NHS
Bassetlaw
Clinical Commissioning Group

NHS
Doncaster and Bassetlaw
Teaching Hospitals
NHS Foundation Trust

Please Note: This policy is currently under review and is still fit for purpose.

Referral to Hospital Access Policy

This procedural document supersedes: **PAT/PA 1 v.8 – Referral to Hospital Access Policy**

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Date written/revised:	March 2018
Approved by:	NHS Doncaster Clinical Commissioning Group Bassetlaw Clinical Commissioning Group Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust
Date of approval:	20 June 2018
Ratified by:	Policy Approval and Compliance Group
Date issued:	30 July 2018 – **[reissued – 23 July 2019]**
Next review date:	June 2021 – **extended to November 2021**
Target audience:	Trust-wide

Amendment Form

Version	Date Issued	Brief Summary of Changes	Author
Version 9 (amended June 19)	23 July 2019	• Appendix E – wording of letter • Appendix G – added to the policy • Page 18 – slight amendment to the section patients who lack capacity.	Emma Challans Emma Challans Emma Challans
Version 9 [amended March 2019]	7 May 2019	• Slight amendments within sections 4.3.1 - Patient Initiated and 4.3.4 – Managing Electronic Referrals. • Updated link within Appendix B – Commissioning for value (CfV) policy – Procedures of Limited Clinical Value. • Addition regarding referrals for Endoscopy within Appendix C – Diagnostic Referrals. • Additional appendix insertion at Appendix E – Example letter for discharge of patients back to the referrer following a review of non-attendance.	Emma Challans
Version 9	30 July 2018	Included: • Full review of policy in line with the Model Access Policy (Aug 17) • Sections A-C reviewed	Emma Challans
Date of Review		**Amendment Details**	
October 2015		Included: • Section 2 - Pre referral diagnostics • 2.1.6 Upgraded referrals) • 1.2 Patient information • 4.3 Internal reporting	
March 2015		Included: • 5.1.3 Reference to patient/public engagement in the policy. • 2.2.1 'Direct Access' Diagnostics • 5.5 Active monitoring or Watchful wait. • Appendix A – Active monitoring definition	

October 2013 to August 2014	• Policy changed to reflect the transition from Doncaster Primary Care Trust to NHS Doncaster Clinical Commissioning Group (CCG) as statutory body. • Updated to reflect latest Planning Guidance, NHS Mandate and Constitution. • Heading numbers, paragraph numbers and layout of policy changed to reflect the standard Policy on Procedural Documents approved by NHS Doncaster CCG governing body on 2 April 2013. • Clarified: Length of time allowed for treatment delays DNA and CNA's Timescales for prior approval requests The section on Follow up waiting lists Definition of vulnerable patients Timescales for reviewing referrals	

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1 INTRODUCTION

The Trust is committed to delivering high quality and timely elective care to patients. This policy:

- sets out the rules and principles under which the Trust manages elective access to outpatient appointments, diagnostics and elective inpatient or day case treatment
- gives staff clear direction on the application of the NHS Constitution in relation to elective waiting times
- demonstrates how elective access rules should be applied consistently, fairly and equitably.

The Trust's elective access policy was developed following consultation with staff, clinical commissioning groups (CCGs), general practitioners, clinical leads and CCG lay members. It will be reviewed and ratified at least annually or earlier if there are changes to national elective access rules or locally agreed principles.

The access policy should be read in full by all applicable staff once they have successfully completed the relevant elective care training. It should not be used in isolation as a training tool.

The access policy is underpinned by a suite of detailed standard operating procedures (SOPs). All clinical and non-clinical staff must ensure they comply with both the principles within this policy and the specific instructions within SOPs. All relevant staff will be trained in elective care pathway management.

The Trust is committed to promoting and providing services which meet the needs of individuals and does not discriminate against any employee, patient or visitor. The policy is in place to ensure patients attending for elective care receive timely, equitable treatment in line with national access standards and the NHS Constitution.

1.1 Purpose

The purpose of this policy is to ensure all patients requiring access to outpatient appointments, diagnostics and elective inpatient or day-case treatment are managed equitably and consistently, in line with national waiting time standards and the NHS Constitution.

The policy:

- Is designed to ensure the management of elective patient access to services is transparent, fair, equitable and managed according to clinical priorities
- Sets out the principles and rules for managing patients through their elective care pathways
- Applies to all clinical and administrative staff and services relating to elective patient access at the trust.

1.2 Roles and Responsibilities

The NHS Constitution recommends the following actions patients can take to help in the management of their condition:

- Patients can make a significant contribution to their own, and their families, good health and wellbeing, and should take personal responsibility for it.
- Patients should be registered with a GP practice as this is the main point of access to NHS care as commissioned by NHS bodies.
- Patients should provide accurate information about their health, condition and status.

1.3 Principles

Following principles are by which the health community will work in partnership to achieve:

- Patients receive treatment in line with agreed access targets according to their clinical priority. Routine patients and those with the same clinical priority are treated in chronological order.
- The time patients spend on the waiting list is managed effectively and where appropriate is minimised to improve the quality of patient experience.
- The number of cancelled operations for non-clinical reasons is reduced.
- Patients maximise their right to patient choice in the care and treatment they need.
- Patients are provided with information in a range of formats relating to their care and treatment by the provider at relevant points in their pathway.
- Patients are fit, ready and willing to access services within a maximum of 18 weeks. The exception being patient choice and overriding urgent patient pathways.
- The number of patients with a booked outpatient or in-patient/day case attendance is increased, thereby minimising Did Not Attends (DNA), cancellations and improving patient experience.
- All referrals, additions and removals from the waiting list will be made in accordance with national Referral to Treatment policy.
- Clarity around consultant to consultant referrals (including referrals initiated by junior medical staff and nurse specialists) – Consultants will only refer directly to other consultants in urgent cases (e.g. two week wait conditions or other urgent conditions), or for conditions related to the original reason for the referral (“related conditions”).
- Military veterans should receive priority access to NHS secondary care for any conditions which are likely to be related to their service, subject to the clinical needs of all patients, in line with current guidance.

2 LEGISLATION AND GUIDANCE

The following legislation and guidance has been taken into consideration in the development of this policy:

- NHS Constitution (2013) Department of Health – updated 27th July 2015
- Everyone counts: Planning Guidance as applicable
- 'The Government's Mandate to NHS England 2017-18'
- Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care (2015) https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/
- Making Time in General Practice 2016
- NHS England Contract Requirements 2017/18-2018/19
- Operational guidance to the NHS: Extending Patient Choice of Provider (2011) Department of Health
- Standard NHS Contract as applicable
- Maximum Waiting Times – Guidance for Commissioners (2013) NHS England
- Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust – PAT/PS 10 Safeguarding Children Policy
- Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust – PAT/PS 8 Safeguarding Adults Policy
- NHS Improvement Model Access Policy: https://improvement.nhs.uk/resources/elective-care-model-access-policy/

This policy should also be used in conjunction with the policy for management of overseas visitors, policy on procedures of low clinical value (prior approval), cancer access policy, military veteran guidance and the outpatient guide and any other relevant policies relating to patient access.

3 ROLES AND RESPONSIBILITIES

3.1 Provider

Overall accountability for ensuring that there are systems and processes to guarantee effective and reliable referral and admission management throughout the hospital, lies with the Trust **Chief Executive**.

The **Chief Operating Officer** has delegated authority for ensuring:

- the Policy is adopted by the organisation following formal governance process
- compliance with the Policy and national requirements
- clinical staff are aware of and comply with all elements of the Policy
- practical implementation and monitoring by the Divisional General Managers
- Weekly Patient Tracking List (PTL) meetings are held with all Divisions covering all patient exceptions. Action plans are delivered and reported to the Executive team.

- Performance and breaches are reported to the wider management team including the Trust Board and commissioners via regular partnership meetings.

The **Chief Information Officer** is responsible for the timely production and interoperability of PTLs that support the Division in managing waiting lists and RTT standards.

The **Divisional Director** is accountable for implementing, monitoring and ensuring compliance with the policy within their Division. They are to work with the Division **General Manager, Associate Director of Nursing** and **Business Manager** to ensure data is accurate and services are compliant with the policy.

At a granular operational level, all staff with access to and a duty to maintain elective care information systems are accountable for their accurate upkeep. For example:

- Business Managers are responsible for ensuring the NHS e-referral service (ERS) directory of services (DOS) is accurate and up to date.
- Waiting list administrators, including clinic staff, secretaries and booking clerks, are accountable to General Managers and responsible to Business Managers for compliance with all aspects of the trust's elective access policy.
- Waiting list coordinators outpatients and elective inpatient or day care services are responsible for the day-to-day management of their lists and are supported in this function by the Business Managers, General Managers and Division Clinical Leads who are responsible for achieving access standards.
- The information team is responsible for producing and maintaining regular reports to enable Divisions to accurately manage elective pathways, and ensure compliance with this policy.

3.2 Commissioner

Overall accountability for ensuring that there are systems and processes to guarantee effective, efficient and reliable referral management into, the hospital lies with the CCG **Chief Officer.**

The **Director of Strategy and Delivery** has delegated authority for ensuring:

- The Policy is adopted by the organisation following formal governance process
- administrative, clinical staff providing services across the local health community along with key stakeholders are aware of and comply with all elements of the policy
- **The CCG will work with Primary Care clinicians** to ensure they are aware of their responsibility in effective management of elective pathways. This includes to:
    - ensure the electronic referral management systems are fully utilised
    - ensure timely and accurate information at point of referral providing a minimum data set
    - ensure General Practitioners (GP) inform the patient of next steps by ensuring the patient understands why they are being referred and expectations of the patient in the referral process

- ensure GP relays to the patient likely waiting times for a new outpatient consultation and of the need to be contactable and available when referred.
- ensure that GP offers and utilises next available appointment across all Trust sites to minimise patient waiting time and increase efficiency
- ensure that GP utilises all consultant led capacity to minimise waiting times and ensure equitable access to patients
- ensure patients are only referred after robust primary care management and intervention

- The CCG is responsible for ensuring there are robust communication links for feeding back information to GPs.

3.3 Competency Trust

- As a key part of their induction programme, all new starters to the Trust will undergo mandatory contextual elective care training applicable to their role.
- All existing staff will undergo mandatory contextual elective care training on at least an annual basis.
- All staff will carry out competency tests that are clearly documented to provide evidence that they have the required level of knowledge and ability.
- This policy, along with the supporting suite of SOPs, will form the basis of contextual training programmes.
- Elective Care administrative teams, specialties and staff will be performance managed against key performance indicators (KPIs) applicable to their role. Role- specific KPIs are based on the principles in this policy and specific aspects of the trust's standard operating procedures.

3.4 Primary Care (referrers)

- Practice clinical teams and administrative staff will undergo mandatory training of the elective care policy and best practice standards.
- GPs and Primary Care Teams are responsible and accountable for ensuring that clinical information is attached to the electronic referral. Information includes; letters, forms, results and proforma checklists relating to the commissioning for value policy.
- GPs and Primary Care Teams are to make every effort to ensure that patients understand the need and expectation in making themselves available to attend a hospital appointment. Thus meaning, the patient is fit, willing and able to accommodate meeting access targets (18 weeks)
- Referrals for Consultant led clinics into the hospital are only to be submitted via the national Electronic Referral Service (e-RS). Exceptions; dentists, prisons, other agreed.
- Primary Care teams are to utilise the hospital Advice and Guidance service as part of the referral process.
- All referrals must contain a Minimum Data Set (MDS) which includes:

- Referring GP Practice and GP

- NHS Number
- Patient details including:
  - Full Name
  - Date of Birth (DOB)
  - Current address
  - Contact information (day and evening) – email, telephone if available
- Clinical history/current medication regime
- Reason for referral (including specialty)
- Blood test results/any other relevant investigations requested relevant to the referral

Other useful information if possible to include:

- Ethnicity
- Overseas visitor status
- Next of Kin
- Primary spoken language

3.5 Commissioning for Value (CfV) – Procedures of Limited Clinical Value

- There are a number of interventions/procedures for which CCGs across South Yorkshire and Bassetlaw has published specific policy statements, setting out restrictions to patient access, based on evidence of clinical effectiveness.
- Procedures listed in the South Yorkshire & Bassetlaw Commissioning for Value (CfV) policy are not commissioned by the CCG and should not be carried out by the Trust. Please refer to **Appendix B** for full guidance on procedures and criteria. Procedures will not be paid for if undertaken outside of the policy criteria.
- Individual Funding Requests – Commissioners are to ensure that a robust process is in place to manage IFRs supported by an agreed decision making timeline. The specialty based consultant team will support application where responsible.
- Any GP referring for a specific exclusion procedure is responsible for obtaining prior approval for funding before referring the patient to secondary care. The Prior Approval letter should be sent/attached with the referral letter. If the provider receives a referral for an exclusion procedure that does not include evidence of prior approval, this should be returned to the referring GP. The commissioner will not pay for the procedure if it is carried out without prior approval.
- If a GP refers a patient for an opinion then they must state so in the referring information. If following the outpatient appointment the consultant decides that a restricted procedure is required then it is the responsibility of the consultant to obtain prior funding approval following the process as highlighted above. If the procedure is carried out without this approval then the commissioner will pay for the outpatient attendance, but will not pay for the procedure.

Please refer to APPENDIX B for the latest CfV Policy. Version 20.

4 PROCEDURE

4.1 18 Weeks Clock Rules

The 18-week pathway does not replace existing shorter waiting time guarantees, for example cancer and heart disease waits.

4.1.1 Clock Starts

1. A waiting time clock starts when any referring healthcare professional refers to:

    a) A consultant led service, regardless of setting, with the intention that the patient will be assessed and, if appropriate, treated before responsibility is transferred back to the referring health professional or general practitioner;

    b) An interface, referral management or assessment service, which may result in an onward referral to a consultant led service before responsibility is transferred back to the referring health professional or general practitioner.

2. A waiting time clock also starts upon a self-referral by a patient to the above services, where these pathways have been agreed locally by commissioners and providers and once the referral is ratified by a care professional permitted to do so.

3. Upon completion of a consultant-led referral to treatment period, a new waiting time clock only starts:

    a) When a patient becomes fit and ready for the second of a consultant- led bilateral procedure;

    b) Upon the decision to start a substantially new or different treatment that does not already form part of that patient's agreed care plan;

    c) Upon a patient being re-referred in to a consultant-led; interface; or referral management or assessment service as a new referral;

    d) When a decision to treat is made following a period of active monitoring when a patient rebooks their appointment following a first appoint Did Not Attend (DNA) that stopped and nullified their earlier clock

4.1.2 Clock Stops

1. A clock stops for treatment when:

    a) First definitive treatment starts. This could be:

i) Treatment provided by an interface service;

ii) Treatment provided by a consultant-led service;

iii) Therapy or healthcare science intervention provided in secondary care or at an interface service, if this is what the consultant-led or interface service decides is the best way to manage the patient's disease, condition or injury and avoid further interventions;

b) A clinical decision is made and has been communicated to the patient, and subsequently their GP and/or other referring practitioner without undue delay, to add a patient to a transplant list (for matched donors).

2. Clock stops for 'non-treatment' – a waiting time clock stops when it is communicated to the patient, and subsequently their GP and/or other referring practitioner without undue delay that:

a) It is clinically appropriate to return the patient to primary care for any non-consultant-led treatment in primary care;

b) A clinical decision is made to start a period of active monitoring; For sample letter see **Appendix D**.

c) A patient declines treatment having been offered it;

d) A clinical decision is made not to treat;

e) A patient DNAs (does not attend) their first appointment following the initial referral that started their waiting time clock, provided that the provider can demonstrate that the appointment was clearly communicated to the patient;

f) A patient DNAs any other associated appointment and is subsequently discharged back to the care of their GP, provided that:

i) The provider can demonstrate that the appointment was clearly communicated to the patient;

ii) Discharging the patient is not contrary to their best clinical interests, obtained from speaking with the patient and/or clinical information

iii) Discharging the patient is carried out according to local, publicly available/published, policies on DNAs;

iv) These local policies are clearly defined and specifically protect the clinical interests of vulnerable patients (e.g. children) and are

agreed with clinicians, commissioners, patients and other relevant stakeholders.

3. Consultant to Consultant Referrals

a) Consultants will only refer directly to other consultants

i) Referrals that are part of the continuation of investigation and/or treatment of the problem or condition for which the patient was referred – this includes referrals to pain management where surgical intervention is not intended

ii) Urgent referrals for a new or unrelated condition

iii) Suspected cancer referral - this will be vetted and dated (date of dictated letter to the receiving consultant) by the receiving consultant and upgraded if deemed necessary. Once upgraded the patient will be treated within 62 days of the date the referral was received by consultant.

b) For referrals for conditions not related to the original referral the patient will be returned to their GP. The GP should be informed by letter with a clinical opinion on options for further management of the patient's condition. The Trust will ensure that all of its clinical staff are aware of and comply with this.

c) At the point where a consultant, or nurse specialist, makes the decision to refer an existing patient onto another consultant within the trust or to another service provider, the patients registered GP must receive notification and details of the nature of the referral within 5 working days of the referral. Consultant to Consultant referrals for related conditions will be included within the 18 week pathway, with the wait continuing from the original referral.

d) Consultant to consultant referrals for a different condition will start a new patient pathway with a new 18 week pathway clock. The original referral wait will continue concurrently until the patient is discharged or treated by the original consultant.

4.2 Patient Pathway Delays

This section details the most common scenarios where the patient's pathway may incur non clinical delays; ensuring a safe and consistent approach to capturing, reviewing and taking appropriate action in line with best practice and NHS constitution principles and values. The section covers:

- Reasonableness
- DNAs – Did not attend
- CNA – Could not attend (patient initiated cancellations)
- Hospital Initiated Cancellations

4.2.1 Reasonableness

Setting	Reasonable Timeframe
Outpatient	**7 working days**
Diagnostic Outpatient	**7 working days**
Daycase/Inpatient	**3 weeks**
Diagnostic daycase/inpatient	**3 weeks**

Reasonableness is applicable to all stages of the elective pathway. Reasonableness refers to specific criteria which should be adhered to when offering routine appointments and admission dates to patients to demonstrate that they have been given sufficient notice and choice of dates. A reasonable offer is defined as a **choice of two dates with reasonable notice (see reasonable notice criteria in this section) with** at **least 1 week (7 working days) notice.**

Appointment dates can be offered with less than the reasonable notice period and if the patient accepts, this can then be defined as 'reasonable'. The trust must be able to evidence that an appointment was agreed with the patient by recording this on the PAS system.

4.2.2 Did Not Attend (DNA)

****for RTT clock rules in relation to DNAs, refer to 18 Week Clock Rules**

First Appointment DNAs

The RTT clock is stopped and nullified in all cases (as long as the trust can demonstrate the appointment was booked in line with reasonableness criteria). If the clinician indicates another first appointment should be offered, a new RTT clock will be started on the day the new appointment is agreed with the patient.

Subsequent (follow-up) appointment DNAs

The RTT clock continues if the clinician indicates that a further appointment should be offered. If patients wait more than 18 weeks as a result of such delays, the 8% tolerance is in place to account for this. The RTT clock stops if the clinician indicates that it is in the patient's best clinical interests to be discharged back to their GP/referrer.

The below is relevant to all hospital settings including outpatients, theatres and diagnostic contacts.

A DNA is defined as – patients who do not give prior notice of their non-attendance
A DNA will be recorded in the following circumstances:

- patient fails to attend a predetermined appointment/activity without giving prior notice via the communicated channels
- patient arrives for an appointment/activity after the scheduled time and seeing the patient would have a negative impact on the session/other scheduled patients.

- patient arrives for an appointment/activity after the scheduled time and cannot be seen as above and makes a further appointment

The following checks will be made before a DNA is confirmed and recorded:

- system check that patient was made aware of the appointment either by letter and/or mutually agreeing the appointment and in line with reasonableness criteria (choice of 2 reasonable dates)
- patient has not made contact with the Trust to cancel the appointment ahead of the scheduled time
- patient demographics were correct at the time of making the appointment (where the appointment was not verbally agreed)

The trust will ensure that all confirmed DNAs are presented to the Consultant and/or delegated member of the consultant team for clinical decision on next steps.

The Consultant/delegated member of the consultant team will review the patient's case, where necessary contact the patient and consider next steps in line with the following:

- The clinician will discharge the patient back to the care of the referrer if it is clinically appropriate to do so and in line with trust paediatric/vulnerable patient safeguarding policy. *Examples of this could include referrals/conditions that are deemed routine in nature*
- The clinician will reappoint the patient if it is clinically appropriate to do so i.e. serious nature of condition/referral. Attempts will be made to contact the patient to agree the next appointment.
- Clinician will discharge the patient back to the care of the referrer where it is felt that it is in the patient's best clinical interest to do so to ensure continuity of care.

The clinical decision will be supported by communication to the referrer and the patient to confirm the decision. The communication method will be documented in the patient's case notes for later reference.

Where patients are contacted and advised that they no longer wish to be seen, the patient will be discharged back to the care of the referrer. The trust will ensure a procedure is in place to inform both the referrer and clinician whose care the patient is under. Examples of where this could occur is, if, a patient is under the care of a consultant and referred for a diagnostic test. The diagnostic team would refer back to the consultant for further management/clinical decision.

See specific guidance in 2ww section (page 22) for patient DNAs on Cancer Pathway

See specific guidance in relation to safeguarding policy for paediatrics and vulnerable adults (Trust Website Policy section)

4.3 Appointment Changes and Cancellations

4.3.1 Patient Initiated

Could Not Attend (CNA) is defined as – a patient that gives prior notice that they cannot attend their appointment (including on the day of clinic)

A CNA will be recorded in the following circumstances:

- Patient contacts the Trust via communicated method to amend their given appointment
- Patient contacts the Trust via the communicated method to advise that they wish to delay their appointment for a set period of time

Patients will be offered an alternative appointment which will be agreed at the time of the cancellation. The patient will be offered 2 reasonable dates and such offers will be recorded in the comments field of the appointment on the PAS system. Patients may also be offered alternative dates outside of reasonable criteria which will be recorded as mutually agreed on PAS if accepted.

Patients who lack capacity

There will be occasions when the patient lacks the capacity to agree to, attending his or her appointment, or to physically access the appointment independently. In these instances a capacity assessment should be documented within the care records.

A Best Interest Decision should then be taken in respect of further appointments or follow up, in conjunction with the guidelines within the MCA Policy (PAT/PA19).

Consideration should be given to how the patient will get to the appointment, and any family, friends or carers should be consulted.

Consideration should be given to those patients with extra vulnerabilities which may hinder or prevent their attendance at appointments for example time or place of appointment.

Where patients are requesting to change/delay their care:

- If the patient requests another appointment, this will be agreed at the time of the cancellation (if there are no available slots within pathway milestones or within agreed clinically safe timeframes, this will be referred to the specialty via agreed escalation processes)
- If the patient is requesting to postpone their appointment outside of agreed clinically appropriate timeframes, the case will be referred to the consultant whose care the patient is under or the clinical lead/Divisional Director for appropriate action (appendix E example letter)

Patients will be referred back to the care of the referrer in the following cases:

- Patient advises that they no longer wish to be seen

- It is in the best clinical interest for the patient to be referred back to the referrer i.e. clinically unsafe period of delay at the request of the patient
- Following a clinical discussion between the GP (referrer) and Consultant it is in the best interest for the patient

In all of the above cases the patient will be advised that their referrer and consultant will be made aware. The consultant whose care the patient is under will write to the patient and referrer to confirm the decision
see specific guidance in 2ww section (page 22) for patient DNAs on Cancer Pathway

4.3.2 Hospital Initiated Changes

All staff holding clinics (including consultants) should provide as much notice as possible of any planned leave. Clinics may be booked up to 12 weeks and patient inconvenience and distress are minimised by staff providing as much notice of leave as possible. Consultants must give a minimum of 6 weeks' notice for planned leave and for any other staff holding clinics, the exigencies of the service will be interpreted as a minimum of 6 weeks' notice. There should not be any clinic cancellations or reductions for this reason without at least 6 weeks' notice.

The Trust has in place an annual leave policy and a supporting SOP for any clinic change and cancellation to clinics. This will be monitored at a Division and Specialty level.

It is acknowledged that there may be occasions where agreed appointments will be cancelled by the hospital.

4.4 Referrals

This section gives a summary of referral, diagnostic and admission management procedures based on changes introduced by the 18 week RTT.

Where pre referral diagnostics are required they will be defined within the appropriate directory of service.

4.4.1 Outpatient Referrals

Methods currently employable to access services:

- Electronic referrals received through the e-Referral Service (e-RS). **in line with the NHS Trust and GP Contract, all consultant led referrals must be sent through the e-RS. Mandatory requirement from 1st October 2018.**
- Paper referrals: only where the service is not published through e-RS.
- Telephone bookings for services that are indirectly booking and a rebooking service for patients who wish to change appointment times (within agreed parameters) or who have been incorrectly referred or appointed and need to change their clinic or priority

4.4.2 Managing Referrals

- *Reviewing referrals* – a maximum time limit of three working days to review referrals and upgrade/change the priority set by the GP, if required. Any upgrade will be managed in line with the appropriate clinical pathway.
- *Rejected referrals – if proper processes are followed then* referrals are not expected to be routinely rejected. The Directory of Services will be regularly updated and refined to ensure that information is accurate and current and reflects the service offered. In the event that a rejection is the only appropriate action, the standard operating procedure will be followed. ***Examples;*** none e-RS referral (paper) and CfV policy criteria. Outside of this, communication to the GP will be provided.
- *Redirected referrals* – where appropriate, referrals received into the incorrect pathway will be directed by the outpatient coordinator into the correct clinic

4.4.3 Managing Electronic Referrals

Defer to Provider – this functionality enables practices and patients to place a request onto a chosen provider work list in the event that there are no appointment slots available. This facility can only be used where there are no slots, due to either lack of capacity or technical issues with the E-Referral System. Practice staff should therefore be aware of this when booking appointments. . The patient will be advised that the provider has a certain number of days in which to book the patient, depending on the urgency of the appointment.

The Provider must contact the patient within these timescales and must wherever possible; book the appointment via the E-Referral system. Where no appointments are available the patient must still be contacted and reassured that they will be contacted as soon as an appointment becomes available. Only under exceptional circumstances, should the request be cancelled and booked manually, and certainly not without consultation with the patient.

Where the E-referral system is used, GPs should ensure that routine referral letters and required clinical checklists are attached or received within 24hours in order to facilitate the booking process. Providers will ensure that sufficient capacity is available on the system to enable electronic booking to take place.

4.4.4 Named Consultant-led Teams

The patient's right to choose a Named Consultant-led team in certain circumstances became mandatory on 1 April 2011, and all Directories of Service support this functionality. Patients may *choose* to be referred to a named consultant-led team or there may be genuine clinical reasons why a referrer may suggest to the patient that referral to a specific clinical team is preferable. These might include:

- referral to a consultant-led team known to have a particular specialist or subspecialist interest in the patient's condition
- referral back to a consultant-led team which had previously managed a patient
- as a follow-up to an advice and guidance (A&G) request, where it seems most appropriate and where the patient has chosen to see the clinician who has provided the A&G response

Referrals to a named consultant-led team should only be made where the patients informed choice has been fully taken into account and where such a referral is clinically appropriate. Indiscriminate use of this facility will reduce available slots for that particular service. The Electronic Referral Service system will be kept up to date to provide and signal Consultant-led team specialties.

4.4.5 Clinic Cancellation or Reduction

The only acceptable reason for any clinic to be cancelled is due to the unplanned absence of medical staff (or nurse/therapist in nurse/therapist led clinics), for example, unplanned sickness absence. Clinics will not be cancelled for any other purpose unless exceptional circumstances arise and all alternative channels have been explored to cover. Clinics should not coincide with other known commitments.

Clinic cancellation can only be authorised by the appropriate Divisional Manager. A minimum of six weeks' notice of annual or study leave is required for clinic cancellation or reduction. In the event of cancellation of patients:

- The patient services team will ensure patients are contacted as soon as possible by the appropriate method of contact e.g. short notice cancellations by telephone, 1st class post or text information.
- Patients will be offered the choice of two new appointments within the target timeframe, or should the patient wish to, may choose a date beyond that.

4.4.6 Patients Found to be Unfit for Treatment at Outpatient Appointment

When a patient is found to be unfit for treatment – clinically it needs to be determined whether it is a short-term illness or a long term illness.

For short-term illnesses such as a cold – this would not impact on the clinical plan and, therefore, the clock for RTT continues.

For long term illnesses, such as uncontrolled diabetes / high blood pressure, where the patient requires optimisation and/or treatment before the initial agreed clinical plan can take place – then the responsible clinician needs to indicate to administrative staff:

- If it is clinically appropriate for the patient to be placed on a period of active monitoring – clock stop. Optimisation / treatment can take place either in secondary care or primary care;

If the patient should be discharged back to the care of their GP to be referred back to the Service when fit – clock stop

4.5 Diagnostics

A 'diagnostic' test is defined as a test or procedure used to identify a patient's disease or condition with the intention of enabling a medical diagnosis to be made.
The following section covers patients with an RTT and diagnostic clock, direct access and diagnostic only patients.

Patients with a diagnostic and RTT clock
Many patients will be referred for a diagnostic test while on an open RTT pathway. In these circumstances the RTT clock and diagnostic clock will be running concurrently:

- their RTT clock which started at the point of receipt of the original referral
- their diagnostic clock which starts at the point of decision to refer for diagnostic test (often at the first outpatient consultation).

Direct Access Endoscopy
The Trust has a Direct Access service to Endoscopy for GP referrals. As this is a consultant-led service, whereby the responsibility lies with the consultant responsible (whom the patient is under on the waiting list) – an RTT clock starts on the date of receipt of the referral / request.

Patients with a diagnostic clock only
Patients who are referred directly for a diagnostic test (but not consultant-led treatment) by their GP, i.e. clinical responsibility remains with the GP, will have a diagnostic clock running only.

- Echocardiogram – not applicable to RTT as not consultant-led (results returned to GP for review / decision making).

Patients may also have a diagnostic clock running only where they have had an RTT clock stop for treatment or non-treatment and their consultant refers them for a diagnostic test with the possibility that this may lead to a new RTT treatment plan.

National diagnostic clock rules
- **Diagnostic clock start:** the clock starts at the point of the decision to refer for a diagnostic test by either the GP or the consultant.
- **Diagnostic clock stop:** the clock stops at the point at which the patient undergoes the test.

Where a patient has cancelled, declined and/or not attended their diagnostic appointment and a clinical decision is made to return them to the referrer, ***the RTT clock continues to tick. Only the referring consultant can make a clinical decision to stop the RTT clock, if this is deemed to be in the patient's best clinical interests, by discharging the patient or agreeing a period of active monitoring.***

Booking diagnostic appointments
Wherever possible the appointment will be booked directly with the patient.

If the patient declines, cancels or does not attend a diagnostic appointment, the diagnostic clock start can be reset to the date the patient provides notification of this. However:

- The Trust must be able to demonstrate that the patient's original diagnostic appointment fulfilled the agreed reasonableness criteria for the clock start to be reset

- Resetting the diagnostic clock start has ***no effect on the patient's RTT clock. This continues to tick from the original clock start date.***

See **appendix C** for local access policies for Diagnostic Referrals; Endoscopy and Radiology.

4.6 Adding patients to an inpatient waiting list (Therapeutic Procedure)

This is the final stage of the 18 week RTT episode, and on the date of admission the clock will stop for that episode unless either:

a) the patient is cancelled, once admitted, for non-clinical reasons (in which case the clock continues to run), or
b) the patient is cancelled for a short term clinical reason, i.e. cold (in which case the clock continues to run), or
c) the patient is cancelled for a long term clinical reason, i.e. high blood pressure (in which case the clock for RTT will be stopped on active monitoring, if the patient is deemed to be fit within 3 months they can re-access the service through pre-operative assessment to be relisted.

The decision to add patients to the waiting list will be made by the consultant or under an arrangement agreed with the consultant and after discussion with the patient, and at that point the consultant will also discuss the rules around choice of delaying treatment.

Patients will only be added to the waiting list if there is an expectation of treating them, and when the patient has accepted the clinician's advice on elective treatment. The patient will be added to the waiting list within one working day of the decision to admit (DTA). Patients will not be added if:

- They are unfit for procedure
- They are not ready for the surgical phase of treatment within 2 weeks and require longer thinking time.
- There is no serious intention to treat them
- The procedure is not currently available or funded within the Trust

4.6.1 Managing Patients on the 18 Week Pathway

1. Waiting lists will be kept up to date using data from various sources. It is essential that data is entered on to the PAS within the next working day of decision to list in order to maintain

accuracy of data collection and waiting list management. Patients who no longer need their operations will be removed from the waiting list.

2. Amendments to, or overwriting of TCI dates on PAS are only acceptable if a date is entered in error and corrected on the same working day, if this timeframe is exceeded the TCI should be cancelled as an administrative error and a correct TCI allocated.

3. DBTH may hold a follow up waiting list in appropriate circumstances:

   - A follow up waiting list will be proactively managed and monitored, given the same status as the 18 Weeks PTL
   - It is acknowledged that it is not appropriate for all patients/clinics to hold a follow up waiting list
   - Division Clinical Director approval will be required to hold a follow up waiting list
   - All patients on the follow up waiting list will be dated 6 weeks prior to their appointment due date
   - As part of on-going monitoring DBTH will formally review the follow up waiting list and report their findings both internally and to commissioners
   - No patient will be added to a follow up waiting list who is an active 18 Weeks waiter.

4. All active 18 Week waiters will be pro-actively managed through the 18 Weeks PTL on a weekly basis.

5. It should be noted that for diagnostic investigations, and some other services, this may be on local bespoke systems.

6. It may also be appropriate to start a period of monitoring in secondary care without clinical intervention of diagnostic investigations/procedures, known as Active monitoring or Watchful wait.

4.6.2 Patients who are not fit for surgery – reflect unfit section

When a patient is found to be unfit for treatment – clinically it needs to be determined whether it is a short-term illness or a long term illness.

- For short-term illnesses such as a cold – this would not impact on the clinical plan and, therefore, the clock for RTT continues.
- For long term illnesses, such as uncontrolled diabetes / high blood pressure, where the patient requires optimisation and/or treatment before the initial agreed clinical plan can take place – then the responsible clinician needs to indicate to administrative staff:
- If it is clinically appropriate for the patient to be placed on a period of active monitoring (if the patient is on the waiting list they should be removed at this point) – clock stop. Optimisation / treatment can take place either in secondary care or primary care;
- If the patient should be discharged back to the care of their GP to be referred back to the Service when fit – clock stop.

4.6.3 Selecting Patients for Admission

- Patients will be selected from the waiting list according to clinical priority, and then in accordance with the individuals' 18 week pathway.
- All patients will have pre-assessment screening as part of their 18 week pathway where clinically appropriate.
- Wherever possible an admission date will be negotiated with the patient at the time the decision to admit is made
- Patient admissions should not be cancelled for non-clinical reasons

4.6.4 Confirmation to the Patient

Every patient will be sent confirmation that he or she has been put on to the waiting list, and/or confirming the date of their admission, and requesting that they confirm attendance.

4.6.5 Reasonableness of dates for admission

Reasonableness for admission is defined as 3 weeks' notice (though patients can choose an earlier date if they so wish) and 2 separate offered dates.

4.6.6 Patients who choose to delay treatment

Patients can choose to postpone or amend their appointment or treatment if they wish. However, the responsible clinician will be informed of patient-initiated delays outside of the clinically agreed timeframe of delay for each specialty. Where necessary, clinicians will review every patient's case individually to determine whether:

- the requested delay is clinically acceptable (clock continues)
- the patient should be contacted to review their options – this may result in agreement to the delay (clock continues) or to begin a period of active monitoring (clock stops)
- shared decision making; considering the patient's best clinical interest. Utilising the Care Portal and if appropriate discussing options with the referrer. Decision to discharge patient back to the care of their GP (clock stops)
- the requested delay is clinically acceptable, but the clinician believe the delay will have a consequential impact (where the treatment may fundamentally change during the period of delay) on the patient's treatment plan – active monitoring (clock stops)

4.6.7 Cancellations on the day of surgery

It is the expectation that no patient will be cancelled by the hospital on day of surgery. However in extreme circumstances when this is unavoidable patients must be booked a new date either within 28 days (as per the national standard) or before their 18 week breach date if this is shorter than 28 days. **NB – please note** that if a date cannot be offered within 28 days then an alternative provider is sourced if chosen to accept.

4.6.8 Patient exclusions for 18 week waits

There are a group of patients for whom it is inappropriate to begin treatment within 18 weeks. These are described as:

- Clinical Exceptions – where it is not clinically appropriate for treatment to begin within 18 weeks of referral, because the patient is either unfit for treatment or there is

genuine clinical uncertainty about the diagnosis. These patients will fall under the operational tolerances already built into the national target.

- Other Exclusions – such as obstetrics and midwifery, direct access diagnostics (excluding Endoscopy), planned patients, referrals to a non-consultant-led service, overseas visitors, and emergency activity, fall outside the scope of 18 week wait.

4.7 Tertiary Referrals and Inter-Provider Transfers (IPT)

- IPT is a critical mechanism to manage and monitor performance and *performance sharing* on the 18-week pathway and to allow equitable attribution of breaches of that pathway. When clinical responsibility for a patient is transferred, there is a danger that the administrative data on the patient does not pass to the new organisation and subsequent responsibility for breach sharing lacks clarity.
- The IPT minimum data set is designed to support the transfer of administrative data from the referring provider to the receiving provider, thus allowing the receiving provider to report on the 18 week patient pathway. By sharing information via the minimum data set for inter provider transfers; all parties involved can be fully aware of the patient's pathway. All services that refer *onwards* into provider services must use the IPT process. This includes such interface services such as Clinical Assessment and Treatment services (CATS) that may refer a patient into secondary care.
- All IPT minimum data sets (IPTMDS) will be completed and sent to the receiving provider within 48 hours (DSCN 44/2007). It is the referring organisation's responsibility to ensure the IPTMDS is sent and that an NHS.net address is used as the secure email service.

4.8 Cancer Referrals

Since 1 January 2009, all cancer pathways have been subject to monitoring on 18 week pathways, although still managed to guidance linked to specific cancer waiting time guidance.

NB – please note that at the current time Doncaster & Bassetlaw Teaching Hospitals NHSFT offers 2WW (suspected cancer) first appointment/investigations across all four of their hospital sites. Working in partnership with primary care colleagues, patients are encouraged to attend either site based on the next available appointment. This will support urgent access times for patients.

The following principles will be applied to all 2WW referrals made either via ERS of other methods from Primary Care. It is acknowledged that by October 2018 all referrals will be received via an electronic process.

- Where a service is not directly bookable or there is an issue with slot availability or other substantial reason the electronic booking service (EBS) via the e-Referral System

cannot be used, referrals should revert to paper and be emailed via a secure address to the relevant booking team.

4.8.1 Multiple declined appointments offers

All patients who are referred on a 62-day GP pathway or breast symptomatic referral that decline the offer of two consecutive appointments for 1st attendance (i.e. outpatient, diagnostic investigation) will be contacted by an appropriate member of staff to identify any factors that may be stopping the patient attending. Another appointment will be offered if the patient agrees. From this point the patient will be transferred onto a Consultant Upgrade pathway from the date of the 1st appointment offered

4.8.2 Virtual Clinic Referrals Cancer

Virtual Clinic referrals made by ERS – these referrals requiring vetting to proceed the 62 day pathway

At the point of all Virtual Clinic appointments being made in Primary Care via the ERS system it is the expectation that the accompanying referral letter will be added with 24 hours.

Where the Primary Care referral has not been attached within the 24 hour window and the Trust has been required to contact the GP practice to receive a copy of the referral – the start date of the 14/62 day clock with start at the receipt of the referral electronically within the Trust Systems. The Trust ASI SOP should be followed for accurate pathway management.

4.8.3 First appointment

All patients referred as suspected cancer including 2WW, screening, upgrade and breast symptomatic who DNA their first outpatient appointment should be offered an alternative date within 14 days of the DNA.

A waiting-time adjustment applies from receipt of referral to the date the patient makes contact to rearrange the appointment and all details must be recorded on the cancer management system.

If a patient DNAs their first appointment for a second time they will be escalated to the consultant in clinic for a decision on the next step which may include discharge back to the GP or being transferred onto a Consultant upgrade pathway .

4.8.4 Multiple cancellations

All patients who are referred on a 62-day GP pathway, screening pathway or breast symptomatic referral who cancel two consecutive appointments (i.e. outpatient, diagnostic investigation) will be contacted by an appropriate member of staff to identify any factors that may be stopping the patient attending. Another appointment will be offered if the patient agrees.

Patients can be discharged after multiple (two or more) appointment cancellations if this have been agreed with the patient. However, where a patient has cancelled multiple appointments on a 62-day GP pathway, screening pathway or breast symptomatic referral (i.e. outpatient, diagnostic investigation), an appropriate member of staff will contact the patient to identify any factors that may be stopping the patient attending. If required, then the referring GP will

be contacted for support to respond in a timely manner to avoid further delay. If agreed with the patient a further appointment will be offered. From this point the patient will be transferred onto a Consultant Upgrade pathway from the date of the 1st appointment offered.

4.9 Patients Transferring Between NHS and Private Care

As outlined in 'A Code of Conduct for Private Practice, Recommended Standards of Practice for NHS Consultants':

- Any patient referred for an NHS service following a private consultation or private treatment should join any NHS waiting list at the same point as if the consultation or treatment were an NHS service. Their priority on the waiting list should be determined by the same criteria applied to other NHS patients.
- The patient should not be referred back to General Practice for a decision about onward referral unless the patient wishes to take this course of action.
- It is essential that the Trust ensures its clinicians fully understand and apply this condition and ensures consistency of this condition in its other operating protocols.
- Trust will manage, including clock statuses patient s who decide to transfer part or all of their treatment to a private provider
- Patients can choose without prejudice to move between NHS and private status
- If a surgical procedure is necessary patient can be added directly to elective waiting list if clinically appropriate, and RTT starts at the point of GP or original referrer letter arrives into hospital
- RTT Pathways of patients that notify trust decision to seek private care will be closed and clock stopped on notification date

4.10 Quality Assurance

1. In order to establish that the Policy and Procedures are appropriately carried out, and reflect current standards, an audit of the processes will be undertaken periodically. This process will be led by the Data Quality Leads, in conjunction with the Internal Audit Office, and compliance will be assessed against national benchmarks.

2. Waiting lists will also be subject to rolling validation programmes according to current best practice.

5 EDUCATION, TRAINING/SUPPORT

1. All grades of staff that use PAS as part of their daily work requirements will undergo education and training in the use of PAS, and in the management of waiting list processes. It is the responsibility of the Trust to ensure that all staff required to access waiting list systems will attend, as minimum, mandatory induction training.

2. All staff required to access waiting list systems will attend mandatory induction training on basic processes and thereafter yearly updates in order to maintain current knowledge and skill in relation to waiting list administration and management.

3. New changes in processes will be managed by ad hoc training.

4. The 18 week rules suite at Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care (2015) will be the definitive document for training purposes

6 MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
Adherence and compliance against the overall policy	Divisional Director through the Divisional management and service team	Weekly Monthly	Weekly PTL meetings Daily escalations Monthly performance reports
Regular reporting and escalation of information to Divisional teams	Information Manager	Weekly Monthly	PTL report and WL information at a specialty level Reported to all nominated patient management leads
Training and Education on 18 week policy, CaMIS and other patient management systems. Trust Training Strategy	Jon Sargeant through Tracy Crookes, Head of Applied Information	Ongoing	Progress report against the Trust Training Strategy
Waiting List quality	Internally via DQ Team Externally via KPMG annual audit	Daily Annual	Reported to Divisional leads Reported to Trust Audit Committee

7 EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and assessing the impact of a procedural document any discriminatory factors must be identified.

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. (See Appendix F).

8 ASSOCIATED TRUST PROCEDURAL DOCUMENTS

- CORP/ICT 2 - Information Management and Technology (IM&T) Security Policy
- CORP/ICT 7 - Data Protection Policy
- CORP/ICT 8 - Safe Haven Guidelines
- CORP/ICT 9 - Information Governance Policy
- CORP/ICT 10 - Confidentiality - Code of Conduct
- CORP/ICT 11 - Information and Communications Technology (ICT) Business Continuity Policy
- CORP/ICT 14 - Information Records Management - Code of Practice
- CORP/ICT 15 - Freedom of Information (FOI) Policy
- CORP/ICT 16 - Information Governance Strategy
- CORP/ICT 20 - Bulk Data Transfer Guidelines
- CORP/ICT 21 - Information Risk Management Policy
- CORP/ICT 22 - 3rd Party Access to the Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust's Network and Core Patient Systems.
- CORP/ICT 27 - Email and Internal Communications Policy
- CORP/ICT 28 - Internet Usage Policy
- PAT/PA 19 – Mental Capacity Act 2005 – Policy and Guidance, including Deprivation of Liberty Safeguards (DoLS)
- PAT/PS 10 – Safeguarding Children Policy

9 SECURITY AND CONFIDENTIALITY

All staff engaged in the application of this policy is bound by the LHC Information Management & Technology (IM&T) Security and Confidentiality policies.

Legislative note: All DBTH Policies which reference the Data Protection Act (DPA) 1998 will – within the Trusts General Data Protection Regulation (GDPR) Implementation programme – be amended and updated to ensure that they detail the appropriate legislative references as the GDPR comes fully into force on the 25th May 2018, and as The Data Protection Bill 2017 receives Royal Ascent.

From the Information Commissioners Office (ICO): The GDPR has direct effect across all EU member states and has already been passed. This means organisations will still have to comply with this regulation and we will still have to look to the GDPR for most legal obligations. However, the GDPR gives member states limited opportunities to make provisions for how it applies in their country. One element of the DP Bill is the details of these. It is therefore important the GDPR and the Bill are read side by side.

10 REFERENCES

- NHS Constitution (2013) Department of Health – updated 27th July 2015
- Everyone counts: Planning Guidance as applicable
- Standard NHS Contract as applicable
- 'The Government's Mandate to NHS England 2017-18'
- Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care (2015)
- https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/
- Maximum Waiting Times – Guidance for Commissioners (2013) NHS England
- Operational guidance to the NHS: Extending Patient Choice of Provider (2011) Department of Health

APPENDIX A - DEFINITIONS

For the purposes of this policy, the following terms have the meanings given below:

Term	Definition
Active Waiting List	Patients awaiting elective admission for treatment and are currently available to be called for admission.
Active monitoring	A diagnosis has been reached, but a period of active monitoring of the patient is deemed clinically appropriate. If a patient subsequently required further treatment after this monitoring period, a new 18 week clock would begin.
Clinical Assessment and Treatment Service (CATS)	A specialist interface service between Primary and Secondary Care. Designed to ensure patients are directed efficiently and effectively into the most appropriate care pathway. CATS are bound by both choice and 18-week clock rules.
Can Not Attend (CNA)	Patients who, on receipt of reasonable offer(s) of admission, notify the hospital that they are unable to attend.
Date Referral Received (DRR)	The date on which a hospital receives a referral letter from a GP. The waiting time for outpatients should be calculated from this date.
Day cases	Patients who require admission to the hospital for treatment and will need the use of a bed but who are not intended to stay in hospital overnight.
Decision to Admit date (DTA)	The date on which a consultant decides a patient needs to be admitted for an operation. This date should be recorded in the case-notes and used to calculate the total waiting time.
Did Not Attend (DNA)	Patients who have been informed of their date of admission or pre-assessment (inpatients/day cases) or appointment date (outpatients) and who without notifying the hospital did not attend for admission/ pre-assessment or outpatient appointment.
E-referral system	A method of electronically booking a patient into the hospital of their choice.

First Definitive Treatment	An intervention intended to manage a patient's disease, condition or injury and avoid further intervention. What constitutes First Definitive Treatment is a matter for clinical judgement, in consultation with others as appropriate, including the patient.
Indirectly Bookable Service (IBS)	Some provider services are not directly bookable through the E-referral system so patients cannot book directly into clinics from a GP practice. Instead they contact the hospital by phone and choose an appointment date. This is defined as an Indirectly Bookable Service.
Inpatients	Patients who require admission to hospital for treatment and are intended to remain in hospital for at least one night.
Inter Provider Transfer (IPT)	The inter-provider transfer is a system whereby minimum data set (MDS) information is transferred electronically (best practice) from one provider to another and helps to track patients as they move between providers.
Outpatients	Patients referred by a General Practitioner or another health care professional for clinical advice or treatment.
Patient Tracking List (PTL)	The PTL is a list of all RTT (Referral to Treatment) patients (both inpatients and outpatients) who are actively waiting to be treated. The PTL is used to actively manage patients to ensure they are treated in clinical priority followed by chronological wait order in line with the 18 Weeks standard. The PTL is also used for performance monitoring and reporting of the 18 Weeks standard.
Reasonable Offer	For an offer of an appointment to a patient to be deemed reasonable, the patient must be offered the choice of 2 different dates within the timescales referred to for outpatients, diagnostics and inpatients.
Referral to Treatment (RTT)	Instead of focusing upon a single stage of treatment (such as outpatients, diagnostic or inpatients) the 18 week pathway addresses the whole patient pathway from referral to the start of treatment.
To Come In (TCI) date	The offer of admission, or TCI date, is a formal offer in writing of a date of admission. A telephone offer of admission should not normally be recorded as a formal offer. Usually telephoned offers are confirmed by a formal written offer.

TWW	Two Week Wait appointment is requested by a referring GP for suspected cancer cases.
Watchful waiting	An 18w clock may be stopped where it is clinically appropriate to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures. A new 18 week clock would start when a decision to treat is made following a period of watchful waiting/active monitoring.
Urgent	Urgent referrals are only to be used for cancer patient pathways, a potential life threatening illness, or a potential risk of loss of limb.

APPENDIX B - COMMISSIONING FOR VALUE (CfV) POLICY - PROCEDURES OF LIMITED CLINICAL VALUE

Appendix B - South Yorkshire and Bassetl

APPENDIX C - DIAGNOSTIC REFERRALS

Referrals for Radiology diagnostic tests/procedures
Referrals for radiology diagnostic tests/procedures are accepted from the following sources:

- GPs
- Dental
- Community
- Consultant referral (internal to DBTH)
- Consultant referral (tertiary)
- Private
- Cat II
- Radiology approved Non-Medical Referrers - Community and DBTH

Patients should only be referred to the radiology department if they are available to attend their appointment within the next 6 weeks, unless the diagnostic test being sought is planned and therefore to be arranged at a specific date in the future.

If a patient is being urgently referred on a 2WW or other urgent pathway then their availability will be sought within 2 weeks of the date of referral.

It is essential that all referrals received - paper or electronic -are accurate, legible, complete and contain the appropriate patient and clinical information to ensure accuracy in both the diagnostic examination undertaken and to minimise the patient safety risk of delayed diagnosis and treatment.

The majority of imaging undertaken is governed by Radiation Protection legislation in order to ensure patient safety i.e. the Ionising Radiation Medical Exposure Regulations 2000 (IR(ME)R 2000) including amendment to the regulations in 2006 and 2011. Intrinsic within the legislation is assurance that the right patient receives the right test using the minimal radiation dose necessary to produce diagnostic images. Included is the service's requirement to clinically 'justify' all referrals received. Referral inaccuracies that prevent the justification process may therefore result in the referral being returned to the referrer for further information.

If referrals are returned to a referrer and imaging still sought, a **new** clinically updated and accurate referral will need to be submitted.

Radiology is unable to process the original request therefore if a new referral is not made the patient cannot be appointed or imaged.

Please refer to the Radiology Referral Guidance SOP for further and more detailed information about how to submit a diagnostic imaging referral.

On receipt and acceptance of a diagnostic imaging referral by Radiology, the referral will be directed to the correct modality for vetting and clinical prioritisation where appropriate (Vetting Overview SOP).

DBTH Radiology requires vetting to be done within:

- 1 working day of receipt for urgent/2WW referrals
- 2 working days of receipt for routine referrals

Upgrading or downgrading requests for tests and rejecting requests

Where, on consideration of the clinical information provided or known, a possible diagnosis of cancer is suggested, the referral will be upgraded from routine to urgent. In these instances, the member of Radiology staff vetting the referral must inform the referrer that the clinical priority of their patient has been changed

Referrals cannot be downgraded without discussion and agreement by the receiving Radiology consultant and the original referrer.

Redirecting and rejecting referrals

Amendment of referrals – If, based on the clinical information provided by the Referrer, the Radiologist believes that the wrong examination has been requested, the Radiologist will amend the referral accordingly and redirect it to the appropriate modality. The Referrer will be advised of the change in examination requested.

Rejecting referrals - Any referrals that a Radiologist deems inappropriate will be returned to the referrer with an explanation for the rejection. It is the responsibility of the Referrer to notify the patient that the referral has not been accepted by Radiology.

The duty of care to the patient sits with the referrer until a referral is accepted by Radiology. Patients should wait no longer than 6 weeks for any routine diagnostic examination and no longer than 2 weeks for an urgent or 2WW examination. Urgent/2WW referrals will be allocated the next available appointment.

For all urgent suspected cancer referrals, the referrer must clearly annotate the referral with '**2WW'** to ensure it is prioritised and processed accordingly by Radiology.

The majority of CT and MRI examinations require the use of radiology contrast agents to visibly enhance a patient's anatomy.

Use of contrast agents can affect kidney function. Therefore when a referral indicates use of a contrast agent, a recent creatinine level for the patient must be included on the referral to minimise risk and allow the referral to be clinically justified.

Referrals without a recent creatinine level i.e. within 12 weeks of date of referral will be **declined** and **returned** to the referrer.

If a referral is declined and returned to the referrer, the referrer must decide, depending on the patient's clinical condition at the time, whether imaging is still required. If an examination is still warranted, a **new**, clinically updated and accurate referral for the patient will need to be submitted to Radiology.

National diagnostic clock rules

- **Diagnostic clock start:** The diagnostic clock starts on the date a referral for a diagnostic test or procedure is made. This can be a GP referral or at the first outpatient appointment.
- **Diagnostic clock stop**: The diagnostic clock stops on the date the patient receives the diagnostic test/procedure.

The national standard is that no more than 1% of patients referred for imaging should wait more than 6 weeks for a diagnostic test.

The exception is where the examination/procedure requested is defined as Radiology delivered treatment/therapy. In these instances, the 18 week referral to treatment clock will stop when the Radiology treatment/therapy is received by the patient.

The diagnostic imaging target of a maximum 6 week wait does not apply to Radiology delivered treatment/therapy referrals.

Straight-to-test arrangements

For patients who are referred for a diagnostic test where one of the possible outcomes is review, and if appropriate, treatment within a consultant-led service and where the patient has not initially been reviewed by their GP, the RTT clock will start on receipt of the imaging referral. These are called straight-to-test referrals.

Booking radiology diagnostic appointments

- Diagnostic examinations are booked in order of clinical priority i.e. 2ww, urgent, routine and then in chronological order.
- Referrers should advise patients that their diagnostic examination will be within the following 6 weeks and that they will be allocated an appointment in the next available slot.
- Due to subspecialisation and the available clinical expertise, the examination requested may only be undertaken at one of the 4 Trust sites. The referrer must therefore advise patients that they may be required to travel depending on the examination they are having.
- Every effort is made to contact the patient directly to agree the date of their diagnostic examination/ procedure especially when the referral is urgent. Therefore an up-to-date telephone number for the patient should always be included on a referral to minimise delay in appointing.
- After several attempts at contacting the patient by telephone and assurance that the correct contact information for them is held, the patient will be allocated the next available appointment and sent an appointment letter to confirm the date , time and Trust site where their examination will take place. The letter will also outline the Trust policy for not attending or cancelling appointments plus who to contact if they have any queries.
- Patients are encouraged to accept an offer of at least 2 appointment dates with at least 10 days' notice of their appointment. This does not preclude offering patients the choice of an earlier date if one is available and they agree.

- The imaging appointment **must** be made within the 6 week diagnostic target.
- If a patient turns down reasonable offers of an appointment i.e. 2 separate dates offered with 10 days' notice of each, then the diagnostic clock start for that examination/procedure can be reset to zero from the date the first offer of an appointment was made.
- Radiology will advise the referrer of any patient that declines 2 reasonable appointment offers made.

Planned diagnostic examinations (surveillance)

Planned diagnostic examination/procedures are usually requested and undertaken over a period of time for clinical reasons.

The time a patient therefore waits for their planned diagnostic examination is as stated by the referrer on the referral e.g. examination in 3 months' time. The waiting time involved can vary or be set depending on the clinical reason for the planned examination e.g.:

- 6 month check following a new treatment
- Ongoing CT staging examination where tumour growth or soft tissue degeneration is monitored on a regular basis

If a planned examination is required, the referrer **must** clearly annotate the referral as **planned** and state the date on the referral when they wish the patient to have the examination.

An appointment should be offered to the patient on or as close to the planned date stated by the referrer.

A planned request does **not** mean that the patient has to wait the time stated on the referral e.g. 3 months, and then the referral added to the 6 week diagnostic waiting list for a subsequent appointment to be made. The appointment must be made for the planned date stated on the referral.

A patient who is receiving follow up treatment and is referred for a routine, 6 week wait imaging examination as part of their ongoing treatment is **not** a planned examination.

There are no exceptions to the rules for planned examinations.

Radiology/Trust appointment cancellations

Ideally eight weeks' notice of any planned leave for clinical, patient facing staff should be given to support a session cancellation or a reduction in appointments for the session in order to minimise any inconvenience to patients.

Six weeks' notice for planned leave is the minimum notice required as per the Trust's Leave Policy. Urgent planned leave with less than 6 weeks' notice can only be authorised by the Assistant Division Director or Head of Service with assurance that there is no disruption to booked sessions or patients cancelled e.g. peer group support required to cover booked sessions.

If cancellations of sessions arise due unknown, unplanned absence or a domestic or personal emergency, every attempt must be made in the first instance not to not cancel lists or patients e.g. peer group support; redeployment of booked patients onto other staffed lists. If patients are delayed due to urgent cover of unplanned absence, assurance is required that they are fully appraised if a delay with their appointment time occurs.

If, ultimately, the department/Trust cancels a diagnostic examination appointment, the patient should be reappointed as close to their original appointment date and within the 6 week target date; 2WW and urgent patients as appropriate.

The diagnostic clock continues in these instances and is not restarted.

Patient initiated appointment cancellations/changes

When a patient cancels an appointment for a diagnostic examination/procedure, the diagnostic waiting time is nullified and the clock restarted from the date of the cancelled appointment.

A new appointment should be given as close to their cancelled appointment as possible and within the new, recalculated 6 week target date ensuring due consideration to RTT and cancer target dates where applicable.

Patients who cancel their appointment more than twice will be removed from the diagnostic waiting list unless:

- It is clinically inappropriate
- Evidence that appointments were not clearly communicated
- Evidence that reasonable offers were not made

Where there is an associated RTT clock for the patient this will continue. In the event a decision is made not to discharge the patient, the diagnostic clock would also continue.

The referrer will be notified by letter if a patient cancels their appointment more than twice.

Patients who do not attend (DNAs) Radiology

All patients who do not attend their appointment or have not been brought in for their diagnostic appointment by a 3rd party as planned, must be reviewed by the referrer as to whether a further appointment is required based on the patients clinical and personal circumstances.

Radiology would not routinely offer a further appointment unless:

- Discharging the patient would be contrary to the patient's best clinical interests; i.e. patient is on a suspected cancer pathway
- When the appointment was not clearly communicated or reasonably offered e.g., sent to the incorrect address.

There must **always** be evidenced assurance for the protection of the clinical interests of suspected cancer patients, infants, and young people under 18 year's old and vulnerable adults. In these instances, the DNA process will be reviewed on an individual patient basis.

If the decision to discharge the patient has been made, a letter or other form of communication will be sent to both the patient and the referrer to advise and the diagnostic target clock for the patient stopped.

If a diagnostic examination is reappointed after a DNA, the diagnostic clock start date will be the date of the DNA.

Where there is an associated RTT clock for the patient this will continue.

If the referrer decides on review that an examination is still sought, a new clinically updated referral for the patient will need to be submitted. This is to ensure accuracy in clinical information and legislation compliance.

Radiology is unable to process the original request therefore if a new referral is not made the patient cannot be appointed or imaged.

Referrals for Endoscopy

Referrals for Endoscopy diagnostic tests/procedures are accepted from the following sources:

- GPs
- Community
- Consultant referral (internal to DBTH – GI/ Gastro)
- Consultant referral (internal to DBTH – Non GI/Gastro these will be vetted prior to acceptance)
- Clinical nurse specialists – colorectal
- Consultant referral (tertiary)
- Private

Routine patients should only be referred to the department if they are fit ready and able to attend their appointment within the next 6 weeks, unless the diagnostic test being sought is planned and therefore to be arranged at a specific date in the future.

2WW or other urgent patient's pathways will need to be fit and able to attend within 2 weeks of the date of referral.

It is essential that all referrals received are accurate, legible and include all appropriate relevant patient and clinical information to ensure accuracy and patient safety and avoid delayed diagnosis and treatment. Incorrect or incompletely completed referrals will be returned to the referrer and a new referral will need to be submitted.

Intrinsic within the legislation is assurance that the right patient receives the right test. Included is the service's requirement to clinically 'justify' all referrals received.

Referral inaccuracies that prevent the justification process may therefore result in the referral being returned to the referrer for further information (Enclosed GMC guidance on good clinical practice)

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On receipt and acceptance of a diagnostic referral by Endoscopy, the referral will be directed to the appropriate specialist for vetting and clinical prioritisation.

DBTH Endoscopy requires vetting to be done within:

- 1 working day of receipt for urgent/2WW referrals
- 1-2 working days for ERCP (Endoscopic Retrograde Cholangio- Pancreatography)referrals
- 2 working days of receipt for routine referrals

Upgrading or downgrading requests for tests and rejecting requests

Where, on consideration of the clinical information provided or known, a possible diagnosis of cancer is suggested, the referral will be upgraded from routine to urgent

Where referrals have been downgraded or rejected the referring clinician will be informed of this decision and in the event of any disagreement arbitration can be sought. It is the responsibility of the Referrer to notify the patient that the referral has not been accepted by Endoscopy

Redirecting and rejecting referrals

Amendment of referrals – If, based on the clinical information provided by the Referrer, the endoscopist believes that the wrong examination has been requested, the endoscopist will amend the referral accordingly and request the correct examination with the appropriate modality. The Referrer will be advised of the change in examination requested i.e. a change from a colonoscopy to a CT Colon where the patients is deemed too frail and colonoscopy is not appropriate first investigation.

Rejecting referrals - Any referrals that an endoscopist deems inappropriate will be returned to the referrer with an explanation for the rejection.

The duty of care to the patient lies with the referring clinician until the referral is accepted by Endoscopy.

Patients should wait no longer than 6 weeks for any routine diagnostic examination and no longer than 2 weeks for an urgent or 2WW examination. Urgent/2WW referrals will be allocated the next available appointment these targets are in line with JAG requirements.

For all urgent suspected cancer referrals, the referrer must clearly annotate the referral with '2WW' to ensure it is prioritised and processed accordingly by Endoscopy.

If a referral is declined and returned to the referring clinician, the referrer must decide, depending on the patient's clinical condition at the time, whether diagnostic investigation is still required. If an

examination is still warranted, a new, clinically updated and accurate referral for the patient will need to be submitted to Endoscopy.

National diagnostic clock rules

- Diagnostic clock start: The diagnostic clock starts on the date a referral for a diagnostic test or procedure is made. This can be a GP referral or at the first outpatient appointment.
- ERS referrals – the Diagnostic clock starts on the day the referrer uploads the referral details on to the system as the team cannot process the request without the patient information so it can be appropriately vetted.
- Diagnostic clock stop: The diagnostic clock stops on the date the patient receives the diagnostic test/procedure.

The national standard is that no more than 1% of patients referred for diagnostic test should wait more than 6 weeks.

Internal referral

For patients who are referred for a diagnostic test where one of the possible outcomes is review, and if appropriate, treatment within a consultant-led service and where the patient has not initially been reviewed by their GP, the RTT clock will start on the date the referral is completed by the referring clinician.

Booking Endoscopy diagnostic appointments

- Diagnostic examinations are booked in order of clinical priority i.e. 2ww, urgent, routine and then in chronological order.
- Referrers should advise patients that the above time scales and that they will be allocated an appointment in the next available slot.
- Due to subspecialisation and the available clinical expertise, the examination requested may only be undertaken at one of the 2 Trust sites. The referrer must therefore advise patients that they may be required to travel depending on the examination they are having.
- Every effort is made to contact the patient directly to agree the date of their diagnostic examination/ procedure especially when the referral is urgent. Therefore an up-to-date telephone number for the patient should always be included on a referral to minimise delay in appointing.
- After several attempts at contacting the patient by telephone and assurance that the correct contact information for them is held, the patient will be allocated the next available appointment and sent an appointment letter to confirm the date , time and Trust site where their examination will take place. The letter will also outline the Trust policy for not attending or cancelling appointments plus who to contact if they have any queries.
- Routine patients will be offered two dates with 7 days reasonable notice they will be expected to accept one of these dates. 2WW patients will be offered two dates with a minimum of 2 days reasonable notice prior to the appointment date and are expected to accept one of these dates. This does not preclude offering patients the choice of an earlier date if one is available and they agree.
- The Endoscopy appointment must be made within the 5.9 week diagnostic target.
- If a patient turns down reasonable offers of an appointment i.e. 2 separate dates offered with 7days' notice, then the diagnostic clock start for that examination/procedure can be reset to zero from the date the first offer of an appointment was made.

- Endoscopy will advise the referrer and GP of any patient that declines 2 reasonable appointment offers made.

Planned diagnostic examinations (surveillance)

Planned diagnostic examination/procedures are usually requested and undertaken over a period of time for clinical reasons.

The time a patient therefore waits for their planned diagnostic examination is as stated by the referring clinician on the referral e.g. examination in 3 months' time. The planned re-scope involved can vary or be set depending on the clinical reason for the examination and can vary from a few weeks to a few years. e.g.:

If a planned examination is required, the referrer must clearly annotate the referral as planned and state the date on the referral when they wish the patient to have the examination.

An appointment should be offered to the patient on or as close to the planned date stated by the referrer.

A patient who is receiving follow up treatment and is referred for a routine, 6 week wait endoscopy examination as part of their ongoing treatment is not a planned examination.

There are no exceptions to the rules for planned examinations.

Endoscopy/Trust appointment cancellations

Ideally eight weeks' notice of any planned leave for clinical, patient facing staff should be given to support a session cancellation or a reduction in appointments for the session in order to minimise any inconvenience to patients. Six weeks' notice for planned leave is the minimum notice required as per the Trust's Leave Policy. Urgent planned leave with less than 6 weeks' notice can only be authorised by the Clinical Director or Head of Service with assurance that there is no disruption to booked sessions or patients cancelled e.g. peer group support required to cover booked sessions.

If cancellations of sessions arise due unknown, unplanned absence or a domestic or personal emergency, every attempt must be made in the first instance not to not cancel lists or patients e.g. peer group support; redeployment of booked patients onto other staffed lists. If patients are delayed due to urgent cover of unplanned absence, assurance is required that they are fully appraised if a delay with their appointment time occurs.

If, ultimately, the department/Trust cancels a diagnostic examination appointment, the patient should be reappointed as close to their original appointment date and within the 6 week target date; 2WW and urgent patients as appropriate. Patients cancelled on the day (at any point forward of bowel prep) will have to be reappointed within the maximum of 28 days.

The diagnostic clock continues in these instances and is not restarted.

Patient initiated appointment cancellations/changes

When a patient cancels an appointment for a diagnostic examination/procedure, the diagnostic waiting time is nullified and the clock restarted from the date of the cancelled appointment.

A new appointment should be given as close to their cancelled appointment as possible and within the new, recalculated 6 week target date ensuring due consideration to RTT and cancer target dates where applicable.

Patients who cancel their appointment more than twice will be removed from the diagnostic waiting list unless:

- Evidence that appointments were not clearly communicated
- Evidence that reasonable offers were not made

Where there is an associated RTT clock for the patient this will continue. In the event a decision is made not to discharge the patient. A new diagnostic clock will start if the patient is referred back in.

The referrer and GP will be notified by letter if a patient cancels their appointment more than twice.

Patients who do not attend (DNAs) Endoscopy

All patients who do not attend their appointment will be removed from the diagnostic waiting list. Referral will be sent back to the referrer and must be reviewed as to whether a further appointment is required based on the patients clinical and personal circumstances. If the referrer decides on review that an examination is still sought, a new clinically updated referral for the patient will need to be submitted. This is to ensure accuracy in clinical information and legislation compliance. Endoscopy is unable to process the original request therefore if a new referral is not made the patient cannot be appointed.

Endoscopy would not routinely offer a further appointment unless:

- When the appointment was not clearly communicated or reasonably offered e.g., sent to the incorrect address.

When discharging a patient, a letter or other form of communication will be sent to the patient, referrer and GP to advice and the diagnostic target clock for the patient has stopped.

If a diagnostic examination is reappointed after a DNA, the diagnostic clock start date will be the date of the DNA.

Where there is an associated RTT clock for the patient this will continue.

Results normal

After the endoscopy if the patients results are normal, either on a STT (straight to test) pathway or on an 18 week pathway (where the referrer stated that if endoscopic procedure is normal patient will be discharged). The patient will be discharged from the service and the 18 week pathway. This will stop the endoscopy clock and the 18 week pathway clock. A letter will be sent to Patient, Referrer and GP.

APPENDIX D - EXAMPLE LETTER FOR ACTIVE MONITORING

Doncaster and Bassetlaw Teaching Hospitals NHS
NHS Foundation Trust

Doncaster Royal Infirmary
Armthorpe Road, Doncaster
South Yorkshire DN2 5LT
Tel: 01302 366666

Secretary: 01302 642143
Appointments: 7660
Fax: 01302 761208

Dr A N Other

Our Ref: AN/AM

Date Dictd: 14/12/2017
Date Typed: 18/12/2017

Dr MC Coleman
Kingthorne House
83a Thorne Road
Doncaster
South Yorkshire
DN1 2EU

Dear Dr Coleman

Daff O'DILL **D.O.B. 01/10/1970**
Doncaster Royal Infirmary, Armthorpe Road **Hospital No. D0000001**
Doncaster, DN2 5LT **NHS No.**

I have now received the results of the above patient's echocardiogram. This is essentially normal. As discussed in Clinic previously, as the result is normal no current intervention is required and Ms O'Dill will now be placed on active monitoring. We will review her in 6 months' time.

Yours sincerely

Dr A N Other
Consultant Cardiologist

cc Daff O'Dill
Doncaster Royal Infirmary

APPENDIX E - EXAMPLE LETTER FOR DISCHARGE OF PATIENT BACK TO THE REFERRER FOLLOWING A REVIEW OF NON ATTENDANCE

Doncaster and Bassetlaw Teaching Hospitals NHS
NHS Foundation Trust

Doncaster Royal Infirmary
Armthorpe Road, Doncaster
South Yorkshire DN2 5LT
Tel: 01302 366666

Secretary: 01302 642143
Appointments: 7660
Fax: 01302 761208

Dr A N Other

Our Ref: AN/AM

Date Dictd: 14/12/2017
Date Typed: 18/12/2017

Dr MC Coleman
Kingthorne House
83a Thorne Road
Doncaster
South Yorkshire
DN1 2EU

Dear Dr Coleman

Daff O'DILL **D.O.B. 01/10/1970**
Doncaster Royal Infirmary, Armthorpe Road **Hospital No. D0000001**
Doncaster, DN2 5LT **NHS No.**

I have reviewed the referral information for Ms O'Dill due to non-attendance of a number of planned hospital appointments. My conclusion in review of this information is, to, discharge this patient back to yourself, the referrer.

Yours sincerely

Dr A N Other
Consultant Cardiologist

cc Daff O'Dill
Doncaster Royal Infirmary

APPENDIX F – EQUALITY IMPACT ASSESSMENT - PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	Care Group/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
PAT/PA 1 v.9	Operations and Performance	Emma Challans	Existing	13 July 2018

1) Who is responsible for this policy? Name of Care Group/Directorate: Operations and Performance

2) Describe the purpose of the service / function / policy / project/ strategy? The Access Policy is for the benefit of patients and staff to ensure that the NHS Constitution and National contractual requirements are delivered.

3) Are there any associated objectives? NHS Constitution, RTT, Clinical Safety, Access

4) What factors contribute or detract from achieving intended outcomes? Lack of process and understanding of the policy and requirements of providers and partners

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? no

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation]

6) Is there any scope for new measures which would promote equality? N/A

7) Are any of the following groups adversely affected by the policy? N/A

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1 ✓	Outcome 2	Outcome 3	Outcome 4

Date for next review: June 2021

Checked by: David Purdue **Date:** July 2018

APPENDIX G

Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

Management of children (under 18) not brought to follow up appointments