2024

National Inpatient, Day Case, Planned Procedure (IDPP), and GI Endoscopy Waiting List Management Protocol

ntpf an ciste náisiúnta um cheannach cóireála the national treatment purchase fund

HSE Seirbhís Sláinte Níos Fearr á Forbairt | Building a Better Health Service

An Roinn Sláinte Department of Health

Table of Contents

List of Abbreviations

Terminology	Definition
AQA	Audit and Quality Assurance
BPR	Best Practice Reporting
CNA	Can Not Attend
CCP	Clinical Care Programmes
CPC	Clinical Prioritisation Category
CRT	Clinical Recommended Timeframe
DCDQ	Data Completeness Data Quality
DNA	Did Not Attend
DOH	Department of Health
GI	Gastrointestinal
GP	General Practitioner
GRS	Global Rating Scale
HCAN	Hospital Cancelled Appointment
HCR	Health Care Record
HIPE	Hospital Inpatient Enquiry
HSE	Health Service Executive
IDPP	Inpatient, Day Case, Planned Procedure
ID	Identification
IHI	Individual Health Identifier
JAG	Joint Advisory Group
KPI	Key Performance Indicator
MDS	Minimum Dataset
MOU	Memorandum of Understanding
MRN	Medical Record Number
NTPF	National Treatment Purchase Fund
OP	Outpatient
P1	Priority 1
P2	Priority 2
PAS	Patient Administration System
SC	Scheduled Care
SDU	Special Delivery Unit
SOP	Standard Operating Procedure
SOR	Source of Referral
TCI	To Come In
TOR	Terms of Reference

NOTES

Section One

1 | Introduction

1 | Introduction

1.1. Summary

This protocol is a refresh of the 2017 National Inpatient, Day Case, and Planned Procedure (IDPP) Waiting List Management Protocol. This protocol is intended to provide updated guidance, and ensure there is a consistent and standardised approach to the management and scheduling of patients on Inpatient, Day Case, Planned Procedure and GI Endoscopy waiting lists within each hospital and across hospital groups/HSE Health Regions.

The purpose of this protocol is to ensure that patients seeking access to IDPP and GI Endoscopy services are administratively managed in a safe, timely, fair and equitable manner.

The NTPF has undertaken a collaborative approach to updating this protocol, which has involved a 'top down', 'bottom up' approach to stakeholder engagement, with the patient as the central focus.

This approach included input from the following external stakeholders;

- Hospital Groups/HSE Health Regions
- Individual Hospital Representatives
- National Lead for Integrated Care, Clinical Design and Innovation, OoCCO, HSE
- National Clinical Advisor and Group Lead (NCAGL), Acute Operations, HSE
- Scheduled Care, Acute Operations, HSE
- Scheduled Care Transformation Programme (SCTP), Acute Strategy & Planning, HSE
- National GI Endoscopy Programme, Acute Operations, HSE
- Scheduled Care Performance Unit, Department of Health (DOH)

It is intended that development of an expanded Minimum Data Set (MDS) will commence during 2024. This will incorporate operational changes and updated data fields required to support the roll out of the IDPP & GI Waiting List Management Protocol, while also supporting the implementation of the Best Practice Reporting (BPR) Programme. The scope of the BPR programme is to implement 'Best Practice Reporting of waiting time and waiting list reporting for patients on public Outpatients, Inpatients and Radiology Diagnostic waiting lists in Ireland'.

1.2. Background

In 2017 the National Treatment Purchase Fund (NTPF) led on the development of a technical guidance protocol to ensure the highest standards of IDPP waiting list data quality and to promote optimal practice for the management and scheduling of patients on Inpatient, Day Case, Planned Procedure and GI Endoscopy hospital waiting lists in Ireland.

The completion of Quality Assurance Audits, undertaken by the NTPF during the period 2019 - 2022, identified many instances of compliance with the waiting list management protocol. However, it also identified the need for an improvement in some practices, which are proposed through:

- Delivery of a refresh of the IDPP Waiting List Management Protocol 2017
- Delivery of a training programme, including a HSeLanD module, to support managers, administrators and clinicians in the management of patients on Inpatient, Day Case, Planned Procedure (IDPP) and GI Endoscopy waiting lists
- Delivery of an expanded Minimum Data Set (MDS)

1.3. Clear Governance and Reporting Structures

To effectively manage waiting lists there is a requirement to have clear 'top down', 'bottom up' governance and reporting structures at both hospital and hospital group/HSE Health Region level.

Scheduled Care Leads or those with responsibility and accountability for all aspects of waiting list management, including the implementation of the National IDPP & GI Endoscopy Waiting List Management Protocol, should be appointed and in place at hospital and hospital group/HSE Health Region level.

Active waiting list management must be a standing agenda item for discussion at scheduled care and performance related meetings. Items such as access, key performance indicators (KPIs) and waiting list initiatives should be discussed, and waiting list management plans developed and agreed. Meetings should be held on a regular basis and the minutes from these meetings must be documented and available for audit purposes.

1.4. Standard Operating Procedures (SOPs)

To standardise IDPP and GI Endoscopy waiting list management nationally, each Hospital Group/HSE Health Region Scheduled Care Lead must ensure that individual hospitals within their group have implemented an IDPP & GI Endoscopy Waiting List Management SOP that is in line with the latest National IDPP and GI Endoscopy Waiting List Management Protocol.

1.5. Audit and Quality Assurance (AQA)

Implementation of this protocol at individual hospital level will be subject to audit by the NTPF AQA Team to:

Establish if hospital IDPP and GI Endoscopy waiting list management practices are in line with national protocol.

Determine if IDPP and GI Endoscopy waiting list data submissions to the NTPF are in compliance with national Minimum Data Set (MDS) reporting requirements.

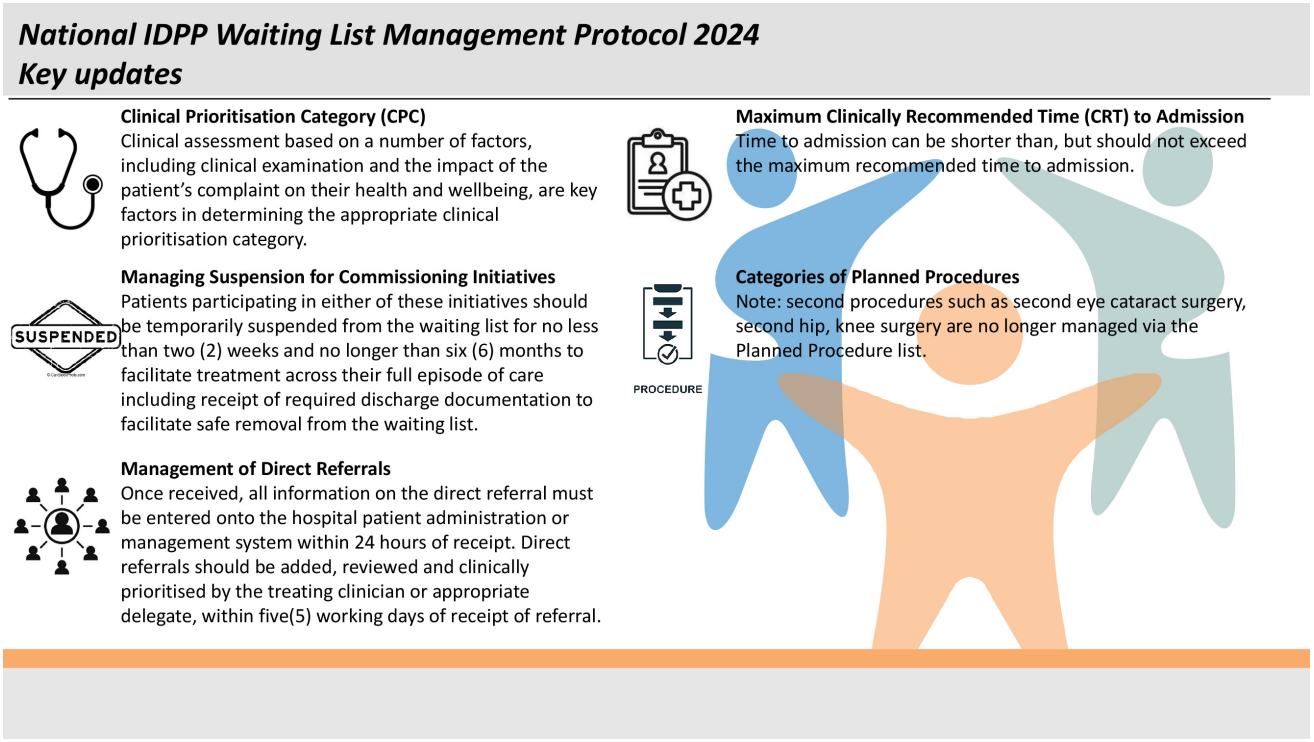
Identify issues which impact on the accuracy of the data and common trends affecting national reporting.

Make recommendations to improve data accuracy and hospital compliance with national protocol and MDS requirements based on generated findings for individual hospitals.

Support standardisation and promote improvements in IDPP and GI Endoscopy waiting list management practices nationally.

1.6. Key updates contained in this Protocol

The below 'Postcard' details some of the key updates that form part of the National IDPP and GI Endoscopy Waiting List Management Protocol 2024



Section Two

2 | Patient and Waiting List Definitions

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In line with Hospital Inpatient Enquiry (HIPE) definitions, a patient who is admitted to hospital and treated is classified as an inpatient or day case. All patients must be classified to ICD-10-AM coding. A separate free text description field should also be completed.

2.1. Inpatient (IP)

A patient placed on a waiting list for an **inpatient admission** is a patient who will require the use of a hospital bed overnight. Classification of inpatient must meet the HIPE and hospital classification standard.

2.2. Day Case (DC)/Side Room/Procedure Room

A patient placed on a waiting list for a **day case/side room/procedure room** admission is a patient who will be admitted to hospital on an elective basis for care and/or treatment which does not require the use of a hospital bed overnight. Classification of day case must meet the HIPE and hospital classification standard.

2.3. Ambulatory Day Service

Ambulatory Care is defined by the Acute Medicine National Clinical Programme as clinical care provided on a "day basis" that is not provided within the traditional hospital bed base or outpatient service. It includes diagnosis, observation, treatment and rehabilitation. Ambulatory Care will have competent clinical decision makers. There will be immediate access to diagnostic support to facilitate "one stop" rapid diagnosis, treatment and/or reassurance (National Acute Medicine Programme).

2.4. See and Treat Clinics facilitated in Ambulatory Day Service

A patient seen and treated within the **Ambulatory Day Service** as part of a 'See and Treat/One Stop Outpatient Clinic' should not be placed on a day case waiting list for day case admission. These clinics should be managed in line with the Outpatient Waiting List Management Protocol 2022. Patients who received treatment on the day may be converted to a day case admission where the procedure meets the HIPE and hospital classification standards.

2.5. Planned Procedure (PP)

A patient placed on a waiting list for a **planned procedure** is a patient who had an initial episode of care and requires recall for a further planned, timed or surveillance procedure in the future as part of their ongoing clinical care and/or treatment (see section 6).

2.6. Waiting List Categories

All patients added to a waiting list must be ready, willing, clinically suitable and available for admission. Waiting list categories include patients who are:

- Active - Waiting for a scheduled date for admission in the future (no TCI date assigned)
- TCI - Scheduled for a date 'To Come In'
- Suspended - Temporarily unavailable or clinically unsuitable for their procedure

2.7. High Clinical and/or Social Needs

In some cases, patients can be identified by a clinician as high clinical and/or social needs patients. In this case, it should be noted by the clinician on the patient's booking form or medical record. Patients identified as high clinical and/or social needs on their booking form/record may require extra consideration to ensure they receive appropriate levels of care throughout their inpatient/day case episode of care.

Section Three

3 | Categories of Patients not submitted to the NTPF

3 | Categories of Patients not submitted to the NTPF

All public patients awaiting access to Inpatient, Day Case, Planned Procedure and GI Endoscopy care, who are listed under a valid ICD-10 AM code, should be submitted to the NTPF via a weekly extract file. Patients should also be listed for admission to a registered inpatient ward/day ward/side room/procedure room as per Hospital Pricing Office (HPO) definition.

Categories of patients who should **not** be submitted via the weekly extract include, but are not limited to:

- Private patients on public hospital waiting lists
- Private patients on a consultant's private waiting list
- Patients awaiting access to National Screening Services such as:
  - BowelScreen
  - Breast Check
  - Cervical Screening
  - Diabetic Retina Screen
- Patient awaiting access to diagnostics such as:
  - Cardiology (Echo, EST, Holder, Event monitors)
  - Radiology Diagnostics (MRI, CT, US)
  - Respiratory Pulmonary Function Tests (PFTs)

Section Four

4 | Source of Referral

4 | Source of Referral

Patients requiring an inpatient, day case or planned procedure admission can be identified at various access points in the healthcare system, generally referred to as the Source of Referral (SOR). Referrals can be received in paper or electronically via completed booking forms or direct referrals.

4.1. Outpatients Department

Patients requiring admission are usually referred by their General Practitioner (GP) and attend an outpatient consultation. At this consultation, the clinical decision will be made as to whether or not an inpatient or day case admission is required. Where an admission is required, a booking form should be completed.

4.2. Direct Referral

A direct referral is an external referral, usually received from a primary care setting, which may not require an outpatient consultation. Direct referrals should be entered onto the hospital patient administration or management system within 24 hours of receipt, and the referral should be sent for clinical prioritisation by the clinician.

4.3. Emergency Department

Patients who present to the Emergency Department, who do not require an immediate admission, but who do require an inpatient or day case admission at a date in the future, must be placed on the waiting list and scheduled in line with Section 6.

4.4. Internal Hospital Referral

A patient seen by a particular service or speciality, and deemed to require treatment by a consultant in another service or speciality, will require an internal hospital referral. Internal hospital referrals should be on a consultant-to-consultant basis.

4.5. Inter-Hospital Referral

Inter-hospital referrals are becoming a feature in the optimisation of capacity utilisation within hospital groups/HSE Health Regions. This occurs when a patient is transferred from one hospital to another for care and/or treatment.

4.6. Private Entity Referral

Patients often attend a private entity for a review or consultation. In some cases, patients who require care and/or treatment may be placed on a waiting list in a public hospital.

Section Five

5 | Clinical Prioritisation Process

5 | Clinical Prioritisation Process

5.1. Background to Clinical Prioritisation Process and Categories

In 2017 the Office of the National Clinical Advisor to Acute Hospitals, HSE and the NTPF worked together to develop a process to support the clinical prioritisation of patients who require Inpatient or Day Case admission.

Recommendations around Clinical Prioritisation Categories (CPC) and Clinically Recommended Timeframes (CRT), as set out in Table 1, were agreed and approved by the HSE Leadership Team, and subsequently rolled out by the NTPF. These Clinical Prioritisation Categories and Clinically Recommended Timeframes were further reviewed and approved by the National Clinical Advisors and Group Lead (NCAGL) Forum in 2023.

5.2. Clinical Prioritisation Categories

Clinical Prioritisation Category (CPC) is the level of urgency that a clinician assigns to a patient on their booking form or direct referral. These categories are urgent, semi-urgent or non-urgent (routine).

5.3. Clinical Prioritisation Time Frames

Each category of clinical prioritisation is accompanied by a Maximum Clinically-Recommended Time (CRT) to admission. The clinical prioritisation category should be appropriate to the patient, their clinical situation and, sometimes, other exceptional social circumstances.

Note, Maximum Clinically Recommended Times (CRTs) to admission are set to minimise risk and/or achieve best clinical outcome for patients, and differ from National Sláintecare maximum wait time target of 12 weeks of Inpatient, Day Case and GI Endoscopy.

5.4. Decision to Admit

Once a patient has been seen by a consultant and/or senior clinician and the decision to admit has been made, the patient is verbally informed. A waiting list booking form must be completed and forwarded to the booking administrator or booking office within one (1) working day. The *Waiting List Category* (e.g. inpatient, day case or planned procedure) and *Clinical Prioritisation Category* (CPC) or indicative date must be clearly indicated on this form.

5.5. Planned Procedure

A patient placed on a waiting list for a **planned procedure** is a patient who had an initial episode of care and requires recall for a further planned, timed or surveillance procedure in the future as part of their ongoing clinical care and/or treatment. Patients who are added to a planned procedure list should not be issued with a clinical prioritisation category; they must be advised on the day of an indicative date or approximate timeframe in the future for their procedure.

5.6. Direct Referral

When a direct referral is received, all information on the referral should be entered onto the hospital patient administration or management system within 24 hours of receipt, and the referral should be sent for clinical prioritisation.

Table 1: Clinical Prioritisation Categories and Clinically Recommended Time to Admission

*Clinical Prioritisation Process for Elective Patients who require Inpatient or Day Case Admission		
Clinical Prioritisation Categories (CPC)	Maximum Clinically Recommended Time (CRT) to admission	Clinical characteristics/outcomes of conditions within the Prioritisation Category
Urgent	< 28 days	• Risk of permanent damage to organ systems if treatment is delayed beyond CRT • Major functional impairment • Suspected malignant neoplastic disease - Rapidly progressing dysfunction (over a period of days or weeks) in established conditions
Semi Urgent	< 13 weeks	• Risk of damage to organ system if treatment is delayed beyond CRT • Moderate functional impairment or progressive loss of function over a period of months or years • Benign neoplastic disease • Significant restriction of economic activity[1]
Non Urgent(Routine)	<9 months	• Minimal risk of damage to organ system if treatment is delayed beyond 13 weeks • Moderate functional impairment • Significant restriction of social activity[2] • Management issues in established conditions • Reassessment of stable/chronic conditions that meet the criteria for review

* Inpatient and Day Case Clinical Prioritisation Categories and CRTs are in line with the National Outpatient Waiting List Management Protocol 2022.

Unscheduled Care Admission

- Patients who require same day admission should be admitted and recorded as unscheduled care admissions. These patients **should not be** added to an Inpatient or Day Case waiting list.

Clinical Prioritisation Categories (CPC)

- Clinical assessment based on a number of factors, including clinical examination and the impact of the patient's complaint on their health and wellbeing, are key factors in determining the appropriate clinical prioritisation category.

Maximum Clinically Recommended Time (CRT) to admission

- Time to admission can be shorter than, but should not exceed the maximum recommended time to admission.

Exclusions

- Inappropriate direct referrals for Inpatient and/or Day Case admission should be excluded and redirected accordingly.

[1] Significant restriction resulting in inability to work/support self and/or dependants

[2] Resulting in a deterioration of the person's overall well-being and/or mental health

NOTES

Section Six

6 | Adding a Patient to the Waiting List

6 | Adding a Patient to the Waiting List

Upon decision to admit, a booking form must be completed by the clinician. Completed booking forms must be added to the appropriate waiting list of the hospital patient administration or management system within 24 hours of receipt.

- Booking forms must be date-stamped on receipt in the booking office. Electronic booking forms/processes are recommended.
- When adding a booking form to the hospital patient administration or management system, the administrator must first search the system to see if the patient already exists with an established Medical Record Number (MRN), Patient Identification (ID) or Individual Health Identifier (IHI).
- Once the patient record is identified, the administrator must ensure that the patient does not already have a waiting list entry for the same procedure. Taking the time to do this will reduce the risk of duplicate entries on the IDPP Waiting List.
- Patients identified for urgent admission must be prioritised.
- Booking forms should be retained in the booking office until such time as the patient is admitted or removed from the waiting list, when the booking form should be added to the patient's Health Care Record (HCR).

All information on the waiting list booking form must be entered onto the hospital patient administration or management system. The date that the "decision to admit" was made must be entered on the system as the **date added to the waiting list,** this will inform the patient's "start wait time" on the IPDC waiting list. **This date must not be changed or altered by the hospital at any point during the patient's journey.**

All patients must be placed on the electronic waiting list before a date 'To Come In' (TCI) is given.

6.1. Adding a Direct Referral to the Waiting List

Direct referrals received must be added to the electronic waiting list within 24 hours of receipt. Electronic booking processes are recommended. Patients identified for urgent admission must be prioritised.

Once received, all information on the direct referral must be entered onto the hospital patient administration or management system within 24 hours of receipt. Direct referrals should be added, reviewed and clinically prioritised by the treating clinician or appropriate delegate, within five (5) working days of receipt of referral.

Paper Referral

- The "start wait time" is the date that the paper referral is received by the hospital, date stamped and entered on the electronic waiting list

eReferral

- The "start wait time" is the date that the eReferral was created and sent on the e-referral system by the referrer

Referrals redirected from the outpatient department, which have been deemed suitable by the clinician for direct listing, must be added to the appropriate waiting list.

The "start wait time" on the IDPP waiting list is the date that the clinician deemed the patient suitable for direct listing. See section 6.3 of the Outpatient Waiting List Management Protocol 2022 for more detail.

This "start wait time" date must not be changed or altered by the Hospital at any point during the patient's journey through the scheduled care system.

Figure 1 below illustrates the minimum information required when booking a patient onto an IDPP waiting list to ensure safe, effective waiting list management and reporting.

Figure 1 Minimum Information Required on a Waiting List Booking Form

Clinician Details *Clinician completing the form	
List of Consultant	✔
Specialty	✔
MCRN	✔
Signature*	✔
Mobile/Bleep*	✔
Date	✔
Source of Referral	✔
Patient Details	
Patient Healthcare Record Number	✔
Surname/Forename	✔
Address	✔
DOB	✔
Phone	✔
GP Details	✔
Interpreter	✔
Public/Private	✔
Insurance/Provider	✔
Inpatient/Day Case Waiting List	
Clinical Prioritisation	✔
Inpatient/Day Case	✔
TCI Date	✔
Procedure(s)/Investigation(s)	✔
ICD-10 Procedure Code	✔
Planned Procedure List	
Indicative Treatment Date(s)/Timeframe	✔
Inpatient/Day Case	✔
Procedure(s)/Investigation(s)	✔
ICD-10 Procedure Code	✔
Admission Details	
Medical Condition/Clinical Information	✔
Date of Surgery Admission	✔
General Anaesthetic/Regional Anaesthetic	✔
Medications to be discontinued prior to surgery	✔
Allergies	✔
Pre-operative Assessment	✔
Pre-operative Tests Required	✔
Infection Status	✔
Infection Status	✔

Figure 2 Waiting List Booking Form Template

Insert Name of Hospital

BOOKING FORM FOR INPATIENT, DAY CASE & PLANNED PROCEDURE

This form requests important information. All sections to be completed fully by a Clinician.

CLINICIAN DETAILS	PATIENT DETAILS
List of Consultant: _____	**Patient Healthcare Record No:** _____
Specialty: _____	**Surname:** _____
MCRN: _____	**Forename:** _____
Signature*: _____	**Address:** _____ ADDRESSOGRAPH LABEL HERE
Mobile/Bleep*: _____ **Clinician completing the form*	**Date of Birth:** ____/____/_____ **M □ / F □**
Date^: ___/____/_____ *^Decision to Admit / Start of Wait Time*	**Phone No:** 08( ) _____/_____
SOURCE OF REFERRAL	**GP Details:** _____
OPD □ **ED □** **Ward □**	**Interpreter** **Y □** **N □** **Language** _____
Other Hospital □ **Private Clinic □** **Other □**	**Public □** **Private □**
Please Specify: _____	**Insurance** **Y □** **N □** **Provider**_____
Direct Referral □ **Date:** ____/____/_____	

EITHER SECTION A OR B MUST BE COMPLETED

SECTION A — **INPATIENT/DAY CASE WAITING LIST**

Select one of the following

Urgent (≤ 28 days) □ **Semi Urgent (≤ 13 weeks) □** **Non Urgent (≤ 9 months) □**

Select one from each line below

Inpatient □ **Day Case □**

AM □ **PM □**

To Come In Date (TCI) _____/_____/20_____ **Ward** _____

Procedure(s) / Investigation(s) *(please insert site/side if relevant)*

_____

_____

Right □ **Left □** **Bilateral □** **ICD-10-AM Procedure Code** _____

SECTION B — **PLANNED PROCEDURE LIST**

(Procedure following initial episode of care and requiring recall for further treatment relating to that initial episode)

Indicative Treatment Date(s) / Timeframe

_____

(No patient should be added to a planned procedure list without an indicative date or approx timeframe)

Select one from each line below

Inpatient □ **Day Case □**

AM □ **PM □**

Procedure(s) / Investigation(s) *(please insert site/side if relevant)*

_____

_____ **ICD-10-AM Procedure Code** _____

ADMISSION DETAILS

Medical Condition / Clinical Information:

_____

Day of Surgery Admission (DOSA) **Yes □** **No □**

General Anaesthetic / Regional Anaesthetic □ **Local Anaesthetic □** **Sedation □** **Fasting □**

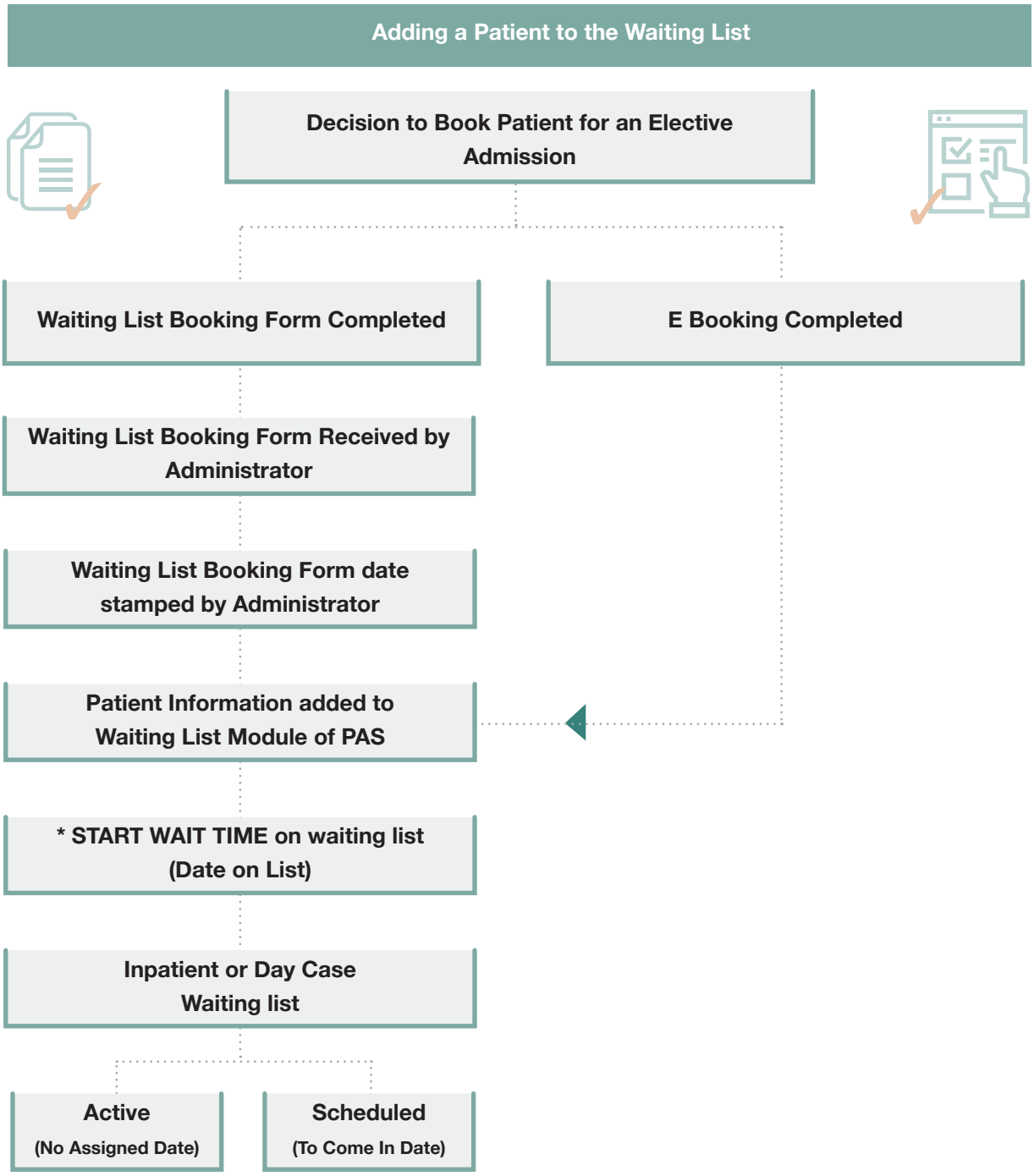
Medications to be discontinued prior to surgery: _____ Timeframe: _____

Allergies (please specify medication or other): _____

Pre-Operative Assessment required: **Yes □** **No □** **Special Requirements:**_____

Pre-Operative Tests required: _____

Infection Status: _____ Isolation Required □ IC Alert □ Please specify: _____



* General Referral Start Wait Time

The date that the "decision to admit" was made must be entered on the system as the date added to the waiting list, this will inform the patient's "start wait time" on the IPDC waiting list.

* Direct Referral Start Wait Time

Paper Referral

- the "start wait time" is the date that the paper referral is received by the hospital, date stamped and entered on the electronic waiting list

eReferral

- the "start wait time" is the date that the eReferral was created and sent on the e-referral system by the referrer

6.2. Adding a Patient to the Planned Procedure List

Planned procedures refer to those patients who have had an initial episode of care and require recall, follow up or further treatment relating to that initial episode of care.

There are three (3) categories of planned procedures as set out in table 2 below:

Table 2: Categories of planned procedures

CATEGORIES	OTHER COMMON TERMS	EXAMPLES
I. PLANNED *(MULTIPLE TREATMENT DATES)*	• Series • Sequence	• Skin grafting • Series of injections • Series of transfusions
II. TIMED *(SPECIFIC DATE/TIMELINE)*	• Staged • Removal/Replacement of	• Removal of metals • Removal of stents
III. SURVEILLANCE	• Check • Repeat • Re-Do	• Cystoscopy • GI Endoscopy

*Note: second procedures such as second eye cataract surgery, second hip/ knee surgery are no longer managed via the Planned Procedure list. These should be added to the waiting list as two separate episodes of care.

A booking form should be completed for the three (3) planned procedure categories outlined above and the patient should be added to the planned procedure list.

Where a patient requires multiple dates as part of a series or sequence of treatments, the initial episode should be added to the Active list with a TCI date, with the remaining dates added to the planned list with an indicative date or timeline.

Patients who are added to a planned procedure list must be advised on the day of an indicative date or approximate timeframe in the future for their procedure. No patient should be added to a planned procedure list without an indicative date or approximate timeframe.

6.3. Scheduling a Planned Procedure

Patients on the planned procedure list must be scheduled for their date within two (2) weeks of their indicative date, as this is considered a reasonable offer (two (2) weeks' notice) of care and/or treatment. Patients due for a planned procedure must be considered when capacity and demand planning.

All patients must be placed on the electronic waiting list before a TCI date is given.

6.4. Scheduling an Elective Admission (TCI)

Once a patient has been added to a waiting list, they are actively waiting for a date 'To Come In' (TCI), to receive their care and/or treatment. In order to ensure fair, equitable access to hospital capacity patients should be scheduled in line with their clinical prioritisation category (CPC),

The patient's clinical requirements must be taken into consideration when scheduling.

6.5. Scheduling in line with the Clinical Prioritisation Category (CPC)

Patients should be scheduled having regard to the assigned CPC and maximum Clinically Recommended Time (CRT) to admission (see Table 1) or within a shorter time line where such has been agreed nationally as part of a care pathway.

Where locally agreed timeframes are not in place, patients allocated the same CPC should be scheduled in chronological order from oldest **'date added to the waiting list'** to newest.

6.6. Scheduling Timeframe

In order to facilitate planning, to ensure the maximum use of available capacity and to reduce DNAs and cancellations, the following criteria must be adopted when scheduling patients for a date 'To Come In':

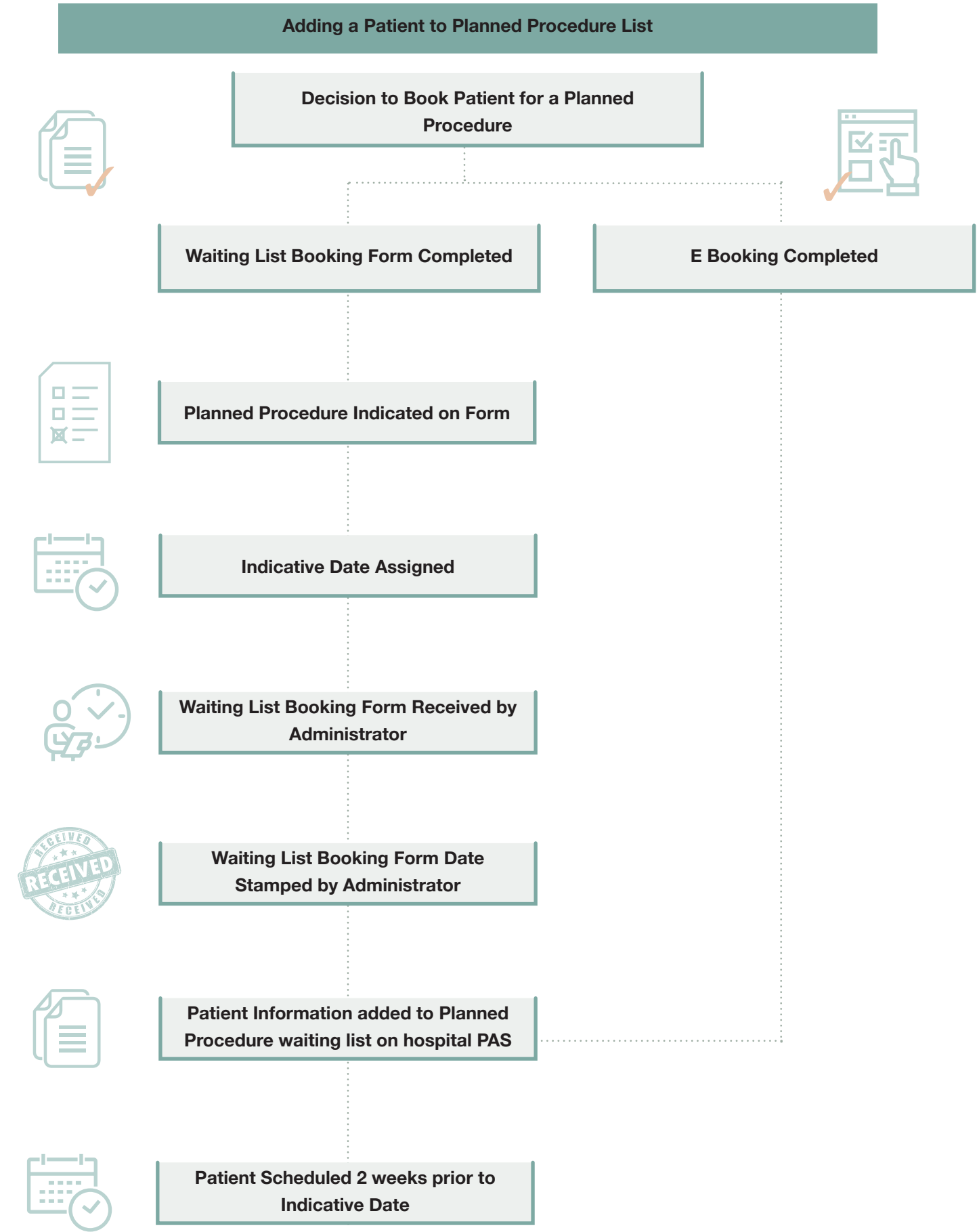
- Patients must not be scheduled more than six (6) weeks into the future.
- Patients should be given a minimum of two (2) weeks' notice of a TCI date, as this is considered a reasonable offer.
- Patients must confirm their availability to attend a TCI date – the recommended method of scheduling patients is partial booking, offering patient choice (see Appendix 1 for offer letter templates)
- When scheduling urgent appointments it may not be possible to give two (2) weeks' notice (reasonable offer), short notice rules apply.

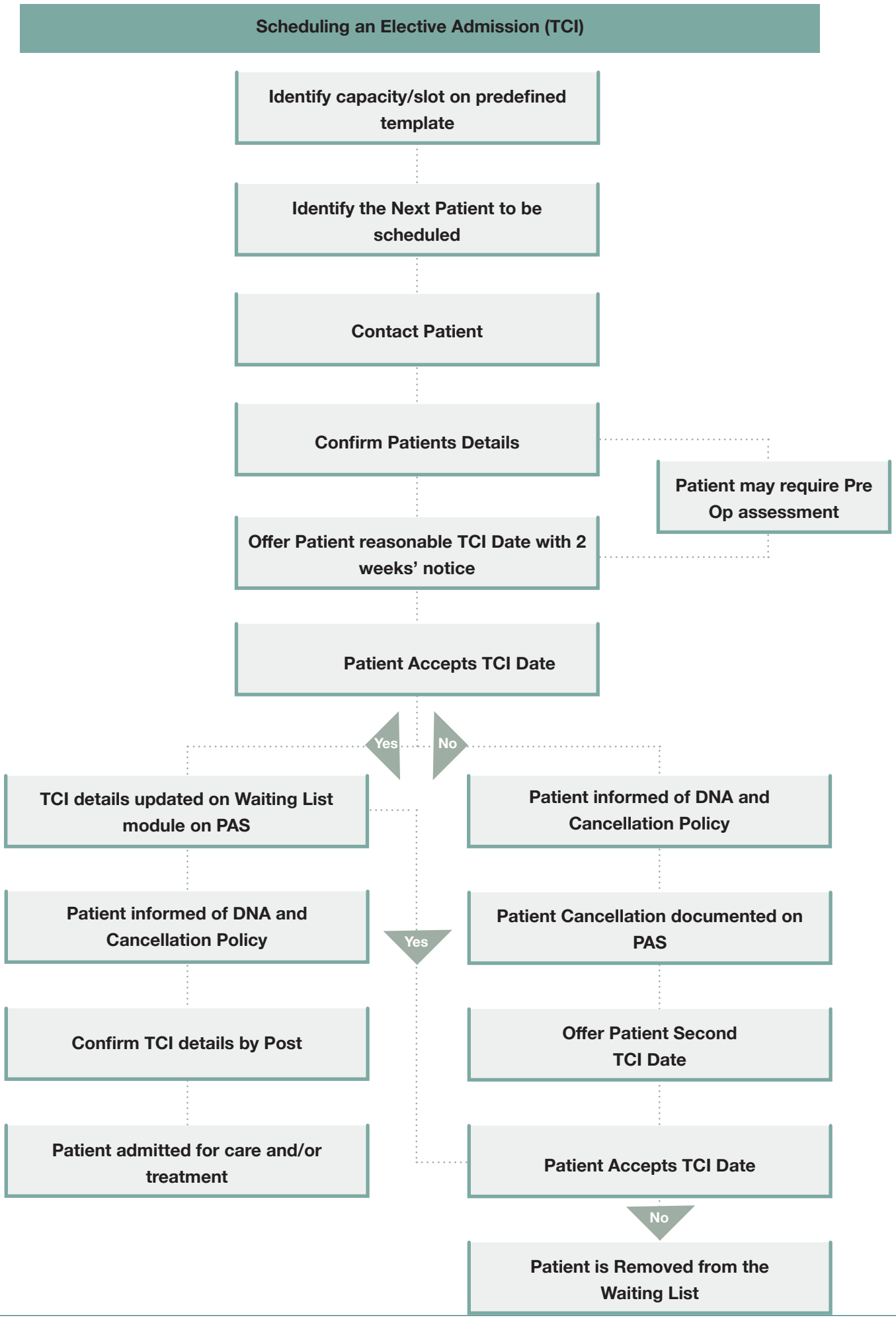
In the event of a TCI date becoming available at short notice the available slot should be offered to the next suitable patient in **chronological order,** i.e. 'Treated in Turn'. Patients who decline this offer will **NOT** have their waiting time clocks reset unless it was a reasonable offer (two (2) weeks' notice). Urgent and/or high clinical and/or social needs patients should be reviewed by the clinician to inform rescheduling. If reasonable notice is given the patient's wait time clock will be reset at national level.

Patients who decline two reasonable offers of a TCI date (two (2) weeks' notice) should be removed from the waiting list and the removal process must be followed. Exceptions to this should be approved on a case-by-case basis by the Scheduled Care Lead and/or Clinician. This decision must be documented on the patient's record and/or hospital patient administration or management system.

6.7. Short Notice Appointments

In the event of a To Come In (TCI) date becoming available at short notice, the available slot should be offered to the next suitable patient in strict chronological order, i.e. 'Treated in Turn'. Patients who decline this offer should NOT have their waiting list clocks reset unless it was a reasonable offer (two (2) weeks' notice).


Adding a Patient to Planned Procedure List
Decision to Book Patient for a Planned Procedure
Waiting List Booking Form Completed
E Booking Completed
Planned Procedure Indicated on Form
Indicative Date Assigned
Waiting List Booking Form Received by Administrator
RECEIVED
Waiting List Booking Form Date Stamped by Administrator
Patient Information added to Planned Procedure waiting list on hospital PAS
Patient Scheduled 2 weeks prior to Indicative Date


Scheduling an Elective Admission (TCI)
Identify capacity/slot on predefined template
Identify the Next Patient to be scheduled
Contact Patient
Confirm Patients Details
Patient may require Pre Op assessment
Offer Patient reasonable TCI Date with 2 weeks' notice
Patient Accepts TCI Date
Yes
No
TCI details updated on Waiting List module on PAS
Patient informed of DNA and Cancellation Policy
Patient informed of DNA and Cancellation Policy
Yes
Patient Cancellation documented on PAS
Confirm TCI details by Post
Offer Patient Second TCI Date
Patient admitted for care and/or treatment
Patient Accepts TCI Date
No
Patient is Removed from the Waiting List

NOTES

Section Seven

7 | Cancellations

7 | Cancellations

There are two types of cancellations, those initiated by the hospital and those initiated by the patient or their guardian. In both scenarios, the relevant information must be captured, and recorded by selection of the correct cancellation reason code on the hospital patient administration or management system; thus providing an accurate audit trail which reflects the patient's waiting list journey.

7.1. Hospital Initiated Cancellation (Hospital Cancellation - HCAN)

A hospital initiated cancellation is defined as any rescheduling of a patient's TCI date by the hospital due to circumstances beyond their control, for example national emergency, extreme weather, industrial action, theatre or bed capacity, resource constraints or leave arrangements.

Patients cancelled by the hospital must be given as much notice as possible and allocated a new TCI date. In this event, every effort must be made to update the affected patients or their guardians by phone and reschedule a new TCI date. This date should be scheduled within six (6) weeks of the cancellation and agreed with the patient to confirm their availability to attend.

Clinical guidance must be sought when managing and rescheduling patients cancelled by the hospital to ensure that urgent and/or high clinical and/or social needs patients are scheduled appropriately. Patients cancelled by the hospital will not incur a wait time clock reset.

7.2. Patient Initiated Cancellation (Can Not Attend - CNA)

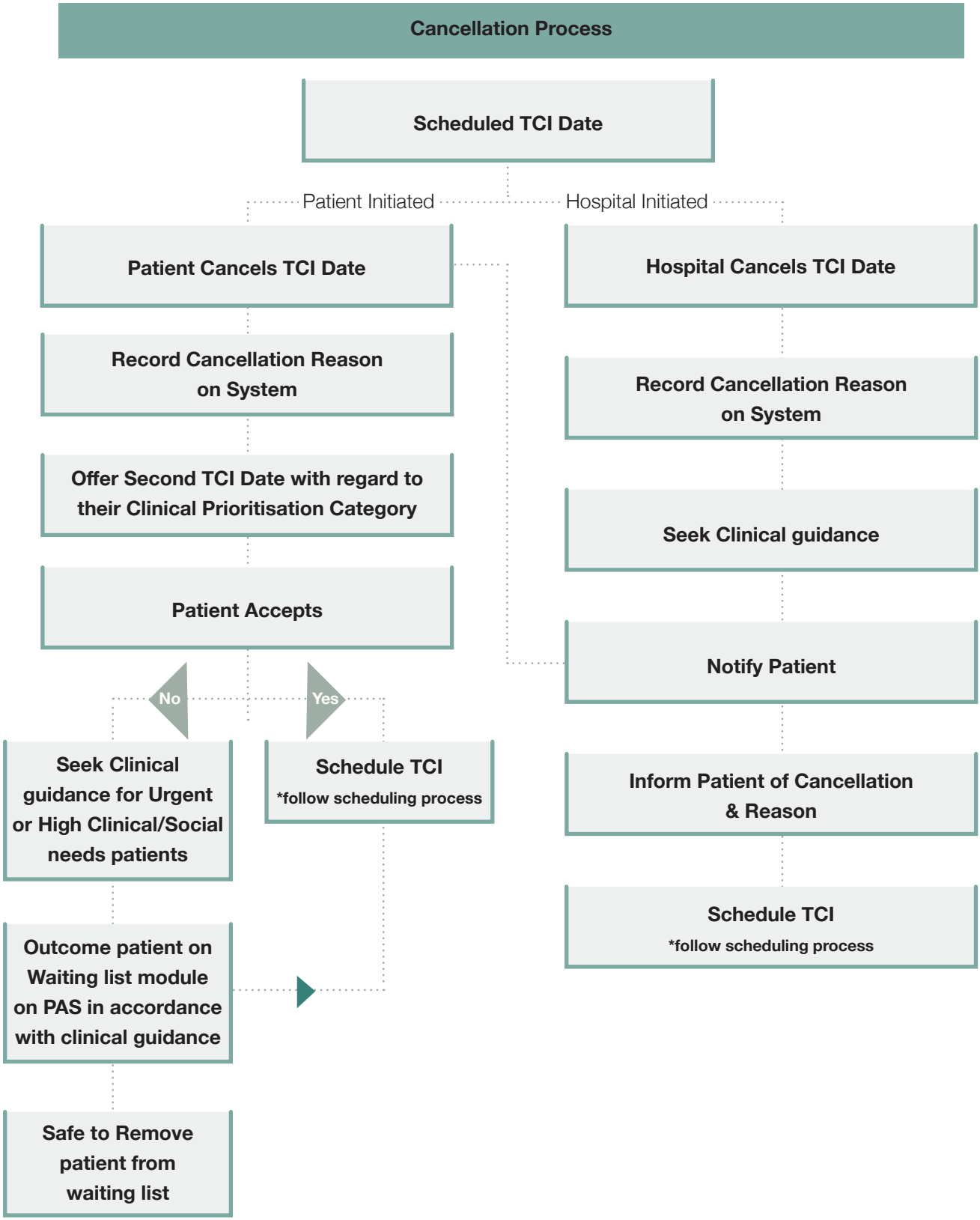
When a patient or their guardian cancels a first TCI date, they must be informed that if they cancel a second appointment, they will be removed from the waiting list. Clinical guidance must be sought when managing urgent and/or high clinical and/or social needs patients who cancel a TCI date.

Following clinical review, it is sometimes necessary to assign another appointment. However, it is mandatory that the SOR and GP are notified of the patient's cancellation history. All decisions must be documented on the patient's healthcare record.

Patients or their guardian must also be informed that, as a result of their initial cancellation, their wait time clock will now restart at national level. **The date must not be changed or altered by the local hospital at any point during the patient's journey through the scheduled care system.**

Patients who cancel two scheduled TCI dates should be removed from the waiting list and the safe removal process must be followed (see section 12). Clinical guidance must be sought when managing urgent and/or high clinical and/or social needs patients who cancel a TCI date.

Patients who cancel a TCI date due to clinical reasons should be cancelled under the appropriate reason code, thus not restarting the patient's wait time clock.


Cancellation Process
Scheduled TCI Date
Patient Initiated
Hospital Initiated
Patient Cancels TCI Date
Record Cancellation Reason on System
Offer Second TCI Date with regard to their Clinical Prioritisation Category
Patient Accepts
No
Yes
Seek Clinical guidance for Urgent or High Clinical/Social needs patients
Schedule TCI
*follow scheduling process
Outcome patient on Waiting list module on PAS in accordance with clinical guidance
Safe to Remove patient from waiting list
Hospital Cancels TCI Date
Record Cancellation Reason on System
Seek Clinical guidance
Notify Patient
Inform Patient of Cancellation & Reason
Schedule TCI
*follow scheduling process

NOTES

8 | Did Not Attend (DNA)

8 | Did Not Attend (DNA)

Where a patient has been issued with a TCI date and fails to attend, it is classified as a 'Did Not Attend' (DNA).

To facilitate the active management of DNAs, when scheduling the first TCI date, patients must be informed of the DNA protocol. Patients **not identified on their record as urgent and/or high clinical and/or social needs** who do not attend one reasonable scheduled TCI date (two (2) weeks' notice) will be removed from the waiting list using the appropriate removal reason code on the hospital patient administration or management system.

Patients **identified on their record as urgent and/or high clinical and/or social needs** should not be removed from the waiting list after a DNA. Their record must be brought to the attention of the clinician for review to determine if it is appropriate to remove the patient from the waiting list, or if a further TCI should be issued. To facilitate this review, patients may be suspended for a maximum period of four (4) to six (6) weeks, choosing the appropriate suspension code, and validated or rescheduled accordingly (see section 9 Suspensions).

Every reasonable effort must be made to contact patients **identified on their record as urgent and/or high clinical and/or social needs** and/or GP within this timeframe to establish the patient's status.

Patients must also be informed that, as a result of their DNA, their wait time clock will now restart at national level. **The date must not be changed or altered by the local hospital at any point during the patient's journey through the scheduled care system.**

8.1. Administrator DNA Management

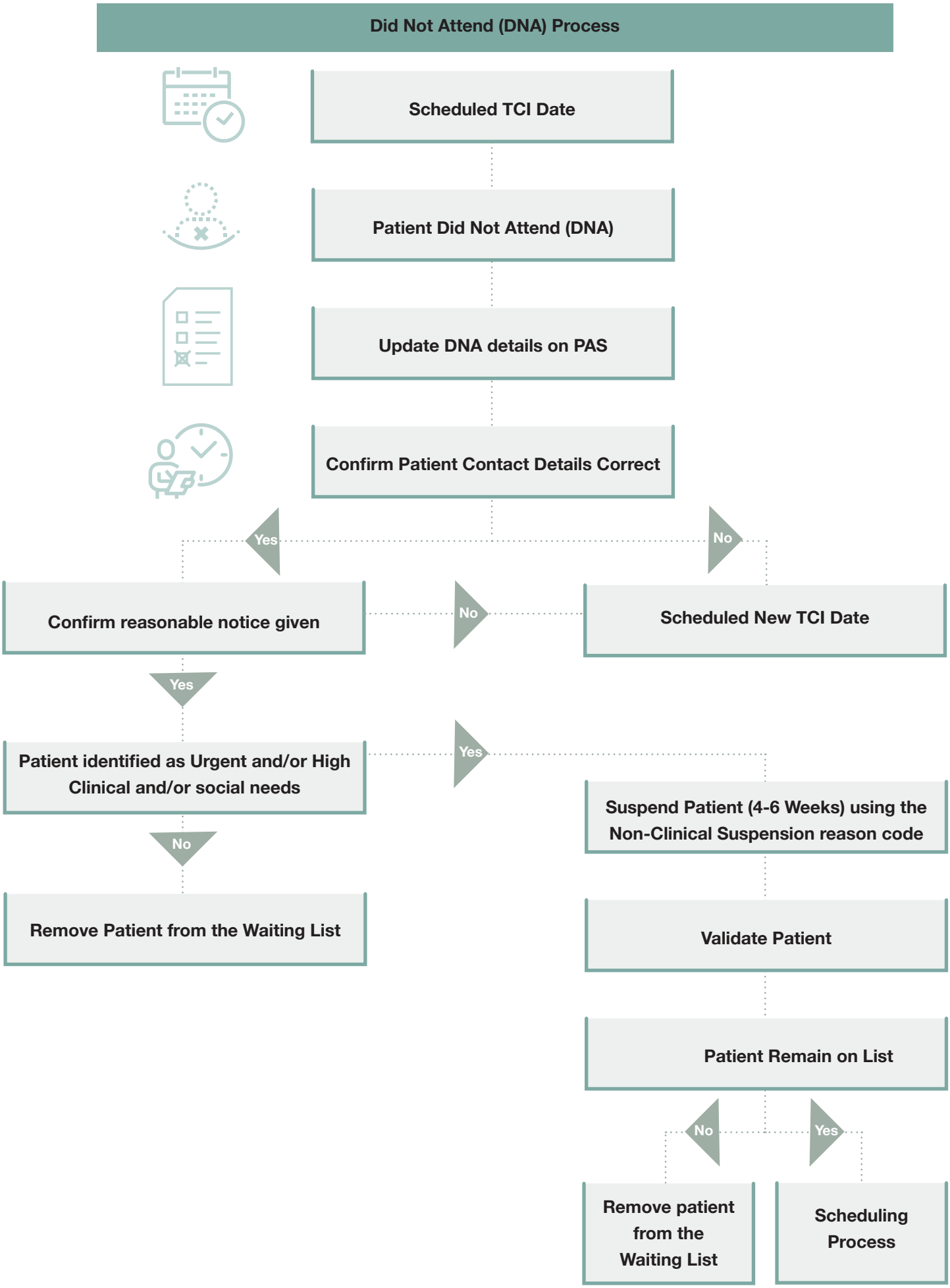
- Identify patients who did not attend (DNA) on their TCI date and **are identified on their record as urgent and/or high clinical/social needs**
- Provide clinician with relevant available notes including booking form and/or patient healthcare record (HCR)
- Collect DNA outcomes assigned by the clinician
- Record DNA outcome on the hospital patient administration or management system as "Patient DNA"
- Issue appropriate communication to the clinician, SOR, GP, patient or their guardian

8.2. Removing a Patient following DNA

Prior to removing a patient from the waiting list following a DNA, the following should be checked:

- Were the patient's contact details correct?
- Was the patient given reasonable notice? (two (2) weeks)
- Is the patient **identified on their record as urgent and/or high clinical and/or social needs?** If so, the patient's record must be brought to the attention of the clinician for review to determine if it is appropriate to remove the patient from the IDPP waiting list, or if a further TCI should be issued.

Following clinical review, where a patient requires removal from the hospital patient administration or management system, this must be done in line with the safe Removal and Reinstatement Process in Section 12.3.


Did Not Attend (DNA) Process
Scheduled TCI Date
Patient Did Not Attend (DNA)
Update DNA details on PAS
Confirm Patient Contact Details Correct
Yes
No
Confirm reasonable notice given
No
Scheduled New TCI Date
Yes
Patient identified as Urgent and/or High Clinical and/or social needs
Yes
Suspend Patient (4-6 Weeks) using the Non-Clinical Suspension reason code
No
Remove Patient from the Waiting List
Validate Patient
Patient Remain on List
No
Yes
Remove patient from the Waiting List
Scheduling Process

NOTES

Section Nine

9 | Suspensions

9 | Suspensions

Patients with an offer of a TCI date who, for clinical, personal or social reasons, are not ready to proceed with their care and/or treatment may be temporarily suspended on the waiting list on one occasion only. To support the management of patients being treated through NTPF or HSE funded commissioning initiatives, it is also recommended to use the suspension process.

Suspension periods must have a start and end date entered onto the hospital patient administration or management system and should last:

- no less than two (2) weeks and no longer than *three (3) months* for clinical and non-clinical suspension
- no less than two (2) weeks and no longer than *six (6) months* for commissioning initiatives

It is recommended that suspension end dates are aligned to the first week of the month as this offers the best opportunity for the patient to receive treatment.

9.1. Managing Clinical Suspensions

Clinical suspension is informed by clinical decisions. This is usually due to the patient being deemed not fit to proceed with care and/or treatment at this time. Periods of clinical suspension should last no less than two (2) weeks and no longer than three (3) months. Each clinical team should review suspensions prior to re-instatement to ensure that the patient is fit to return to the active waiting list.

Patients who are added to an active waiting list must be ready, willing and available to proceed with hospital care. If, upon review, the patient is deemed not suitable to return to the active waiting list, the patient should be removed from the list and returned to the care of the SOR and/or GP.

9.2. Managing Non-Clinical Suspensions

If a patient declines an offer of a reasonable TCI date or cancels a confirmed TCI date due to personal or social reasons (e.g. exams/school or primary carer obligations), they should be temporarily suspended from the waiting list for **no less than two (2) weeks and no longer than three (3) months.**

Patients **identified on their record as urgent and/or high clinical and/or social needs** who DNA must be brought to the attention of the clinician for review as set out in section 8. To facilitate this review, patients may be suspended for a maximum period of four (4) to six (6) weeks, choosing the appropriate suspension code, and validated or rescheduled accordingly.

The period of suspension time will be deducted from the patient's overall waiting list time. The patient's original date added to the waiting list should not be changed or revised at any point in the patient's waiting list journey.

9.3. Managing Suspensions for Commissioning Initiatives

In order to support and facilitate the management of patients accessing care through NTPF or HSE funded insourcing and outsourcing commissioning initiatives, the suspension process should be used. As outlined in Section 10, it is recommended to use the suspension processes for insourcing initiatives where additional capacity has been sourced in another public hospital, and outsourcing initiatives where capacity is procured with a private hospital or service-provider.

Patients participating in these initiatives should be temporarily suspended from the waiting list for **no less than two (2) weeks and no longer than six (6) months** to facilitate treatment across their full episode of care, including receipt of required discharge documentation, to facilitate safe removal from the waiting list.

The suspension period must start from the date the patient accepts the offer to access hospital care in another hospital.

Suspension start date = Date the patient accepts offer

The referring hospital must suspend the patient in line with above timeframes or timelines agreed within the Memorandum of Understanding (MOU). It is important that patients are suspended using the appropriate suspension reason.

Suspension Reasons for Insourcing and Outsourcing Initiatives are:

- NTPF Outsourcing Initiative
- NTPF Insourcing Initiative (See Section 10.3.2)
- HSE Outsourcing Initiative
- HSE Insourcing Initiative (See Section 10.3.2)

Suspension periods to facilitate Insourcing and Outsourcing Initiatives will not incur a 'stop start' in the patient's waiting time period.

Exceptional cases for re-suspension can be agreed by the Waiting List Lead, in consultation with the Clinical Lead.

NB: The NTPF and HSE are committed to working together to review the suspension process to manage patients participating in Insourcing and Outsourcing Initiatives.

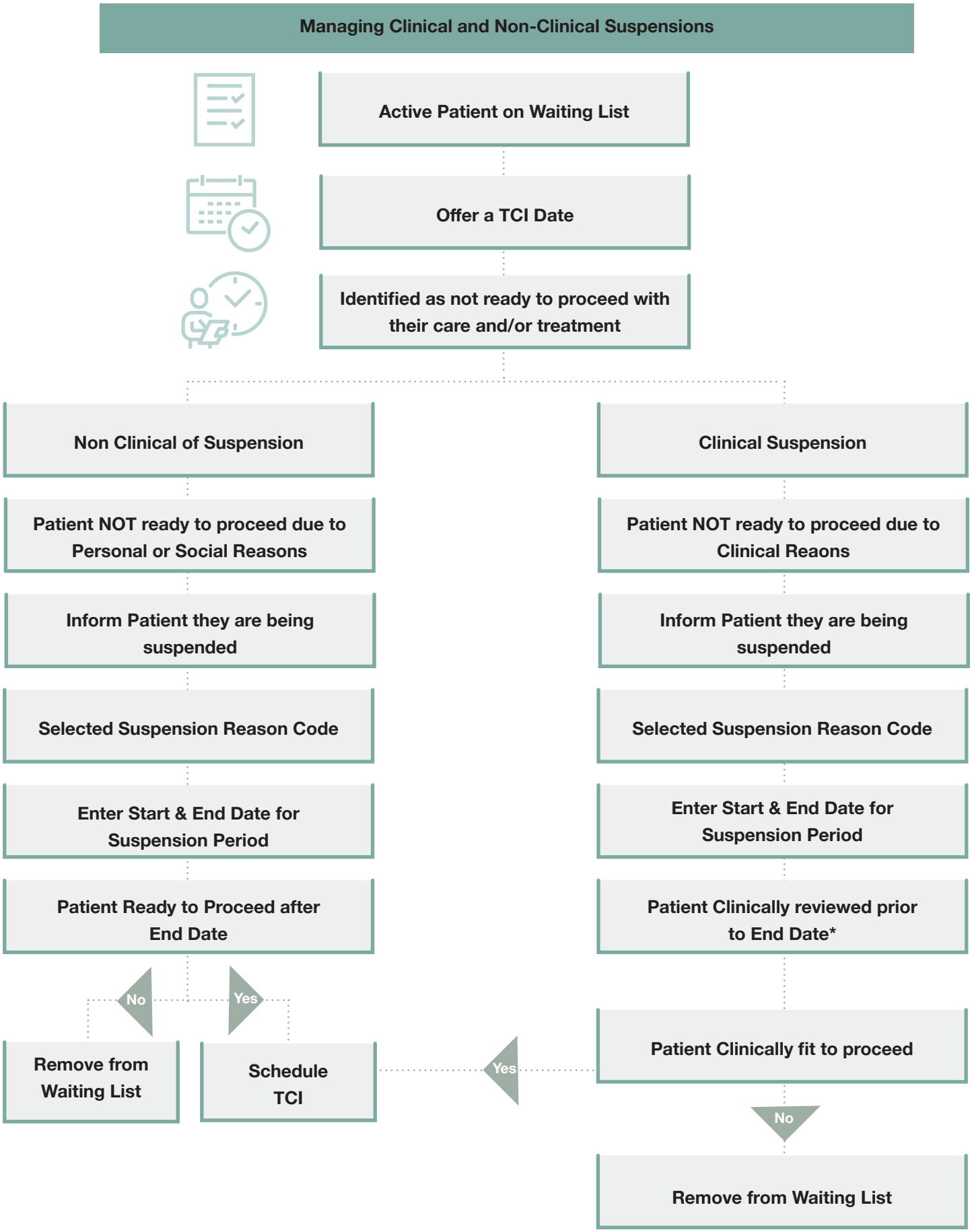
9.4. Extending the Suspension Period

Patients must not incur multiple suspensions. For example, if a patient is on an agreed treatment plan in the treating hospital and the suspension period is due to lapse, the suspension period should be extended by a further three (3) months.

This is done by extending the suspension end date on the local hospital patient administration or management system. The referring hospital must not change the suspension start date; this remains the date the patient accepted the offer of care in another hospital.

The referring hospital must not change the suspension start date

Extend the suspension end date on the local hospital patient administration or management system.



* In some cases a clinical decision may be made to extend the suspension period, this is done by extending the suspension end date on the local hospital patient administration or management system.

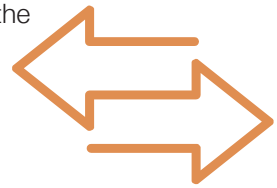
Section Ten

10 | Commissioning Insourcing and Outsourcing Initiatives

10 | Commissioning Insourcing and Outsourcing Initiatives

10.1. Insourcing and Outsourcing Initiatives

Insourcing is the provision of additional capacity in a public hospital; whilst outsourcing is the provision of procured capacity within a private hospital or service-provider.



Insourcing and outsourcing initiatives aim to improve public hospital wait times, especially for the most critical patients and those waiting the longest.

The hospital that seeks the additional capacity is known as the referring hospital and the service that provides the additional or procured capacity is known as the treating hospital or service-provider. In some insourcing initiatives, it is possible for the same public hospital to be the referring hospital as well as the treating hospital or service-provider.

10.2. Valid Offer for Insourcing and Outsourcing Initiative

Once a patient or their guardian has accepted the offer of treatment, and agreed to participate in an insourcing or outsourcing initiative, this is considered a 'Valid Offer'. The patient should be managed in line with the relevant sections set out in this protocol.

10.3. Insourcing Initiative Process

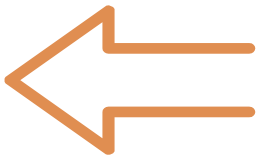
Stakeholders across both sites participating in an insourcing initiative must identify and agree the profile of patients suitable to participate, e.g. clinical, anaesthetic and bed requirements.

At this stage, pathways must be agreed to support those patients requiring further treatment and/or follow-up after the initial episode of care is received.

Patients must then be contacted and offered the opportunity to receive care and/or treatment in the referring hospital or an alternative public hospital.

Insourcing initiatives can be facilitated through:

- Additional capacity in the referring hospital
- Additional capacity in another public hospital
- Theatre rental in a private hospital
- External service-provider coming on site in the referring hospital out of hours



10.3.1. Additional capacity in the referring hospital

Where additional capacity has been identified within the referring hospital, the hospital acts as both the referring and treating hospital. For insourcing initiatives, all capacity provided in the referring public hospital must be additional to the hospital's core activity. This can be facilitated through additional resources i.e. additional theatre session in current theatres, or through opening additional theatres.

The patient **is not suspended** from the IDPP waiting list. The hospital patient administration or management system is used to manage the patient's episode as part of the insourcing initiative. Normal scheduling rules apply (see section 6).

10.3.2. Additional capacity in another public hospital

In this initiative, the treating service-provider is another public hospital in the same or different Hospital Group/HSE Health Region. For this type of insourcing initiative, once suitable patients have accepted the offer of treatment in another public hospital, the patient is suspended on the referring hospital IDPP waiting list using the appropriate suspension code, and added to the treating hospital or service-provider waiting list.

In cases where both public hospitals share the same instance of patient administration or management system, the patient should be managed in line with section 10.3.1.

Referring hospital tasks include:

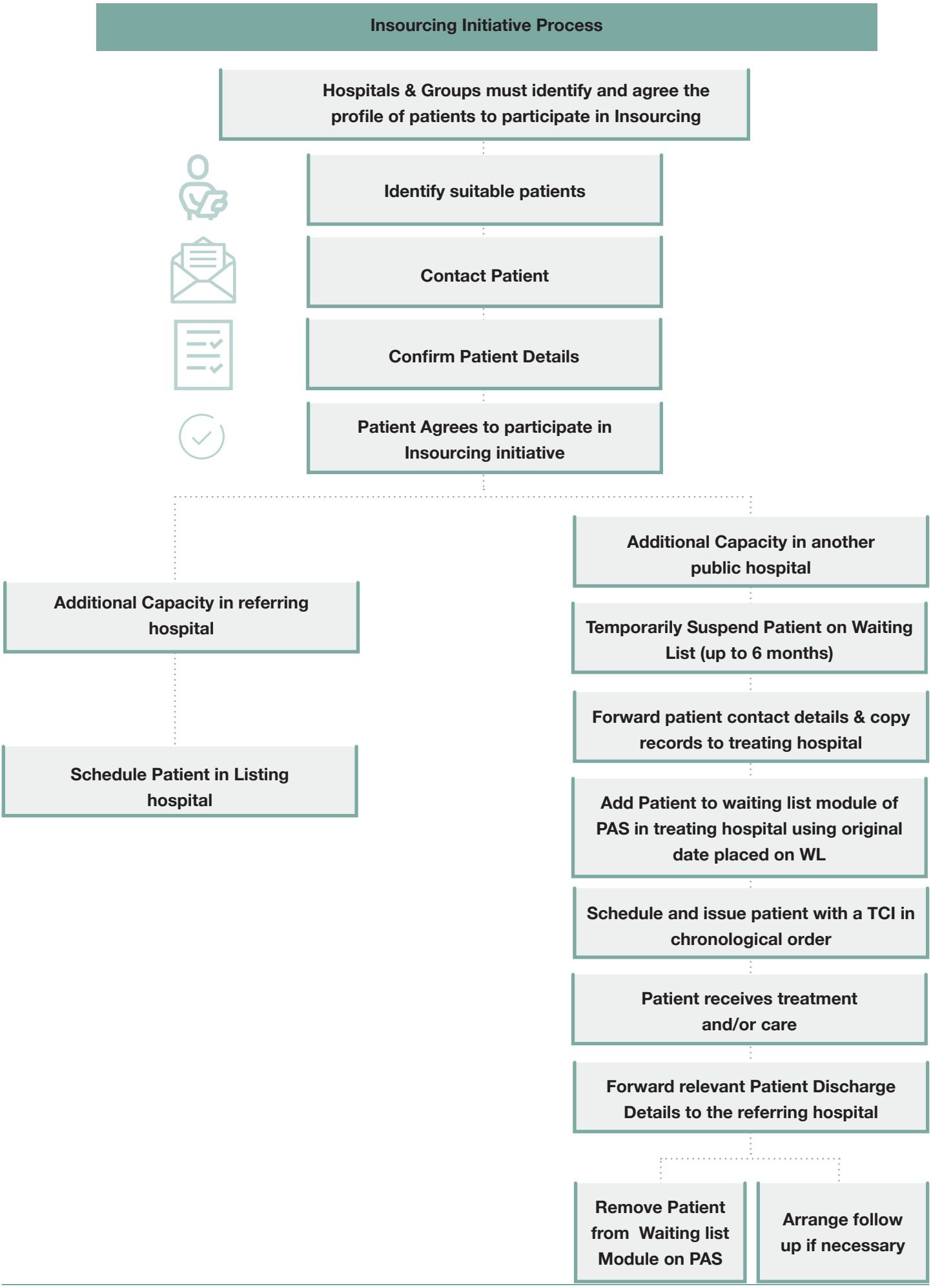
- Setting the suspension start date as the date the patient accepts the offer of access to hospital care
- Suspending the patient for up to six (6) months or timelines agreed within the Memorandum of Understanding (MOU)
- Extending the suspension end-date if necessary, in line with section 9.4 Extending the Suspension Period
- Removing the patient from the IDPP waiting list once formal communication, including discharge documentation, is received confirming that the patient has completed their episode of care

Treating service-provider (other public hospital only) tasks include:

- Adding the patient to the IDPP waiting list on receipt of a copy of their contact details, and a copy of their relevant healthcare records transferred
- Adding the patient using the original date placed on waiting list
- Scheduling and issuing the patient with a TCI once they are added to the IDPP waiting list
- Issuing formal communication to the referring hospital once the patient has completed their treatment/episode of care

Suspension periods to facilitate this type of insourcing initiative will not incur a stop start in the patient's waiting time period.

Patients must not be removed until the relevant discharge documentation is received, updated on the hospital patient administration or management system, and filed in the patient's healthcare record.


Insourcing Initiative Process
Hospitals & Groups must identify and agree the profile of patients to participate in Insourcing
Identify suitable patients
Contact Patient
Confirm Patient Details
Patient Agrees to participate in Insourcing initiative
Additional Capacity in referring hospital
Schedule Patient in Listing hospital
Additional Capacity in another public hospital
Temporarily Suspend Patient on Waiting List (up to 6 months)
Forward patient contact details & copy records to treating hospital
Add Patient to waiting list module of PAS in treating hospital using original date placed on WL
Schedule and issue patient with a TCI in chronological order
Patient receives treatment and/or care
Forward relevant Patient Discharge Details to the referring hospital
Remove Patient from Waiting list Module on PAS
Arrange follow up if necessary

10.4. Outsourcing Initiative Process

Outsourcing initiatives occur when there is an identified need for an intervention to provide capacity for treatment for patients waiting the longest on Inpatient and Day Case waiting lists. This capacity is procured with a private hospital or service-provider.

10.5. Use of Suspension Process for Outsourcing Initiatives

Once a suitable patient has accepted the offer of treatment in a private hospital or service-provider, the referring hospital must suspend the patient on the IDPP Waiting List for a period of up to six (6) months or timelines agreed within the Memorandum of Understanding (MOU) using the appropriate suspension code.

Patients must not be removed until the relevant discharge documentation is received, updated on the hospital patient administration or management system and filed on the patient's healthcare record.

Referring hospital tasks include:

- Suspend the patient for a period of up to six (6) months or in line with the timelines agreed within the Memorandum of Understanding (MOU)
- Setting the suspension start date as the date the patient accepts the offer of access to hospital care (see Section 9 Suspensions)
- Extending the suspension end-date if necessary, in-line with section 10.8 Extending the Suspension Period
- Removing the patient from the IDPP waiting list once formal communication, including discharge documentation, is received confirming that the patient has completed their episode of care

The suspension period must start from the date the patient accepts the offer to access hospital care in another hospital

Suspension start date = Date the patient accepts offer

Private hospitals or service providers that act as the treating hospital are responsible for the scheduling and management of the patient through their episode of care, and for communicating to the public hospital when the patient has completed their episode of care.

When the patient's treatment is completed, the treating hospital or service provider must issue a formal communication, including discharge summary/documentation, which then enables the referring hospital to remove the patient from their IDPP waiting list.

10.6. Patients returned from Insourcing or Outsourcing Initiatives

Patients can be returned to the referring hospital for a number of reasons:

- **Multiple cancellations –** the patient may be returned to the referring hospital after multiple cancellations (or as set out in most recent commissioning MOU)
- **Did Not Attend –** the patient may be returned to the referring hospital after two (2) DNAs (or as set out in most recent commissioning MOU)
- **Clinically Unsuitable –** the patient may be returned to the referring hospital when clinically assessed as too complex or otherwise clinically unsuitable to be accepted by the treating service-provider
- **Patient requests return to the referring hospital**
- **Patient requires long term follow-up.**

10.7. Management of Patients returned from an Insourcing or Outsourcing Initiative

As the patient has accepted the offer of treatment in another location (public or private) and agreed to participate in an insourcing or outsourcing initiative this is considered a 'Valid Offer'.

The referring hospital should, therefore, manage the patient in line with the appropriate section within the IDPP Waiting List Management Protocol 2024.

- Patient Initiated Cancellation – See Section 7.2
- Patient DNA – See Section 8

Clinical review must be sought when managing patients identified as urgent and/or high clinical and/or social needs who have not had their care progressed within the treating hospital and are returned to the referring hospital for onward management.

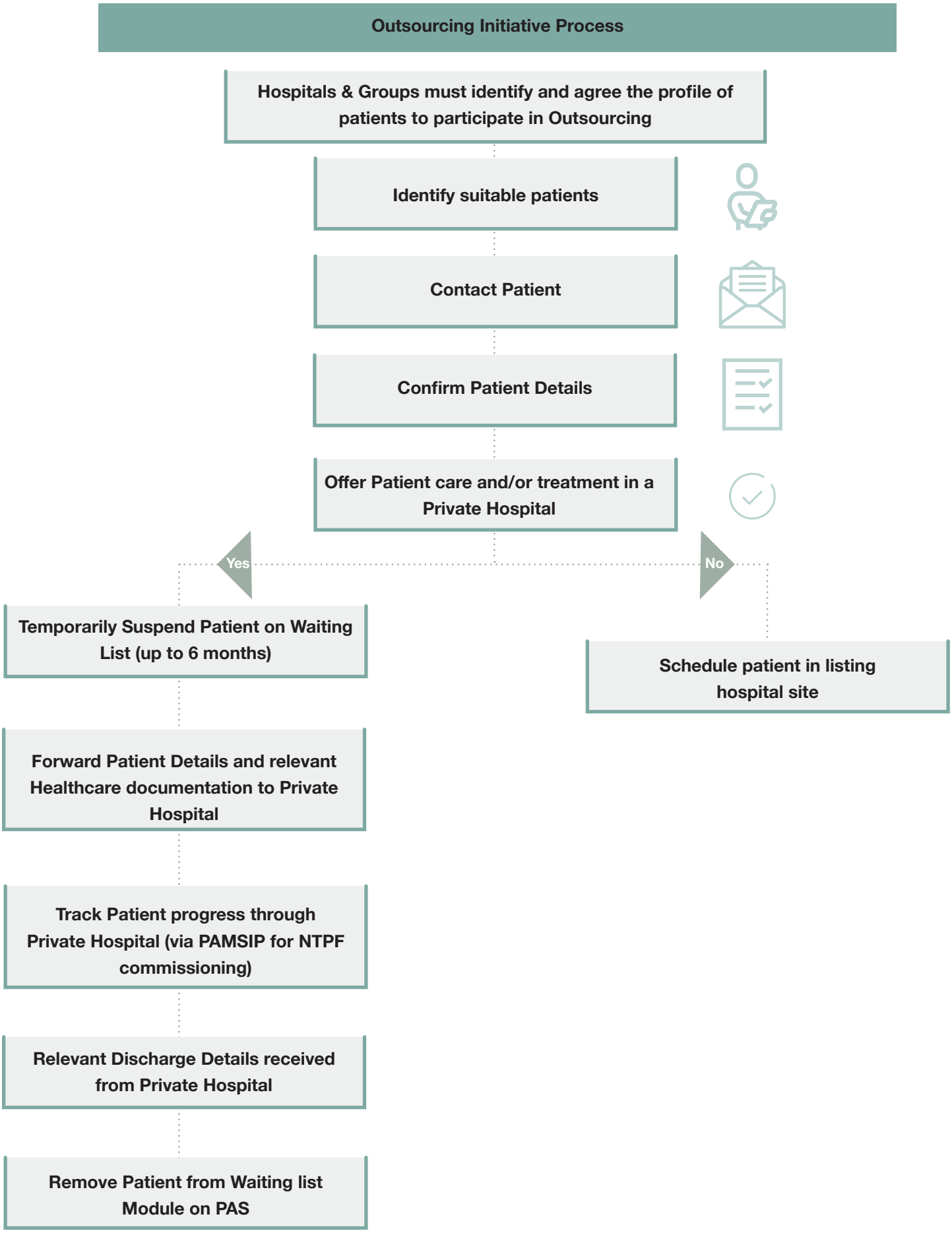
Where the hospital has not received a discharge summary from the treating hospital or service provider within three (3) months, the patient must be followed up by the referring hospital and a treatment plan put in place. A second suspension period should only be utilised when a treatment plan has been agreed.

Patients suspended due to participation in an outsourcing initiative will not incur a stop start in their waiting time period.

10.8. Extending the Suspension Period

Patients must not incur multiple suspensions. For example, if a patient is on an agreed treatment plan in the treating hospital and the suspension period is due to lapse, the suspension period should be extended by a further three (3) months.

This is done by extending the suspension end date on the hospital patient administration or management system. The referring hospital must not change the suspension start date, this remains the date the patient accepted the offer of care in another hospital.


Outsourcing Initiative Process
Hospitals & Groups must identify and agree the profile of patients to participate in Outsourcing
Identify suitable patients
Contact Patient
Confirm Patient Details
Offer Patient care and/or treatment in a Private Hospital
Yes
No
Temporarily Suspend Patient on Waiting List (up to 6 months)
Forward Patient Details and relevant Healthcare documentation to Private Hospital
Track Patient progress through Private Hospital (via PAMSIP for NTPF commissioning)
Relevant Discharge Details received from Private Hospital
Remove Patient from Waiting list Module on PAS
Schedule patient in listing hospital site

NOTES

Section Eleven

11 | Waiting List Validation

11 | Waiting List Validation

11.1. Validation Process

Validation is a process whereby patients on waiting lists are contacted to confirm if they are ready, willing and available to proceed with hospital care. This process also assists hospitals in improving the accuracy of waiting list information.

The purpose of Waiting List Validation is to:

- Maintain hospital-patient communication during the patient's waiting list journey
- Update the patient record
- Reduce DNA and patient cancellation rates
- Provide clean, accurate, up-to-date waiting list data which reflects the demand for hospital services.

There are three types of waiting list validation:

Administrative Patient Validation

Data Validation

Clinical Validation

11.2. Administrative Patient Validation

Administrative patient validation is a task carried out on a monthly, or bi-annual basis, to ensure that waiting list data is kept accurate and up-to-date.

The administrative patient validation process is facilitated by the NTPF for public hospitals nationally. This ensures that patients are validated in a standardised, equitable, efficient and fair manner.

Patients are issued a validation letter asking if they still require access to hospital care. Patients can respond to a validation letter online via the Patient Online Automated Response (POLAR) system at www.waitinglist.ie or by post using the free-post return envelope provided. If a response is not received, the patient is subsequently issued with a reminder letter. Where a patient fails to respond to the reminder letter they may be removed from the waiting list (see Section 12).

Hospitals, together with the NTPF, identify and agree on cohorts of patients for validation on a monthly (maintenance) or biannual basis. Validation cycles are managed using an online automated reporting system, which enables hospitals to action patient validation responses in real-time on their hospital patient administrative or management system.

Following the completion of the Validation Programme, the hospital is issued with an Action Plan outlining the final validation results which must be completed within the set deadline.

11.3. Data Validation

Data validation is an administrative task carried out by the hospital on a regular basis to ensure that waiting list data is kept accurate and up-to-date. As part of this process, a hospital administrator generates and reviews NTPF and hospital patient administration or management system waiting list reports weekly to identify data discrepancies or anomalies. Any identified discrepancies must be followed up and corrected immediately.

Data validation exercises should focus on the following areas:

- Duplicates
- Patients with DNA history
- Patients with CNA history
- TCI dates in the past
- Lapsed suspension dates
- Data entry errors (especially relating to dates)

11.4. Clinical Validation

The clinical validation process is carried out by a clinician or a delegated clinical team member. This process requires the review of a patient's booking form, healthcare record and/or medical notes to establish if:

- the patient should remain on the waiting list
- there is a change to their clinical prioritisation category
- any tests are required in advance of admission

Where the clinician or delegated clinical team member contact each patient by phone as part of the clinical validation process, this should be recorded as a virtual clinic. However, clinical validation should not be confused with Pre-Operative Assessment. The use of virtual clinics should follow the Procedure for the Management of Virtual Outpatient Clinics.

11.5. Removal following Validation

Following a validation exercise patients may be removed from an IDPP waiting list. Patients must be removed from the waiting list on the hospital patient administration or management system in line with the removal process in section 12.

Patients identified as urgent and/or high clinical and/or social needs should be brought to the attention of the consultant and should only be removed under clinical guidance.

If an SOR, GP, patient or their guardian request reinstatement to the IDPP waiting list within four (4) weeks of the notification of the decision to remove, the patient may be reinstated. When reinstating a patient to the IDPP waiting list, the patient must be added using the original date on the list in line with the reinstatement process in Section 13.3.

NOTES

12 | Admitting a Patient from the Waiting List

12 | Admitting a patient from the Waiting List

When patients present on the day for their treatment, they are admitted via the admissions office or day ward reception. When admitting a patient, it is important that the waiting list episode is selected and progressed through the admission process on the hospital patient administration or management system.

The key steps for admitting a patient are shown below:

- Admin staff search PAS and locate patient
- Select the waiting list episode the patient is presenting for on the day
- Admit the patient to the relevant ward (inpatient, day ward or procedure room)
- Enter admission date (usually defaults to the current date) and admission type (elective)
- Print front sheet and labels for patient's HCR (if applicable)

Where retrospective admissions are required to manage TCIs' in the past, ensure that the correct admission date is added to the hospital patient administration or management system.

	Search PAS and locate patient
	Select the waiting list episode
	Admit the patient
	Enter admission date
	Print front sheet and labels

Section Thirteen

13 | Removing a Patient from the Waiting List

13 | Removing a Patient from the Waiting List

Patients can be removed from the waiting list for a number of reasons without ever having their care and/or treatment. Patients who are removed from a waiting list must be removed in a safe manner with a clear, consistent, well documented audit trail to support the removal process.

13.1. Reasons for Removal

- Patient admitted via normal TCI Process for this procedure.
- Patient admitted via Outpatient Department for this procedure.
- Patient admitted via Emergency Department for this procedure.
- Patient declined two reasonable offers of an appointment.
- Patient cancelled two consecutive reasonable TCI dates (two (2) weeks' notice).
- Patient did not attend (DNA).
- Patient suspension period lapsed and patient still not suitable.
- Patient failed to respond during the validation process.
- Patient requests removal (admission no longer required) during the validation process.
- Clinician requests removal following clinical validation.
- Clinician requests removal as care and/or treatment no longer required.
- Patient treated in another hospital via an insourcing or outsourcing initiative.
- Patient is deceased.
- Patient details have been entered in error.

When a decision is made to remove a patient from a waiting list, the relevant documentation and communication must be sent to the patient, their GP and Source of Referral within two (2) working days of removal. This must be recorded and documented on the patient's health care records and the hospital patient administration or management system.

13.2. Removal of an Urgent and/or High Clinical and/or Social Needs Patient

In some cases patients can be identified in their Healthcare record as urgent and/or high clinical and/or social needs. Consideration should be given to the management of patients identified as high clinical and/or social needs throughout the inpatient pathway.

Patients identified as urgent and/or high clinical and/or social needs must be clinically reviewed and should only be removed under clinical guidance.

13.3. Reinstatement of a Removal

If a request for reinstatement to the IDPP waiting list is made by the patient or their guardian, SOR or GP, within four (4) weeks of the notification of the decision to remove, the patient may be reinstated at the discretion of the clinician, in consultation with the Scheduled Care Lead.

When reinstating a patient to the IDPP waiting list, the patient must be added using the original date on the list, unless the patient was removed following a DNA where they should be reinstated from the date of their DNA unless otherwise stated.

If the request is made after four (4) weeks from the date of notification of removal from the waiting list, the source of referral must submit a new referral.

13.4. Removal Process Communication

To ensure that patients are removed safely from waiting lists, and to provide evidence of a complete audit trail on the patient's record, formal correspondence, electronic or hard copy, must be issued to the following:

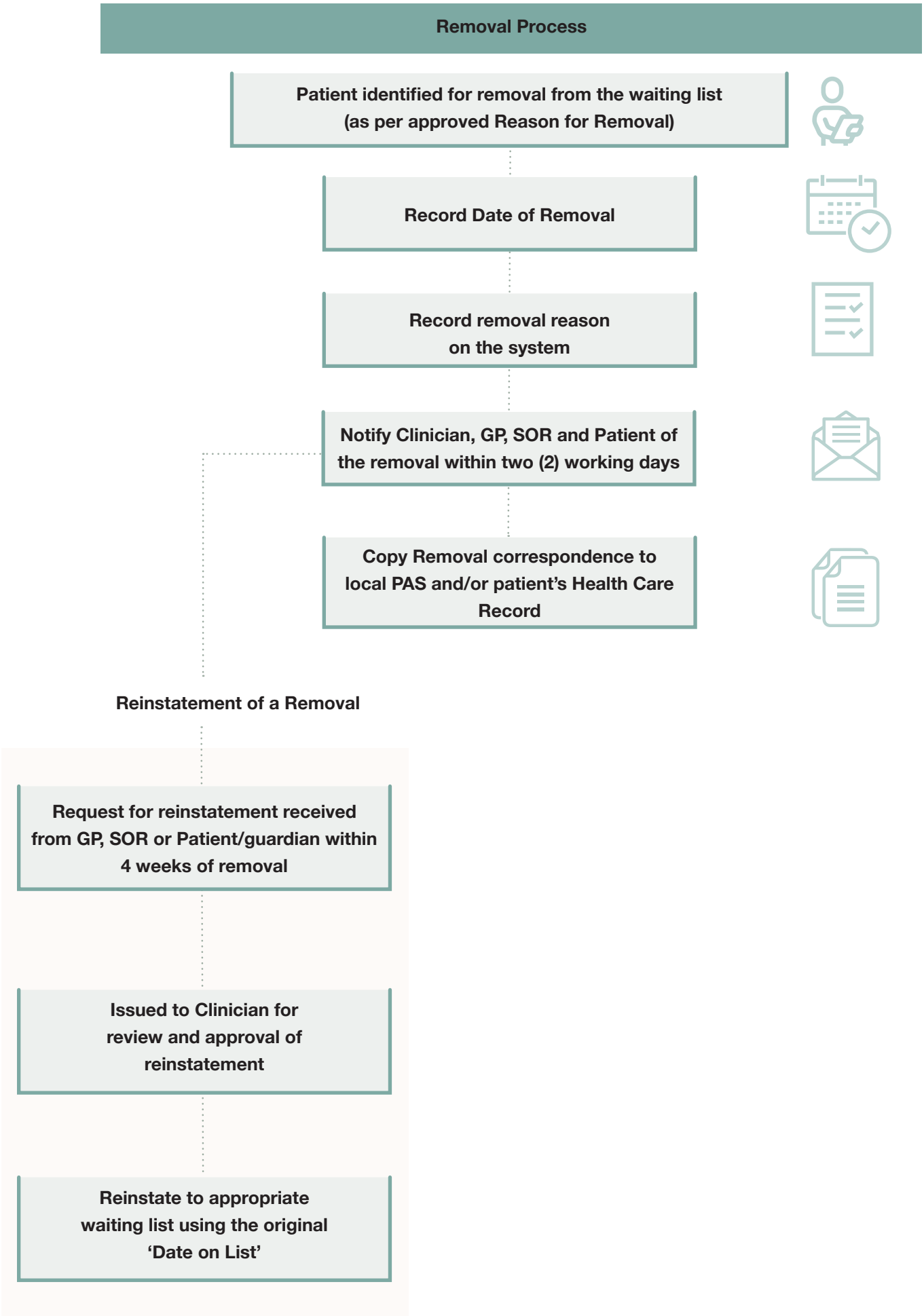
- GP (other than when patient requests communication with SOR only)
- Consultant
- Other source of referral
- Patient or their guardian
- Patient's healthcare records

Removal correspondence must be sent to the patient or their guardian, GP and/or SOR within two (2) working days of removal.

Removal correspondence must include details of:

- Date and reason for removal from the waiting list
- Details of the reinstatement process and relevant hospital contact details

From time to time, a patient or their guardian may request that the hospital only communicates with the referrer (SOR) and not the GP. Requests such as these must be documented on the hospital patient administration or management system and adhered to.


Removal Process
Patient identified for removal from the waiting list (as per approved Reason for Removal)
Record Date of Removal
Record removal reason on the system
Notify Clinician, GP, SOR and Patient of the removal within two (2) working days
Copy Removal correspondence to local PAS and/or patient's Health Care Record
Reinstatement of a Removal
Request for reinstatement received from GP, SOR or Patient/guardian within 4 weeks of removal
Issued to Clinician for review and approval of reinstatement
Reinstate to appropriate waiting list using the original 'Date on List'

Gastrointestinal (GI) Endoscopy Waiting List Management

A1. Gastrointestinal (GI) Endoscopy

This section of the protocol is intended to provide updated guidance, and ensure there is a consistent and standardised approach, to the management and scheduling of patients on GI Endoscopy waiting lists within each hospital and across hospital groups/HSE Health Regions.

While the fundamentals of waiting list management, standard operational procedures, waiting list terminology and definitions apply to the management of all patients on Inpatient, Day Case, GI Endoscopy and Planned procedure lists, there are also a number of unique elements that apply to the management of patients on GI Endoscopy waiting lists only.

The national standardisation of GI Endoscopy waiting list management processes will significantly reduce operational variation.

A1.1. Key Differences

There are several key differences between the GI Endoscopy waiting list and Inpatient and Day Case waiting lists. These include:

- GI Endoscopy patient priority status – urgent (P1) and routine (P2)
- Different maximum clinically recommended times to admission
- BowelScreen and the management of their patients
- Management of the GI Endoscopy Planned procedure list
- Direct referral to a GI Endoscopy waiting list without first being seen by a consultant in the GI outpatient clinic

A1.2. Standard Process Management

Active waiting list management of patients on GI Endoscopy waiting lists must be carried out in line with those set out in the earlier sections of this protocol.

Please refer to the relevant section in this document:

- Hospital Initiated Cancellations (HCAN) – Section 7.1
- Patient Initiated Cancellations (CNA) – Section 7.2
- Did Not Attend (DNA) – Section 8
- Suspensions – Section 9
- Removing patients – Section 13

The hospital patient administration or management system must be updated when any of the above occur, and where appropriate the patient or their guardian, and source of referral / GP must be informed.

A1.3. Clear Governance and Reporting Structures

In order to effectively manage waiting lists there is a requirement to have clear ‘top down’, ‘bottom up’ governance and reporting structures at both hospital and hospital group level.

Scheduled Care Leads, or those with responsibility and accountability for all aspects of waiting list management including the implementation of the National IDPP & GI Endoscopy Waiting List Management Protocol, should be appointed and in place at hospital and hospital group level.

Active waiting list management must be a standing agenda item for discussion at scheduled care and performance related meetings where access, Key Performance Indicators (KPIs) and waiting list initiatives are discussed and waiting list management plans are developed and agreed. The minutes from these meetings must be documented and available for audit purposes.

A1.4. Sources of Referral

Patients referred to a GI Endoscopy service can be identified at various points in the healthcare system. Typically, the sources of referral are from one of these access points:

- Primary care (GP)
- Outpatient department
- Emergency department
- Internal hospital referral
- Inter-hospital referral
- Private entity referral
- National Screening Service – BowelScreen

A1.5. Referral Types

Referrals can be received into the GI Endoscopy Unit in the form of completed GI Endoscopy hospital booking forms (electronic or paper based) for internal or inter-hospital referrals, or external referrals from primary care or private entities, which can be received in a range of formats.

A1.5.1 Internal or Inter-Hospital Referrals

- **Hospital Booking Forms:** Referrals to the GI Endoscopy service from within the hospital, and inter-hospital referrals must be completed on a GI Endoscopy booking form. Section 3.2 sets out the minimum information to be included in a GI Endoscopy booking form.

A1.5.2 External Referrals

- **GI Endoscopy eReferral Forms (preferred method):** Referrals from external sources of referral such as primary care, or private entities, should be completed on the GI Endoscopy eReferral form on HealthLink, or can also be received on the general eReferral form.

- **Paper Referrals:** Referrals from external sources of referral can also be received by referral letter.

A2. Clinical Prioritisation Category (CPC)

Clinical Prioritisation Category (CPC) is the level of urgency assigned to a referral by a clinician or a delegated clinical team member.

Patients who require a GI Endoscopy procedure are clinically prioritised as Priority 1 (P1 or urgent) or Priority 2 (P2 or routine).

Clinical Prioritisation Categories for GI Endoscopy	
Clinical Prioritisation Categories (CPC)	Maximum Clinically Recommended Time (CRT) to admission
Urgent Priority 1 (P1)	Up to one month. Note: urgent colonoscopy patients, however, need to be scheduled for an appointment < 28 days
Routine Priority 2 (P2)	< 13 weeks (91 days)

A3. Adding a Patient to a GI Endoscopy Waiting List

A3.1. Receipt of Hospital Booking Form

GI Endoscopy booking forms must be completed by the referring clinician for all internal hospital referrals (i.e. outpatient, emergency department). Completed waiting list booking forms must be added to the hospital patient administration or management system within 24 hours of receipt.

Booking forms should be:

- Date-stamped on receipt in the booking office.
- Electronic booking processes are recommended.
- Patients identified as P1 for urgent admission must be prioritised.
- Booking forms must be retained in the booking office until such time as the patient is admitted or removed from the waiting list, at which point the booking form should be added to the patient's Health Care Record (HCR).

All information on the waiting list booking form must be entered onto the hospital patient administration or management system. The date that the *"decision to admit"* was made must be entered on the system as the **date added to the waiting list;** this will inform the patient's "start wait time" on the IPDC waiting list. **This date must not be changed or altered by the hospital at any point during the patient's journey.**

All patients must be placed on the electronic waiting list before a 'To Come In' (TCI) date is given.

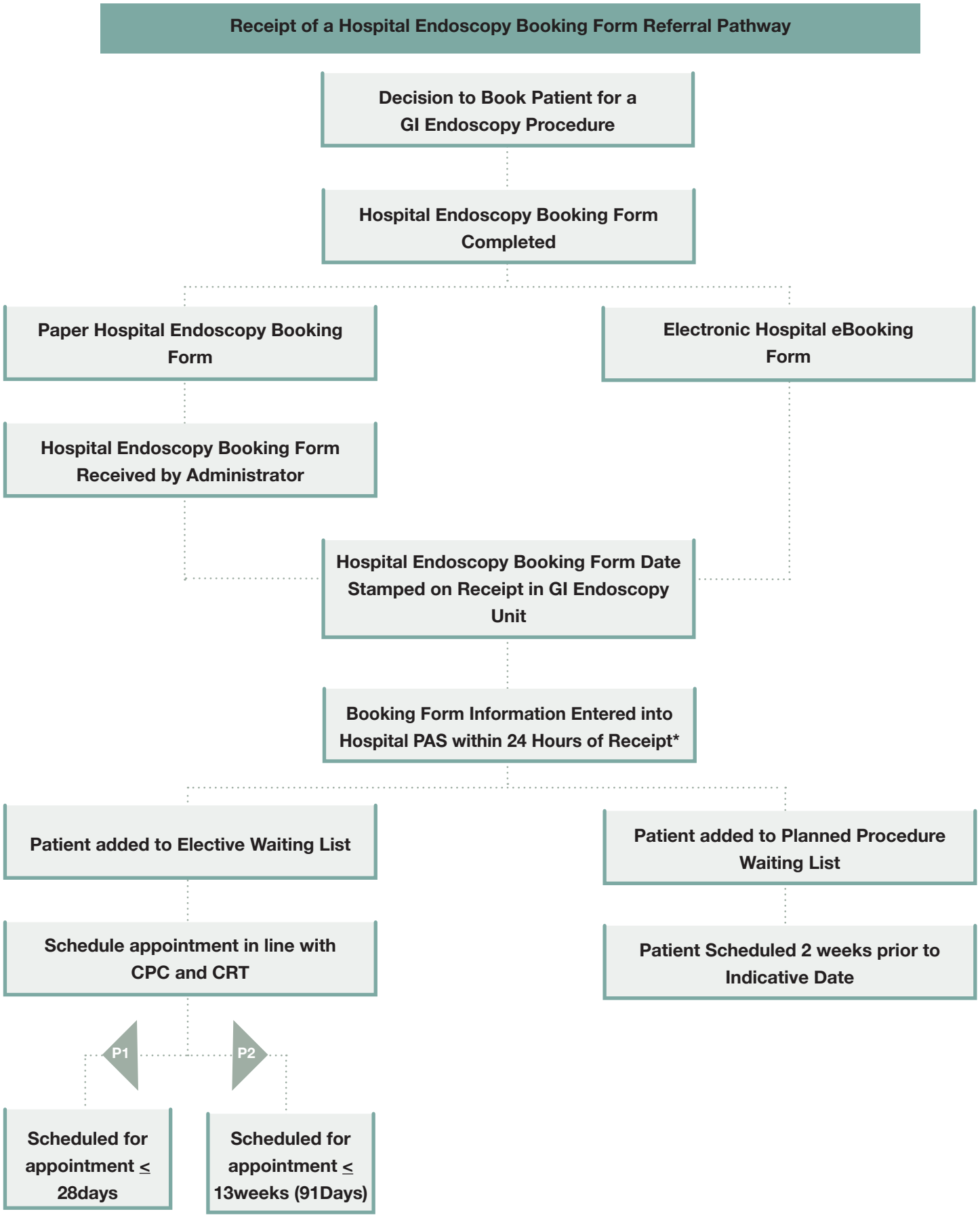
A3.2. Minimum Information to include on a GI Endoscopy Booking Form

While many hospitals already use a GI Endoscopy booking form, the below table suggests the minimum information that should be included on GI Endoscopy booking form.

Where possible, booking forms should be digitalised and replicated on the electronic booking system.

Table 01: GI Endoscopy Waiting List Booking Form Minimum Information Required

GI Endoscopy Booking Form	
Referring Clinician Details	
Date of referral	✔
Referring clinician name	✔
Referring clinician name MCRN	✔
Referring clinician specialty	✔
Referring clinician hospital	✔
Patient Details (to be completed by referring clinician)	
Patient Healthcare Record Number	✔
Surname/Forename	✔
Address	✔
DOB	✔
Phone	✔
GP Details	✔
Interpreter needed. Please state language required	✔
Additional supports needed for patient	✔
Infection Status	✔
Allergies	✔
Medical Condition/Clinical Information	✔
Treatment requested (e.g. colonoscopy)	✔
Triage/decision making (to be completed by GI Endoscopy team)	
Referral accepted Y/N	✔
Procedure(s)/Investigation(s) required (e.g. colonoscopy)	✔
ICD-10 Procedure Code	✔
Clinical Prioritisation Category assigned e.g. P1, P2	✔
TCI date assigned	✔
Suitable for insourcing/outsourcing Y/N	✔
Planned Procedure List (if the booking form is used for requesting planned procedures)	
Procedure(s)/Investigation(s) required (e.g. colonoscopy)	✔
Indicative Date(s)/Timeframe	✔
ICD-10 Procedure Code	✔



* The date that the "decision to admit" was made must be entered on the system as the **date added to the waiting list;** this will inform the patients "start wait time" on the IPDC waiting list.

A3.3. Receipt of GI Endoscopy Referral from an external source of referral

When a GI Endoscopy referral is received from primary care or other external entity (i.e. GP, Private rooms), all information on the referral should be entered onto the hospital patient administration or management system within 24 hours of receipt, and the referral should be sent for clinical prioritisation.

Paper Referral

- The "start wait time" is the date that the paper referral is received by the hospital, date stamped and entered on the electronic waiting list.

eReferral

- The "start wait time" is the date that the eReferral was created and sent on the eReferral system by the referrer

Referrals redirected from the outpatient department, which have been deemed suitable by the clinician for direct listing, must be added to the appropriate waiting list. The "start wait time" on the IDPP waiting list for redirected referrals is the date that the clinician deemed the patient suitable for direct listing. See section 6.3 of the Outpatient Waiting List Management Protocol 2022 for more detail.

The clinical prioritisation process for GI Endoscopy must be completed, sent for clinical prioritisation, and returned to the GI Endoscopy administrative office within five (5) working days.

The patient's clinical prioritisation outcome should then be entered onto the hospital patient administration or management system.

When a clinician assesses a new referral they decide if the referral will be:	
	Accepted and assigned a Clinical Prioritisation Category (CPC)
	Redirected
	Rejected

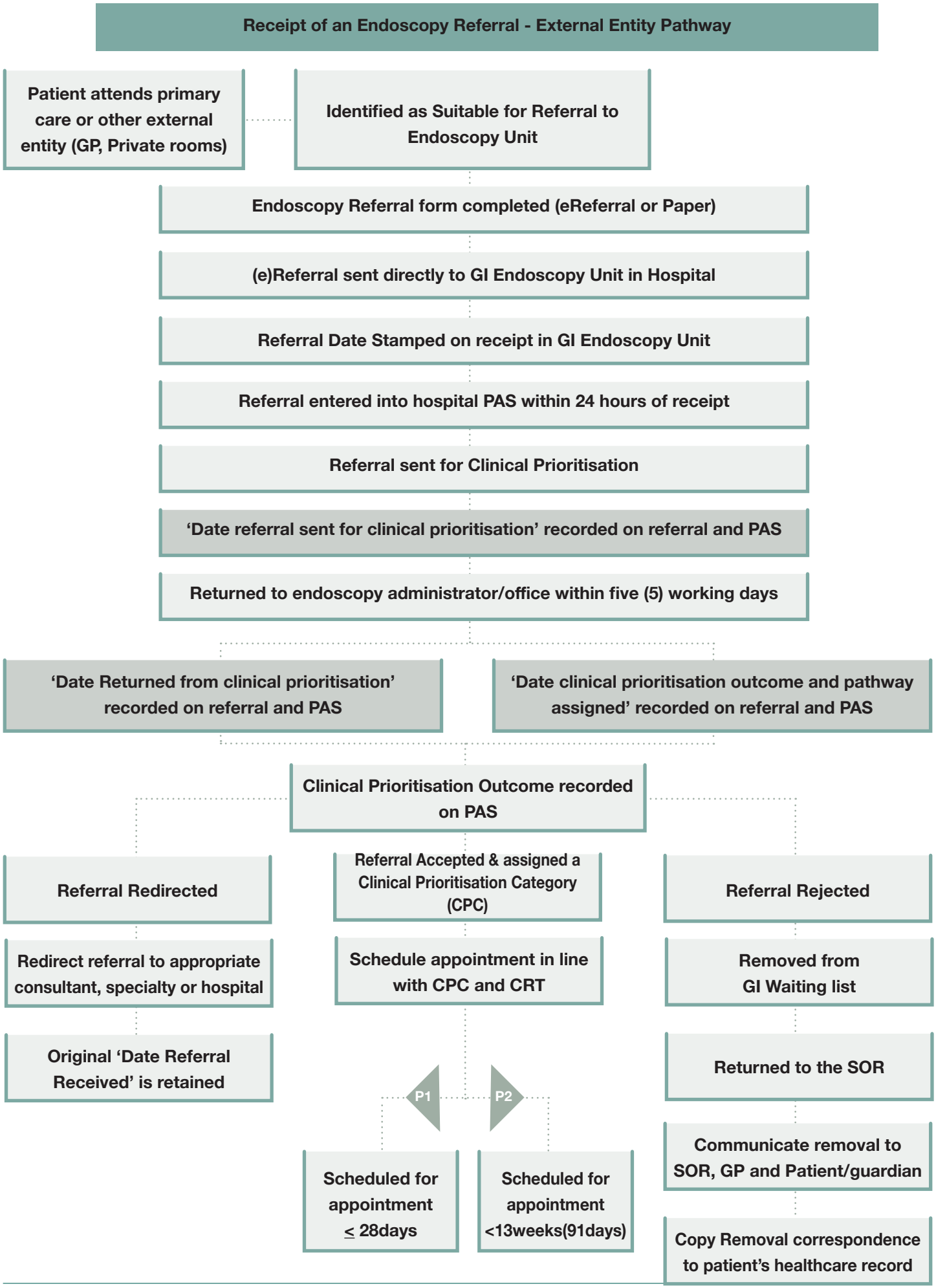
Patients that need a GI Endoscopy procedure should be assigned a Clinical Prioritisation Category (CPC) by a member of the clinical team.

Clinical members of the GI Endoscopy team that can assign a CPC include:

- Consultants
- Senior Registrars
- GI Endoscopy Triage Nurses

Once a patient has been added to a waiting list, they are actively waiting for a 'To Come In' (TCI) date to receive their care.

This "start wait time" date must not be changed or altered by the hospital at any point during the patient's journey through the scheduled care system.


Receipt of an Endoscopy Referral - External Entity Pathway
Patient attends primary care or other external entity (GP, Private rooms)
Identified as Suitable for Referral to Endoscopy Unit
Endoscopy Referral form completed (eReferral or Paper)
(e)Referral sent directly to GI Endoscopy Unit in Hospital
Referral Date Stamped on receipt in GI Endoscopy Unit
Referral entered into hospital PAS within 24 hours of receipt
Referral sent for Clinical Prioritisation
'Date referral sent for clinical prioritisation' recorded on referral and PAS
Returned to endoscopy administrator/office within five (5) working days
'Date Returned from clinical prioritisation' recorded on referral and PAS
'Date clinical prioritisation outcome and pathway assigned' recorded on referral and PAS
Clinical Prioritisation Outcome recorded on PAS
Referral Redirected
Redirect referral to appropriate consultant, specialty or hospital
Original 'Date Referral Received' is retained
Referral Accepted & assigned a Clinical Prioritisation Category (CPC)
Schedule appointment in line with CPC and CRT
P1
P2
Scheduled for appointment ≤ 28days
Scheduled for appointment <13weeks(91days)
Referral Rejected
Removed from GI Waiting list
Returned to the SOR
Communicate removal to SOR, GP and Patient/guardian
Copy Removal correspondence to patient's healthcare record

A3.4. BowelScreen patients

BowelScreen is the national bowel cancer screening programme. Not all hospitals are BowelScreening sites.

BowelScreen patients **DO NOT** belong on the GI Endoscopy waiting list. Colonoscopy appointments for BowelScreen patients are managed directly by BowelScreen nurses. Endoscopy administration is informed of the appointment details. BowelScreen patients are registered on the hospital patient administration or management system as a Day Case procedure with the referral source as 'BowelScreen'.

These patients should not be submitted to the NTPF in the hospital's weekly extract file.

A3.5. Managing patients on the GI Endoscopy Planned Procedure list

Planned procedures refer to those patients who have had an initial episode of care and require recall for further treatment relating to that initial episode of care in the future.

Examples of planned procedures include surveillance GI Endoscopy procedures.

A3.6. Adding patients and the importance of entering an indicative date

Once the patient is identified as requiring a planned procedure, their details are added to the hospital patient administration or management system, and added to the GI Endoscopy planned procedure list.

Patients added to the planned procedure list **must** have an indicative date or approximate timeframe included on the hospital patient administration or management system. This will ensure that they are treated within the appropriate timeframe.

No patient should be added to a planned procedure list without an indicative date or approximate timeframe.

A3.7. Managing a Planned Procedure

The key steps for managing a GI Endoscopy planned procedure are shown below.

- Treating clinician completes a booking form indicating that the patient is for a planned procedure, and the patient is added to the GI Endoscopy planned procedure list.
- Patients must be advised, by a clinician, on the day of their first procedure, of an indicative date or approximate timeframe in the future for their next procedure. The indicative date or approximate timeframe must be included on the hospital patient administration system.
- Scheduling of a GI Endoscopy planned procedure must occur within two (2) weeks of their indicative date, ensuring that it is a reasonable offer of care and/or treatment. However, recall for a GI Endoscopy surveillance procedure can be up to 13 weeks beyond the planned indicative date
- Patients awaiting a date for a planned procedure must be taken into consideration when capacity and demand planning.
- Cancellations (hospital and patient) and DNAs are managed in line with IDPP Protocol (See Section 7 and 8).

A4. Scheduling a GI Endoscopy Appointment

When scheduling patients for a GI Endoscopy appointment, the patient must be informed in writing or by phone of their appointment details. This must be updated on the hospital patient administration or management system to ensure an adequate audit trail is provided. A patient must not be scheduled more than six (6) weeks in advance and should also be given a minimum of two (2) weeks' notice of a TCI date to ensure that it is a reasonable offer.

A4.1. Short Notice Appointments

In the event of an appointment becoming available at short notice, the available slot should be offered to the next suitable patient **in strict chronological order,** i.e. 'Treated in Turn'. Patients who decline this offer should NOT have their waiting list clocks reset unless it was a reasonable offer (two (2) weeks' notice).

A5. GI Endoscopy Validation Process

Validation is a process whereby patients on waiting lists are contacted to confirm if they are ready, willing and available to proceed with hospital care. This process also assists hospitals in improving the accuracy of waiting list information.

There are three types of validation:

Administrative Patient Validation

Data Validation

Clinical Validation

A5.1. Administrative Patient Validation

Administrative validation is a task carried out on a regular basis to ensure that data relating to patients on the active GI Endoscopy waiting list is kept accurate and up-to-date.

The administrative patient validation process is facilitated by the NTPF for public hospitals nationally. This ensures that patients are validated in a standardised, equitable, efficient and fair manner.

Patients are issued a validation letter asking if they still require access to hospital care. Patients can respond to a validation letter online via the Patient Online Automated Response (POLAR) system at www.waitinglist.ie or by post using the free post return envelope provided. If a response is not received the patient is subsequently issued with a reminder letter. Where a patient fails to respond to the reminder letter they may be removed from the waiting list.

Hospitals, together with the NTPF, identify and agree cohorts of patients for validation on a monthly (maintenance) or biannual basis. Validation cycles are managed using an online automated reporting system which enables hospitals to update patient validation responses in real time.

Following the completion of the Validation Programme, the hospital is issued with an Action Plan outlining the final validation results which must be completed within the set deadline. This action plan includes the removal of non-responders from the waiting list.

A5.2. Data Validation

Data validation is an administrative task carried out by the hospital on a regular basis to ensure that waiting list data is kept accurate and up-to-date. As part of this process, a hospital administrator generates and reviews NTPF and hospital patient administration or management system waiting list reports weekly to identify data discrepancies or anomalies. Any identified discrepancies must be followed up and corrected immediately.

Data validation exercises should focus on the following areas:

- Duplicates
- Patients with DNA history
- Patients with CNA history
- Lapsed TCI dates
- Lapsed suspension dates
- Patients >4 weeks past indicative date
- Data entry errors (especially relating to dates)

A5.3. Clinical Validation

The clinical validation process is carried out by clinical members of the GI Endoscopy team. This includes:

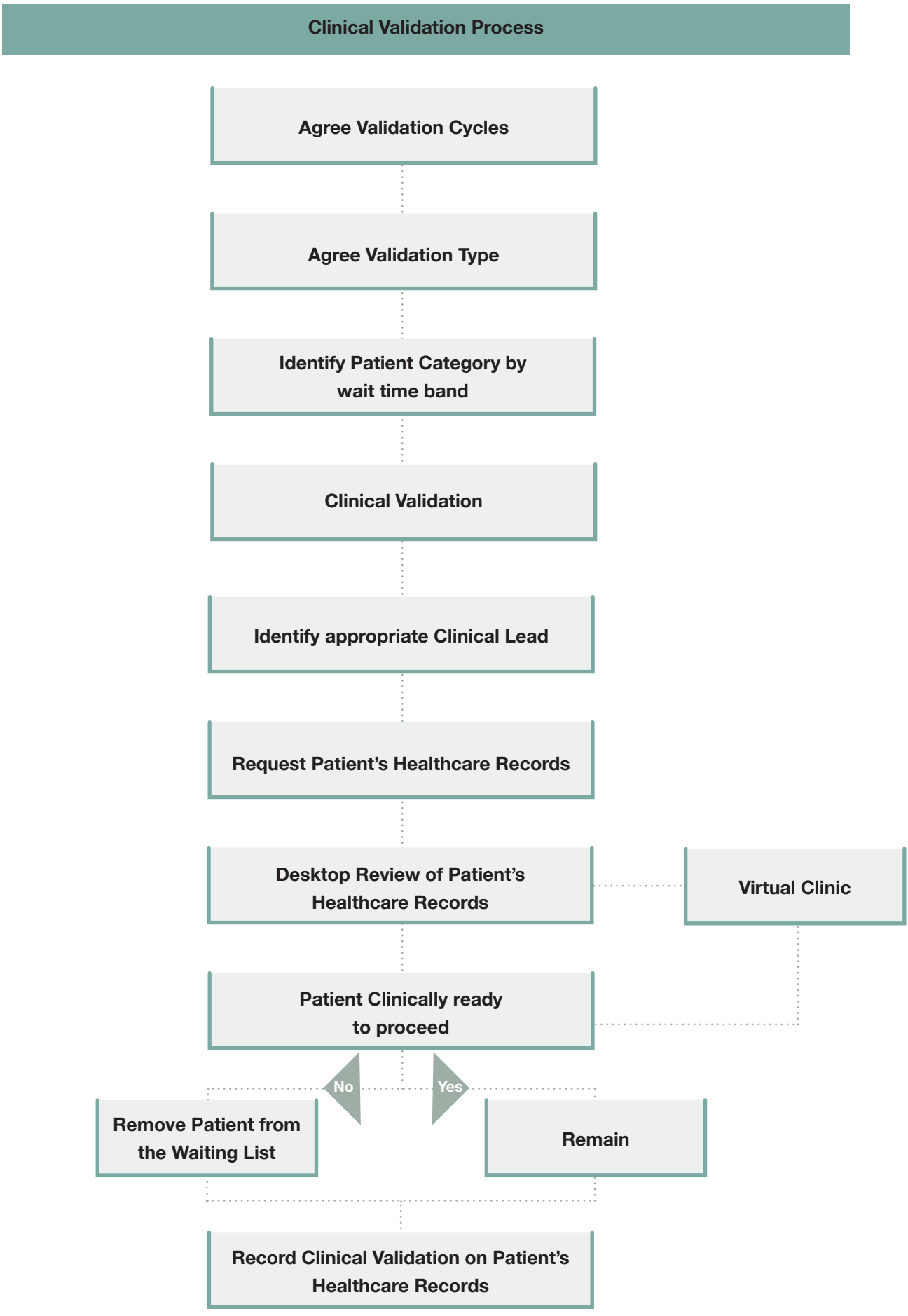
- Consultants
- Registrars
- GI Endoscopy Clinical Validation Nurses or other suitably qualified senior nurses

This process requires the review of a patient's referral letter, healthcare record and/or medical notes to establish if:

- The patient should remain on the waiting list
- There is a change to their clinical prioritisation category
- Any tests are required in advance of a TCI
- The patient is suitable for:
  -Insourcing or outsourcing initiatives
  -New Clinical Diagnostic Initiatives

Once assigned a clinical validation outcome by the appropriate clinical staff, the administration staff must update the patient's records including the hospital patient administration or management system as appropriate.

Where the clinician or delegated clinical team member contacts each patient by phone as part of the clinical validation process, this should be recorded as a virtual clinic. However, clinical validation should not be confused with Pre-Operative Assessment. The use of virtual clinics should follow the Procedure for the Management of Virtual Outpatient Clinics.


Clinical Validation Process
Agree Validation Cycles
Agree Validation Type
Identify Patient Category by wait time band
Clinical Validation
Identify appropriate Clinical Lead
Request Patient's Healthcare Records
Desktop Review of Patient's Healthcare Records
Virtual Clinic
Patient Clinically ready to proceed
No
Yes
Remove Patient from the Waiting List
Remain
Record Clinical Validation on Patient's Healthcare Records

Acknowledgements

The NTPF wishes to thank and acknowledge the many stakeholders who contributed to and supported the development of the National Inpatient, Day Case, Planned Procedure (IDPP), and GI Endoscopy Waiting List Management Protocol 2024.

Department of Health

- Scheduled Care Performance Unit, Department of Health

Health Service Executive

- National Lead for Integrated Care, Clinical Design and Innovation, OoCCO, HSE
- National Clinical Advisor and Group Lead, Acute Operations, HSE
- GI Endoscopy Programme, Acute Operations, HSE
- Access Team, Acute Operations, HSE

Members of the National Waiting List Forum

- Director of Waiting List Governance and Reform, NTPF (Chair)
- Group Performance Manager, DMHG
- Scheduled Care Lead, IEHG
- Scheduled Care & Operations Project Manager, Saolta
- Scheduled Care Lead, SSWHG
- Scheduled Care Lead, RCSI
- Directorate Manager, ULHG
- Scheduled Care Lead, CHI
- Operational Services Manager, CHI at Crumlin
- Scheduled Care, Acute Operations, HSE
- Scheduled Care Performance, Department of Health
- Waiting List Reform Manager, NTPF
- Director of ICT, NTPF
- Head of Waiting List Governance, NTPF

National Treatment Purchase Fund

- Waiting List Governance and Reform Team
- Audit and Quality Assurance Team
- Commissioning Team
- ICT Team

Peer Review Groups

Thanks to all of the hospital representatives who participated in the IDPP and GI Endoscopy Waiting List Management Protocol Peer Review Groups.

Inpatient, Day Case, Planned Procedure and GI Endoscopy Workshop Attendees

Thanks to all of the HSE, DoH, GI Endoscopy Programme, Hospital Group/HSE Health Regions and individual hospital representatives who participated in the NTPF IDPP Workshop in September 2022.

Quick reference guide for process maps

Glossary of Terms

Term	Explanation
Clinical Prioritisation Category	Clinical Prioritisation Category (CPC) is the level of urgency that a clinician assigns to a patient on their booking form or direct referral. These categories are urgent, semi-urgent or non-urgent (routine).
Clinical Prioritisation Outcome	The outcome assigned to a referral by the clinician which can be Accept, Redirect or Reject.
Clinical Prioritisation Process	Process where a relevant specialty department, service or clinician reviews a patient's referral/booking form, and determines the Clinical Prioritisation Outcome, and Category to assign.
Clinically Recommended Time Frame (CRT)	The Maximum Clinically Recommended Time (CRT) to admission.
Clock Start	The beginning of the patient's wait to be seen.
Clock Stop	A termination or pause in the patient's wait to be seen in inpatient services.
Clock Restart	When the patient's wait-time re-commences after a clock stop.
Clock Reset	When the patient's wait-time is reset, wait clock reset to 0 days.
Direct Referral	A direct referral is an external referral, usually received from a primary care setting, which may not require an outpatient consultation.
Duplicate Referral	Following on from the receipt of a referral letter, a referrer may resend the same referral letter; this is known as a Duplicate Referral.
High Clinical and/or Social Needs	In some cases, patients can be identified by a clinician as high clinical and/or social needs patients. In this case, it should be noted by the clinician on the patient's referral letter or medical record. Patients identified as high clinical and/or social needs on their record may require extra consideration to ensure they receive appropriate levels of care throughout their inpatient pathway.
Hospital Initiated Cancellation (HCAN)	A hospital initiated cancellation is defined as any rescheduling of a patient's TCI date by the hospital due to circumstances beyond their control, for example national emergency, extreme weather, industrial action, theatre or bed capacity, resource constraints or leave arrangements.
IDPP Suspensions	Patients with an offer of a TCI date who, for clinical, personal or social reasons, are not ready to proceed with their care and/or treatment may be temporarily suspended on the IDPP waiting list on one occasion only. It is also recommended to use the suspension process to manage patients who accept an offer of treatment through NTPF or HSE funded commissioning initiatives.

Term	Explanation
Insourcing Initiative	Insourcing is the provision of additional capacity in a public hospital.
Minimum Information Required	To enable safe processing and clinical assessment of a Hospital Booking Form it must contain, at a minimum, the data set out in Figure 1, Section 6 of the protocol.
Outsourcing Initiative	Outsourcing is the provision of procured capacity with a private service-provider.
Patient Initiated Cancellation (CNA)	Where a patient or their guardian who cancels a first outpatient appointment as they 'cannot attend' (CNA), and does not request a further appointment, it is classified as a CNA.
Patient Did Not Attend (DNA)	Where a patient has been issued with a TCI date and fails to attend, it is classified as a 'Did Not Attend' (DNA).
Planned Procedure	A patient placed on a waiting list for a planned procedure is a patient who had an initial episode of care and requires recall for a further planned, timed or surveillance procedure in the future as part of their ongoing clinical care and/or treatment (see section 6)
Short Notice Appointments	In the event of a To Come In (TCI) date becoming available at short notice, the available slot should be offered to the next suitable patient in strict chronological order, i.e. 'Treated in Turn'.
Source of Referral	Patients requiring an inpatient, day case or planned procedure admission can be identified at various access points in the healthcare system, generally referred to as the Source of Referral (SOR).
Validation Process	Validation is a process whereby patients on waiting lists are contacted to confirm if they are ready, willing and available to proceed with hospital care.
Valid Offer for Insourcing and Outsourcing Initiative	Once a patient or their guardian has accepted the offer of treatment, and agreed to participate in an insourcing or outsourcing initiative, this is considered a 'Valid Offer'.

Appendix 1: Better Letter Initiative (BLI) Standardised Inpatient, Day Case and Planned Procedure (IDPP) Correspondence

The NTPF worked together with Research Services and Policy Unit in the Department of Health, the Health Service Executive (HSE) and an advisory group to design a behaviourally informed and tested appointment correspondence for inpatient and day case patients.

The Better Letter Initiative (BLI) Project

The redesigned correspondence was tested in the Midland Regional Hospital Portlaoise (MRHP) and Midland Regional Hospital Tullamore (MRHT), who at the time were both members of the Dublin Midlands Hospital Group. The objective of this project was to reduce in both test sites the number of patients who do not contact the hospital when they received the letter. Another objective in MRHP was to monitor the impact on attendance on appointment day.

The impact of the redesigned correspondence was tested by using both existing and redesigned correspondence over the same period and comparing patient engagement with both types.

Results

Patient engagement was improved by the use of the redesigned appointment letter and patient preparation note. The redesigned correspondence increased the number of patients making contact, as requested, when they received their appointment offers.

Better performance in the MRHP saw a reduction of 9.4 percentage points or 34% in people not making contact, equivalent to one third of non-responders changing their behaviour. In MRHT this better performance saw a reduction of 10.6 percentage points or 72% in people not making contact, equivalent to two thirds of non-responders changing their behaviour.

Conclusion

This study shows that when you ask patients to phone to confirm acceptance of an appointment date (using the redesigned material), it is likely to improve patient engagement both when they received the appointment offer and on appointment day. We suspect this is because the redesigned correspondence makes clearer what the patient is asked to do (simplification, call for action and salience), makes it easier to make contact (simplification and voicemail option), and makes it easier to remember to attend (simplification and commitment device).

Where the practice is to ask patients to phone only if they cannot accept an appointment date, it may also be the case that using an appointment letter and patient preparation note based on the one used in this project may also help to improve patient engagement.

Overall, it is likely that use of the redesigned correspondence for inpatient and day case procedures (offer letter and preparation note) will improve patient engagement and will enable better use of resources.

Click here to view the full report; The Better Letter Initiative: An Impact Evaluation of a Redesigned Inpatient and Day Case Appointment Letter

The below appendix provide templates for:

1.1. 1st Offer Patient (confirmation required)
1.2. 1st Offer Parent/Guardian (confirmation required)
1.3. 2nd Offer Patient (confirmation required)
1.4. 2nd Offer Parent/Guardian (confirmation required)
1.5. Patient Preparation Note
1.6. TCI Offer confirmation is NOT required

Appendix 1.1. 1st Offer Patient (confirmation required)

Strictly Private and Confidential

<Title> <Pt Forename> <Pt Surname>
<Pt. Address Line 1>
<Pt. Address Line 2>
<Pt. Address Line 3>
<Pt. Address Line 4>

Medical Record No.: <Patient MRN>
DOB: <Patient DOB>

<Insert current date>

Please phone to confirm your appointment for admission

Dear <Pt Forename>

I have booked you an **appointment for admission** to <Specialty> at <<Hospital>> under the care of <Title> <Consultant Forename> <Consultant Surname>.

Date: <Insert day and date>
Time: <Insert time>
Procedure:

Please phone to confirm you can attend

We need you to please call <<insert number>> to confirm or cancel your appointment. If you cannot call during office hours, you can leave a voicemail at this number 24-hours a day.

If you do not confirm by < **date** >, your procedure may be cancelled. If you cannot attend, please phone to let me know so another patient can use this valuable appointment.

If you do not attend once or if you cancel twice, you may be removed from the waiting list. This follows national protocol. We will seek clinical guidance where appropriate.

It is important that you read the enclosed **Preparation Note** for fasting and other instructions. If you have any questions, I will be happy to answer them when you call me.
Kind regards,
<<Insert forename surname of staff member>>, Clinic Secretary

✂.....

Reminder: After you phone, fill in this slip and place it somewhere you can see it.

I will attend my < specialty > appointment at _____on _____at _____.

Place Date Time

Appendix 1.3. 2nd Offer Patient (confirmation required))

Strictly Private and Confidential

<Title> <Pt Forename> <Pt Surname>
<Pt. Address Line 1>
<Pt. Address Line 2>
<Pt. Address Line 3>
<Pt. Address Line 4>

Medical Record No.: <Patient MRN>
DOB: <Patient DOB>

<Insert current date>

Please phone to confirm your appointment for admission

Dear <Pt Forename>

I have booked you an **appointment for admission** to <Specialty> at <<Hospital>> under the care of <Title> <Consultant Forename> <Consultant Surname>.

Date: <Insert day and date>
Time: <Insert time>
Procedure:

Please phone to confirm you can attend

We need you to please call <<insert number>> to confirm or cancel your appointment. If you cannot call during office hours, you can leave a voicemail at this number 24-hours a day.

If you do not confirm by < **date** >, your procedure may be cancelled. If you cannot attend, please phone to let me know so another patient can use this valuable appointment.

As you cancelled your previous appointment, if you again cancel or do not attend you may be removed from the waiting list. This follows national protocol. We will seek clinical guidance where appropriate.

It is important that you read the enclosed **Preparation Note** for fasting and other instructions. If you have any questions, I will be happy to answer them when you call me.
Kind regards,
<<Insert forename surname of staff member>>, Clinic Secretary

✂.....

Reminder: After you phone, fill in this slip and place it somewhere you can see it.

I will attend my < specialty > appointment at _____on _____at _____.

Place Date Time

Appendix 1.4. 2nd Offer Parent/Guardian (confirmation required)

Strictly Private and Confidential
Parent/Guardian of
<Title> <Recipient Forename> <Recipient Surname>
<Rt. Address Line 1>
<Rt. Address Line 2>
<Rt. Address Line 3>
<Rt. Address Line 4>

Medical Record No.: <Patient MRN>
DOB: <Patient DOB>

<Insert current date>

Please phone to confirm appointment for admission

Dear Parent/Guardian

I have booked <1st name> an **appointment for admission** to <Specialty> at <<Hospital>> under the care of <Title> <Consultant Forename> <Consultant Surname>.

Date: <Insert day and date>
Time: <Insert time>
Procedure:

Please phone to confirm you can attend

We need you to please call <<insert number>> to confirm or cancel the appointment. If you cannot call during office hours, you can leave a voicemail at this number 24-hours a day.

If you do not confirm by < **date** >, this procedure may be cancelled. If <1st name> cannot attend, please phone to let me know so another patient can use this valuable appointment.

As you cancelled the previous appointment, if you again cancel or do not attend <1st name> may be removed from the waiting list. This follows national protocol. We will seek clinical guidance where appropriate.

It is important that you read the enclosed **Preparation Note** for fasting and other instructions. If you have any questions, I will be happy to answer them when you call me.
Kind regards,
<<Insert forename surname of staff member>>, Clinic Secretary

✂.....

Reminder: After you phone, fill in this slip and place it somewhere you can see it.

We will attend a < specialty > appointment at _____on _____at _____.

Place Date Time

Appendix 1.5. Patient Preparation Note

Here is important information to help you prepare and to receive the best service possible.

Before your admission

- If you have had a recent chest infection or runny nose within the last 2 weeks, or if you have flu-like symptoms, please contact your GP (family doctor) for advice before attending the hospital.
- Have a bath or shower the night before you come to the hospital.
- You are OR are not required to fast before your procedure. See instructions overleaf.
- If you are taking medications including the following: Aspirin, Warfarin, Plavix, Pradaxa, Xarelto, Asantinin, Persantin, HRT, or the oral contraceptive pill, or having hormonal injections or have an implant in place, please contact <<insert phone number>>.
- Phone the bed manager on <<insert phone number>> on the morning of admission to confirm a bed is available for you. If a bed is not available your procedure will be rescheduled for the earliest possible date.

Be sure to

1. Bring your appointment letter ☐
2. Bring your medical card or health insurance details, if applicable ☐
3. Bring your own phone number and a relative's contact number ☐
4. Bring a prescription list or any medications you are taking ☐
5. Pack a dressing gown and a pair of slippers (onesies are not suitable) ☐
6. Phone the bed manager as requested above ☐
7. For female patients between the ages of 12 and 55 please bring a urine sample for analysis when attending for surgery under general anaesthesia ☐

On the day of your admission

- Double check you have completed the above checklist.
- Arrive on time for your appointment. If you arrive late your procedure may not take place.
- Check in at the Admissions Office. This is the Main Hospital on the first floor, at the top of the stairs, inside the doorway marked "Day Hospital".
- Any person under the age of 16 years undergoing an operation must have a parent/guardian present to sign a consent form in the presence of a hospital doctor.

Please

- do not chew gum before you are admitted or while waiting for your procedure, as it will produce more saliva and acid.
- do not wear make-up, jewellery, including all body piercings, false eye lashes, false or gel nails or nail polish of any sort. This is because doing so could interfere with the procedure. For example, when you are in theatre observation measurement is taken through your fingernail as part of the procedure.
- do not bring valuables or large amounts of money with you.
- do not provide onesies if you are the parent/guardian of a child going to theatre.

After your procedure

After an anaesthetic or sedation, for your own safety, please follow this advice

- do not drive, operate machinery, or drink alcohol within 24 hours.
- be brought home by an adult.

Hospital policies

- Some patients will be asked to attend pre-op assessment and will need to pass a pre-op assessment before their appointment. In certain circumstances the hospital may need to reschedule your appointment.
- When you arrive, relatives or friends will be told the estimated time you can leave.
- Children will not be able to stay with you while you are attending the hospital.
- The hospital is a smoke-free campus and smoking is not allowed on hospital grounds.
- "Clean Hands Save Lives". Please use hand gel as you enter and leave the hospital to protect you and your family.

Details on fasting

It is important that you adhere to fasting guidelines. If you have food or drink in your stomach, there is a higher risk of you being sick during the procedure and so your procedure cannot go ahead if you have not fasted properly.
Do not eat or drink anything after midnight prior to admission except for prescribed medication with half a glass of water only.
OR
Eat a small snack such as tea and biscuits near to midnight the night before your planned procedure. On the morning of your procedure, you may drink up to 500mls (2 cups) of water or clear liquids before 5.30am. Clear liquids include water, black coffee, tea without milk and prescribed pre-op medicinal drinks.

Appendix 1.6. TCI Offer Patient (confirmation NOT required)

Strictly Private and Confidential

<Title> <Pt Forename> <Pt Surname>
<Pt. Address Line 1>
<Pt. Address Line 2>
<Pt. Address Line 3>
<Pt. Address Line 4>

Medical Record No.: <Patient MRN>
DOB: <Patient DOB>

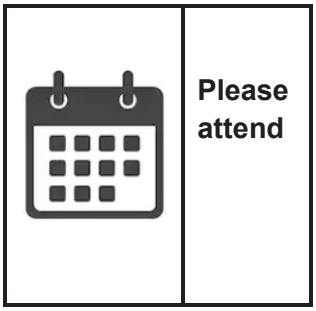
<Insert current date>

Please note your appointment for admission

Dear <Pt Forename>

I have booked you an **appointment for admission** to <Specialty> at <<Hospital>> under the care of <Title> <Consultant Forename> <Consultant Surname>.

Date: **<Insert day and date>**
Time: <Insert time>
Procedure:



We look forward to seeing you. If you cannot attend, please phone to let me know so another patient can use this valuable appointment.

If you do not attend once or if you cancel twice, you may be removed from the waiting list. This follows national protocol. We will seek clinical guidance where appropriate.

It is important that you read the enclosed **Preparation Note** for fasting and other instructions. If you have any questions, please phone me.

Kind regards,
<<Insert forename surname of staff member>>, Clinic Secretary

✂.....

Reminder: Please fill in this slip and place it somewhere you can see it.

I will attend my < specialty > appointment at _____on _____at _____.

Place Date Time

National Inpatient, Day Case, Planned Procedure (IDPP), and GI Endoscopy Waiting List Management Protocol Protocol 2024