in Difficulty*** The Southern Trust has launched a Supporting Doctors in Difficulty Hub to provide clinical mangers with all the latest guidance, advice and support at their fingertips. This was circulated to all clinical leads and is available on Trust Share-point and covered in the training sessions. Link Here - https://view.pagetiger.com/Hub/doctors-in-difficulty-hub ***Establishment of a Locum Oversight Review Group*** The Southern Trust is in the process of launching an Oversight Review group to bring a more formal and structured approach to review locums engaged across the organisation. The purpose will be to develop a framework to provide clinical mangers a forum to support decisions, spot trends with a strong focus on patient safety and ultimately seek to reduce reliance on locum doctors. **Medical Appraisal and Revalidation** Processes that govern Medical Appraisal, Professional Medical Governance Review, Medical Performance Review and Revalidation are being reviewed in 2021. The Trust is liaising

					with Heart of England/ Birmingham Foundation to Trust to learn from their remodelling of their Medical Appraisal and Revalidation processes following the publication of the report into the practices of Ian Paterson, Consultant Surgeon. Appraisal: Initial changes have been made to the processes which include: • Appraisees being assigned an appraisers via random selection • Medical Staff only able to be appraised by staff of the same grade (e.g. Consultant grades are only appraised by fellow Consultant grades) • Annual Appraisal Timetable being developed to follow job planning, Individual Governance review and Performance Support meetings to support Appraisal's intention of being reflective and developmental. **Establishment of Medical Revalidation Oversight Group** The Medical Revalidation Oversight Group is attended by AMDs (some posts soon to convert to DivMD) / DMDs and chaired by the Trust Medical Director. The aim of the Group is to ensure that decisions regarding Medical Revalidation are consistent, robust and quality assured by the relevant Trust Senior Medical Leader. To meet this aim each relevant Associate Medical Director / Divisional Medical Director for doctors under their leadership is required to: • Provide assurance that opportunities for reflection, learning and development e.g. significant events and

					complaints have been adequately discussed and reflected on appropriately at appraisal • Ensure there is / has been a formative approach taken to the doctors' appraisal process and there has been an appropriate level of engagement by each doctor • Ensure outputs are adequate and identify if additional time is required to review a doctor's portfolio before the RO's decision prior to the revalidation recommendation date • Assure that all summaries from all sources accurately reflect the doctor's work and if the documentation is inadequate, advise the Responsible Officer allowing for an informed decision to be made regarding a recommendation for revalidation • Bring to the attention of the RO any additional information that has not been captured in other sources that require the consideration of the RO prior to making a revalidation recommendation.  Medical Revalidation Oversight Group ToR
11	Consultant 1 Needs to review his chosen 'advanced' method and degree of triage, to align it more completely with that of his Consultant colleagues, thus ensuring all patients are triaged in a timely manner.	MD	Consultant 1 is no longer employed in SHSCT	June 2020	COMPLETE
12	Consultant 1	MD	Consultant 1 is no	June 2020	COMPLETE

	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.		longer employed in SHSCT		

NICaN SUSPECT BLADDER CANCER REFERRAL AND DIAGNOSTIC PATHWAY



Received from SHSCT on 05 May 2023. Annotated by the Urology Services Inquiry.

Final Proposed Prostate Diagnostic Pathway December 2019

NICaN SUSPECT PROSTATE CANCER DIAGNOSTIC PATHWAY

GP RED FLAG REFERRAL

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

PSA <20 and ECOG ≥2 or CCI ≥5

Abnormal DRE
PSA >20
•Biopsy
•CT/ Bone Scan
•+/- MRI

Benign DRE and PSA >20: **MRI**
OR
Benign DRE and PSA >40: **Biopsy**

ECOG <2 or CCI <5

DRE normal
And
PSAD (US/ DRE) <0.1

Abnormal DRE
Or
DRE Normal and PSAD (US/DRE) >0.1
Or
PSADT (on PSA Monitoring) <4yrs

MRI prostate

MRI PSAD <0.15
And
MRI No Abnormality

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

MDM DISCUSSION
Malignant Diagnosis Only

PSA monitoring
(Education of patients regarding PSA monitoring, alert symptoms and access to services)

Prostate biopsy (TP or TRUS) + targeted biopsies of MRI abnormality
(Consider prostate volume as part of the initial assessment of a patient with a raised PSA and before MRI)

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

Watchful Waiting / Symptomatic management
(Refer to NICaN Watch and Wait Pathway)

Guidance Notes
To help men decide whether to have a prostate biopsy, discuss with them their prostate-specific antigen (PSA) level, digital rectal examination (DRE) findings (including an estimate of prostate size) and comorbidities, together with their risk factors.
Prostate volume should form part of the discussion with a man about whether further investigation (eg MRI +/- biopsy) or monitoring.
Give men and their partners or carers information, support and adequate time to decide whether or not they wish to undergo prostate biopsy.

Southern Health and Social Care Trust

Quality Care - for you, with you

Female Lower Urinary Tract Symptoms

History;

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

Examination;

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

Investigations;

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

Primary Care management;

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

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

    If urinary incontinent,

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

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

Referral;

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

Southern Health and Social Care Trust

Quality Care - for you, with you

Female Urinary Tract Infection

History;

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

Examination;

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

Investigations;

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

Primary Care treatment;

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

Referral to Urology;

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

Southern Health and Social Care Trust

Quality Care - for you, with you

Male Lower Urinary Tract Symptoms

History

Storage symptoms – Frequency, Urgency, Nocturia

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

Incontinence

Comorbidities – constipation, review of relevant medication

Consider IPSS record and frequency / volume chart.

Examination

External genitalia specifically foreskin and meatus

Abdomen specifically to exclude a palpable bladder

DRE

Investigation

Urine Dipstick test for glucose, haem and nitrites/leucocytes

MSU if indicated

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

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

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

Refer if:

urinary incontinence

suspect urological cancer – raised PSA, abnormal DRE

palpable post void bladder

bothersome phimosis, meatal stenosis

haematuria (see Red Flag guidelines)

recurrent or persisting UTI

Hydronephrosis or bladder residual more than 200mls

Renal impairment if suspected if relating to lower urinary tract dysfunction

Primary care management

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

- Co-morbidity issues (eg constipation)

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

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

Refer if :

Initial concerns met

Lack of response to initial management plan

Southern Health and Social Care Trust

Quality Care - for you, with you

Male Urinary Tract Infection

History;

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

Examination;

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

Investigations;

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

Primary Care treatment;

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

Referral;

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

Department of
Health, Social Services
and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí

www.dhsspsni.gov.uk

INTEGRATED ELECTIVE ACCESS PROTOCOL
30th April 2008

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

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.**

INTEGRATED ELECTIVE ACCESS PROTOCOL

June 2020

Received from SHSCT on 05 May 2023. Annotated by the Urology Services Inquiry.

Integrated Elective Access Protocol

Protocol Summary -

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

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

Integrated Elective Access Protocol

Version

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

Integrated Elective Access Protocol Review Group

The Integrated Elective Access Protocol Review Group consisted of;

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

Integrated Elective Access Protocol

Document control

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

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

Monitoring compliance with protocol

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

Contents

Abbreviations

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

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 1

CONTEXT

1.1 INTRODUCTION

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

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

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

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

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

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

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

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

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

1.2 METHODOLOGY

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

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

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

1.2.4 For the purposes of this protocol, the term;

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

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

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

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

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

1.3 UNDERPINNING PRINCIPLES

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

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

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

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

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

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

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

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

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

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

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

Have we anything in place for 1.3.10

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

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

1.4 BOOKING PRINCIPLES

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

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

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

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

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

1.4.6 The definition of a booked appointment is:

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

1.4.7 Principles for booking Cancer Pathway patients:

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

1.4.8 Principles for booking Urgent Pathway patients:

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

c) If clinical priority is not received from consultants within 72 hours, processes should be in place to initiate booking of urgent patients according to the referrers's classification of urgency.

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

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

1.4.9 Principles for booking Routine Pathway patients:

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

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

c) Approximately eight weeks prior to appointment, Trusts should calculate prospective slot capacity and immediately implement escalation policy where capacity gaps are identified.
Rotas are not normally available 8 weeks out (annual leave/study leave notification period is 6 weeks. What escalation policy is being followed and where are the capacity gaps being escalated to? If this is an already known and accepted capacity gap, eg, through discussions with HSCB, vacant posts, do we always have to escalate?

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

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

1.4.10 Principles for Booking Review Patients;

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

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

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

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

1.5 VIRTUAL ACTIVITY

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

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

1.5.3 The call/contact should be prearranged with the patient and /or their proxy. Patients should not be disadvantaged where a decision is made to assess their clinical need through the use of virtual clinics.
Not all patient contact is pre-arranged, there has been a number of virtual clinics following validation when contact is made with the patient at the point of validation and a decision/treatment plan agreed.

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

1.6 COMPLIANCE WITH LEAVE PROTOCOL

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

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

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

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

1.7 VALIDATION

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

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

Have we anything set up for the ongoing clinical validation

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 2

GUIDANCE FOR MANAGEMENT OF OUTPATIENT SERVICES

2.1 INTRODUCTION

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

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

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

2.1.4 Fixed appointments should only be used in exceptional circumstances.

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

Is there anything we need to have n place here?

2.2 KEY PRINCIPLES

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

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

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

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

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

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

2.2.4 Patient appointments for new and review should be **partially booked.** **In the case of red flag appointments and 14 day target, it is not always possible to partial book appointments. The principles in section 1 are applied, ie the 2 attempts at telephone contacts and 1 fixed appointment.**

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

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

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

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

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

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

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

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

2.3 NEW REFERRALS

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

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

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

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

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

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

2.4 CALCULATION OF THE WAITING TIME – STARTING TIME

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

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

2.5 REASONABLE OFFERS

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

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

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

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

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

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

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

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

2.6 REVIEW APPOINTMENTS

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

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

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

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

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

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

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

2.7.1 DNAs – New Outpatient

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

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

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

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

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

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

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

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

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

2.7.2 DNAs – Review Outpatient

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

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

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

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

2.7.2(d) *Patients being discharged from the list should be advised to contact the Trust booking office if they have any queries. Where unforeseen or exceptional circumstances meant that the patient was unable to attend, and the patient makes contact within **four** weeks*

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

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

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

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

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

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

2.7.3 CNAs – Patient Initiated Cancellations of Outpatient Appointments

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

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

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

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

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

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

2.8 CNAs – HOSPITAL INITIATED CANCELLATIONS

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

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

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

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

2.9 CLINIC OUTCOME MANAGEMENT

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

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

2.10 CLINIC TEMPLATE CHANGES

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

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

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

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

2.11 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

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

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

2.12 OPEN REGISTRATIONS

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

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

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

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

2.13 TIME CRITICAL CONDITIONS

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

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

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

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

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

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

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

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

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

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

2.14 TECHNICAL GUIDANCE

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

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

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

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

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 3

GUIDANCE FOR MANAGEMENT OF DIAGNOSTIC SERVICES

3.1 INTRODUCTION

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

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

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

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

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

3.2 KEY PRINCIPLES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.3 NEW DIAGNOSTIC REQUESTS

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

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

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

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

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

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

3.4 CALCULATION OF THE WAITING TIME – STARTING TIME

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

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

3.5 REASONABLE OFFERS

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

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

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

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

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

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

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

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

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

3.6 FOLLOW UP APPOINTMENTS

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