INTEGRATED ELECTIVE ACCESS PROTOCOL

OCTOBER 2026

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	**5.1** This guidance replaces the Integrated Elective Access Protocol, September 2025
Status	Approved
Date	October 2026 (reissued to reflect regional update requests)

Integrated Elective Access Protocol Version 5.1

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	December 2021	Update and relaunch IEAP to provide updated regional guidance on administration of patients on elective care pathways.	L. Mc Laughlin, Regional IEAP Review Group.
4.0	September 2023	Refresh and relaunch IEAP to provide updated regional guidance on administration of patients on elective care pathways.	WLMU, Regional IEAP Review Group
4.1	February 2024 (see summary of change for same version issued Sept 23)	Additional narrative included in Section 1, Underpinning Principles. New point added as 1.13.12.	WLMU
4.2	May 2024	Additional narrative added into sections: 2.3.6, 1.3.12, 1.4.5, 1.7.4 and 5.3.5.	WLMU
4.3	March 2025	Additional narrative added to sections Pages 28, 29, 34, 43, 44, 57, 69 & 70. Also note of change to members of the Review Group on Page 2.	WLMU
5.0	September 2025	Regional Review of IEAP	WLMU Regional Review Group
5.1	October 2026	Regional update to Reasonable Offers sections 2.5, 3.5, 4.5, 5.5. Regional update to Upgrade/downgrade of	WLMU Regional Review Group

		Waiting List Work Queue Priority section 1.5 New Time Critical Conditions Two Week Waits (Red Flag/suspect cancer) sections as below: Diagnostic Services – 3.13 Elective Admission - 4.13	

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Integrated Elective Access Protocol

Document control

The current and approved version of this document can be found on the Department of Health website https://www.health-ni.gov.uk and on the Strategic Planning and Performance Group and Trusts websites.

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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 admissions 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 (HSCNI) and Department of Health (DoH) Information Standards and Guidance.
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Monitoring compliance with protocol

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

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Abbreviations

AHP	Allied Health Professional
CCG	Clinical Communication Gateway
CNA	Could Not Attend (appointment or admission)
DNA	Did Not Attend (appointment or admission)
DoH	Department of Health
Encompass/Relevant Electronic System	Refers to a subset of systems, Encompass/EPIC, CCG – Interfacing with Other systems
E Triage	An electronic triage system
GP	General Practitioner
HR	Human Resources (Trusts)
IEAP	Integrated Elective Access Protocol
IS	Independent Sector (provider)
IR(ME)R	Ionising Radiation (Medical Exposure) Regulations
IT	Information Technology
MDT	Multidisciplinary Team
NI	Northern Ireland
TCI	To Come In (date for patients)
Waiting List Work Queue	Work Queue – Encompass System

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 health professional (AHP) bookings, including cancer pathways and waiting list work queue 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 allied health professionals (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, AHPs, managers and clerical staff have an important role in ensuring access for patients in line with maximum waiting time targets and good clinical practice, managing waiting list work queues 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, 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 work queue 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 list work queues. 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 list work queues, 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;
- 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; and
- 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).

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 administrative training. All patient information should be recorded and held on the Encompass/relevant electronic system. Manual patient information systems should not be maintained.

1.2.6 All staff involved in the administration of waiting list work queues 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 the Encompass/relevant electronic system 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 clinical, managerial or administrative staff 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 list work queues 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 via the Encompass/relevant electronic system is managed on a chronological basis within clinical priority.

1.3.4 Patients who are added to the active waiting list work queue must be clinically and socially ready for admission on the day of the decision to add the patient to the waiting list work queue, 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 care is promoted. The purpose of this principle is to move 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 the Encompass/relevant electronic system aimed at making hospital appointments more convenient for patients. Trusts should move away from fixed appointments to partially booked appointments.

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

1.3.9 In all aspects of the booking processes, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language**. It is essential that patients who are considered at risk for whatever reason have their needs identified and prioritised at the point of referral and appropriate arrangements made. Trusts must have mechanisms in place to identify such cases.

1.3.10 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.

1.3.11 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.

1.3.12 In line with best practice, where clinically appropriate, clinic outcome letters should be copied to both the GP/Referrer and Patient.

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 appointments that are convenient for them.

Note: If patients fail to respond to a partial booking letter, Trusts should ensure that they have processes in place to verify the patients' demographic details are accurate prior to discharge.

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.

Where Trusts identify service issues which are likely to have a significant and sustained impact on capacity, an early alert should be send to the department and formal communication issued to primary care.

1.4.6 The definition of a partially-booked appointment is:

a) The patient is given the choice of when to attend or have a virtual appointment if appropriate.
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 Two Week Wait (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-ordinator 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 referrer'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 the appointment (including virtual appointment) is within the maximum waiting time guarantees for routine appointments.
b) Referrals will be received, registered within one working day at booking teams and forwarded to consultants for prioritisation.
c) Approximately eight weeks prior to appointment, Trusts should calculate prospective slot capacity and immediately implement escalation policy where capacity gaps are identified.
d) Patients should be selected for booking in chronological order from the waiting list work queues.
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 work queue.
c) Patients will be added to the review waiting list work queue with a clearly indicated date of treatment and selected for booking according to this date.
d) Six weeks prior to the indicative date of treatment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment within a clinically agreed window either side of the indicative date of treatment.

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

1.5 UPGRADE/DOWNGRADE OF WAITING LIST WORK QUEUE PRIORITY

1.5.1 When a patient has their priority upgraded/downgraded, whether due to a secondary referral or validation, the date the patient is added to the relevant waiting list work queue must be the date of first registration.

Note: *For Red Flag/Two Week Wait upgrades, the date the patient is added to the Red Flag/Two Week Wait work queue is the date that they are reclassified as red flag. Any previous waiting time under a routine or urgent referral is not carried forward.*

1.6 VIRTUAL ACTIVITY

1.6.1 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.

1.6.2 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.

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

1.6.4 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.

1.6.5 For patients attending a virtual clinic and requiring onward diagnostics, the referrer is responsible for ensuring that any supplementary tests are carried out, for example, blood tests required prior to imaging.

1.7 COMPLIANCE WITH LEAVE PROTOCOL

1.7.1 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 services and the work associated with the re-booking of appointments.

1.7.2 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.

1.7.3 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.

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

1.8 VALIDATION

1.8.1 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 list work queues are regularly validated to ensure that only those patients who want or still require a procedure are on the waiting list work queue.

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

1.8.3 Where a patient is removed from a waiting list work queue following validation, both the patient and the GP/Referrer should receive a copy of the removal letter detailing reason for removal.

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 2

GUIDANCE FOR MANAGEMENT OF OUTPATIENT SERVICES

2.1 INTRODUCTION

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

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

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

2.1.4 Fixed appointments should only be used in exceptional circumstances.

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

2.2 KEY PRINCIPLES

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

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

1. Two Week Wait (red flag/suspect cancer);
2. Urgent; and
3. Routine.

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

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

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

2.2.5 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 quickly identified and escalated.

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

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

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

2.2.9 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.

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

2.2.11 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 within **a maximum of three** working days of date of receipt of referral. Note: Two Week Wait (red flag/suspect cancer) referrals require **daily** triage.

2.3.5 Following prioritisation (as outlined in section 2.3.4), referrals must be actioned on the Encompass/relevant electronic system and appropriate correspondence (including electronic), e.g. acknowledgement letter/text or appointment letter, issued to patients within **one** working day.

Acknowledgement letters/text should include:

- Receipt of referral
- The name of specialty referred to
- Clinical urgency
- Contact details (appropriate service)

2.3.6 Time line - below are the principles to be followed in relation to referral management:

- Receipt of referral registered within one working day;
- Referral triaged and prioritised within 3 working days;
- Acknowledgement letter/text to patient within 1 working day following triage/prioritisation.

As part of the text message reminder service (referral acknowledgment) patients will be notified of their clinical urgency following the triage process taking place.

2.3.7 Inappropriate and inadequate referrals should be returned to the referral source immediately and the referral closed and managed in line with clinical 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 date, irrespective of provider or location, that gives the patient a minimum of **three** weeks' notice and a minimum of **two** appointment dates or more, and
- at least **one** offer must be within Northern Ireland (NI), except for any regional specialties where there are no alternative providers within NI.

For Further guidance on what action to take in the event of a DNA and/or Cancellation - see section 2.7 (Management of Patients who Did Not Attend or Cancelled (CNA)

- Travelling to locations other than the patient's local health Trust will be considered reasonable.
- Refusal of two appointment dates at locations within or outside the patient's local health Trust will be considered refusing a reasonable offer (both offers may be the same provider), or
- Refusal of two appointment dates at a regional provider or outsourced contract will be considered refusing a reasonable offer.

2.5.2 Where a patient is available during the offer period, but refuses a reasonable offer, the waiting time clock will be reset. It will be clearly explained to the patient when contact is made that refusal of a reasonable offer to be treated at an alternative provider may result in them waiting longer for their procedure in their own Trust. The new waiting time clock will start from the date that the patient refuses the offered appointment.

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 of the referral. 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 are required to support specialties and booking staff in these circumstances.

2.5.6 Trusts/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 that the second appointment was offered, and then refused for this transaction.

2.5.8 For patients who are offered fixed appointments, a reasonable offer is defined as:

- The patient will be given **three weeks'** notice of their appointment date.
- If the patient does not respond to the first appointment offer, their waiting time clock will not be reset.
- The patient will then be issued with a second appointment date, providing a further three weeks' notice. If the patient does not respond to this second offer, they will be removed from the waiting list.

Under exceptional circumstances, a clinician may decide that a patient who has not accepted two appointment offers within the three-week notice period should not be removed from the waiting list and should be offered a further appointment.

For Further guidance on what action to take in the event of a DNA and/or Cancellation - see section 2.7 (Management of Patients who Did Not Attend or Cancelled (CNA)

2.5.9 For management of Time Critical Condition Two Week Wait (red flag/suspect cancer) – refer to section 2.13.

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 the Encompass/relevant electronic system 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 the Encompass/relevant electronic system updated.

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

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

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

2.7.1 DNAs – New Outpatient

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

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

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 work queue and should be offered a second appointment. Trusts should put in place local agreements with clinicians, regarding those referrals (e.g. Two Week Wait (red flag/suspect cancer) 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* work queue *(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* work queue *at the date that they have made contact (i.e. not the date they were originally referred) 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 work queue.

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 work queue and the steps in 2.7.1(d) should be followed.

2.7.1(h) If a patient DNAs 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.

2.7.1(i) If a patient is offered and agrees a fixed appointment with less than 3 weeks' notice, which should be clearly noted in the patients record, and subsequently DNAs that appointment, then the patient should be removed from the waiting list work queue with clinical agreement.

2.7.2 DNAs – Review Outpatient

If a patient DNAs their review outpatient appointment, 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 work queue. 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 work queue with a revised clinically indicated date at the date they make contact (i.e. not the date they were originally referred) 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 work queue.

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 DNAs a virtual outpatient review appointment this should follow the above protocol based on whether the appointment is partially booked or fixed. The Trust should ensure that the contact details of the patient are up to date and available.

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

2.7.2(i) If a patient is offered and agrees a fixed appointment with less than 3 weeks' notice, which should be clearly noted in the patients record, and subsequently DNAs that appointment, then the patient should be removed from the waiting list work queue with clinical agreement.

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 work queue. 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.

Booking staff should use the correct cancellation codes.

2.9 CLINICAL OUTCOME MANAGEMENT

2.9.1 Changes in the patient's details must be updated on the Encompass/relevant electronic system 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.

2.9.3 Changes in the patient's details must be updated on the Encompass/relevant electronic system and the medical records on the date of clinic.
Patients should also be advised to update their personal details with their GP practice.

2.10 CLINIC TEMPLATE CHANGES

2.10.1 Clinic templates should be agreed between the consultant and service manager.

2.10.2 Templates will identify the number of slots available for Two Week Wait (red flag/suspect cancer), 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 be managed in line with technical guidance (see also Reasonable Offers, section 2.5). Administrative

efficiency and effective communication with the patient are essential to ensure this process runs smoothly.

2.12 REFERRALS WITH NO NEXT STEPS

2.12.1 Referrals with no next steps that have been opened on the Encompass/relevant electronic system should **not** be left open. When a patient referral for a new outpatient appointment has been opened on the Encompass/relevant electronic system, and their referral information has been recorded correctly, the patient will appear on the waiting list work queue 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 the Encompass/relevant electronic system and should be recorded on the day of the patient's appointment.

The possible outcomes are that the patient is:

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

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 Two Week Wait (red flag/suspect cancer)

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 Two Week Wait (red flag/suspect cancer) 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.

Note: Patients will be provided with a minimum of seven days' notice from the date of contact. This is deemed as reasonable notice and clinically appropriate.

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/Referrer 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/Referrer 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/Referrer 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/Referrer 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.

2.13.11. If a patient is offered and agrees a fixed appointment with less than 3 weeks' notice, which should be clearly noted in the patients record, and subsequently DNAs that appointment, then the patient should be removed from the waiting list work queue with clinical agreement.

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 administration and management of requests for diagnostics, waiting list work queues and appointments within and across Trusts should be consistent, easily understood, patient focused and responsive to clinical decision making.

3.1.3 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 fit for purpose.

3.1.4 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 (IR(ME)R).** 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 list work queues should be managed according to clinical priority. Priorities must be identified for each patient on a waiting list work queue and allocated according to urgency of the diagnostic procedure.

Trusts will manage patients in the following priorities, i.e.:

1. Two Week Wait (red flag/suspect cancer)
2. New Cancer/CA (Imaging only)
3. Urgent
4. Routine
5. 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 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 quickly identified and escalated.

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

3.2.7 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.

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

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

3.2.10 Trusts will work towards providing a single point of contact for all patients across each of the diagnostic appointment services. It is recognised that there will be services which require alternative processes.

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

3.2.12 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 staff 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 within **three** working days of date of receipt of referral.

3.3.5 Inappropriate and inadequate requests should be returned to the GP/Referrer and the referral closed where appropriate.

3.4 CALCULATION OF WAITING TIME

3.4.1 The waiting time is the date the complete request is received and is 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 date, irrespective of provider or location, that gives the patient a minimum of **three** weeks' notice and a minimum of **two** appointments dates or more, and
- at least **one** offer must be within Northern Ireland (NI), except for any regional specialties where there are no alternative providers within NI.

For Further guidance on what action to take in the event of a DNA and/or Cancellation - see section 3.8 (Management of Patients who Did Not Attend or Cancelled (CNA)

- Travelling to locations other than the patient's local health Trust will be considered reasonable.
- Refusal of two appointment dates at locations within or outside the patient's local health Trust will be considered refusing a reasonable offer (both offers may be the same provider), or
- Refusal of two appointment dates at a regional provider or outsourced contract will be considered refusing a reasonable offer.

3.5.2 Where a patient is available during the offer period, but refuses a reasonable offer, the waiting time clock will be reset. When contacted, the patient will be advised, that refusal of a reasonable offer to receive treatment at an alternative provider may result in a longer wait for treatment within their own Trust. Where a reasonable is declined, a new waiting time clock will start from the date on which the patient refuses the offered appointment.

3.5.3 This does not prevent patients being offered earlier appointment dates. However, 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 Trusts/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 that the second appointment was offered, and then refused for this transaction.

3.5.7 Urgent patients must be booked within the locally agreed maximum waiting time from the date of receipt of the referral. 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 are required to support specialties and booking staff in these circumstances.

3.5.8 For patients who are offered fixed appointments, a reasonable offer is defined as:

- The patient will be given **three weeks'** notice of their appointment date.
- If the patient does not respond to the first appointment offer, their waiting time clock will not be reset.

- The patient will then be issued with a second appointment date, providing a further three weeks' notice. If the patient does not respond to this second offer, they will be removed from the waiting list.

  Under exceptional circumstances, a clinician may decide that a patient who has not accepted two appointment offers within the three-week notice period should not be removed from the waiting list and should be offered a further appointment.

  For Further guidance on what action to take in the event of a DNA and/or Cancellation - see section 3.8 (Management of Patients who Did Not Attend or Cancelled (CNA)

3.5.9 For management of Time Critical Condition Two Week Wait (red flag/suspect cancer) – refer to section 3.13.

3.6 PLANNED PATIENTS

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

3.6.2 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 work queue for statistical purposes.

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

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

3.6.5 There may be local arrangements in place to cover other scenarios for imaging requests. For example, when the patients have indicated a choice to wait for their examination. In this scenario the referrer (and cancer tracking team if applicable) should be contacted if deemed clinically necessary.

3.7 PATIENTS LISTED FOR MORE THAN ONE DIAGNOSTIC TEST

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

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

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

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

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

3.8.1 <u>DNAs – Diagnostic Appointment</u>

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

3.8.1(a) Patients who have been partially booked will **<u>not</u>** be offered a second appointment and should be removed from the waiting list work queue. 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 work queue.

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

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

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

3.8.1(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 work queue.

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

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

3.8.1(h) If a patient is offered and agrees a fixed appointment with less than 3 weeks' notice, which should be clearly noted in the patients record, and subsequently DNAs that appointment, then the patient should be removed from the waiting list work queue with clinical agreement.

3.8.2 DNAs – Follow up Diagnostic Appointment

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

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

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

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

3.8.2(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* work queue *with a revised clinically indicated date at the date they make contact (i.e. not the date they were originally referred) with the Trust.*

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

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

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

3.8.2(h) If a patient is offered and agrees a fixed appointment with less than 3 weeks' notice, which should be clearly noted in the patients record, and subsequently DNAs that appointment, then the patient should be removed from the waiting list work queue with clinical agreement.

3.8.3 CNAs – Patient Initiated Cancellations of Diagnostic Appointment

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

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

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

3.8.3(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 work queue. The referring clinician (and the GP, where they are not the referring clinician) should also be informed of this.

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

3.9 CNAs - HOSPITAL INITIATED CANCELLATIONS

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

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

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

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

3.10 SESSION OUTCOME MANAGEMENT

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

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

3.10.3 Changes in the patient's details must be updated on the Encompass/relevant electronic system and the medical records on the date of clinic.
Patients should also be advised to update their personal details with their GP practice.

3.11 SESSION TEMPLATE CHANGES

3.11.1 Session templates should be agreed with the healthcare professional and service manager.

3.11.2 Templates will identify the number of slots available for new Two Week Wait (red flag/suspect cancer), new urgent, new routine, planned and follow up appointments; specify the time each session is scheduled to start and finish; and identify the length of time allocated for each appointment slot.

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

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

3.12 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

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

3.12.2 Transfers to alternative providers must always be with the consent of the patient and the receiving clinician and be managed in line with technical guidance (see also Reasonable Offers, section 3.5). Administrative efficiency and effective communication are essential to ensure this process runs smoothly.

3.13 TIME CRITICAL CONDITIONS Two Week Wait (red flag/suspect cancer)

3.13.1 All diagnostic requests for 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.

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

Note: Patients will be provided with a minimum of seven days' notice from the date of contact, this is deemed as reasonable notice and clinically appropriate.

3.13.3 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/Referrer should be informed.

3.13.4 If the patient refuses the first appointment they should be offered a second appointment during the same telephone call. 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.

3.13.5 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/Referrer should be informed.

3.13.6 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/Referrer should be informed.

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

3.13.8 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/Referrer should be informed.

3.13.9 With regard to 3.13.4 to 3.13.8 above, it is the responsibility of each individual Trust to agree the discharge arrangements with the clinical team.

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 4

GUIDANCE FOR MANAGEMENT OF ELECTIVE ADMISSIONS

4.1 INTRODUCTION

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

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

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

4.2 KEY PRINCIPLES

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

1. active,
2. planned and
3. deferred

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

1. Two Week Wait (red flag/suspect cancer),
2. urgent,
3. routine and
4. planned.

Patients should be categorised as per Surgical Prioritisation, no other clinical priority categories should be used for inpatient and daycase services.

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

4.2.4 Maximum waiting times for urgent patients should be agreed locally with clinicians and made explicit, through internal processes, to booking

office staff. Booking staff should ensure that patients are appointed within the clinical timeframe indicated by the consultant and capacity issues are quickly identified and escalated.

4.2.5 Trusts should ensure that theatre sessions are constantly reviewed to meet changes in demand and new clinical practice.

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

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

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

4.2.9 Changes in the patient's details must be updated on the Encompass/relevant electronic system and the medical records on the date of clinic.
Patients should also be advised to update their personal details with their GP practice.

4.3 PRE-ASSESSMENT

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

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

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

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

4.4 CALCULATION OF WAITING TIME

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

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

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

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

4.5.2 All patients must be offered reasonable notice. Patients should be made reasonable offers to come in (TCI) on the basis of clinical priority. Within clinical priority groups offers should then be made on the basis of the patient's chronological wait.

4.5.3 A reasonable offer is defined as:

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

For Further guidance on what action to take in the event of a DNA and/or Cancellation - see section 4.10 (Management of Patients who Did Not Attend or Cancelled (CNA)

- Travelling to locations other than the patient's local health Trust will be considered reasonable.
- Refusal of two appointment dates at locations within or outside the patient's local health Trust will be considered refusing a reasonable offer (both offers may be the same provider), or
- Refusal of two appointment dates at a regional provider or outsourced contract will be considered refusing a reasonable offer.

4.5.4 Where a patient is available during the offer period, but refuses a reasonable offer, the waiting time clock will be reset. When contacted, the patient will be advised that refusal of a reasonable offer to receive treatment at an alternative provider may result in a longer wait for treatment within their own Trust. Where a reasonable offer is declined, a new waiting time clock will start from the date on which the patient refuses the offered admission date.

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

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

4.5.7 Urgent patients must be booked within the locally agreed maximum waiting time from the date of receipt of referral. 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 are required to support specialties and booking staff in these circumstances.

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

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

4.5.10 For patients who are offered fixed appointments, a reasonable offer is defined as:

- The patient will be given **three weeks'** notice of their admission date.
- If the patient does not respond to the first admission offer, their waiting time clock will not be reset.
- The Patient will then be issued with a second admission date, providing a further three weeks' notice. If the patient does not respond to this second offer, they will be removed from the waiting list.

Under exceptional circumstances, a clinician may decide that a patient who has not accepted two admission offers within the three-weeks' notice period should not be removed from the waiting list and should be offered a further admission date.

For Further guidance on what action to take in the event of a DNA and/or Cancellation - see section 4.10 (Management of Patients who Did Not Attend or Cancelled (CNA)

4.5.11 For management of Time Critical Condition Two Week Wait (red flag/suspect cancer) – refer to section 4.13.

4.6 INPATIENT AND DAYCASE ACTIVE WAITING LIST WORK QUEUES

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

4.6.2 To ensure consistency and the standardisation of reporting with commissioners and the DoH, all waiting list work queues are to be maintained in the Encompass/relevant electronic system.

4.6.3 The order is placed on the Encompass/relevant electronic system within **two** working days.

Failure to do this will lead to incorrect assessment of waiting list work queue

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

4.7 DEFERRED PATIENTS

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

4.7.2 A period of deferral is defined as:

A patient deferred from the active waiting list work queue 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

deferred during any periods when they are unavailable for treatment for personal or medical reasons (but not for reasons such as the consultant being unavailable, beds being unavailable etc.).

A recommended maximum period not exceeding **three** months, but Trusts may put local arrangements in place based on other service pressures.

4.7.3 No patient should be deferred from the waiting list work queue without a deferral end date.

4.7.4 Deferred patients will not count as waiting for statistical purposes. Any periods of deferral will be automatically subtracted from the patient's total time on the waiting list work queue for central statistical returns.

4.8 PLANNED PATIENTS

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

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

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

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

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

4.9 PATIENTS LISTED FOR MORE THAN ONE PROCEDURE

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

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

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

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

DNAs – Inpatient/Daycase

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

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

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

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

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

4.10.1(e) *Patients being discharged from the list should be advised to contact the Trust if they have any queries. Where unforeseen or exceptional circumstances meant that the patient was unable to attend, and the patient makes contact within* ***four*** *weeks of the original date, a clinical*

decision may be made to offer a second date. Where this is the case, the patient should be added to the waiting list work queue *at the date they make contact (ie. not the date they were originally referred) with the Trust. If a patient makes contact after the* ***four-week*** *period they cannot be reinstated*.

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

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

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

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

4.10.1(j) If a patient is offered and agrees a fixed admission with less than 3 weeks' notice, which should be clearly noted in the patients record, and subsequently DNAs that admission, then the patient should be removed from the waiting list work queue with clinical agreement.

4.10.2 CNAs – Patient Initiated Cancellations of inpatient/daycase admission

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

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

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

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

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

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

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

4.11 CNAs - HOSPITAL INITIATED CANCELLATIONS

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

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

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

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

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

4.12 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

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

4.12.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant and be managed in line with technical guidance (see also Reasonable Offers, section 4.5).

Administrative efficiency and effective communication are essential to ensure this process runs smoothly.

4.13 TIME CRITICAL CONDITIONS Two Week Wait (red flag/suspect cancer)

4.13.1 All inpatient/day case requests for 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

4.13.2 Patients will be contacted by phone and if telephone contact cannot be made, a fixed admission date will be issued. Note: Patients will be provided with a minimum of seven days' notice from the date of contact, this is deemed as reasonable notice and clinically appropriate.

4.13.3 If the patient does not respond to an offer of an admission date (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/Referrer should be informed.

4.13.4 If the patient refuses the first admission date they should be offered a second admission date during the same telephone call. In order to capture the correct waiting time, the first admission date 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 admission date was refused.

4.13.5 If the patient cancels **two** agreed admission 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/Referrer should be informed.

4.13.6 If the patient has agreed an admission date 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/Referrer should be informed.

4.13.7 Where the patient DNAs a fixed admission date they should be offered another date for admission.

4.13.8 If the patient DNAs this second fixed admission date 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/Referrer should be informed.

4.13.9 With regard to 4.13.4 to 4.13.8 above, it is the responsibility of each individual Trust to agree the discharge arrangements with the clinical team.

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 5

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

5.1 INTRODUCTION

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

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

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

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

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

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

5.1.7 Fixed appointments should only be used in exceptional circumstances.

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

5.2 KEY PRINCIPLES

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

No other clinical priorities should be used for AHP services.

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

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

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

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

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

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

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

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

5.3 NEW REFERRALS

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

5.3.2 Trusts should ensure that a system is in place whereby the location of all referrals (paper and electronic) not yet prioritised can be identified and tracked.

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

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

5.3.5 Following prioritisation, (as outlined in section 5.3.4) referrals must be actioned on the Encompass/relevant electronic system and appropriate correspondence (including electronic), e.g. acknowledgement or appointment letter, issued to patients within **one** working day or the Encompass/relevant electronic system

Acknowledgement letters/text should include:

- Receipt of referral
- The name of specialty referred to
- Clinical urgency
- Contact details (appropriate service)

As part of the text message reminder service (referral acknowledgment) patients will be notified of their clinical urgency following the triage process taking place.

Note: acknowledgement texts are issued through some AHP services aligned to acute out patients.

5.3.6 Inappropriate and inadequate referrals should be returned to the referral source immediately and the referral closed.

5.4 CALCULATION OF WAITING TIME

5.4.1 The starting point for the waiting time of an AHP new referral is the date the clinician's referral or self-referral is received by the booking office or, for internal referrals, when the referral is received by the booking

office/department. All referrals, including emailed and electronically delivered referrals, will have the date the referral received into the organisation recorded either by date stamp or electronically.

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

5.4.3 The waiting time for each patient is calculated as the time period between the receipt of the referral and the date at the end of the applicable period for the waiting list work queue return.

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

5.5 REASONABLE OFFERS

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

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

For Further guidance on what action to take in the event of a DNA and/or Cancellation - see section 5.7 (Management of Patients who Did Not Attend or Cancelled (CNA)

- Travelling to locations other than the patient's local health Trust will be considered reasonable.
- Refusal of two appointment dates at locations within or outside the patient's local health Trust will be considered refusing a reasonable offer (both offers may be the same provider) or
- Refusal of two appointment dates at a regional provider or outsourced contract will be considered refusing a reasonable offer.

5.5.2 Where a patient is available during the offer period, but refuses a reasonable offer, the waiting time clock will be reset. When contacted, the patient will be advised that refusal of a reasonable offer to receive treatment at an alternative provider may result in them waiting a longer wait for treatment within their own Trust. Where a reasonable offer is

declined, a new clock start will start from the date on which the patient refuses the offered appointment.

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

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

5.5.5 Urgent patients must be booked within the locally agreed maximum waiting time from the date of receipt of referral. 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 are required to support specialties and booking staff in these circumstances.

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

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

5.5.8 For patients who are offered fixed appointments, a reasonable offer is defined as:

- The patient will be given **three weeks'** notice of their appointment date.
- If the patient does not respond to the first appointment offer, their waiting time clock will not be reset.
- The patient will then be issued with a second appointment date, providing a further three weeks' notice. If the patient does not respond to this second offer, they will be removed from the waiting list.

Under exceptional circumstances a clinician may decide that a patient who has not accepted two appointment offers within the three-weeks' notice period should not be removed from the waiting list and should be offered a further appointment.

For Further guidance on what action to take in the event of a DNA and/or Cancellation - see section 5.7 (Management of Patients who Did Not Attend or Cancelled (CNA)

5.6 REVIEW APPOINTMENTS

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

5.6.2 Patients must be recorded on the Encompass/relevant electronic system 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 date of review.

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

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

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

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

5.7.1 DNAs – New AHP Appointments

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

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

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

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

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

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

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

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

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

5.7.1(i) If a patient is offered and agrees a fixed appointment with less than 3 weeks' notice, which should be clearly noted in the patients record, and subsequently DNAs that appointment, then the patient should be removed from the waiting list work queue with clinical agreement.

5.7.2 DNAs – Review Appointments

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

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

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

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

5.7.2(d) Patients being discharged from the list should be advised to contact the Trust booking office if they have any queries. Where unforeseen or exceptional circumstances meant that the patient was unable to attend, and the patient makes contact within **four** weeks of the original appointment date, a clinical decision may be made to offer a second appointment. Where this is the case, the patient should be added to the waiting list work queue at the date they make contact *(i.e. not the date they were originally referred)* with the Trust.

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

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

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

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

5.7.2(h) If a patient is offered and agrees a fixed appointment with less than 3 weeks' notice, which should be clearly noted in the patients record, and subsequently DNAs that appointment, then the patient should be removed from the waiting list work queue with clinical agreement.

5.7.3 CNAs – Patient initiated cancellations (new and review)

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

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

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

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

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

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

5.7.4 Trusts have a responsibility to ensure that children and adults at risk who DNA or CNA their outpatient, inpatient, diagnostic or AHP appointment

are followed up by the most appropriate healthcare professional and a clear link to the referring clinician established.

5.8 CNAs – SERVICE INITIATED CANCELLATIONS

5.8.1 No patient should have their appointment cancelled. Trusts will make best efforts to ensure that a patient's appointment is not cancelled for non-clinical reasons.

5.8.2 If Trusts cancel a patient's appointment, including a virtual appointment, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity.

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

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

5.9 CLINICAL OUTCOME MANAGEMENT

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

5.9.2 Changes in the patient's details must be updated on the Encompass/relevant electronic system and the medical records on the date of clinic.
Patients should also be advised to update their personal details with their GP practice.

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

5.10 CLINIC TEMPLATE CHANGES

5.10.1 Clinic templates should be agreed between the relevant AHP and service manager.

5.10.2 Templates will identify the number of slots available for new urgent and routine and review appointments; specify the time each clinic is

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

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

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

5.11 TRANSFERS BETWEEN TRUSTS or to INDEPENDENT SECTOR

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

5.11.2 Transfers to alternative providers must be managed in line with technical guidance (see also Reasonable Offers, section 5.5). Administrative efficiency and effective communication with the patient are essential to ensure this process runs smoothly.