PATIENT ACCESS POLICY

Document Control

Author/Contact	Nicola Beaumont (Trust 18 weeks RTT Lead & Associate Director of Operations (Surgery, Theatres, Anaesthetics & Critical Care (CBU2))	
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1 Introduction

This policy outlines the expectations and responsibilities of Barnsley Hospital NHS Foundation Trust (BHNFT) for managing patient access in line with the National Referral to Treatment (RTT) standards. The policy covers all stages of the 18 week RTT pathway from referral through to discharge back to primary care and those patients being managed on pathways subject to National Cancer Waiting Times. It provides direction and guidelines to promote consistency, rights and equitable access and aims to ensure that patients have a choice of appointment or admission date and that they see the right professional in the minimum waiting time.

Providing timely access to care is central to improving quality, both by ensuring that care is received when it is most needed, and by contributing to a positive patient experience.

Fair access to secondary care services improves patient flow across the whole of the NHS. This policy aims to balance the requirements of providing highest quality of care whilst ensuring continuous improvement in the patient pathway.

The Referral to Treatment (RTT) pathway focuses on the patient journey to treatment; it records the patient experience to access, referral to the start of treatment. The underlying principle is that patients have a right under the NHS Constitution to care without unnecessary delay.

This latter principle also applies to the management of patients on cancer pathways although some of these will culminate in the exclusion of cancer where no treatment is required.

The Trust will ensure that the management of patient access to services is transparent, fair, and equitable and managed according to clinical priority. This policy applies to all administration and clinical prioritisation processes relating to patient access including outpatient, inpatient, day case and diagnostic services.

This policy should be adhered to by all staff within the Trust who are responsible for referring patients, managing referrals and adding to and maintaining waiting lists for the purpose of progressing a patient through their 18 week RTT or cancer pathway.

2 Objective

The objective of this policy is to ensure all staff involved in elective access can effectively manage the patient referral to treatment without unnecessary delay within the current waiting time standards.

2.1 National Performance Standards

The following national performance standards apply to 18 Week RTT patients:

- 100% of patients admitted for elective surgery will undergo MRSA and MSSSA screening.

- 100% of patients cancelled by hospital on day of admission/operation for non-clinical reasons will be guaranteed an admission/operation date within 28 days of the cancellation and within the waiting time guarantee, or be offered treatment at an alternative provider; unless the patient declines 2 offer dates.

- 98% of patients referred by their General Practitioner (GP) with non acute Rapid Access Chest Pain will be seen within 14 days.

- 92% of incomplete patients will receive their first definitive treatment within 18 weeks (126 days) of their referral.

Cancer

The following are key performance standards for cancer. Patients referred in on a pathway subject to cancer performance standards are also subject to the 18 week RTT running in parallel. The cancer standard ends when the patient has a definitive treatment or when cancer has been excluded. For some patients requiring on-going treatment for a non-cancer cause – the RTT will continue beyond the point the cancer pathway is closed.

- 93% of patients with suspected cancer referrals (2 week waits 2WW)) to be seen with 14 days;

- 93% of patients referred by their GP to Breast Surgery (Breast Symptomatic Patients only) will be seen with 14 days.

- 96% of patients with confirmed diagnosis of cancer and agreed treatment plan will be treated within 31 days of their decision to treat.

- 94% of patients with a confirmed diagnosis of cancer who require second/subsequent surgical intervention will be treated within 31 Days.

- 98% of patients with a confirmed diagnosis of cancer who require second/subsequent drug therapy will be treated within 31 Days.

- 90% of patients referred from any of the 3 NHS Cancer Screening Programmes for suspected cancer will be treated within 62 days of their referral date.

- 85% of patients referred by their GP for suspected cancer, or having been upgraded to the cancer pathway following consultant decision, will be treated within 62 days of their referral date.

Tolerance within these standards is there to deal with valid exceptions such as patient choice, cancellations by hospital or patient and clinical exceptions. However, the overall objective of this policy is to treat all patients within with their rights under the NHS Constitution.

In addition to the level of performance required by NHS England, the Trust has a number of key principals that support the trusts strategic objective.

The following National Performance Standards also apply:

- No patient will wait longer than six weeks for a diagnostic test or image.

2.2 National Health Service (NHS) Constitution

This NHS Operating Framework sets out the planning, performance and financial requirements for NHS organisations. One of the key areas is maintaining a strong grip on service and financial performance, including ensuring that the NHS Constitution, right to treatment within 18 weeks is met. The NHS Constitution was first published on 21st January 2009 and details the legal rights of patients in regards to their care. The Constitution states that from the end of December 2008, patients will have the right to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible.

The Constitutional rights are to:

- Start Consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions.

- Maximum 2 weeks from a urgent GP referral for suspected cancer to first out-patient attendance.

Exceptions to this are:-

- Where the patient chooses to wait longer.

- Delaying the start of treatment is in the patient's best clinical interest. (This does not apply to cancer pathways where no adjustment can be made for this reason).

- It is clinically appropriate for the patient's condition to be monitored in secondary care without clinical intervention or diagnostic procedures at the particular stage.

- The patient fails to attend appointments, which had been chosen from a reasonable set of options.

- The treatment is no longer necessary.

The following services are not covered by the Constitution:

- Non-medical consultant-led mental health services.
- Maternity services.

3.0 Scope of Policy

This policy applies to all staff involved with elective service provision, including those outside centralised registration and booking. It applies to all patients waiting for treatment or being managed on a cancer pathway; and sets out the policy to be followed by all staff when dealing with elective access management for outpatient appointments, including suspected cancer, diagnostic, direct access, admissions, including day case and non-surgical elective interventions.

Patients are required to:

- Keep appointments once agreed or give reasonable notice if unable to.
- Whenever possible help manage their own health to ensure they are fit enough to receive treatment.
- When referred to the Trust be prepared to stay for preoperative assessment appointment following an out-patient appointment if surgery is required.
- Be prepared to negotiate a date for their appointment or treatment.
- Notify the Trust of any change in contact details.
- Notify the Trust of any planned leave of absence. There is an expectation that GP referrers also engage in the principles of this access policy by ensuring patients referred on a cancer 2 week wait pathway are available within the 14 day window and understand they are subject to cancer waiting times.
- Keep the appointments agreed with them or give the hospital reasonable notice of cancellation.

The Trust is required to:-

- Ensure staff have appropriate tools to deliver a professional service to ensure quality of care.
- Make patients aware of their responsibility in achieving Referral to Treatment Waiting Time (RTT).
- Promote patient rights and the consequences of missed appointments under the NHS Constitution on patient letters.

3.1 Patient Safety

Patients will be treated equitably and according to their personal and clinic need giving reasonable notice of their appointment or admission.

Manage a strict order of clinical urgency and waiting time priority. Patients waiting without clinical urgency will be prioritised according to their RTT clinical pathway.

Following contact with a young child/young person, if a professional sends a letter to another colleague, their letter must make it explicit what their expectation is. i.e. if the detail in the letter has been sent for information purposes, or action.

3.2 Financial Health

Patient flow to be optimised.

Efficiency to be maximised and resourced by ensuring patients flow through the RTT pathway with no delay.

Additionally the avoidance of penalties attached to the breaching of national performance targets for both RTT and cancer waits.

3.3 Patient Experience and Quality of Care

Patients will be allowed to negotiate their appointment date and time at their own convenience using the National E-Referral Service and work towards full booking throughout the patient journey.

Communication to patients will provide a clear point of contact within the Trust.

In the event of a cancellation by the Trust, the Trust will negotiate a new date with the patient as soon as possible, a second cancellation is not acceptable.

In order to make best use of limited resources it is essential that there is a mechanism to fast track patients back on to the waiting list who have already been assessed as requiring treatment and have recently been discharged in line with the policy, for example a routine patient who DNA's or a patient who has been temporarily unfit for treatment and has been discharged back to the care of their GP or General Dental Practitioner (GDP). This is not applicable to patients on a cancer pathway:

- Patients who have been on a cancer pathway where malignancy was excluded and the pathway closed, but then are re-referred on another cancer pathway will be subject to the appropriate clinical work up and management (whilst not replicating any unnecessary invasive tests).

- Patients on a cancer pathway who are deemed temporarily unfit to proceed to treatment will not be discharged to their GP; but the medical problem urgently addressed to allow the cancer pathway to progress within the original breach date.

As the Trust will be delivering care with no waits, assurance is given that patients are only referred for elective surgery when they are fit to undergo surgical intervention and they understand the RTT pathway and the shorter waits for surgery. This will manage expectations in terms of preparation for surgery, as well as reducing the number of patients entering the admitted pathway who are not medically fit.

Strict time controls are required to ensure that patients whose condition or circumstances may change significantly over time are still assessed in a Consultant out-patient setting if required.

To ensure consistency and the standardisation of reporting with commissioners, all waiting lists are to be maintained in the EPR system. Manual card based systems and diaries are not acceptable. It is vital for the monitoring of the RTT pathway that there should be no locally held waiting lists.
All appropriate patients are treated on the same day of admission. To accommodate this it is essential that all patients attend a pre-operative assessment, and if applicable, a consultant anaesthetist review.

Patient Correspondence
As soon as a mutually agreed date has been arranged with the patient a confirmation letter must be sent to the patient. This letter is an audit trail of the arrangements and should contain the following core details:

Patients Name

Date letter sent to patient

Date and time of admission/appointment agreed

Where to report to upon arrival

Response required from patient

Named contact for queries relating to admission/appointment

Reference to instructions for admission/appointment and/or booklet

Information about planned treatment

Copying Letters to Patients
According to the NHS Plan, 2000 (paragraph 10.3) and national Quality Surveillance indicators for cancer, clinicians are required to ask patients if they would like to receive copies of correspondence written about them to another professional relating to their medical problem. Frequently this correspondence is from a clinician back to the referring GP.

4.0 Policy - Key Principles of the 18 Week RTT and Cancer Pathways

The referral to treatment pathway includes all the stages that lead up to treatment, including outpatient consultations, diagnostic tests and procedures. The benefits for patients and the NHS are:-

- Patients will receive the most appropriate treatment with far shorter waits.
- Commissioners will be accountable for the performance of providers through their contracts.
- Providers will be managing an integrated patient pathway.
- Working collaboratively with other healthcare providers.

Referral to Treatment (RTT) is concerned with the patient's journey from referral to first definitive treatment rather than measuring the time spent waiting at different stages (formerly Korner) of the pathway. Cancer pathways may differ from this as do not always culminate in treatment; however they still require consistent 'access' related principles to be applied in order to promote timely care and achievement of key performance indicators for cancer.

Broadly speaking, the clock starts when a patient is referred into a consultant-led service (regardless of setting) in which it is expected that the patient will be assessed and, if appropriate, treated within the service before the responsibility is transferred back to the referring health professional.

The appointment centre must ensure all referrals are recorded within 24 hours of receipt of referral. The first outpatient appointment clock starts when:-

- E-Referral Unique Booking Reference Number (UBRN) is used to book an appointment.
- External tertiary referral date provided on the Inter Provider Transfer (IPT) form.
- Other referrals - the date received into the Trust should be used.
- GP 62 day cancer pathways start on receipt of a referral; or in the case of a 62 day Consultant Upgrade – the date the upgrade was made. Referrals in to cancer pathways are managed through the dedicated 2WW co-ordinator team. Involvement of the appointment centre is only triggered when the team are unable to contact patients within office hours and require the centre to call patients out of hours to attend short notice appointments.

Patients who were previously unfit for surgery or patients who were discharged less than 12 weeks previously will receive a new preoperative assessment appointment. All patients attending fast track preoperative assessment appointments will be processed in line with the Policy.

The 18 week referral to treatment pathway does not replace other waiting times, targets or standards where these are shorter than the median waiting times. This includes waiting times for patients with suspected cancer or waiting times for Rapid Access Clinics.

4.1 Summary of Key Elements of RTT

The following points summarise the key elements of the standard:

- All patients should be ready, willing and able to commit to treatment and managed according to their clinical urgency within the 18 week RTT waiting times.

- A non-admitted pathway refers to patients that do not require admission to hospital to receive their first definitive treatment, i.e. that treatment is given or prescribed in out-patients.

- An admitted pathway refers to patients who require admission to hospital as either a day case or an inpatient, to receive their first definitive treatment.

- An incomplete pathway refers to patients who have not yet received their definitive treatment, therefore their 18 week RTT pathway is still open, the patient may be in the non-admitted, diagnostic or admitted part of their pathway.

- Patients will be managed and measured on a non-admitted pathway until the point at which they require admission for treatment as either a day case or inpatient, at which point they are managed and measured within the admitted pathway.

- The 18 week RTT pathway begins on the date that a paper referral is received by the Trust, or when a Unique Booking Reference Number (UBRN) is converted from a E-Referral request to an appointment. The clock then continues to tick until either the first definitive treatment is given, or another event occurs which can stop the clock.

- An 18 week RTT pathway can also be started within another healthcare provider setting and then the patient can be transferred to the Trust, where the clock will continue to tick from the original referral start date.

- The 18 week RTT pathway can be started by a large number of referrers when they refer the patient into a Consultant led service. These include GP's and General Dental Practitioners (GDP's).

- Each 18 week RTT pathway must be measured and monitored separately and will have a unique pathway identifier in the patient administration system (PAS/EPR).

Every step along the 18 week RTT pathway (outpatient, diagnostic, pre-assessment, admission, discharge, decisions made) must be recorded in EPR using a set of RTT

status codes. These steps are referred to as clock starts clock stops. If every step is not captured and recorded correctly, the Trust will build up a database of patients with incorrect open pathways which will lead to difficulties in managing demand and capacity and recognising 'true' patients.

It is therefore imperative that clinic outcome forms are completed at the end of every clinic session to enable the patient pathway to be updated according to the decision made in clinic with the patient and the Clinician.

4.2 Exclusions from the RTT Pathway

The following activity is excluded from the 18 week RTT standard:

- Emergency admissions.
- Obstetric patients.
- Elective patients undergoing planned procedures (check cystoscopies etc).
- Patients receiving ongoing care for a condition whose first definitive treatment for that condition has already occurred.
- Referrals to non-consultant led services.

4.3 Management of Urgent Suspected Cancer Patients (2WW), National Cancer Waiting Times Monitoring Dataset Guidance Version 9.0 2015

The referrer should clarify at time of referral that patients referred as an urgent suspected cancer have been made aware of the urgency of the test and should make themselves available for an appointment within the next two weeks. For example a referral should not be made if a patient has indicated they are going on holiday and therefore would not be available to attend an appointment within two weeks. Otherwise it risks wasting an appointment from which another patient could benefit.

A GP should use their clinical judgement to determine what to tell a patient and when but it is good practice for a GP to ensure that a patient understands why they are being referred and for what reason where possible. NICE NG12 (2015) guidance suggests GPs should always advise patients referred via the 2WW that it is for suspected cancer; and ideally should be provided with a 2WW leaflet explaining the importance of attending their appointments.

In accordance to the National Cancer Waiting Times guidance, patients will not be referred back to their GP if unable to attend an appointment within 2 weeks (from receipt of referral in secondary care). These will be unavoidable 'patient choice' breaches. Operational standards have been set to take account of such breaches.

2WW referrals cannot be 'downgraded' by a secondary care clinician even if the referral is not deemed appropriate. Such referrals can only be downgraded by the referring clinician. Secondary care Consultants must discuss any concerns with the referrer who will then decide whether to agree to downgrade from a 2WW.

4.3.1 Scheduling of 2WW appointments

All patients should be offered at least 2 appointment opportunities within the 14 day window; and that these appointment offers are on different days. Organisational capacity issues which prevent the offer of 2 appointment opportunities within 14 days will be recorded as 'Out-patient capacity inadequate' rather than patient choice breaches. Patients should be given a reasonable notice period of being informed of their offered appointment date – ideally 3 days prior to day of appointment.

4.3.2 Patients who cancel appointments:

By cancelling an appointment a patient has shown a willingness to engage with the NHS. 2WW breaches incurred as a consequence of patient cancellations will be recorded as 'patient choice'.

Patients **will not** be referred back to their GP after a single cancellation.

Patients who cancel 2WW appointments on multiple (two or more) occasions and after discussion with the clinician **will be** referred back to their GP if the cancellations prevent achievement of the further appointment being within the 14 day window. Patients will be informed of this consequence at the point of first cancellation (in a scripted dialogue followed by the 2WW co-ordinator team).

It must be noted that multiple cancellations of 2WW appointments will also impact on the subsequent GP 62 referral to treatment pathway (for those patients not discharged at first 2WW appointment). Therefore the 2WW co-ordinator team will follow a scripted conversation to attempt to re-engage the patient in understanding the importance of attending their appointment.

4.3.3 DNAs (Did not attend)

All patients on a 2WW pathway will automatically be rebooked for a further appointment after failure to attend their first appointment (1st DNA – whether this first appointment is in an out-patient clinic or straight to test diagnostic clinic). This is managed by the 2WW co-ordinator team to ensure the timely re-booking of appointments adheres to standards. An adjustment can be applied in this instance and the clock re-set from the receipt of the referral to the date when the patient makes contact to rebook their appointment.

Following a second DNA of a 2WW appointment, the patient's referral will be reviewed by a member of the clinical team to determine whether there is any 'higher risk indication' that a third appointment must be offered at that point e.g. referral is following a CT scan which clearly indicates a malignant process. However it is expected that in the majority of cases patients will be discharged back to their GP after the second DNA. A letter should be dictated by the clinical team to the GP and copied to the patient informing them that no further appointments will be made at that time.

4.3.4 Cancer Referrals – Follow up (subsequent) Appointment

If a patient referred under the cancer two-week wait standard does not attend a follow up outpatient appointment then they should be contacted and given another appointment as soon as possible. If they DNA this second appointment then they should be referred back to their GP and no further appointments offered unless advised by the GP. If the referral is from another acute provider then the referring clinician will also be informed at the point the patient is referred/discharged back to the GP.

This policy applies to children unless there is concern raised as part of the 'Safeguarding Children Policy' one more appointment may be given, however the clock continues from the date of referral, you may not start a new 18 week clock.

4.4 Reasonable Notice and Booking

Prior to referral, patients should be made familiar with their obligations to the RTT pathway and that recurrent cancellations of their appointments could delay their treatment. Further guidance can be found within the NHS Constitution

The aim of the Trust will always be to offer a date appropriate for a patient's clinical priority and convenience.

Reasonable notice is the offer of two appointments with at least three weeks' notice. A patient may accept a date with less than three weeks' notice but you cannot apply clock pauses in these instances.

Patients have the right as part of the NHS Constitution to make choice about their NHS care and to have information to support these choices. The patient has the right to choose the organisation that provides their NHS care.

4.5 Patients not on an RTT Pathway

Once a patient has received their first definitive treatment which stops their 18 week RTT clock, they may continue to receive ongoing care for the condition that they were referred to the Trust for. Once the 18 week RTT clock has stopped and the pathway ended any treatment received that was discussed with the patient and is in the original plan of care, is not part of an 18 week pathway. This ongoing treatment is classed as 'not applicable to 18 weeks'.

However when a patient has previously received their first definitive treatment and a substantially different or new treatment is required for the patient, then this will start a new 18 week RTT period. For example a patient has tried physiotherapy to treat their condition, but now requires surgery.

If a patient, not on an RTT pathway DNAs or cancels an appointment or admission, the same rules apply as those that are. These should be recorded on EPR using status codes that reflect this.

4.6 Access to Health Services for Military Veterans

A Veteran is someone who has served in the armed forces for at least one day. When servicemen and women leave the armed forces, their healthcare is the responsibility of the NHS. All veterans are entitled to priority access to NHS hospital care for any condition as long as it is related to their service, regardless of whether or not they receive a war pension. GP's should notify the Trust of the patient's condition and its relation to military service when they refer the patient so that the Trust can ensure that it meets the current guidance for priority service over other patients with the same level of clinical need. In line with clinical policy patients with more urgent clinical needs will continue to receive priority.

4.7 Prisoners

All elements of the Access policy are relevant to the population of Her Majesty Prisons (HMP) and HMP & Young offenders Institutes, however all hospital appointments will need to be managed within the prison regime and the Trust Standard Operating Procedures.

5.0 Referral Routes

The most common referral routes are outlined here but it should be considered that referrals may come from other sources.

An RTT Pathway clock will start when a referral is received into a Consultant led service for diagnosis and treatment of a patient's condition, by receipt of paper referral or conversion of UBRN. It is of the utmost importance that there is no delay in the processing of the referral once it has been received in the Trust.

Referrals can be made to the following services:

- Medical or surgical consultant-led services - irrespective of setting.

- Cancer services, for which a 62 day cancer target clock also starts. When a patient is seen in clinic and a diagnosis of cancer is confirmed and their treatment plan discussed (decision to treat). The GP must be notified within 24 hours of diagnosis.

- Diagnostic services provided to the patient will be assessed and, if appropriate, treated by a medical or surgical consultant-led service before responsibility is transferred back to the referring health professional.

- Practitioners with special interests if they are part of a referral management arrangement is defined.

- Where a patient has been seen privately and then is referred by the GP to a NHS Trust after being offered choice.

Referrals to the following services will not start the clock:

- Therapy, healthcare science or mental health services that are not medical or surgical consultant-led, including multi-disciplinary teams and community teams, irrespective of setting.

- Diagnostic services if the referral is a straight-to-test arrangement.

- Primary dental services provided by dental students in hospital settings.

5.1 E-Referral Service

E-Referral is the Trust's preferred referral route for all General Practitioner outpatient referrals.

The Trust is committed to publishing all relevant services on E-Referral. It is the responsibility of the Clinical Leads/Service Managers to ensure that their Directory of Service (DoS) is accurate and kept up-to-date, reflecting any changes in referral criteria, service provision, personnel or instructions for the patient.

- The specialty/clinic types/clinical terms will be maintained as these keywords drive the referral process. Poor quality keywords can lead to an increase in inappropriate referrals or a reduction in referrals to a service.

- The referral criteria (and any exclusion) will be clearly identified, to enable GPs to select the relevant service for their patient and include sufficient information with their referral letter.

- The alert feature will be used to highlight key messages relating to the service and we expect referrers to review this prior to making a referral.

- The instructions section will be used to highlight key messages for the patient and we would expect referrers to ensure that patients see this.

With the exception of 2WW Referrals, clinicians are required to triage all referrals within 3 working days. 2WW Referrals are processed by coordinators in cancer services.

E-Referral encourages referral into specialty areas and clinic types, not to named clinicians, and the Trust works with local GPs and Clinical Commissioning Groups (CCGs) to ensure that services are easily accessible and protocols for referrals into specific specialties are clearly communicated. However, E-Referral can accept named referrals, but these should only be made where that is clinically necessary and clear reasons are provided within the referral letter.

For patients whose first appointment is made via E-Referral, the referral letter will be graded upon receipt by the clinician and either have the priority upgraded or be accepted or rejected. (This does not apply to 2WW e-referrals). If a referral has been upgraded or accepted, a confirmation letter will be sent to the patient. If a clinician deems a referral to be inappropriate, this should be rejected via E-Referral with an explanation for the referrer, who should then update the patient.

Referrers should attach the referral letter to the E-Referral appointment according to these nationally recommended timeframes (72 hours for routine appointments, 24 hours for urgent letters and the same day for 2 week waits), so that our clinicians

have time to review the referral and ensure the patient is going to be seen in the most appropriate clinic/timeframe.

Health Records/CBU teams where non-centralised will contact referrers when the letter has not been attached within this timeframe. In the exceptional circumstances of the referral not being obtained before the clinic, then the patient may be contacted, the original appointment cancelled and a further appointment made within target timescales.

5.2 Non- E-Referrals

For paper referrals, the referral letter will be graded upon receipt by the clinician, an appropriate appointment will be made in the EPR System and a confirmation letter will be sent to the patient. If a clinician deems the referral to be inappropriate, a letter will be sent to the referrer and the patient. Clinicians are required to triage all referrals within 3 working days. This does not apply to faxed paper 2WW referrals.

In circumstances where no appointments are available on the E-Referral Service, the Trust will be notified of 'appointment slot issues' (ASIs) through a E-Referral worklist. This worklist is managed daily and patients will either be given an appointment within E-Referral or if no suitable appointments can be found within 5 days, they will be removed and booked manually.

All tertiary referrals will be made as continuation of care. Where a hospital clinician identifies a separate condition, the GP or GDP should be notified to ensure patient choice could be offered.
There are also patients for whom there is genuine clinical uncertainty about the diagnosis and the clinician (in agreement with the patient) elects to observe the patient over a specified period.

All referrals must be held and managed by the Patient Administration System (Lorenzo EPR) or other trust approved system.

5.3 Consultant to Consultant (Internal) Referrals

Consultant to Consultant referrals are acceptable if the referral is with regards to the condition that the patient was originally referred to the Trust for. If a condition can be managed in primary care then the patient should be referred back to their GP practice. Consultant to consultant referrals must not be made by junior medical staff without the approval of a Consultant.

Consultant to consultant referrals should only be made for:

- Patients requiring urgent attention (including rapid access chest pain clinic and two week waits)
- Patients where a cancer diagnosis is suspicious or confirmed
- Patients requiring further review of their fitness for surgery for the condition they were originally referred for on a recognised treatment pathway, i.e. Joint replacement
- For palliative care
- For children under 16, for conditions that cannot be managed appropriately in primary care

- For pregnant women requiring review by other Specialities as a result of their pregnancy
- For investigation and/or management of the symptom or condition for which the patient was referred, e.g. patient referred to Urologist with pelvic pain and the Urologist thinks that the pain is gynaecological

Consultant to consultant referrals should not be used for:

- Opinions on/treatment of incidental findings for routine cases
- Opinions on/treatment of conditions unrelated to the condition they were referred for unless compliant with protocol section 1.
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- Where a referral would be in breach of any Prior Approval referral process, policy or protocol.

Communication with GPs

- Details of and any indication for any Consultant to Consultant referrals made must be clearly set out in the clinic letter to the GP relating to the patients initial appointment or subsequent clinic attendance.
- Details of any proposed onward referral resulting from inpatient attendance must be clearly set out in the discharge letter (D1) to the GP

Communication with Colleagues

- When initiating a Consultant to Consultant referral clearly indicate on the referral / GP letter from the clinic outcome how the patient meets the above criteria for Consultant to Consultant.
- Note: These referrals should contain the same level of information as referrals from Primary care.

Communication with Patients

- Patients not requiring consultant to consultant referral should be advised to make an appointment with their GP to discuss any new presenting conditions, for the GP to manage. Part of this management may be that a referral to secondary care is necessary but this expectation should not be set by secondary care.
- Patients who are actioned as a Consultant to Consultant referral should be advised that the referral to a colleague is for advice and may lead to an appointment with the Speciality.

If the onward referral to a Consultant led service is for a different/separate condition, the patient must be referred back to their GP in order for the patient to be offered choice. Unless any of the following circumstances apply:-

- For investigation, management or treatment of cancer, or a suspected cancer.
- A life threatening or urgent condition.
- For patients with pre-existing complex medical problems for specialist assessment in relation to anaesthetic risk.

Please see Appendix 2 for worked examples.

For Ophthalmology patients only:
Diabetic Retinopathy Screening (DRS) - patients whose screening results show non DRS pathology to be referred direct to an ophthalmology consultant.

Patient is being treated for a chronic eye condition e.g. Glaucoma, ARMD and then develops other eye conditions, not related to their original referrals, to be referred to the appropriate ophthalmology consultant for treatment.

5.4 Inter-Provider Transfers (IPT)
If a patient is referred from one provider to another as part of their RTT period, their original 18 week RTT clock should keep ticking until first definitive treatment. The originating provider should ensure that the patient's initial RTT start date forms part of the onward referral information, this information is known as minimum data set (MDS) and should form part of the Inter Provider Transfer (IPT) form.
IPTs related to cancer pathways are subject to the original pathway deadline calculated from the pathway start date (referral receipt date).

5.5 Written Advice from Consultant
If a Consultant feels that a referral can be managed more effectively on an alternative treatment pathway within primary care, advice will be given to the GP and the patients 18 week RTT clock will stop, the RTT pathway ended and the patient will be returned to primary care.

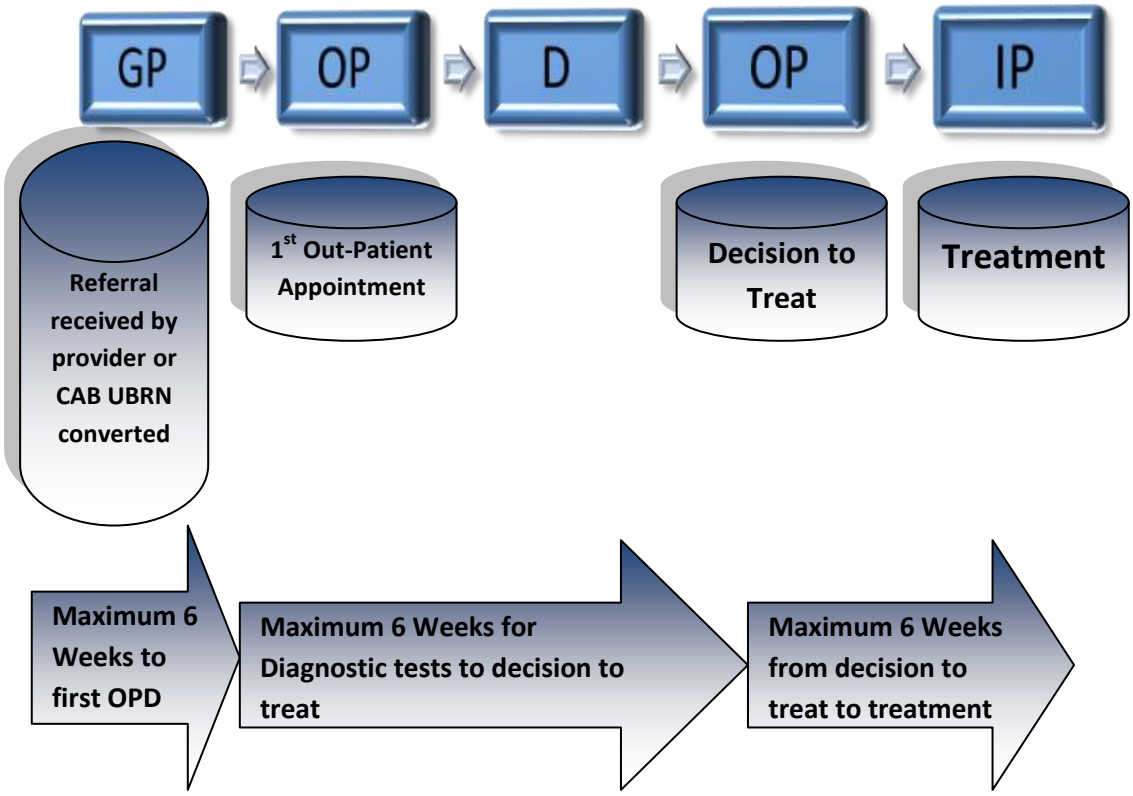
Any written documentation from GP‘s for advice only should be clearly marked in the letter that”this is not a referral”. This type of referral is not applicable to 18 week RTT; therefore a clock will not start.

5.6 Referral Audit Trail
In order to establish that the Policy is appropriately carried out and reflects current standards, an audit of the processes will be undertaken on a quarterly basis. This process will be led by the Data Quality Lead and compliance will be assessed against national standards.

In order to keep EPR accurate and up to date, it is the responsibility of all staff to make sure all activity is recorded accurately. EPR and the data therein must be constantly amended or updated accordingly and reviewed regularly.

6.0 Out-Patients

6.1 General Principles
This is the ‘ideal patient pathway’; most Trusts aim for and achieve shorter pathways. If the patient can be seen in outpatients within six weeks from receipt of referral, requires a diagnostic test, and then requires surgery – this denotes the ideal waits.



Each pathway must be dealt with according to the complexities and clinical decisions for the Patient:-

- Suspected cancer new appointments will be booked within 2 weeks of their referral date. In order to promote the achievement of key pathway milestones (and specifically to diagnose or exclude cancer by Day 28) the Trust will implement a 'soft' target of Day 7 for first 2WW OPA from receipt of referral.

- Waiting Lists and admission schedules will be managed according to clinical priority and then in 18 week RTT chronological order.

- Patients are kept fully informed and have a single point of contact at the Trust.

- Referrals should be accepted or rejected as appropriate by triage within 72 hours of receipt in the Trust (this is not applicable to cancer).

- There must be a new referral for a patient with an existing condition if the request for further consultation is three months after the discharge of the original referral.

- When contacting patients to arrange an appointment three attempts to contact the patient by telephone must be made. If the patient cannot be contacted by telephone then a letter must be sent to the patient advising them to contact the Appointment Booking Centre within seven days to arrange their appointment or

they will be removed from the waiting list. Should the patient fail to contact the Appointment Booking Centre their 18 week RTT clock will be stopped, the RTT pathway ended and the patient returned to primary care.

- The patient will be sent a confirmation letter regarding their booked appointment. The letter must be clear and informative and should include a point of contact and telephone number to call if they have any queries. The letter should explain clearly the consequences, should the patient cancel the appointment or fail to attend the clinic at the designated time.

6.2 Appointment Letter
All appointment letters should follow the Trust set format.

6.3 Reminder Service
The Trust operates a texting reminder service for patients. Patients have the option to request exclusions from this service.

6.4 Outcomes
All outcomes regardless of setting require a national pathway outcome to ensure the patient journey is managed within the RTT waiting time target where applicable.
All outcomes will be recorded on EPR within 24 hours.

7.0 Diagnostic Tests
Many patients require diagnostics to determine the appropriate diagnosis and therefore subsequent treatment required to treat the patient. Diagnostic tests can be in many forms, including blood tests, endoscopy or an x-ray etc. Diagnostic tests must be performed within six weeks of request for the test, to ensure delivery of the national standard. In many instances they will also form part of the patients 18 week RTT pathway.

Patients must be advised by the referrer that their entire diagnostic investigation pathway will be carried out within six weeks.

CT and some MRI investigations require the use of contrast agents; in such cases a recent creatinine result is required before referral (within the last 12 weeks or last 4 weeks if on metformin). Where required, this information is sought during the electronic requesting process via ICE. Requests without this information will be returned to requestor.

Urgent diagnostics will be assessed by the clinician and acted upon accordingly.
In accordance to cancer pathway milestones and the national strategy for cancer (Achieving world class cancer outcomes 2015) recommendation to exclude or diagnose cancer by Day 28; all diagnostic procedures for cancer must be scheduled and completed without delay to allow this target to be achieved. Escalation processes instigated by the cancer services team are in accordance to this pathway milestone.

7.1 Patients who cancel or fail to attend for diagnostic tests - Cancer Patients

Cancer patients who cancel or DNA a diagnostic appointment should be immediately offered a second appointment at the earliest possible date available. . If they cancel or DNA this appointment the referring lead consultant / site specific MDT coordinator must be notified (in < 48 hours) to allow efficient decisions to be made re on-going management. Unless clinically indicated due to high risk of cancer – multiple DNAs (two or more) should result in the patient being referred back to their GP.

7.2 Straight to Test Diagnostics

Where a GP/AHP requests an approved diagnostic test to determine whether onward referral to secondary care or management in primary care is appropriate, then the patient is not on an 18 week RTT pathway and the RTT clock does not start.

The patient must have the diagnostic procedure within six weeks of referral. If the patient is subsequently referred to secondary care, then an RTT pathway will commence on the date the referral is received.

In accordance to NICE guidance ('Suspected cancer: Recognition and referral NG12 June 2015) some patients fulfilling symptomatic criteria which dictates straight to test management, will have the test within 2 weeks of referral. It remains the responsibility of the GP to then refer the patient via the appropriate 2WW pathway if the 'straight to test' diagnostic raises suspicion of cancer.

Where a GP refers a patient for a diagnostic prior to an out-patient appointment with a consultant as part of an agreed pathway, then the patient is on an 18 week RTT pathway and the clock starts on receipt of the referral. A patient must wait no longer than six weeks for their diagnostic procedure.

8.0 Clinical Commissioning Group (CCG) specific procedure management

8.1 Procedures of low clinical effectiveness

Commissioners must provide the Trust with a list of procedures of low clinical effectiveness. Any referrals to the Trust for such procedures must be accompanied by proof of prior approval before the referral is accepted within the Trust. (Please see appendices for a list of these procedures)

8.2 Individual Funding Requests

An Individual Funding Request is normally regarded as being appropriate for a treatment, intervention or drug not routinely commissioned by Barnsley CCG. These requests, for exceptional funding, are considered by the Individual Funding Request (IFR) Panel. The Panel meets on a weekly basis to decide upon funding requests for medical and general health interventions that sit outside that which is routinely commissioned.

The IFR Panel business centres around requests which are either where:

- There is a commissioning standard operating procedure not to fund a health care intervention for the specified indication but a referring clinician considers their patient to be exceptional to that standard Policy, those requests will be considered for funding by the IFR Panel. In addition the IFR Panel will consider a request where the clinical circumstances are so unique that it is unlikely that other patients will require this intervention.

- There is no standard operating procedure in place for the requested health care intervention or indication and the clinical circumstance is so rare that it is unlikely that other patients will routinely require this intervention. Usually these requests are for a new intervention which has become available and which has not previously been considered. The IFR Panel will identify whether this request is likely to apply to a population of patients. The overall aim is to reduce the number of requests to the IFR Panel and to concentrate on developing policies for new and existing interventions and treatments.

NHS Barnsley CCG have a statutory duty to maximise the health of the local population by ensuring the provision of accessible, quality health care services within available resources. However, demand for services for patients may exceed the capacity and resources available. There is, therefore, a constant need to prioritise spending on clinical and cost effective interventions and with due consideration to equity of access. The IFR Panel therefore applies a fundamental set of principles to all such decision making and these are reflected in the work of the IFR department as outlined below:

- The IFR department must ensure that all processes potentially involving patient identifiable information are managed confidentially and comply with data protection standards.

- The IFR Panel must ensure that the intervention requested is likely to be provided where the patient may gain easy access, will be affordable, and have sound evidence of clinical and cost effectiveness.

- The IFR Panel should promote the use of more effective services over less effective (giving due consideration to equity and accessibility) and utilise existing proven pathways of care over new or experimental technologies.

- The IFR Panel will seek to identify interventions producing the greatest health outcomes, and will consider all national and local guidance and local funding priorities.

The IFR Panel is committed to ensuring that decision making is transparent, fair, equitable and open to scrutiny. Application of this standard Policy in practice should ensure that the IFR process stands up to external scrutiny. The standard Policy is available on the Barnsley CCG website.

http://www.barnsleyccg.nhs.uk/CCG%20Downloads/CCG%20Documents/Policies/Approved/IFR%20Policy.pdf

8.3 Clinical Thresholds

The aim of the programme of work, is to reduce variation in existing practice and ensure consistent referral guidance across the Borough and subsequently across the region, in line with neighbouring CCG's.

As a result of evidence provided by national clinical thresholds and procedures of limited clinical value, the CCG will review the best treatment options for the health of the local population in line with the published National Institute of Clinical Excellence (NICE) guidance for a number of conditions (see Appendix 1). Accordingly, the CCG has implemented these thresholds across a range of procedures.

Process for referral

Where a clinical threshold applies, GPs/optometrists/MSK service are required to complete and sign the referral checklist, attaching the document with the referral. Referrals without a completed and signed checklist will be returned to the GP. A referral will only be accepted if the patient meets the clinical threshold. Barnsley Hospital NHS Foundation Trust (BHNFT) will flag all referrals for which clinical thresholds are applicable for vetting by the consultant prior to the appointment being made. The secondary care element of the referral checklist will be completed (where this applies to a condition or procedure) and signed by the Consultant to evidence that the patient meets the criteria. The document will be included within the patient notes.

In some circumstances, GPs, Consultants or NHS clinicians may think that individuals have exceptional clinical circumstances and may benefit from a treatment which is not routinely provided. Requests for such treatments must be made through an Individual Funding Request (IFR) by the clinician. This request will then be considered and approved or rejected by an independent panel

9.0 Treatment/Elective Admission

9.1 Elective Admission (Inpatient/Day case)

All patients should be treated within the national standards. Waiting lists will be managed according to clinical priority, Military Veterans and then in 18 week RTT in chronological order.

The responsibility for the production of waiting lists lies with the Operational Support Manager who should liaise with Consultants. The Operational Support Manager and Service Manager must ensure that there are systems in place for lists to be managed effectively. Waiting List booking will be managed within the Centralised Waiting List Office (CWLO).

The decision to add a patient to an elective admitted pathway must be made by a consultant, or under an arrangement agreed with the consultant. Patients who are added to a waiting list must be 'fit, willing and able' for surgery at pre-assessment. Urgent patients will be treated as a priority. Routine patients will be treated in chronology based on their length of time on the RTT pathway.

When contacting patients to arrange their "to come in date" (TCI), three attempts to contact the patient by telephone must be made. If the patient cannot be contacted by telephone then a letter must be sent to the patient advising them to contact the CWLO within seven working days to arrange their TCI date or they will be removed from the waiting list. Should the patient fail to contact the CWLO their 18 week RTT clock will be stopped, the RTT pathway ended and the patient returned to primary care.

Patients will be offered a date for surgery with a reasonable minimum notice period (2 weeks), if the patient is unable to attend the date offered, they will be offered another date with a reasonable minimum notice period (2 weeks). Patients who are unable or unwilling to accept the second offer to come in for treatment will be referred back to their GP or GDPs care.

9.2 Contents of the To Come In (TCI) Letter

All appointment letters should follow the Trust set format.

9.3 Pre-operative Assessment

All out-patients referred for invasive procedures will be offered to attend or book a pre-operative assessment appointment following their consultation. Patients should be pre-operatively assessed within one week after the decision to admit is made to ensure the patient is fit for procedure.

Patients on a cancer pathway should be sent immediately from the clinical environment to pre-assessment once a decision to admit has been made. The pre-assessment form should be clearly marked with a cancer stamp to identify to the pre-assessment team that they are on a cancer pathway. Such patients will be pre-assessed on the day.

Communication to the GP within 48 hours and will clearly outline:

- The reasons why the patient is not fit for surgery.
- Specify what needs to be done, who by and the timescales.
- Trust contact details to assist the GP with the referral back to the appropriate pre-operative assessment service as soon as the patient becomes fit for surgery.
- Cancer Pathways – patients on cancer pathways who are not deemed fit to proceed with surgery must have their relevant co-morbidity or newly identified problem managed urgently to allow the timeframe of the cancer pathway to be achieved. There is no adjustment of cancer pathways allowed for medically unfit patients. As soon as the patient is deemed unfit to proceed, the pre-

assessment team should notify the relevant referring cancer clinician and site specific MDT co-ordinator (within 24 hours).

If the patient becomes fit for surgery within three months:

- The GP will provide the Trust with a written update on their patient's clinical condition prior to them being booked back into the pre-operative assessment clinic. If at pre-operative assessment the patient is deemed fit for surgery, the clock will continue at the same point where the patient was deemed unfit.

- Pre-operative assessment clinic staff will keep a record of those patients who have the option to return within 3 months.

If a patient is colonised with Methicillin-resistant Staphylococcus aureus (MRSA) you may not pause the 18 week RTT clock, the patient must remain on an 18 week pathway.

Blood updates will be required if surgery is greater than 12 weeks following pre-operative assessment (unless Group and Save is required which will need to be repeated at 6 weeks); the preoperative assessment nurse will determine the need.

9.4 Anaesthetic Review

If during the Pre-operative assessment an anaesthetist is requested to assess the patient, the patient will be booked into an anaesthetist led pre-operative assessment clinic within one week of the pre-operative assessment date.

9.5 Unfit for Surgery

Patients who are not clinically fit for treatment following their pre-assessment, should be discharged back to their GP (unless on a cancer pathway) dependent on the reason for being unfit. If the reason is short-term, e.g. cough or common cold then the patient will be added to waiting list. When the patient is deemed clinically fit by their GP and within 3 months of discharge, the GP can contact the hospital, and following a pre-operative assessment, the patient will be re-added to the waiting list at the point they were removed.

If the patient becomes clinically fit after 3 months of discharge and still requires assessment/treatment then the patient should be re-referred by their GP for a new clinical assessment.

9.6 Planned Admission

Definition:-

Patients should only be added to a planned list where clinically they need to wait for a period of time. This includes planned diagnostic tests or treatments, or a series of procedures carried out as part of a treatment plan – which are required for clinical reasons to be carried out at a specific time or repeated at a specific frequency, or form part of a planned sequence of clinical care determined on clinical criteria (e.g series of injections, removal of metalwork). Patients on planned lists should be booked in for an appointment at the clinically appropriate time and they should not have to wait a further period after this time has elapsed. For example, a patient due

to have a retest in six months' time should be booked in around six months later and they should not get to six months, then have to wait again for non-clinical reasons. This is not an acceptable use of a planned list.

Planned admissions are excluded from the RTT waiting time targets. However if a patient reaches the date that the planned procedure was due and is still waiting, an 18 week RTT clock should start from the date that the procedure was due. There should be no patients on a planned waiting list for social reasons – RTT rules should be applied to these patients.

Planned lists should be continuously reviewed to ensure timeliness.

9.7 Bilateral Procedures

If a decision to treat involves bilateral procedures e.g. both cataracts, both knees, as part of a single pathway of care, the patient should be listed on the waiting list for the initial procedure (first side) with a comment noting that a second 'bilateral' procedure is to take place when the patient has recovered from the first.

After surgery for the first procedure the 18 week RTT clock stops and the RTT pathway closed. When the patient has recovered from the first procedure they should then be placed on the waiting list with a new RTT period and clock start for the second procedure.

9.8 Flight Restrictions

There is no clinical evidence to substantiate flight restrictions for surgical patients. If during consultation a clinical decision is made that a patient must not have surgery before or after a long haul flight, any periods of time must be taken into account within the patient's 18 week RTT pathway. An 18 week RTT clock may not be paused for this reason, therefore when planning surgery for such patients this must be taken into account to prevent the patient from breaching the standard.

10.0 Cancellations and DNAs

10.1 DNA (did not attend)

Excluding cancer patients and considering the Safeguarding Policy, if a patient DNA's a first activity following referral (the very first outpatient appointment or first diagnostic appointment) the patients referral will be reviewed by the clinician who will decide whether it is clinically appropriate that the patient is offered another appointment. In the event that another appointment is not offered, the clock will be nullified (as if the referral never existed), the 18 week RTT pathway ended and the patient returned to primary care.

For patients referred on the cancer 2WW referral pathways who DNA two appointments, the patients 18 week RTT clock will be stopped and the RTT pathway ended. For additional information regarding the management of 2WW DNA and cancellations please see section 4.3

In all instances if a patient is then re-referred back to the Trust, this will be a new referral which starts a new 18 week RTT pathway and clock.

In all instances the Trust must be able to prove that:

- The appointment was clearly communicated
- Discharging the patient is not contrary to their best clinical interest.

New Out-Patient Appointment
2WW patients who DNA their scheduled appointment will be assessed by the clinical team during the clinic session where possible or within 24 hours and offered another appointment before being referred back to their GP or GDP.

Patients who DNA their scheduled appointment will be discharged back to their referring GP/GDP unless the clinical team, after assessment of the referral feel it is inappropriate to do so and the patient will be offered another appointment. The clinical team will communicate its instructions for action within one working day.

If the action is to discharge, the patient will be informed in writing with a copy sent to their GP or GDP.

Follow-up Out-Patient Appointment
Follow up patients who DNA their scheduled appointment twice will discharged back to their referring GP/GDP, unless the clinician feels it is inappropriate to do so. The clinical team will communicate instructions for action within one working day.

The patient will be informed in writing with a copy sent to their GP or GDP.

Diagnostic Assessment
Patients, who are unable to take up an appointment or cancel twice, will be removed from the Diagnostic booking system, and the request returned to the requestor.

Patients who DNA their diagnostic assessment, will be discharged back to their referring GP/GDP unless the clinical team, after assessment of the referral, feel it is inappropriate to do so and the patient will be offered one more appointment. The clinical team will communicate instructions for action within one working day. If a subsequent DNA occurs, the patient will be discharged back to the care of their GP or GDP after clinical review.

If the action is to discharge, the patient will be informed in writing with a copy sent to their GP or GDP.

Pre-Operative Assessment
Unless there is a clinically urgent need for surgery, patients who DNA 2 pre-operative assessments and/or anaesthetic appointments will be clinically assessed prior to being removed from the waiting list. The patient will then be reviewed by the

referring consultant and either given a follow up out-patient appointment or discharged back to their GP.

Elective Admission
Where a patient has agreed an admission date with reasonable notice (2 Weeks) and this has been clearly communicated to them and then subsequently does not attend (DNA) the patient will be discharged back to the care of their GP/GDP, unless the clinical team, after assessment of the referral, feel it is inappropriate to do so and the patient will be offered one more appointment.

If a subsequent DNA occurs, the patient will be reviewed once again by the clinical team and discharged back to the care of their GP or GDP or given an alternative care plan e.g. outpatient appointment. The patient will be informed in writing with a copy sent to their GP or GDP.

If the action is to remove the patient from the waiting list and discharged, the patient will be informed in writing with a copy sent to their GP or GDP.

10.2 Patient Cancellations
Cancellation of Appointments or TCI date
If a patient cancels their first appointment or TCI date anywhere in an RTT pathway, another appointment or TCI date must be re-arranged at that contact, within two weeks of the original appointment or TCI date. If an appointment is not available within two weeks, this must be escalated.

If the next reasonable offer of appointment or TCI date cannot be accepted by the patient, then they will be returned to primary care and the 18 week RTT pathway will stop and the pathway ended.
If the patient cancels an appointment or TCI date for a second time, the patient will be returned to primary care, the 18 week RTT clock will stop and the pathway ended. If the patient is subsequently re-referred to the Trust, this will be a new referral and will start a new 18 week RTT pathway.

If a patient cancels their appointment via E-Referral and does not rebook, following the receipt of the reminder letter, it will be assumed that the referral is not required and the UBRN will be cancelled and the patient referred back to primary care.

If a patient wishes to cancel their TCI date due to a period of illness, which is expected to last longer than two weeks, the patient should be advised that they will be removed from the waiting list. The 18 week RTT clock must be stopped and the pathway ended. BHNFT will write to the GP explaining that if the patient is fit, willing and able within 12 weeks they should contact BHNFT to place the patient back on the waiting list.

If a patient cancels their appointment and does not require further appointments, the 18 week RTT clock will be stopped, the RTT pathway ended and the patient referred back to primary care.

Patients, who contact the Trust on the day of their appointment, will be advised that the consultant will review the patient's case notes and make a decision regarding further management. A letter will be sent to the patient and the GP informing them of the decision.

For 2WW referrals:

- Patients should not be referred back to their GP after a single appointment cancellation.

- Patients should not be referred back to their GP after multiple (two or more) appointment cancellations unless this has been agreed with the patient – by cancelling an appointment a patient has shown a willingness to engage with the NHS.

New Out-Patient Appointment

Patients who cancel their appointment with prior notice, where possible, will be given an alternative date at the time of cancellation where possible. If a patient cancels more than once they will be discharged back to their referring GP/GDP if appropriate to do so after their referral has been clinically reviewed. The clinical team will communicate its instructions (rebook or discharge) for action within one working day.

Patients who cancel their appointment on the date of the appointment will be passed to the clinical team for review. The clinical team will communicate its instructions (rebook or discharge) for action within 1 working day.

If the action is to discharge, the patient will be informed in writing with a copy sent to their GP or GDP.

Urgent 2 week wait patients must be contacted before they are referred back to their GP.

Where a patient cancels their E-Referral appointment and does not rebook within 2 weeks the UBRN will be cancelled. The patient will be sent a reminder letter from the e-referral service and the patient will remain on the GP worklist for on-going management.

Follow-Up Out-Patient Appointment

Patients who cancel their appointment with prior notice, where possible, will be given an alternative date at the time of cancellation. If a patient cancels more than once the detail of the cancellation will be passed to the clinical team for review. The clinical team will communicate its instructions (rebook or discharge) for action within one working day.

Patients who cancel their appointment on the date of the appointment will be passed to the clinical team for review. The clinical team will communicate its instructions (rebook or discharge) for action within one working day.

If the action is to discharge, the patient will be informed in writing with a copy sent to their GP or GDP.

Diagnostic Assessment
Patients who cancel their diagnostic assessment with reasonable prior notice, will be given an alternative date at the time of cancellation, where possible. If a patient cancels more than once the diagnostic team may choose to exercise discretion, but their normal course of action will be to return the request to the referrer.

Pre-Operative Assessment
Patients who cancel their pre-operative assessment will be offered another date as soon as possible, if the patient is unable to attend the date offered they will be offered another date with a reasonable notice period of 2 weeks. Patients who cannot attend within this time period will be informed that they will not be added to a waiting list and their referral will be reviewed by the referring consultant.

Patients who cancel their pre-operative assessment on the date of the appointment will be passed to the clinical team for review. The clinical team will communicate its instructions (rebook or discharge) for action within 1 working day.

If the action is to discharge, the patient will be informed in writing with a copy sent to their GP or GDP.

Elective Admission
Patients who cancel their admission date will be offered another date as soon as possible, if the patient is unable to attend the date offered they will be offered another date with a reasonable notice period of 2 weeks. Patients who cannot attend within this time period will be informed that they will be removed from the waiting list and their referral will be reviewed by the referring consultant.

Patients who cancel their admission on the date of the appointment will be passed to the clinical team for review. The clinical team will communicate its instructions (rebook or discharge) for action within 1 working day.

If the action is to discharge, the patient will be informed in writing with a copy sent to their GP or GDP.

10.3 Hospital Cancellations
If the Trust cancels an appointment or TCI date anywhere on an RTT pathway, the clock continues to tick.

For an Outpatient or Diagnostic appointment, the patient should be re-dated within two weeks.

For reportable theatre cancellations on the day the patient must be re-dated within 28 days or whichever performance standard date is first (RTT or 28 day standards). Ideally the patient should leave hospital with their new TCI date. However, the patient must be offered a new TCI date within 5 working days of their reportable cancellation.

Out-Patient Appointments
Cancellation or reduction of scheduled clinic sessions will not take place at under 6 weeks' notice other than in exceptional circumstances to minimise disruption to patients. The Medical Leave Policy will be followed to ensure this is facilitated. Cancellations more than 6 weeks' notice will be carried out with the patient booked into the next available slot.

Clinics should not coincide with other known commitments. The only acceptable reason for a clinic to be cancelled within six weeks is unplanned absence of medical staff e.g. sickness. However it is expected that all efforts will have been made to replace the clinician before this action is taken. Clinics will not be cancelled for any other purpose unless exceptional circumstances arise

All clinics should be monitored closely and a complete and comprehensive analysis of clinic cancellations should be made available for performance monitoring at Trust Board and with local partners and should include:

- Clinics cancelled with less than six weeks' notice and number of patients affected in each clinic.
- Clinics added at short notice.
- Clinics cancelled with no patients.
- Number of patients with more than one hospital cancelled appointment.

Elective Admission
The Trust should work towards not cancelling any admissions, however in exceptional circumstances this may occur

The Service Manager must authorise a cancellation where the patient has been cancelled previously by the hospital.
Prior to any cancellations and to help make the decisions with regards to which patients to cancel, the Trust should avail themselves of the following information:-

- Is the patient a cancer patient?
- Is the patient clinically urgent?
- Where is the patient on their 18 week RTT pathway?

In the event that the Trust has to cancel a patient's elective procedure on the day of admission or day of surgery for a non-clinical reason, the patient must be offered another TCI date within 28 days of the cancelled operation date. The Trust is monitored on the number of breaches of this national standard

11.0 RTT Clock Activity

11.1 On-Going Clock
A patient's clock is ongoing clock until:

- First definitive treatment.
- A decision not to treat has been made.

- Patient placed on active monitoring.
- The patient is discharged back to primary care.

Activity within an RTT period which does not stop the Clock.

This might be a follow up appointment, or request for a diagnostic test/image or adding a patient to a waiting list for admission.

11.2 Active Monitoring

An 18 week clock maybe stopped when it is clinically appropriate to start a period of monitoring without clinical intervention or diagnostic procedures at this stage.

Active monitoring can be initiated by either the patient or the clinician. The start of a period of active monitoring stops the RTT waiting time.

At the end of Active Monitoring, when the patient or clinician decides that treatment is now appropriate or when the clinician decides that active monitoring is no longer the appropriate course of treatment for the patient, the clock continues from the point at which it was paused.

11.3 Clock Stops

A clock stop is when a clinical decision is made that treatment is not required or when first definitive treatment begins. First definitive treatment is the first clinical intervention intended to manage a person's disease, condition or injury and avoid further clinical interventions. What constitutes first definitive treatment is a matter of clinical judgement in consultation with others, where appropriate, including the patient. This can occur in either an Outpatient or Inpatient setting.

The following is a summary of clock stops. Further information on indicative steps are outlined in the relevant sections of this policy.

Start of a period of Active Monitoring

This is where it is clinically appropriate to monitor the patient in secondary care without clinical intervention or further diagnostic procedures.

Patient does not attend (DNA's) their first care activity following referral - see Section 10.1

This ruling applies to children unless there is concern raised as part of the 'Safeguarding Children Policy', one more appointment may be given, however the clock continues from the date of referral, you may not start a new 18 week clock.

Patient DNA's subsequent activity on pathway – see Section 10.1

This ruling applies to children unless there is concern raised as part of the 'Safeguarding Children Policy', one more appointment may be given, however the clock continues from the date of referral, you may not start a new 18 week clock.

Patient cancels care activity for the second time

If a patient cancels care activity for the second occasion on their pathway (e.g. patient cancels an outpatient appointment and then cancels a pre-op assessment appointment), they will be returned to primary care and their 18 week RTT clock will

be stopped. Should the patient wish to receive treatment they then can be re-referred by their GP – a new RTT pathway would start on receipt of the re-referral to the Trust.

Decision not to treat / no treatment required
When the Clinician and the patient decide that treatment is not required or a decision made that no treatment is to occur; the patient's clock is stopped.

A decision not to treat/ no treatment required may occur outside a face to face clinical consultation, for example if a patient is discharged on the basis of a test result which is communicated to the patient and their GP by letter or telephone. This can occur at any stage of the patient's pathway and will also stop the clock.

Patient declines offered treatment
Patients may choose not to proceed with the treatment offered and therefore their 18 week RTT clock is stopped and the patient referred back to primary care.

Patient dies before treatment
When a patient dies before they receive treatment, their 18 week RTT clock will be stopped and their RTT pathway ended.

12.0 Management Rules

This section covers the general principles that govern progressing patients through their 18 week RTT pathways.

It is the responsibility of the Clinician and Managers, in partnership, to provide the agreed capacity to ensure that demand is met and that the allocation and availability of new and follow up slots are spread between 2WW, urgent and routine appointments are robust enough to meet all performance standards.

12.1 Entitlement to NHS Treatment

The Trust has a legal obligation to identify patients who are not eligible for free NHS treatment. The National Health Service provides healthcare for people who live in the United Kingdom. People who do not normally live in this country are not automatically entitled to use the NHS free of charge – regardless of their nationality or whether they hold a British Passport or have lived and paid National Insurance contributions and taxes in this country in the past.

Patients transferring from private Independent Service Providers (ISP) to the NHS Patients can choose to convert between NHS and private status at any point during their treatment without prejudice.

Patients transferring from the NHS to Private Independent Service Provider can opt to have a private procedure. These patients must be removed from the NHS waiting list, and their 18 week RTT clock stopped and the referral ended.

12.2 Patients requiring commissioner approval – see section 8.0

Clock stops can only be made to a patient's RTT pathway when treatment occurs or a decision not to treat is made. No adjustments or clock stops can be made to a pathway whilst a panel or approval board assesses commissioner approval requests. Patients who require treatment which must have commissioner approval prior to commencement must not be disadvantaged by having their referral returned to primary care. Therefore the referrer to the Trust must seek prior approval before referring the patient. The approval must accompany the referral.

In some instances it will not be apparent until the out-patient consultation or on completion of diagnostic testing, that the patient requires an excluded procedure. Commissioners should hold approval panels in line with the 18 week timeframes for any patient referred for assessment who has already commenced an RTT pathway.

12.3 Annual and Study Leave

All requests for annual and study leave by consultant and career grade doctors must gain written approval from the Clinical Lead and Service Manager within a minimum of six weeks before leave is to be taken.

12.4 Clinic Template Changes

Any requests made for either; cancellation of clinics/patients, reductions in clinics or changes to clinic templates which may result in the movement of patient appointments, must be approved by the General Manager/CBU Management Team, confirming that all alternative options have been assessed prior to patients being inconvenienced.

13.0 Roles, Responsibilities and Accountability

It is the responsibility of all staff involved with waiting lists to familiarise themselves with the policy and all related policies and documentation where applicable.

Chief Delivery Officer

The accountability for effective implementation and adherence to this policy is the responsibility of the Chief Delivery Officer.

Director of Information, Communication & Technology

The Director of Information Communication and Technology (DoICT) is responsible for the strategic direction and senior management of the information for all aspects of access targets.

The DoICT will ensure the production of accurate and timely reporting, to support the management of elective access and the achievement of in-patient, day case and out-patient, diagnostic targets, booking targets, cancer targets and for the supply of all mandatory information to Barnsley CCG and NHS England within the required time scales.

Clinical Director and Consultants
It is the consultant's responsibility to ensure that the policy is read and understood and implemented by their clinical teams.
Clinicians are required to triage all referrals within three working days. Clinical Directors will ensure that this is done.

Clinicians must give at least six weeks' notice of any planned absence in line with the medical leave policy. This is critical to plan theatre lists, booked admissions, outpatient clinics, and diagnostic sessions and to ensure that patients are given reasonable notice.

Clinicians will review all DNA's during the clinic session where possible. Follow up instructions to the appropriate department will be communicated no later than one working day from the time of the clinic session.

Associate Director of Operations
The Associate Director of Operations have responsibility for the strategic direction, senior management and achievement of all access targets, including the Trust elective in-patient and out-patient targets, cancer pathway and diagnostic targets, to ensure the achievement of national targets for waiting times and booking.

Associate Director of Operations are responsible for ensuring their staff comply with the policy and are fully trained by receiving the appropriate annual training and to keep records of staff training.

Service Managers
The CBU Service Managers will ensure the senior management, provision and monitoring of operational booking processes across the Trust to meet outpatient access targets. This includes the component parts of the Referral to Treatment pathway (follow-up waiting times and the linkage with diagnostic tests).
The CBU Service Managers will provide advice and support to all staff in the effective implementation of this policy. They will ensure that staff has read understood and apply the policy and will ensure the implementation of data collection to support the Referral to Treatment pathway monitoring.

Waiting List Co-Ordinators/Clinical Business Unit teams where non-centralised
Maintain the waiting list using the Trust computer system (Lorenzo).

The inpatient booking staff will operationally manage the in-patient/day case waiting lists ensuring patients are appointed in strict accordance with the policy and associated procedures. Inpatient booking staff will work closely with CBUs to ensure that targets are achieved and systems are continuously reviewed and updated.

Data Quality Team
The Data Quality Team will routinely monitor the appropriate application of this policy for 18 week RTT pathways. This will be achieved by:

- RTT Spot Check Programme.
- Validation of RTT pathways for monthly performance reporting purposes.
- Ad hoc spot checks on themes or specialties.

Where issues arise with compliance of the policy, the issue will be highlighted by the Data Quality Team with the appropriate Service Manager. Failure to reach agreement at this stage will be referred to the General Manager.

Health Records Team
The Health Records Team will operationally manage the out-patient waiting lists and appointments system ensuring patients are listed and appointed in accordance with the policy and associated procedures. Health Records Staff will work closely with CBUs to ensure that targets are achieved and systems are continuously reviewed and updated.

14.0 Associated Documentation and References

14.1 Performance Standards

- NHS Plan.
- NHS Cancer Plan.
- National Cancer Waiting Times Monitoring Dataset Guidance - Version 9.0 (NHS England).
- NHS Constitution.

15.0 Education and Training

18 week RTT training will be available for all staff in the Trust to ensure accurate and timely data input to enable the Trust to meet the RTT standards. Staff groups should include all those who have dealings with patients throughout their pathway e.g. Receptionists, Booking Staff, Medical Secretaries, Junior Doctors, Clinicians and Managers.
To ensure high quality waiting list administration and continual maintenance of data quality, all staff involved in waiting list management will be trained to a standard level, tailored to the individual's responsibilities. Each year all relevant staff will undergo compulsory refresher training or when systems are altered or operational practice changes.

16.0 Monitoring and Audit

RTT will be monitored weekly using Patient Target Lists (PTL's) produced by the Corporate Information Team, reports will be delivered via email to the CBUs.

It should be noted that the fast pace of change and drop in waiting times across patients pathways have a large impact on the policy. As a result regular updates will be published over the course of the next 12-month.

The Trust will undertake regular validation of all waiting lists. The processes will ensure that lists are always as up to date as possible, and that the most efficient use is made of the Trust's inpatient and day case resources.

The Inpatient Booking staff will validate using data received from various sources. They need to ensure that patients are listed promptly and that the list does not contain patients who no longer require their operation.

17.0 Equality and Diversity

Trust is committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider. It will adhere to legal and performance requirements and will mainstream equality and diversity principles through its policies, procedures and processes. This policy should be implemented with due regard to this commitment.

To ensure that the implementation of this policy does not have an adverse impact in response to the requirements of the Equality Act 2010 this policy has been screened for relevance during the policy development process and a full equality impact analysis conducted where necessary prior to consultation. The Trust will take remedial action when necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fairly implemented.

This policy and procedure can be made available in alternative formats on request including large print, braille, moon, audio, and different languages. To arrange this please refer to the Trust translation and interpretation policy in the first instance.

The Trust will endeavour to make reasonable adjustments to accommodate any employee/patient with particular equality and diversity requirements in implementing this policy and procedure. This may include accessibility of meeting/appointment venues, providing translation, arranging an interpreter to attend appointments/ meetings, extending policy timeframes to enable translation to be undertaken, or assistance with formulating any written statements.

17.1 Recording and Monitoring of Equality and Diversity

The Trust understands the business case for equality and diversity and will make sure that this is translated into practice. Accordingly, all policies and procedures will be monitored to ensure their effectiveness.

Monitoring information will be collated, analysed and published on an annual basis as part Equality Delivery System. The monitoring will cover the nine protected characteristics and will meet statutory duties under the Equality Act 2010. Where adverse impact is identified through the monitoring process the Trust will investigate and take corrective action to mitigate and prevent any negative impact.

The information collected for monitoring and reporting purposes will be treated as confidential and it will not be used for any other purpose.

18.0 Appendices

1. Glossary of terms used within the Policy
2. Examples of Consultant to Consultant referrals
3. Version Control

Appendix 1

Glossary of Terms Used within this Policy

Active Monitoring (Also known as 'watchful waiting')
An 18 week clock may be stopped where it is clinically appropriate to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures.

Active Waiting List
Patient's currently available for elective admission for treatment.

Clinical Thresholds
A list of the implemented clinical thresholds can be found below. The process followed can be found on page 24.

- Carpal Tunnel
- Dupuytren's Disease
- Trigger Finger
- Ganglion Cyst
- Hip Replacement
- Knee Replacement
- Benign Skin Lesions
- Gall Stones (Cholecystectomy)
- Hernia Repair (Abdominal Wall Hernia)
- Cataract Surgery

Date Referral Received (DRR)
The date on which a hospital receives a referral letter from the GP. The waiting time for outpatients should be calculated from this date.

Day Case
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 Treat date (DTT)
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 (in-patients/day cases) or appointment date (out-patients) and who without notifying the hospital did not attend for admission/ pre-assessment or out-patient appointment.

E-Referral
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 invention. What constitutes First Definitive Treatment is a matter for clinical judgement, in consultation with others as appropriate, including the patient.

Fit, Willing and Able
Patients who are added MUST BE clinically and socially ready for admission on the day the decision to admit is made. Those patients who do not fulfil these criteria on the day the decision to admit is made MUST NOT be added to the waiting list. Patients not clinically ready will either be given another out-patient appointment or referred back to their GPs care together with advice on re-referral when they are fit and ready; whichever is the more appropriate to the individual patient. This also applies to patients who need to lose weight before surgery.

In-Patients
Patients who require admission to hospital for treatment and are intended to remain in hospital for at least one night.

Individual Funding Request (IFR)
An Individual Funding Request is normally regarded as being appropriate for a treatment, intervention or drug not routinely commissioned the CCG.

Inter-Provider Transfer
An Inter-Provider Transfer is where the elective clinical responsibility transfers from a consultant-led service in one organisation to a consultant-led service in another organisation.
Patients may be transferred not having yet had a clock stop (i.e. not started treatment or had a clinical decision not to treat).
Equally, the referring consultant may have already tried one form of treatment or reviewed the patient as part of active monitoring prior to deciding to transfer the patient.

Out-Patients
Patients referred by a GP or another health care professional for clinical advice or treatment.

Patient Tracking List (PTL)
The PTL is a list of patients (inpatients, day case, diagnostic and outpatients) whose waiting time is approaching the guarantee date, who should be offered an admission/appointment before the guarantee date is reached.

Procedures of low clinical effectiveness
Any referrals to the Trust for such procedures must be accompanied by proof of prior approval before the referral is accepted by the Trust.

- Grommets – Adults & Children
- Varicose Veins

- Reversal of Sterilisation
- Tonsillectomy – Adults & Children
- Specialist plastic surgery procedures
- In Vitro Fertilization (IVF)

Reasonable Offer
For an offer of an appointment to a patient to be deemed reasonable, the patient must be offered the choice of dates within the timescales referred to for outpatients, diagnostics and in patients.

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 date (TCI)
The offer of admission, or TCI date, is a formal offer in writing of a date of admission

Appendix 2

Worked examples

1. Hip pain - rheumatologist seeing a patient referred with arthritis thinks it appropriate to refer to an orthopaedic surgeon for consideration of joint replacement (CONSULTANT TO CONSULTANT referral permitted).

2. Hip pain - cardiologist seeing a patient with heart failure; patient complains of hip pain (CONSULTANT TO CONSULTANT referral to rheumatology, orthopaedics or another specialty NOT permitted).

3. Chest pain - Urology seeing a patient with chronic kidney disease; patient complains of chest pain (CONSULTANT TO CONSULTANT referral to cardiology, gastroenterology or another specialty NOT permitted, unless the chest pain falls into one of the categories listed under section 1).

Appendix 3

EQUALITY IMPACT ASSESSMENT TEMPLATE
INITIAL ASSESSMENT STAGE 1 (part 1)

Department:	Corporate	**Division:**	CBU2
Title of Person(s) completing this form:	Associate Director of Operations	**New or Existing Policy/Service**	Existing Policy
Title of Policy/Service/Strategy being assessed:	Patient Access Policy	**Implementation Date:**	October 2018
What is the main purpose (aims/objectives) of this policy/service?	To ensure all staff involved in elective access can effectively manage the patient referral to treatment without unnecessary delay within the current waiting time standards.		

Will patients, carers, the public or staff be affected by this service? Please tick as appropriate.		Yes	No	If staff, how many individuals/which groups of staff are likely to be affected?
	Patients	✓		
	Carers	✓		
	Public			
	Staff	✓		

Have patients, carers, the public or staff been involved in the development of this service? Please tick as appropriate.				If yes, who did you engage with? Please state below:
	Patients	✓		
	Carers	✓		
	Public	✓		
	Staff		✓	

What consultation method(s) did you use?	Please see above.

Equality Impact Assessment Stage 1 PART 2

Based on the data you have obtained during the consultation what does this data tell you about each of the above protected characteristics? Are there any trends/inequalities?

The data is only analysed for bespoke and specific pieces of information.

What other evidence have you considered? Such as a 'Process Map' of your service (assessment of patient's journey through service) / analysis of complaints/ analysis of patient satisfaction surveys and feedback from focus groups/consultations/national & local statistics and audits etc.

This is a local document based on a national document to aid patients, carers etc in understanding their rights when accessing elective care. The access policy is underpinned by the NHS constitution for accessing patient care.

Equality Impact Assessment Stage 1 PART 3

ACCESS TO SERVICES

What are your standard methods of communication with service users?

Please tick as appropriate.

Communication Methods	Yes	No

Face to Face Verbal Communication	✓	
Telephone	✓	
Printed Information (E.g. leaflets/posters)		✓
Written Correspondence	✓	
E-mail		✓
Other (Please specify)		

If you provide written correspondence is a statement included at the bottom of the letter acknowledging that other formats can be made available on request?

Please tick as appropriate.

Yes	No
✓	

Are your staff aware how to access Interpreter and translation services?

Interpreter & Translation Services	Yes	No
Telephone Interpreters (Other Languages)	✓	
Face to Face Interpreters (Other Languages)	✓	
British Sign Language Interpreters	✓	
Information/Letters translated into audio/braille/larger print/other languages?	✓	

EQUALITY IMPACT ASSESSMENT – STAGE 1 (PART 4)

Protected Characteristic	Positive Impact	Negative Impact	Neutral Impact	Reason/comments for positive, neutral or negative Impact Why it could benefit or disadvantage any of the protected characteristics
Men				Patients will be treated equitably and according to their personal and clinical need without unnecessary delay within the current waiting time standards

	X			
Women	**x**			Patients will be treated equitably and according to their personal and clinical need without unnecessary delay within the current waiting time standards
Younger People (17 – 25) and Children	**x**			Patients will be treated equitably and according to their personal and clinical need without unnecessary delay within the current waiting time standards
Older people (60+)	**x**			Patients will be treated equitably and according to their personal and clinical need without unnecessary delay within the current waiting time standards
Race or Ethnicity			**x**	Patients will be treated equitably and according to their personal and clinical need without unnecessary delay within the current waiting time standards. Where there are additional language requirements interpreters can be arranged.
Learning Disabilities			**x**	Patients will be treated equitably and according to their personal and clinical need without unnecessary delay within the current waiting time standards. Staff will ensure that patients or their carer understand their responsibility in achieving the referral to treatment time and the consequences of missed appointments
Hearing impairment			**x**	Patients will be treated equitably and according to their personal and clinical need without unnecessary delay within the current waiting time standards. Staff can arrange for BSL interpreters if required to explain the patient's rights and requirements
Visual impairment			**x**	Patients will be treated equitably and according to their personal and clinical need without unnecessary delay within the current waiting time standards. Patients physical needs should be taken into account in communication with them.
Physical Disability			**x**	Patients will be treated equitably and according to their personal and clinical need without unnecessary delay within the current waiting time standards
Mental Health Need			**x**	Patients will be treated equitably and according to their personal and clinical need without unnecessary delay within the current waiting time standards
Gay/Lesbian/Bi sexual			**x**	Patients will be treated equitably and according to their personal and clinical need without unnecessary delay within the current waiting time standards

Trans			x	Patients will be treated equitably and according to their personal and clinical need without unnecessary delay within the current waiting time standards
Faith Groups **(please specify)**			x	Patients will be treated equitably and according to their personal and clinical need without unnecessary delay within the current waiting time standards
Marriage & Civil Partnership			x	Patients will be treated equitably and according to their personal and clinical need without unnecessary delay within the current waiting time standards
Pregnancy & Maternity			x	Patients will be treated equitably and according to their personal and clinical need without unnecessary delay within the current waiting time standards
Carer Status	x			Patients will be treated equitably and according to their personal and clinical need without unnecessary delay within the current waiting time standards. The trust recognises the part that carers play in patient care. Staff will ensure that carers needs are taken into consideration throughout the pathway.
Other Group **(please specify)**				

INITIAL ASSESSMENT (PART 5)

Have you identified any issues that you consider could have an adverse (negative) impact on people from the following protected groups?

YES	NO
	x

IF 'NO IMPACT' IS IDENTIFIED Action: No further documentation is required.

IF 'HIGH YES IMPACT' IS IDENTIFIED Action: Full Equality Impact Assessment Stage 2 Form must be completed.

(c) Following completion of the Stage 1 Assessment, is Stage 2 (a Full Assessment) necessary?

YES	NO
	x

Assessment Completed By: Nicola Beaumont Date Completed: 13/12/18

Line Manager …….. Date……..

Head of Department …… Date……..

When is the next review? Please note review should be immediately on any amendments to your policy/procedure/strategy/service.

1 Year ✓	2 year	3Year

Appendix 4

Version Control

Record of document history/reviews and key changes made, including versions and dates)

Version	Date	Comments	Author & Job Role
1.0	October 2016		S.Burgan Operational Support Manager for CBU2
2.0	September 2017		N.Beaumont Associate Director of Operations for CBU2
3.0	October 2018		N.Beaumont Associate Director of Operations for CBU2

Review Process Prior to Ratification:

Name of Group/Department/Committee	Date
ET	October 2018