# Access to Treatment Policy

This policy sets out the expectations of Leicestershire Partnership NHS Trust (LPT) on the management of referrals for planned care and treatment within the organisation. The policy reflects national standards, data definitions and aligns to national guidance as appropriate for the category of care. For the purposes of this policy planned care and treatment is defined as care that is planned in advance and does not require an emergency or urgent response.

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# Policy On a Page

## Summary & Aim

This policy sets out the expectations of Leicestershire Partnership NHS Trust (LPT) on the management of referrals for planned care and treatment within the organisation. The policy reflects national standards, data definitions and aligns to national guidance as appropriate for the category of care. For the purposes of this policy planned care and treatment is defined as care that is planned in advance and does not require an emergency or urgent response.

## Key Requirements

The content of this policy set out the approach to the effective management of access to assessment and treatment for services delivered by Leicestershire Partnership NHS Trust. Compliance with the content of this policy will ensure services are consistent with national and local guidance and that patients / service users are treated equitably in line with their clinical need.

## Target Audience

This policy is applicable to all staff, clinical and non-clinical, who support patients / service users to access assessment and treatment within LPT, deliver clinical services and those responsible for the management and oversight of these services. The policy is also applicable to enabling staff who support clinical service delivery.

## Training

The training required to support this policy will comprise a combination of generic and service specific training to accommodate the needs of local services. Training will be delivered in local training sessions via MS Teams / face to face to meet the requirements of individual services. Delivery of training will be the joint responsibility of the service Business Managers and Associate Director – Contracts and Planning.

## 1.0 Quick Look Summary

Please note that this is designed to act as a quick reference guide only and is not intended to replace the need to read the full policy.

### 1.1 Version Control and Summary of Changes

| Version number | Date | Comments (description change and amendments) |
|---|---|---|
| 2.1 | October 2024 | This policy has been significantly updated and rewritten to take account of national and local changes rewritten. |

For further information contact:
Associate Director Contracts and Planning
Leicestershire Partnership NHS Trust
Room 100/110
County Hall
Glenfield
Leicester
LE3 8TH
anne.senior2@nhs.net

### 1.2 Key Individuals Involved in Developing and Consulting on the Document

| Name | Designation |
|---|---|
| Anne Senior | Associate Director - Business Development and Contracting |
| Prakash Patel | Head of Information |
| Nicola Stones | Business Manager DMH |
| Tiffany Webster | Head of Transformation and Business FYPC-LDA |
| Vicki Quinn | Head of Transformation and Business CHS |

This policy has been circulated for comment to via members of the Access Delivery Group which includes members who fulfil the role of policy experts and has been shared for comment with Operational DMTs.

### 1.3 Governance

**Level 2 or 3 approving delivery group**
Access Delivery Group

**Level 1 Committee to ratify policy**
Accountability Framework Meeting

See Appendix 5 for governance flow chart.

### 1.4 Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment

on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

If you would like a copy of this document in any other format, please contact lpt.corporateaffairs@nhs.net

### 1.5 Due Regard

LPT will ensure that due regard for equality is taken and as such will undertake an analysis of equality (assessment of impact) on existing and new policies in line with the Equality Act 2010. This process will help to ensure that:

- Strategies, policies and procedures and services are free from discrimination.
- LPT complies with current equality legislation.
- Due regard is given to equality in decision making and subsequent processes.
- Opportunities for promoting equality are identified.

Please refer to due regard assessment (Appendix 3) of this policy

### 1.6 Definitions that Apply to this Policy.

In order for ALL waiting lists and waiting times to be recorded accurately the following definitions should be applied:

| Term | Definition |
|---|---|
| **Consent:** | A patient / service user's agreement for a health professional to provide care. Patients may indicate consent non-verbally (for example by presenting their arm for their pulse to be taken), orally, or in writing. For the consent to be valid, the patient must:<br>• be competent to take the particular decision.<br>• have received sufficient information to take it and not be acting under duress. |
| **Due regard** | Having due regard for advancing equality involves:<br>• Removing or minimising disadvantages suffered by people due to their protected characteristics.<br>• Taking steps to meet the needs of people from protected groups where these are different from the needs of other people. Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low. |
| **Elective care** | Care planned in advance and not requiring an emergency or urgent response. |
| **First appointment** | The first clinically relevant appointment (this could include face to face, telephone, video, or group consultation etc. and will be as defined in the service Standard Operating Procedure) after a patient/service user has been referred. Waiting list returns for first appointments include all referrals to all members of a clinical team. |

| Term | Definition |
| --- | --- |
| **Full booking** | Where a patient/service user is contacted by the service and offered a choice in the time, date and, where applicable, appointment location. |
| **Partial booking** | Where a patient/service user is asked to contact the service and is able to choose and confirm their appointment in advance. |
| **Fixed booking (non-negotiated)** | Where a patient/service user is allocated an appointment and can choose to reschedule if required. |
| **Cancelled appointment (patient / service user)** | Where the patient / service user is offered a date/time for an appointment and cancels ahead of the appointment time. |
| **Cancelled appointment (provider)** | Where the Trust cancels or postpones an appointment for **any** reason after it has been confirmed to the patient / service user.<br>All staff (including clinicians) are required to comply with the Trust Leave Policy, book annual leave and study leave as early as possible and provide (other than in exceptional circumstances) at least 6 weeks' notice if appointments need to be cancelled / changed. |
| **Did not attend appointment** | Where a patient / service user does not attend an appointment and does not give prior notice[1]<br>The process for managing this is covered in the Trust's The Management of Non-Attendance/ Did Not Attend (DNA)/ Was not brought (WNB), including Did Not Gain Access Policy for Adults. |
| **Was not brought (child / young person)** | Where a child or young person is not brought to their appointment.<br><br>The process for managing this is covered in the Trust's Policy for Children and Young People who Was Not Brought (WNB) or Did Not Attend (DNA) Health Appointments (including No Access Visits (NAV) |
| **Was not brought (vulnerable adult)** | Where a vulnerable adult is not brought to their appointment the process for managing this is covered in the Trust's The Management of Non-Attendance/ Did Not Attend (DNA)/ Was not brought (WNB), including Did Not Gain Access Policy for Adults |
| **Referral to team or named clinician** | All referrals are received as team referrals. Referrals marked for the specific attention of a named clinician will be deemed to be a team referral. |
| **Urgent referrals** | Referrals received and agreed by the receiving team to be 'urgent' |

| Term | Definition |
|---|---|
| **Routine referrals** | Referrals which are not deemed urgent by either the referrer or the receiving team. |
| **Referral date** | The date the referral is received and entered onto the EPR in line with the Trust's Record Keeping Policy. |
| **Clock start** | Where no service / target specific guidance published at a national or local level (e.g. PIER, CMHT 4 week wait, 2 hr UCR) the following definition should be used.<br><br>A waiting time clock starts on receipt of a referral from any care professional or other service / professional permitted to refer (will be included in service specification)<br><br>Where a patient self refers the clock starts when the referral is ratified by a care professional permitted to do so. |
| **Clock stop** | Where no service / target specific guidance published at a national or local level (e.g. PIER, CMHT 4 week wait, 2 hr UCR) the following definition should be used.<br><br>Date first definitive treatment starts when an intervention intended to manage a condition and avoid further intervention commences.<br><br>**Or** where:<br>➢ It is clinically appropriate to return the patient to primary care for treatment in primary care<br>➢ A clinical decision is made to start a period of **active monitoring**<br>➢ A patient declines treatment having been offered it.<br>➢ A clinical decision is made not to treat.<br>➢ A patient DNA's the first appointment that started their waiting time clock(where able to demonstrate the appointment was clearly communicated to the patient)<br>➢ If a patient DNAs first appointment and the provider determines it to be appropriate to offer a new appointment, a new clock starts on the date the patient agrees the new appointment date<br>➢ If a patient DNAs any other appointment(s) and is subsequently discharged back to the care of their GP.<br><br>*all clock stops linked to a DNA or patient cancellation must be made taking into account the requirements of the Trust DNA Policy (available on Staffnet). |

| Term | Definition |
|---|---|
| **Consultant-led service** | A consultant-led service - where “a medical consultant retains overall clinical responsibility for the service, team or treatment”. The consultant will not necessarily be physically present for each appointment but takes overall clinical responsibility for patient care.<br><br>LPT does not deliver any services defined as consultant-led, consultants work within an MDT |
| **First definitive treatment** | The first clinical intervention intended to manage a patient's disease, condition or injury and avoid further clinical interventions. This may be the first or a subsequent appointment depending on the service and the condition being treated. |
| **Standard operating procedure (SOP)** | The written instructions necessary to achieve a consistent approach to a process and provide a platform for providing training, monitoring compliance and assessing quality. |
| **Referral to treatment** | Period from receipt of referral and first definitive treatment |
| **Active monitoring** | Where it is clinically appropriate to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures. This can stop the clock.<br><br>Where it is clinically appropriate to start a period of active monitoring if a patient declines 2 reasonable treatment date offers. This can stop the clock. |

[1] Prior notice is defined as any time up to the time of the appointment.

## 2.0 Purpose of This Policy

This policy defines the accountabilities and responsibilities of those involved in the processes covered by this policy and supersedes all previous versions.

The purpose of the Access to Treatment policy is to provide a framework for managing patient/service user access to services delivered by the Trust and to ensure all service user/patients are treated fairly and equitably. This policy supports the Trust priority to improve access to services.

It will support best practice in managing waiting times and will apply to all referrals into Leicestershire Partnership NHS Trust (LPT) where there is a defined wait between referral and subsequent care/ treatment.

Where a referral requires an immediate response (i.e. within hours or days) the principles of this policy will apply however the detail for the management of these referrals will be covered in the service's Operational Policy/ Standard Operating Procedure.

Local Standard Operating Procedures (SOPs) will be written and available in each service to enable staff to implement and comply with the Access to Treatment policy.

## 3.0 Policy Requirements

This policy describes the roles and responsibilities for all staff in the effective management of access to services / waiting times for patients / service users referred to Leicestershire Partnership Trust. This policy updates the previous Access to Treatment Policy issued in 2020 and takes into account changes in national and local requirements in the intervening period.

### 3.1 Introduction

The Trust is committed to ensuring patients/service users will be treated at the right time and according to clinical priority. Those with similar clinical needs will be treated in chronological order, in line with the NHS Constitution (Section 3a).

The Access to Treatment policy supports best practice in managing waiting times, minimising appointments lost and maximising the opportunity to see patients/service users as quickly as possible and supports the achievement of national and local access targets. This Policy covers all referrals into Leicestershire Partnership NHS Trust (LPT), regardless of service, appointment location, or health professional delivering the services, treatment or intervention offered.

Each service must have a Standard Operating Procedure in place to describe the recording and reporting mechanisms in place. This will ensure any delays in accessing the service and the impact of any such delays are rapidly identified promptly escalated through established governance routes.

### 3.2 Reporting

The Trust will report waiting times (for access and / or treatment) through the Waiting Times Compliance Report with additional tailored reports provided for governance committees including Access Delivery Group, Accountability Framework Meeting and

Finance and Performance and Quality Assurance Committees. This information will enable an accurate and consistent understanding of service capacity and the demand for services and any delays in assessment and/or treatment.

### 3.3 Information Assurance Framework

All definitions used will be consistent with the principles of statutory returns/national guidance.

All waiting times will be recorded and reported in line with national guidance as appropriate to the individual service.

The Head of Information / Integrated Information Team will work with Directorate Business Teams to support a consistent and appropriate approach to recording and reporting of waiting times.

All staff are responsible for ensuring correct definitions are used for recording / reporting purposes and must raise any queries with their line manager to support organisational consistency.

The Head of Information / Integrated Information Team must be alerted to any actual or proposed variation from agreed definitions in order to maintain data quality standards in order to agree an appropriate response.

### 3.4 National and Local Operating Standards

The Trust will aim to provide access to services / treatment within the timeframes defined in its contracts and these will be the basis for measurement of performance in all monitoring reports.

All services must have a Standard Operating Procedure (SOP) in place which reflects national or where appropriate local expectations. All SOPs must be regularly reviewed and be updated when local or national requirements change.

### 3.5 Standard Operating Procedures

Local SOPs will cover all aspects of this policy and will ensure;

- patients/service users are seen and treated according to clinical priority and then chronological order.
- the process of managing patient/service user waits is transparent internally, to the public and external organisations.
- a consistent and standardised approach to access to treatment is established.
- accurate and timely information is collected and reported on the length of wait for service users/patients.
- effective communication between stakeholders including service users, carers, referrers, LPT staff and other individuals involved in the care of the service user.
- fairness and equity.
- compliance with the six data quality domains of reliability, validity, timeliness, completeness, accuracy and relevance
- waiting lists/waiting times are managed effectively and consistently.
- the Trust has timely and accurate information to inform operational management and decision-making processes, and to manage the performance of its clinical services.
- clinical screening for allocating patients for priority of access.

### 3.6 Patient Entitlement to NHS Treatment

All NHS Trusts have a legal obligation to identify patients/service users not eligible for free NHS treatment and to:

- check patient/service user eligibility and identify those not ordinarily resident in the UK.
- assess liability for charges in accordance with Department of Health Overseas Visitors Regulations.
- charge those liable to pay in accordance with Department of Health Overseas Visitors Regulations.

Where staff identify patients / service users as overseas visitors, they will refer them to the Associate Director – Contracts and Planning for clarification of entitlement to NHS treatment and advice on next steps. This should take place before their first appointment is booked.

The Trust Overseas Visitor Policy (to be developed) will enable staff to implement and comply with national policy.

### 3.7 Inappropriate Referrals

Where a referral is deemed to be inappropriate, the referrer will be advised as to the most appropriate alternative route within five working days of the decision.

If this requires redirection within LPT the referral will be forwarded to the appropriate service and the referrer advised accordingly. Where a referral is redirected within LPT the clock start date will remain as the date the referral was originally received.

Referrals requiring redirection to another provider will be returned to the referrer with a request to redirect **or** if an agreed process is in place, the referral will be re-directed, and the referrer informed.

### 3.8 Referrals Requiring Commissioner Approval

Referrals for an excluded intervention or an intervention deemed to be of low clinical value (these are described in the LLR Treatments of Low Clinical Value Policy – available on LLR ICB website) will not be accepted without the relevant approval.

If the referral does not have the relevant approval, the patient/service user must not be treated and must be referred back to the referrer.

At the time of development of this policy LPT does not deliver any excluded interventions or interventions of low clinical value; should this change the policy will be updated and services advised accordingly.

### 3.9 Tertiary Referrals

Where referral to a tertiary (specialist) provider is required, clinical staff should follow the relevant commissioned pathway. Clinical staff should seek advice from the Directorate Business Manager or Trust Contracting Team on the appropriate route for such referrals if not described in the service SOP.

If a referral is agreed, services will ensure contact is made with the patient / service user and that all necessary permissions are sought prior to communicating clinical and demographic details to the new provider.

### 3.10 Military Veterans

LPT is a signatory to the Armed Forces Covenant and services must ensure they are familiar with its contents.

This requires that all veterans and war pensioners receive priority access to NHS care for any conditions related to their service, subject to the clinical needs of all patients. Military veterans do not need to have applied for and become eligible for a war pension before receiving priority treatment and should be identified at referral to avoid any delay in offering timely and appropriate treatment. Military veterans are not entitled to clinical priority treatment for other interventions.

The referrer should ensure all relevant information to a patient/service user's status as a military veteran is clearly communicated within the referral letter.

### 3.11 Serving Military Personnel and Families

Healthcare for serving military personnel and for military families registered with military forces GPs is commissioned by NHS England and is not routinely commissioned from or provided by LPT. In the event of referral of serving personnel (or family member registered with a military GP) the service should seek advice from the Directorate Business Team to agree the action required.

Families of serving personnel registered with a civilian GP should be treated as per any other registered patient/service user. Where a family of serving personnel have recently moved into LLR and are either already in receipt of treatment or are on a waiting list, they must not be disadvantaged as a result of the move.

### 3.12 Looked after Children

Where a looked after child is moved into LLR from another health and care community and is either already in receipt of treatment or are on a waiting list, they must not be disadvantaged as a result of the move.

### 3.13 Exceptional Circumstances

Patients/service users should not be penalised where exceptional circumstances prevent them from attending an appointment. Staff should exercise discretion in such situations, seeking guidance from their line manager if required.

### 3.14 Booking of Appointments

All services will operate a system, whereby patients / service users have a choice in the time, date and (where possible) location of their appointment. This may be via a partial or full booking system, where a fixed (non-negotiated) appointments is offered this must include the option to rebook an alternative without penalty if the offered option is not suitable.

Services will ensure processes support waiting times being kept to a minimum and offer a choice of appointment date, time and (where possible) location.

Services will ensure all patients/service users have the information required to enable them to contact the service, including telephone numbers, email addresses and hours of operation and will enable messages to be left out of hours.

All initial appointments offered must be followed by a confirmation letter (by post or email) which includes:

- a point of contact
- telephone number (including details of how to leave a message) and email address for queries
- details of what to do if the patient/service user is unable to attend the appointment,
- what to do if unavoidably arriving late or if there is a need to cancel and rearrange the appointment
- additional information relating to the clinic or tests the patient/service user may be asked to go through
- location details (including parking), directions and public transport options
- details of assisted travel and criteria
- details on the availability of the interpretation service
- where an appointment is virtual provide the necessary details for the patient / service user to access log-on details

Services must monitor processes to ensure:

- service users are offered flexibility / choice of appointment date and time and (where appropriate) location;
- appointments are booked in clinical priority and chronological order; and
- all aspects of booking are in accordance with this policy.

### 3.15 Reasonable Notice

All routine appointments should be offered to the patient / service user with reasonable notice; national guidance defines '*Reasonable notice*' as an offer of two appointment dates with at least 3 weeks' notice. This has been established in the context of an 18 week waiting time target, where a shorter timescale is in place the service must establish a suitable local alternative and include this in the service SOP.

All definitions of 'reasonable notice' and their implementation must take into account the needs of patients / service users and ensure that they are not disadvantaged by the agreed definition of reasonable notice.

If a patient declines two offers of an appointment within the above definition of 'reasonable notice' the service may wish to consider referral back to the GP or may offer a period of active monitoring (see 5.11). This needs to be considered in the context of Management of Non-Attendance/ Did Not Attend (DNA)/ Was Not Brought (WNB), including Did Not Gain Access Policy for Adults and/or Policy for Children and Young People who Was Not Brought (WNB) or Did Not Attend (DNA) Health Appointments (including No Access Visits (NAV).

### 3.16 Active Monitoring (also referred to as watchful waiting)

Active monitoring is where a clinical decision is made that a patient may not require treatment at this time but should be monitored in secondary care.

When a decision is made by a clinician to begin a period of active monitoring and communicated with the patient, the RTT clock stops. Stopping a patient's clock for a period of active monitoring requires careful consideration on a case-by-case basis and needs to be consistent with the patient's perception of their wait.

Active monitoring may be appropriate in the following situations:

**Clinical active monitoring**
When a period of monitoring is appropriate before further clinical intervention is needed, and the patient does not require any immediate diagnostic or clinical treatment but referral back to primary care is not appropriate.

The RTT clock will stop, and the patient will be monitored for an agreed period of time. If their condition deteriorates and they require treatment, a new RTT clock will start at zero however if / when a further appointment is deemed necessary this should be offered in line with their original clock start date in order to avoid a delay in treatment.

**Social active monitoring**
As an alternative to referring back to primary care a clinical decision could be made to enter a patient into social active monitoring if they cancel or decline two reasonable appointments including first appointments.

In this scenario the principles of the Trust DNA Policy should be applied in determining next steps and the action to be taken. The RTT clock would stop on the date of the second cancelled / declined date and a new clock should start at zero when the patient is available. However, the patient should be scheduled from their original clock start date, as opposed to the new one.

The SOP for each service MUST include clear guidance on where ACTIVE MONITORING is appropriate and how / when it may be used. Patient safety must be the over-riding factor in all instances of active monitoring and in all instances where it is used patients must continue to be visible on a relevant PTL.

The SOP must also include the requirement for patients to be provided with contact details and a clear process for two-way communication between them and the service in in the event their condition or circumstances change

### 3.17 Patients Unable to Attend Due to Hospitalisation

Where a patient/service user is unable to attend their appointment due to hospitalisation or other health related needs the responsible clinician will need to make a decision on the best course of action dependent on the circumstances of the individual case.

If the illness or other health-related need is short-term in nature the patient/service user should be offered another appointment within a mutually agreed and clinically appropriate timescale. In this instance the waiting time will continue to be measured from the date of the original referral.

If the illness or health-related need is longer-term the responsible clinician should discuss and agree the best course of action with the patient / service user, the referrer and the wider multi-disciplinary team. This may include, for example:

- referral back to the GP/original referrer with a request to re-refer at a clinically appropriate time. If this action is taken the clock will stop and a new clock start initiated at the point of re-referral. At this point the clinical team should exercise clinical judgement as to the timing of the offer of an appointment.
- In the case of a hospital admission the responsible clinician may decide, where it is

clinically appropriate and can be facilitated, to undertake the appointment during the inpatient stay.

### 3.18 Patients Wishing to Transfer from Private Care

If a patient has been seen privately (for investigations, diagnosis or treatment) and subsequently wishes to be treated as an NHS patient, this will require a referral from a GP or other health professional (this can be the private provider as long as the referrer is a registered health professional). A self-referral will be accepted if this an agreed route of referral as per the service specification.

On receipt of a referral it will be actioned as a new referral to the service and placed on a waiting list and seen in accordance with the same principles as any other referral i.e. chronological order and clinical priority. The clock will start at the date of receipt of the referral.

Patients cannot gain a clinical advantage through choosing to access private diagnosis or treatment. The NHS principle is that privately and publicly funded care cannot be part of the same treatment pathway. A patient who has already received a privately funded diagnosis but has not commenced treatment will be added to the assessment waiting list in line with other newly received referrals and offered an appointment in order of chronology unless otherwise clinically indicated.

Advice should be sought from Directorate Business Teams if further clarity is required. The guiding principle will always be clinical need / priority of the patient referred and those who are waiting.

The above **does not include** patients who receive diagnosis or treatment in the private sector through Right to Choose. If there is a decision to transfer into the NHS In this instance their pathway will continue with their place on the waiting list determined by chronology and clinical priority based on the date of referral to the private provider. For these patients the clock start date is the date of receipt of their referral to the private provider.

### 3.19 Clock Stop / Start Rules for Referral to Treatment Pathways

Where services have specific parameters set out in national guidance this should be followed. Examples of this are PIER, CAMHS ED, Mental Health 4 week wait and 2 hr UCR. Where no such parameters exist national RTT rules should be followed and can be found via the hyperlink below:
Referral to treatment consultant-led waiting times: rules suite (October 2022) - GOV.UK (www.gov.uk)

Service SOPs will detail the application of waiting times guidance for individual services. Clinically appropriateness and patient safety will be the primary factor in determining local application to the service.

### 3.20 Reasonable Adjustment Digital Flag

Under the Equality Act 2010, organisations have a legal duty to make changes (reasonable adjustments) in their approach or provision to ensure services are as accessible to people with disabilities as they are for everybody else. The Reasonable Adjustment Flag (RADF) is added to health care records to enable health and care workers to record, share and view details of reasonable adjustments, wherever a person is treated.

SystmOne (LPT EPR) includes the RADF in patient / service user records and staff must

- View the patient record prior to arranging an appointment to ensure those with a RADF are identified.
- Any reasonable adjustments required must be agreed and be in place to facilitate access this might include a different location, time allowed, support/advocate booked, easy read information provided etc.
- Any updates to the adjustments recorded on SystmOne must be amended at appointment by the clinician to ensure they remain up to date.

## 3.21 Monitoring

### 3.21.1 Patient Tracking List (PTL)

The purpose of a PTL is to:

- Manage and monitor flow of activity for patient/service user pathways.
- Ensure appointments are offered according to clinical priority and chronological order.
- ensure full oversight of the service waiting list.
- support rapid intervention where a patient/service user's condition has deteriorated or otherwise requires expediting.

Regular PTL meetings must be in place for all services. It is recommended that PTLs are held no less frequently than fortnightly and where a service has a waiting time target of less than 18 weeks or is unable to meet their national / local target (as set out in their service specification) PTLs should be held weekly.

The service manager responsible for service delivery will determine the required attendees and frequency of meetings and agree these via local governance processes with any exceptions to the above recorded and formally agreed.

The PTL will be action-orientated and focus on:

- existing/imminent breaches
- data quality issues.
- prospective management of service users along the pathway.
- clearing any backlog of service users waiting longer than national or local targets.
- identify any patient/service user waiting over 52 weeks and ensure these are prioritised.
- delivery of service's clinical pathways.
- monitoring and managing the number of incomplete pathways.
- share learning across teams, services and directorates.
- performance management and accountability
- escalation of unresolved clinical and operational issues

PTL meetings will ensure plans are in place at individual patient/service user level which:

- ensure appointments are booked.
- address key issues for individual patients/service users, identifying and implementing any actions required.
- escalate issues that cannot be resolved within the service.

The service/operational manager will ensure patient/service user issues raised during

PTL meetings are addressed. All agreed actions will be reviewed at the following meeting to monitor progress. There will be an audit trail of agreed actions including their impact on the following week's PTL numbers and profiles.

Services will have clear escalation processes to enable resolution of issues not addressed between PTL meetings.

#### 3.21.2 Monitoring Compliance Reporting: internal and external

Accurate, timely and clearly presented information and analysis will underpin effective waiting list management to maximise efficiency and support delivery of national and local targets.

Information reports will be:

- accurate and timely with any known or potential data quality inaccuracy explained and understood.
- developed by the Information Team in collaboration with the target audience.
- exception-based to highlight areas for attention/concern.
- consistent with Key Performance Indicators (KPIs) used throughout the organisation / local health economy.
- secure with patient/service user-identifiable information used only where absolutely necessary.
- explained to ensure the implications of incorrect/inaccurate information are known and understood.

All statutory and local returns will be submitted to NHSE / commissioners by the Trust's Information Team. The Head of Information will work with services to ensure they are sighted on returns and any issues contained therein and that these are escalated as appropriate.

Service-level waiting time information will be presented to the Accountability Framework meeting, Quality and Safety and Finance and Performance Committees and Trust Board regularly, in accordance with the Trust Accountability Framework.

## 4.0 Duties Within the Organisation

The governance arrangements underpinning this policy are provided in Appendix 6 of this policy.

### 4.1 Governance

- The Trust Board has a legal responsibility for Trust policies and for ensuring that they are carried out effectively.

- Performance oversight will be provided through Performance Reviews to Access Delivery Group, Accountability Framework, Finance and Performance Committee and Trust Board via the Trust Governance structure.

- Clinical Governance oversight will be provided through Directorate Clinical Governance Teams to Accountability Framework and to Quality and Safety Committee via the Trust Governance structure.

### 4.2 Executive Responsibility

- The **Chief Executive** has executive responsibility for application of this policy.
- The **Medical Director** is the Trust's Caldicott Guardian.
- The **Director of Finance and Performance** is the Trust SIRO and responsible for the Information Governance and data quality aspects of this policy.

### 4.3 Operational Responsibility

**Service Directors** will:

- Be accountable for ensuring compliance with the standards documented in this policy.

**Clinicians** will**:**

- Ensure they comply with their responsibilities as outlined in this Policy**.**
- Use clinical judgement to manage service users following a DNA, patient not brought or patient cancellation in line with the Trust Policy.
- Comply with Trust Leave Policies to ensure adequate notice, cover for absences and so reduce the need to cancel / reschedule appointments.
- Work with administrative and managerial colleagues to manage waiting lists to maximise compliance with national and local targets.
- Ensure patients / service users are medically fit for assessment/treatment, and are able to consent in line with the requirements of the Mental Capacity Act (as detailed in Mental Capacity Act Policy)
- Ensure that a process is in place that patients and carers are partners in keeping themselves safe whilst waiting for treatment.

**Business/Service and Operational Managers** will ensure:

- All services have up-to-date Standard Operating Procedures (SOP) which enable this policy to be implemented.
- All relevant staff are aware of the policy contents and receive training as necessary.
- appointment slots available reflect the capacity of the service as defined by its demand and capacity review
- The Directory of Service on the electronic Referral Service (eRS) is managed and up to date (where applicable)

- Operational users of systems have access to functionality appropriate to their role.
- Patients / service users are managed in order of clinical urgency (this may be adjusted to take account of protected characteristics that increase the risk of harm whilst waiting) followed by chronological order of referral. PTLs and supporting meetings will be used to facilitate this.
- Service users are tracked along their pathway to minimise delays in diagnosis or treatment.
- No one is disadvantaged as a result of a protected characteristic
- All staff work to service SOPs

**Clinical Services** will ensure:

- maximum appointment slots are made available;
- services are delivered in accordance with agreed pathways;
- wherever possible patients/service users are seen within waiting time targets
- dates and times agreed with patients/service users are honoured and are kept up to date with any changes in particular in relation to time spent waiting for an appointment
- investigating and reporting any breaches of pathways or treatment time targets;
- effective systems are in place to monitor service user pathways, including transfers within or between organisations;
- referrers know to refer to a 'service' and not a named professional;
- they communicate with referrers and patients / service users at appropriate points along a pathway;
- that patients are partners in keeping themselves safe whilst waiting for treatment
- patient / service user and carer experience and satisfaction are regularly measured, and issues responded to.

### 4.4 Enabling Responsibility

**Associate Director of Contracts and Planning** will:

- Review any requests for counting changes and feed into contract negotiations.
- Report on overall performance on waiting times to Access Delivery Group and Accountability Framework.

**Integrated Information Team** will:

- Ensure performance management and operational reports support effective waiting list management.
- Provide reports to monitor compliance with this policy.
- Support the evaluation of requests for counting and coding changes.
- Ensure robust data quality processes support accurate waiting times data.

**Leicestershire Health Informatics Service (LHIS)**

- Act on requests for system configuration to support accurate recording of waiting times data.

### 4.5 Clinical Staff Responsibility

Clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment described in this policy is delivered. Consent can be given orally and/ or in writing. Someone could also give non-verbal consent as long as they understand the treatment or care about to take place. Consent must be voluntary and informed, and the person consenting must have the capacity to make the decision.

In the event that the patient's capacity to consent is in doubt, clinical staff must ensure that a mental capacity assessment is completed and recorded. Someone with an impairment of or a disturbance in the functioning of the mind or brain is thought to lack the mental capacity to give informed consent if they cannot do one of the following.

- Understand information about the decision.
- Remember that information.
- Use the information to make the decision.
- Communicate the decision.

### 4.6 External Stakeholders

**Services will work with patients / service users to support them to:**

- consider the choice options available to them.
- communicate to the service and/or their GP if treatment is no longer required.
- inform the service of any change to personal or demographic information.
- keep their appointment and inform the service in good time where this is not possible.
- understand the importance of sharing relevant health information e.g. medication,
- share any changes that may affect their attendance or care plan.
- share any specific needs they may have, e.g. language interpreter, guardianship, literacy difficulties, safeguarding issues, residency, etc.
- be involved in management of their own health needs.

**The Trust will work with referrers to ensure:**

- patients/service users are clinically suitable for referral.
- accurate, complete, timely, and clinically relevant information is provided.
- all pre-referral diagnostic tests and results are communicated in a timely fashion.
- referrals are made only after relevant alternatives have been explored.
- referral to the 'service' and not a named individual.
- provision of the national minimum core data set.
- choice options are discussed with patients / service users, and they understand the nature of the referral;
- details are provided of any specific patient/service user needs e.g. language, interpreter, guardianship, literacy difficulties, safeguarding issues, residency, etc.
- the patient/service user is available for treatment.
- after a referral has been made inform of any changes e.g. change of address, patient / service user no longer wishes to be seen, or is deceased.
- patients / service users are aware of their responsibilities.

## 5.0 Consent

Clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment described in this policy is delivered. Consent can be given orally and/ or in writing. Someone could also give non-verbal consent if they understand the treatment or care about to take place. Consent must be voluntary and informed, and the person consenting must have the capacity to make the decision.

In the event that the patient's capacity to consent is in doubt, clinical staff must ensure that a mental capacity assessment is completed and recorded. Someone with an impairment of or a disturbance in the functioning of the mind or brain is thought to lack the mental capacity to give informed consent if they cannot do one of the following:

- Understand information about the decision
- Remember that information
- Use the information to make the decision
- Communicate the decision

## 6.0 Monitoring Compliance and Effectiveness

### 6.1 Monitoring Policy Compliance

| **Page/ Section** | **Minimum requirements to monitor** | **Method of monitoring** | **Responsible individual / group** | **Where results and any associated Action Plan will be reported to, implemented and monitored** (usually via the relevant governance group) and frequency |
|---|---|---|---|---|
| Section 3.5 | Standard Operating Procedures (SOP) developed and in place for all services and reflect national / local requirements incl. PTL. Staff will be trained in content and application as part of local training. | Service level assurance groups | Service Directors / DMT / ADG/ AFM | Directorate DMT with assurance through Access Delivery Group and Accountability Framework as required. DMT are held monthly, with all SOP reviewed annually or more frequently if wider changes require this. |
| 3.21.1 / 3.21.2 | Trust level Waiting Times Compliance Report and local dashboards available for all services | Service level assurance groups / Access Delivery Group / Board Performance Report. | Service Directors / DMT / ADG/ AFM | Directorate DMT with assurance through Access Delivery Group and Accountability Framework as required. DMT are held monthly with services of concern escalated to ADG / AFM as required |

### 6.2 Care Quality Commission Regulations

This policy will support compliance with CQC Regulations 9, 12 and 17

### 6.3 National Standards

This policy will support compliance with the following national access standards:

| TARGET/STANDARDS | KEY PERFORMANCE INDICATOR |
| --- | --- |
| 60% | Early Intervention in Psychosis (PIER) – two weeks from referral to NICE concordant treatment |
| 99% | Referral to Diagnostic Test (Audiology) – 6 weeks from referral to test |
| 95% | CAMHS ED – one week to NICE Concordant treatment (urgent referrals) |
| 95% | CAMHS ED – four weeks to NICE Concordant treatment (routine referrals) |
| 70% | Urgent Community Response - 70% achievement of two-hour UCR care standard. |
| Shadow monitoring from April 2025. | People of all ages presenting to community-based mental health services should commence care within four weeks of referral. |

### 6.4 Local Standards

This policy will support the delivery of service specifications in the Trust's contracts with its commissioners. These documents are subject to regular review to ensure they are appropriate and consistent with the commissioned service. Each service specification will include an agreed set of KPI which, where relevant, will include a waiting time standard. These will reflect national standards where these are in place, where no national standards apply local standards will be agreed. It is expected that these will reflects the principles of RTT i.e. measure a wait from referral to treatment. Treatment may commence at first appointment or at a later point depending on the clinical pathway.

It is recommended that where local standards are agreed that, unless clinically indicated, these are consistent across all services. Services may agree differential targets for urgent and routine cases.

The Trust and its commissioners will maintain an ongoing review of local waiting times targets and standards across all service lines and agree the action required to align these to national approaches to waiting time measurement should these be developed.

## 7.0 References and Bibliography

The policy was drafted with reference to the following:


- Referral to treatment consultant-led waiting times rules suite – Department of Health and Social Care October 2022

- Community Health Services Two-Hour Urgent Community Response Standard – NHSE March 2022

- Mental Health Access and Waiting Times Standards - Early Intervention in Psychosis, Children and Young People Eating Disorders, Adult and Children Community Mental Health Services

- The Management of Non-Attendance/ Did Not Attend (DNA)/ Was Not Brought (WNB), including Did Not Gain Access Policy for Adults

- Policy for Children and Young People who Did Not Attend (DNA) or Were Not Brought (WNB) for Health Appointments (including No Access Visits (NAV))


## 8.0 Fraud, Bribery and Corruption Consideration

The Trust has a zero-tolerance approach to fraud, bribery and corruption in all areas of our work and it is important that this is reflected through all policies and procedures to mitigate these risks.

Fraud relates to a dishonest representation, failure to disclose information or abuse of position in order to make a gain or cause a loss. Bribery involves the giving or receiving of gifts or money in return for improper performance. Corruption relates to dishonest or fraudulent conduct by those in power.

If there is any suspicion that an aspect of this policy or service covered by it is knowingly being used fraudulently or to misrepresent the Trust's performance or compliance with its statutory obligations, contact should be made with the Trust's Local Counter Fraud Specialist (LCFS).

**Appendix 1**

## Training Needs Analysis

| | |
|---|---|
| **Training topic:** | Access To Treatment Policy |
| **Type of training:**<br>(see Study Leave Policy) | Role specific |
| **Division(s) to which the training is applicable:** | Directorate of Mental Health<br>Community Health Services<br>Families Young People Children & Learning Disability and Autism<br>Enabling Services<br>Hosted Services (LHIS) |
| **Staff groups who require the training:** | Clinical Teams (all professions) administrative and clerical staff managers |
| **Regularity of update requirement:** | On review of policy/national or local policy changes |
| **Who is responsible for delivery of this training?** | Line managers |
| **Have resources been identified?** | Training will be provided within existing resources |
| **Has a training plan been agreed?** | To be agreed as part of the Policy Implementation Plan |
| **Where will completion of this training be recorded?** | Local training sessions via MS Teams / face to face sessions to meet the requirements of individual services |
| **How is this training going to be monitored?** | Training will be monitored at a local level by business teams with oversight from the Access Delivery Group |

**Appendix 2**

## The NHS Constitution

- The NHS will provide a universal service for all based on clinical need, not ability to pay.
- The NHS will provide a comprehensive range of services and will:

| | |
|---|---|
| **Shape its services around the needs and preferences of individual patients, their families and their carers** | **Yes** |
| **Respond to different needs of different sectors of the population** | **Yes** |
| **Work continuously to improve quality services and to minimise errors** | **Yes** |
| **Support and value its staff** | **Yes** |
| **Work together with others to ensure a seamless service for patients** | **Yes** |
| **Help keep people healthy and work to reduce health inequalities** | **Yes** |
| **Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance** | **Yes** |

**Appendix 3**

## Due Regard Screening Template

| **Section 1** | |
|---|---|
| **Name of activity/proposal** | Access to Treatment Policy |
| **Date Screening commenced** | 1 October 2024 |
| **Directorate / Service carrying out the assessment** | Finance and Performance |
| **Name and role of person undertaking this Due Regard (Equality Analysis)** | Anne Senior – Associate Director |
| **Give an overview of the aims, objectives and purpose of the proposal:** | |
| **AIMS:**<br>The purpose of this policy is to ensure best practice is adopted in the management of access to treatment and that this is underpinned by sound and consistent decision making, ensuring that all service users can access services in line with clinical need. | |
| **OBJECTIVES:**<br>The Access to Treatment Policy is intended to provide clinical and non-clinical staff with a clear statement on how to manage access to treatment in a way that supports clinical need, minimises the risk of harm to patients / service users as a result of waits and to improve outcomes and quality of care. | |

| **Section 2** | |
|---|---|
| **Protected Characteristic** | **If the proposal/s have a positive or negative impact please give brief details.** |
| Age | N/A |
| Disability | N/A |
| Gender reassignment | N/A |
| Marriage & Civil Partnership | N/A |
| Pregnancy & Maternity | N/A |
| Race | N/A |
| Religion and Belief | N/A |
| Sex | N/A |
| Sexual Orientation | N/A |
| Other equality groups? | N/A |

| **Section 3** | | | |
|---|---|---|---|
| **Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please <u>tick</u> appropriate box below.** | | | |
| Yes | | No | |
| High risk: Complete a full EIA starting click here to proceed to Part B | | Low risk: Go to Section 4. | X |

| **Section 4** | | | |
|---|---|---|---|
| **If this proposal is low risk please give evidence or justification for how you reached this decision:** | | | |
| This policy updates an existing policy framework | | | |
| **Signed by reviewer/assessor** | [signature] | **Date** | 30/09/2024 |
| *Sign off that this proposal is low risk and does not require a full Equality Analysis* | | | |
| **Head of Service Signed** | [signature] | **Date** | 31/10/2024 |

## Appendix 4 DATA PRIVACY IMPACT ASSESSMENT SCREENING

**Data Privacy Impact Assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy.**
**The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.**

| | | | |
|---|---|---|---|
| **Name of Document:** | Access to Treatment Policy | | |
| **Completed by:** | Anne Senior | | |
| **Job title** | Associate Director | | **Date** 30/09/2024 |

| **Screening Questions** | **Yes/No** | **Explanatory Note** |
|---|---|---|
| **1.** Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document. | N | |
| **2.** Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document. | N | |
| **3.** Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document? | N | |
| **4.** Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used? | N | |
| **5.** Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics. | N | |
| **6.** Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them? | N | |
| **7.** As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private. | N | |
| **8.** Will the process require you to contact individuals in ways which they may find intrusive? | N | |

**If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via** lpt.dataprivacy@nhs.net
**In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.**

| | |
|---|---|
| **Data Privacy approval name:** | **Anne Senior - Associate Director Contracts and Planning** |
| **Date of approval** | **30/07/2024** |

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust

**Appendix 5**