Leicestershire Partnership NHS Trust

Access to Treatment Policy

This policy sets out the overall expectations of the Leicestershire Partnership NHS Trust (LPT) on the management of referrals for 'elective care' into and within the organisation, reflecting national standards, data definitions and aligns (where clinically appropriate) to national Referral to Treatment Guidance. For the purposes of this policy elective care is defined as care that is planned in advance and does not require an emergency or urgent response.

Key words:	Bookings, appointments, non-attendance	
Version:	2	
Adopted by:	Trust Policy Committee	
Date this version was adopted:	16 April 2021	
Name of Author:	Anne Senior, Associate Director Business Development and Contracting	
Name of responsible Committee:	Strategic Waiting Times and Harm Review Committee	
Please state if there is reason for not publishing on website:	n/a	
Date issued for publication:	April 2021	
Review date:	March 2023	
Expiry date:	1 October 2023	
Target audience:	All clinical and non-clinical staff involved with the booking, management and performance of elective pathways	
Type of Policy	Clinical ✓	Non Clinical
Which Relevant CQC Fundamental Standards?	9, 12 and 17	

Contents

REFERENCES AND ASSOCIATED DOCUMENTATION

Version Control and Summary of Changes

Version number	Date	Comments (description change and amendments)
AP1.1	13/06/19	First Review
AP1.2	04/10/19	Second Review
AP1.3	09/03/20	Third Review
AP1.4	20/08/20	Fourth Review
AP1.5	02/10/20	Final

For further information contact:

Associate Director Business Development and Contracting
Leicestershire Partnership NHS Trust
Room 170

County Hall
Glenfield
Leicester
LE3 8TH

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.

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 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 4) of this policy.

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:

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, group etc. as defined in the service standard operating process) after a patient/service user has been referred. Waiting list returns for first appointments include all referrals to all clinical teams.

Booked appointment types	Where a patient/service user is given choice in the date, time and, where applicable, the appointment location.

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 First Appointment (patient/service user)	If a patient/service user is offered a date/time for a first appointment and they cancel, the waiting time will continue to accrue from the date of referral until the first successful appointment or discharge without treatment.
Cancelled First Appointment (provider)	If the Trust cancels or postpones a first appointment for **any** reason, the waiting time continues to be counted from the original date of referral. 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 at least 6 weeks' notice if appointments needs to be cancelled/changed.
Did Not Attend First Appointment	If a patient/service user does not attend a first appointment and does not give prior notice[1], the waiting time will be recalculated from the date of the appointment.
Did Not Attend Follow-Up Appointment	Where a patient/service user does not attend a follow-up appointment whilst on a treatment pathway and does not give prior notice, the waiting time continues to be counted from the original date of referral.
Was Not Brought (child/young person)	Where a child or young person is not brought to their appointment. The process for dealing with this is covered in the Trust Guideline covering Safeguarding of Children And Young Adults Not Brought For Appointments
Was Not Brought (vulnerable adult)	Where a vulnerable adult is not brought to their appointment. The process for dealing with this is covered in the Trust DNA Policy
Named Clinician Referral	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'
Routine Referrals	Referrals received which are not deemed urgent by either the referrer or the receiving team.
Rejected Referrals	Referrals can be rejected with the following reasons: • Duplicate referral - patient/service user already undergoing treatment for the same condition by the same or other Health Care Provider;

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

	• Inappropriate referral - referral is inappropriate for the service offered by the Health Care Provider (determined by agreed referral criteria); • Incomplete referral - referral has insufficient information provided to enable referral to be accepted/ processed.
Referral Date	The date the referral is received. All referrals must be entered onto the EPR in line with the Record Keeping Policy.
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.
Treatment	The first clinical intervention intended to manage a patient's disease, condition or injury and avoid further clinical interventions.
Standard Operating Procedure	The written instructions necessary to achieve a consistent approach to a process; they also provide a platform for providing training, monitoring compliance and assessing quality.
Referral to Treatment	Period from receipt of referral and first definitive treatment

1.0 Purpose of the 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, first appointment 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.

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

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

2.0 Summary and Key Points

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 2015 and takes into account changes in national and local requirements in the intervening period.

3.0 Introduction

The Trust is committed to ensuring patients/service users will be treated at the right time and according to their 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 achieve 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.

4.0 Reporting

The Trust will report referral to treatment (or as defined in national/local service specification) waiting times for all services through the Waiting Times Compliance Report with additional tailored reports provided for governance committees including 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.

4.1 Information Assurance Framework

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

All waiting times will be recorded and reported in line with national Referral to Treatment rules or as otherwise defined by NHS England.

The Head of Information will work with Directorate Business Teams to compile and regularly update the Information Assurance Framework to support a consistent, Trust-wide 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 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.

5.0 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. These will reflect national requirements or, where appropriate, locally agreed targets.

5.1 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
- ensure patients/service users not ordinarily resident in the UK are identified;
- 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;

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

5.2 Inappropriate referrals

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

If this requires redirection within LPT the referral will be forwarded to the appropriate service and the referrer advised accordingly.

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

5.3 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 CCG websites) 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 writing 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.

5.4 Tertiary referrals

Where referral to a tertiary provider is required, clinical staff should follow the relevant commissioned pathway. Clinical staff should seek advice from the Directorate Business Manager 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.

5.5 War Veterans

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

War veterans should be identified at referral and are entitled to clinical priority treatment for any condition directly attributable to injuries sustained during their military service. 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 war veteran is clearly communicated within the referral letter.

5.6 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 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 who are registered with a civilian GP should be treated as per any other registered patient/service user.

5.7 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.

5.8 Booking of Appointments

All services will operate a partial or full booking system. Fixed (non-negotiated) appointments should only be used after all reasonable attempts have been made to contact the patient/service user to agree and book an appointment.

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

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 which includes:

All initial appointments offered must be followed by a confirmation letter which includes:

- a point of contact
- telephone number (including details of how to leave a message) and email address for queries
- contact details if the patient/service user is not able 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

Services must monitor processes to ensure:

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

5.9 Reasonable Notice

All routine appointments should be offered to the patient / service user with reasonable notice; national guidance (set out in the 'Consultant-led RTT Clock Rules Suite') 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 Referral to Treatment target. Where targets have a shorter timescale (this is the case for a number of LPT services), the individual services must establish a local alternative and include this in the service SOP.
Alternative definitions of 'reasonable notice' must take into account the needs of patients/service users and ensure that they are not disadvantaged by the agreed definition of reasonable notice.

5.10 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.

5.11 Clock Stop/ Start Rules for Referral to Treatment Pathways

National RTT rules can be found via the hyperlink below:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/255582/RTT_Rules_Suite_April_2014.pdf

Service SOPs will detail the application of national RTT rules in individual services.

6.0 Monitoring

6.1 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 will breach a waiting time target or whose condition has deteriorated.

Regular PTL meetings will be in place for all services. The service manager responsible for service delivery will determine the required attendees and frequency of meetings and agree these via local governance processes. The PTL will be action-orientated and focus on:

- existing/imminent breaches and data quality issues;
- prospective management of service users along the pathway;
- clearing any backlog of service users waiting longer than national or local targets;
- ensure no patient/service user waits over 52 weeks
- 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.

Agreement on good practice, format, content and the review process for PTL meetings will be agreed as part of the implementation programme for this Policy and once agreed will be attached to this policy as an Appendix.

6.2 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 NHSI/E / 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 Executive Team, Quality Assurance and Finance and Performance Committees and Trust Board regularly, in accordance with the Trust Performance Management Framework.

7.0 Duties within the Organisation

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

7.1 Governance

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

- Trust Board Sub-committees have the responsibility for ratifying policies and protocols.

- Performance oversight will be provided through Performance Reviews to Executive Team and to Finance and Performance Committee via the Trust Governance structure.

- Clinical Governance oversight will be provided through Directorate Clinical Governance Teams to Executive Team and to Quality Assurance Committee via the Trust Governance structure.

7.2 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, Business and Estates is the Trust SIRO and responsible for the Information Governance aspects of this policy.

7.3 Operational

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 and cover for absences.
- Work with administrative and managerial colleagues to manage waiting lists to maximise compliance with national and local targets.
- Ensure 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.
- operational users of systems have access to functionality appropriate to their role.
- Patients/service users are managed in order of clinical urgency and then chronological order using PTLs to support 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.

7.4 Corporate

Associate Director of Business Development and Contracting will:

- Review any requests for counting changes and feed into contract negotiations.
- Report on overall performance on waiting times to Executive Team and Finance and Performance Committee

Information Management 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.

7.5 External

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.

Responsibility of Clinical Staff

• 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

8.0 Training Needs

There is a need for training identified within this policy. In accordance with the classification of training outlined in the Trust Learning and Development Strategy this training has been identified as role development training.

The implementation plan for this policy will determine the programme, delivery methods, records required and expected learning outcomes.

The governance group responsible for monitoring the training is the Waiting Times and Harm Review Committee.

9.0 Monitoring Compliance and Effectiveness

Minimum Requirements	Evidence for Self-assessment	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
Standard Operating Procedures developed and in place to cover all services and that these reflect national /local requirements incl. PTL	Standard Operating Procedures in place for all service lines operating a waiting list.	Service level assurance groups	Service Directors	Minimum of annual
Wait times compliance dashboards developed for all services	Adherence to national operating standards/ locally defined requirements	Integrated Quality Performance Report / Waiting Times Compliance	Head of Information	Monthly

Minimum Requirements	Evidence for Self-assessment	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
	as appropriate	Report		

10.0 Standards/Performance Indicators

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

10.1 National 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)

10.2 Local Standards

Local standards are contained within the Trust's contracts with its commissioners and are subject to regular review to ensure that these are appropriate and are consistent with the commissioned service.

During 2020/21 the Trust and its commissioners will review existing 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.

11.0 References and Bibliography

The policy was drafted with reference to the following:

- Referral to treatment consultant-led waiting times Rules Suite – Department of Health 2014
- LPT DNA Policy

Appendix 1

Training Needs Analysis

Training topic:	Access To Treatment Policy
Type of training: (see Study Leave Policy)	Role specific
Division(s) to which the training is applicable:	Adult Mental Health & Learning Disability Services Community Health Services Enabling Services Families Young People Children Hosted Services (HIS)
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 (once permitted) 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 Waiting Times and Harm Review Committee

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

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

Appendix 3

Key individuals involved in developing the document

Name	Designation
Anne Senior	Associate Director - Business Development and Contracting
Laura Hughes	Head of Information
Zayba Joondan	Business Manager AMH.LD
Julia Bolton	Business Manager FYPC
Vicki Quinn	Business Manager CHS
Lyn Williams	Associate Director for Quality Improvement

Circulated to the following individuals for comment

Name	Designation
Alison Wheelton	Senior Mental Health Act Administrator
Anne Scott	Chief Nurse
Avinash Hiremath	Medical Director
Chris Poyser	Corporate Finance Manager
Dani Cecchini	Director of Finance, Business and Estates
Fabida Noushad	Clinical Director – AMH
Frank Lusk	Trust Secretary
Helen Thompson	Service Director FYPC
John Edwards	Associate Director Transformation
Julia Bolton	Business Manager - FYPC
Kamy Basra	Head of Communications
Kate Dyer	Head of Assurance
Laura Hughes	Head of Information
Mark Roberts	Assistant Director – FYPC
Neil King	Trust Lead for Safeguarding
Rachel Bilsborough	Service Director - CHS
Sam Wood	Business Manager - AMH.LD
Sarah Willis	Director of HR & OD
Sharon Murphy	Deputy Director of Finance
Vicki Quinn	Head of Business - CHS
Zayba Joondan	Business Manager - AMH

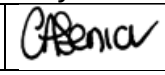
Appendix 4

Due Regard Screening Template

Section 1	
Name of activity/proposal	Access to Treatment Policy
Date Screening commenced	1 Oct 2020
Directorate / Service carrying out the assessment	Business, Finance and Estates
Name and role of person undertaking this Due Regard (Equality Analysis)	Anne Senior – Associate Director, Business Development and Contracting
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: 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: The Access Policy is intended to provide 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 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		**Date**	9 /10/2020
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed		**Date**	

Appendix 5

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** 9/10/20
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@leicspart.secure.nhs.uk **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**		
Date of approval	**9/10/2020**		

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

Appendix 6

WAITING TIMES AND HARM REVIEW – GOVERNANCE STRUCTURE