Ref No: CP1509

Sheffield Children's NHS Foundation Trust

Corporate Policy

Patient Access Policy

Author/Contact Person	Date Approved by Performance Committee	Implementation Date	Version number	Issue Date	Review Date
Killian Burke, Head of Performance and Planning	September 2022	September 2022	9	September 2022	September 2025

REQUIREMENT	ACTION
Who should be aware of the policy and where to access it	Staff who are involved in delivering elective treatment
Who should understand the policy	Chief Executive Associate Directors Medical Director
Who should have a good working knowledge of the policy	Care Group Operational Managers Performance Team Consultants and clinical staff Staff involved in the administration or management of outpatient and/or elective care
Whether the policy should be included in the General Trust Induction Programme and/or departmental specific induction programme	To be included within the local Trust induction of the those staff groups listed above
Where is the Policy available:	Intranet and Trust website
Copy to be sent to personnel with a request for inclusion in induction documents	Yes
Copy to:	Quality and Compliance Department for Intranet site and Policy Database
Process for monitoring the effectiveness of this document	Integrated Performance Report through Executive Team and Performance Committee
Patient version	No
Groups/persons consulted	Corporate and Care Group Harm Panel, Care Group Boards, Data Quality Group, Executive Team and Performance Committee
Training	See enclosed training programme in appendix 3
This Policy is subject to the Freedom of Information Act	

Contents

1 Introduction

1.1 This policy describes how Sheffield Children's NHS Foundation Trust (hereafter referred to as the Trust or SCFT) manages access to its services to ensure equitable access for all patients in line with national and local standards, as set out under the NHS Constitution. The successful management of patient waiting lists is key to ensuring timely access to services and facilitates the delivery of high-quality care.

2 Scope

2.1 This policy is intended to be used by all staff involved with patient pathways and waiting list management. It details how elective patients will be managed administratively at all points of contact with the Trust. This includes patients waiting for outpatient, inpatient and diagnostic services as part of cancer, Referral to Treatment (RTT) and planned pathways of care. It covers patients waiting for both consultant, and non-consultant led services across mental and physical health. Where non-consultant led services have different or additional guidance and management principles, these are included in service specific sections towards the end of the policy.

2.2 This policy does not cover non-elective waiting time standards, such as the requirement for 95% of patients to have a total time in A&E of less than 4 hours from arrival to admission, transfer or discharge. This and other non-elective waiting time standards are managed in accordance with published NHS guidance.

2.3 The policy is not intended to replace departmental standard operating procedures, but act as a framework to support them.

3 Purpose

3.1 Treating patients and delivering a high quality, efficient and responsive service, with prompt communications with patients and families, is a core responsibility of the Trust. By working to the principles and guidelines set out in this policy, colleagues can ensure the Trust delivers this standard of service to patients.

3.2 Adherence to the policy will ensure access to the Trust's services is in line with national standards, including 18-week Referral to Treatment, the Cancer Waiting Time Standards, the 6 week diagnostic waiting time standard and patients' rights under the NHS Constitution. Where services are not covered by national access standards, this policy will ensure that local standards are met.

3.3 The overriding principle of this policy is that patients will be treated in order of clinical priority, and that patients of the same clinical priority will be seen in order of their length of wait. Clinical priority is assigned by clinicians through the grading process when referrals are received. Patients are also clinically prioritised when added to an elective surgical waiting list using Royal College of Surgeons (RCS) Priority (P) codes and a locally agreed clinical harm RAG rating.

4 Definitions

Term	Definition
Active monitoring	A decision is made (and agreed with the patient) that it is clinically appropriate to monitor the development of the patient's condition over time without any specific or significant clinical intervention or treatment, although the patient may receive symptomatic support. The patient remains under the clinical responsibility of the consultant during this period. The patient is not on an active RTT ticking clock.
Careflow	The Trust's main electronic patient record for acute patient care.
eDMS	The Trust's electronic document management system (eDMS). It allows staff to create, capture and handle electronic case notes and provides them with instant, secure online access to accurate, up-to-date case notes at the point of care.
e-RS (Electronic referral system)	The electronic system used by GPs to refer patients into the Trust. It can allow the GP or patient to book directly into an appointment.
First Definitive Treatment	The first clinical intervention intended to manage a patient's disease, condition or injury and avoid further clinical interventions. What constitutes First Definitive Treatment is a matter of clinical judgement in consultation with others, where appropriate, including the patient.
IPT (Inter-provider transfer)	A patient who is referred from a different Trust to SCFT, for investigation and treatment of the same condition. The patient becomes the clinical responsibility of SCFT and if the patient is on an RTT pathway, it is reportable by SCFT. Requests for advice or referrals solely for a diagnostic test are not IPTs.
Patient Hub	Allows patients/parents to view their appointments from their phone or desktop following notification of an appointment booking sent via text and/or email. It allows patients/parents to have access to a range of functions including: view appointment letters in the system, see Google maps directing them to the clinic location, add the appointment to their local calendars, click on a rebook button to put them into the Outpatient Contact Centre, view additional material such as clinic specific videos etc.
Planned Patient	A patient who needs to be admitted for a treatment or investigation, but there is a set timescale for the admission. The patient cannot be admitted before this, for clinical reasons. An example of this would be an annual endoscopy to monitor a chronic gastroenterology condition.
RAS (Referral Assessment Service)	Functionality within e-RS which allows clinicians to triage referrals before booking an appointment, to decide on the most appropriate clinical pathway. If an appointment is not required, the clinician may respond to the original referrer with advice and guidance.
Reasonable offer	Patient is offered 2 two different dates for an appointment or To Come In (TCI) date, with 3 weeks' notice.

5 Roles and Responsibilities

Roles	Responsibilities
Chief Executive and Chief Operating Officer	The Chief Executive Officer (CEO) and Chief Operating Officer (COO) have overall responsibility for the implementation of this policy and board level accountability for the delivery of elective access standards. They are responsible for ensuring the delivery of targets and monitoring compliance of elective access standards.
Clinicians	Clinicians have a responsibility for adhering to key internal procedures in the proactive management of patients along their pathway. Key examples include clinical prioritisation of patients and timely, accurate completion of clinic outcome forms and discharge summaries.
Associate Directors of Operations, Service and Operational Managers	Associate Directors and Service/Operational Managers are responsible for ensuring this policy is implemented within their Care Group. This includes ensuring that processes in place are compliant with this policy, with Standard Operating Procedures (SOPs) documented, and monitoring that these are followed correctly. They have further responsibilities to minimise waiting times in their services, including managing capacity and demand.
Head of Planning and Performance	The Head of Planning and Performance is responsible for ensuring that waiting lists and performance against waiting time standards are accurate, through regular high-quality validation of patient pathways. They are also responsible for the delivery of training about waiting time standards and the access policy for all staff groups.
Head of Information	The Head of Information is responsible for ensuring staff members have access to timely and accurate reports to help them manage patients and avoid breaches. They are also responsible for producing and submitting performance management data to external sources, ensuring it conforms to national guidelines and timeframes.
Administration Staff	Staff members who book or schedule any aspect of patient care are responsible for adhering to this policy and local standard operating procedures on a day-to-day basis. This will ensure patients are prioritised correctly and minimise waiting times. They are responsible for escalating any exceptions where standards or processes are breached, to the relevant management team.

6 Health Inequalities

6.1 Waiting lists, patient pathways and their respective management will be viewed through the health inequalities lens. The Trust works closely with system partners on the Health Inequalities agenda, with this policy aligning and adhering to the Trust Health Inequalities Action Plan. This plan is monitored through an Integrated Performance Report which is presented at Trust Board and its sub committees. The Trust board receive the Health Inequalities Integrated Performance Report on a quarterly basis which disaggregates the waiting list and activity levels by ethnicity and Indices of Multiple Deprivation (IMD) – ultimately highlighting any areas of disparity that require attention.

6.2 The Trust has committed to ensuring all colleagues in the trust have an awareness of health inequalities and will have the training, resources and toolkits to recognise the impacts on access, experience and outcomes and be able to sensitively offer help and improve services to address this. We will use data and feedback to proactively seek out groups that experience health inequalities and consider all services and decisions from a health inequalities perspective, from frontline to board level. This policy has been reviewed with reference to this strategic commitment.

6.3 The Trust has tools to support equity of access for all patients, including, but not limited to, a Was Not Brought (WNB) predictor tool to allow the Trust to identify and contact patients most likely to not attend appointments, with the intention to work with families to remove any potential barriers to attending.

6.4 Through the Waiting Well programme of work the organisation seeks to communicate with patients and families whilst they are awaiting an appointment or procedure. This is to both offer advice and support whilst waiting, alongside clear route via which to contact the organisation if a child's condition or needs have changed. The organisation seeks to understand the best mechanisms to communicate with and engage patients and families in their care whilst waiting, and responses to Waiting Well communications are monitored by ethnicity and IMD to continually review the methods utilised.

7 Waiting Time Standards

7.1 The current national waiting time standards fall into three areas:

- Referral to treatment time (maximum 18 weeks)
- Waiting times for Cancer treatment
- Diagnostic Waiting Times

7.2 Patients may fall under several of these waiting time standards at once, e.g. a patient may be on an active RTT pathway and a diagnostic pathway, if a consultant refers the patient to a diagnostic test before first definitive treatment.

Referral To Treatment (RTT)

7.3 Patients on consultant-led pathways have the right to start their first definitive treatment within a maximum of 18 weeks from referral, as per the NHS Constitution. This is measured from when the Trust received the referral.

7.4 The performance of the Trust against this standard is required to be:

Target	Standard	National Guidance
92%	Patients on an incomplete pathway (i.e. still waiting for treatment) should be waiting no more than 18 weeks (or 127 days)	https://www.england.nhs.uk/rtt/

18 Week RTT Pathway Clock Starts

7.5 RTT pathways start when a referral is made to:

- A Consultant-Led service, regardless of setting, with the intention that the patient will be assessed and, if appropriate, treated before responsibility is transferred back to the referring health professional or general practitioner
- A referral management or assessment service, which may result in an onward referral to a consultant-led service before responsibility is transferred back to the referring health professional or general practitioner

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

- when a patient becomes fit and ready for the second of a consultant-led bilateral procedure;
- upon the decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan;
- upon a patient being re-referred into a consultant-led; referral management or assessment service as a new referral;
- when a decision to treat is made following a period of active monitoring;

- when a patient rebooks their appointment following a first appointment Was Not Bought/Did Not Attend (WNB/DNA) that stopped and nullified their earlier clock.

- A planned patient becomes overdue for their planned procedure.

18 Week RTT Pathway Clock Stops

7.7 A clock stops when first definitive treatment starts. This could be:

- Treatment provided by a consultant-led service;

- Non consultant led treatment is provided, if the consultant decides it the best way to manage the patient's disease, condition or injury and avoid further interventions;

7.8 A clock may also stop without a patient receiving treatment. In this situation, the waiting time clock stops when it is communicated to the patient and referrer that:

- A clinical decision is made to start a period of active monitoring

- A patient declines treatment having been offered it

- A clinical decision is made not to treat

- Patient has treatment as an emergency which was previously intended to be done electively

- A patient WNB/DNAs their first appointment following the initial referral that started their waiting time clock, provided that the provider can demonstrate that the appointment was clearly communicated to the patient (WNB/DNAs for a first appointment following the initial referral that started a waiting time clock nullify the patient's clock)

Cancer Waiting Times

7.9 There are a number of key cancer waiting times standards that the Trust must comply with.

Cancer waiting times standards	
93%	Patients must have their first outpatient appointment within 14 days of the referral received date for: • Urgent GP (General Medical Practitioner or General Dental Practitioner) referral for suspected cancer • Referral of any patient with breast symptoms (where cancer not suspected)
75%	Patients must have a diagnosis of cancer confirmed or ruled out within 28 days of the referral received date
96%	Patients must receive their first definitive treatment within 31 days from decision to treat.

94%	Patients must receive their first definitive treatment within 31 days from decision to treat/earliest clinically appropriate date (ECAD) to start of subsequent treatment(s) where the subsequent treatment is surgery
98%	Patients must receive their first definitive treatment within 31 days from decision to treat/ECAD to start of subsequent treatment(s) where the subsequent treatment is drug treatment
94%	Patients must receive their first definitive treatment within 31 days from decision to treat/ECAD to start of subsequent treatment(s) where the subsequent treatment is radiotherapy
85%	Maximum 62 days from urgent GP referral for suspected cancer to first treatment However, for the Trust, the following standard overrides the 62 day wait, as all cancers seen at the Trust are children's cancers: Maximum 31 days from urgent GP referral to first treatment for acute leukaemia, testicular cancer and children's cancers
90%	Maximum 62 days from urgent referral from an NHS cancer screening programme for suspected cancer to first treatment
No operational standard yet	Maximum 62 days from consultant upgrade of urgency of a referral to first treatment

National guidance can be found at https://www.england.nhs.uk/statistics/statistical-work areas/cancer-waiting-times/

Cancer Pathway Clock Starts

7.10 Two week wait pathways start on the referral received date.

7.11 A 62-day cancer clock can start following the below actions:

- urgent two-week wait referral for suspected cancer
- urgent two-week wait referral for breast symptoms (where cancer is not suspected)
- a consultant upgrade where the consultant has made the patient aware that they are now on a cancer pathway
- referral from NHS cancer screening programme
- non NHS referral (and subsequent consultant upgrade).

7.12 A 31-day cancer clock will start following:

- a decision to treat for first definitive treatment

- a decision to treat for subsequent treatment
- application of an ECAD (Earliest Appropriate Clinical Date).

Diagnostic Waiting Times (DM01)

7.13 For the applicable diagnostic tests, the performance of the Trust against this standard is required to be:

Diagnostics	
99%	Patients must undergo the relevant diagnostic investigation within 5 weeks and 6 days (or 41 days) from the date of decision to refer to appointment date. This excludes planned diagnostic investigations. This is reported for each patient waiting on the last day of the month.

Diagnostic tests applicable to DM01 standard	
Imaging	Magnetic Resonance Imaging (MRI)
	Computed Tomography (CT)
	Non-obstetric ultrasound
	Barium Enema
	DEXA Scan
Physiological Measurement	Audiology - Audiology Assessments
	Cardiology - echocardiography
	Cardiology - electrophysiology
	Neurophysiology - peripheral neurophysiology
	Respiratory physiology - sleep studies
	Urodynamics - pressures & flows
Endoscopy	Colonoscopy
	Flexi sigmoidoscopy
	Cystoscopy
	Gastroscopy

8 Clinical Priority and Clinician Harm Ratings

8.1 As stated above, the overriding principle of this policy is that patients will be treated in order of clinical priority, and that patients of the same clinical priority will be seen in order of their length of wait. Clinical priority is assigned by clinicians through the grading process when referrals are received.

8.2 There are a number nationally mandated priority ratings which are to be applied to any patient requiring a diagnostic procedure and any patient who is added to an inpatient waiting list for surgery. Where patients are added to a non-surgical waiting list for treatment, they are prioritised based on whether they are Urgent or Routine.

8.3 The priority of a diagnostic test is determined by the potential of a condition to cause harm to the patient, if not diagnosed and treated.

Priority	Definition
D1	Potentially life-threatening or time-critical conditions, including emergency patients
D2	Potential to cause severe disability or severe reduction to of quality of life, including 2WW Cancer patients
D3	Chronic complaints that impact on quality of life and may result in mild or moderate disability, including routine patients normally seen within 6 weeks.
D4	Chronic complaints that impact on quality of life and may result in mild or moderate disability. Routine patients that would normally be seen within the next 6-12 weeks
D6	Patient choice to delay

8.4 Patients are clinically prioritised when added to an elective inpatient surgical waiting list using Royal College of Surgeons (RCS) Priority (P) codes and a locally agreed clinical harm RAG rating. All patients added to a surgical waiting list should have both a P code and RAG rating at the point they are listed.

8.5 RCS P codes are procedure based, with set guidelines for certain procedures being completed within a given timeframe.

RCS Priority	Definition
RCS P1a	Emergency procedures to be performed in <24 hours
RCS P1b	Procedures to be performed in <72 hours
RCS P2	Procedures to be performed in <1 month
RCS P3	Procedures to be performed in <3 months
RCS P4	Procedures to be performed in >3 months
RCS P6	Patient choice to delay after they have been added to a waiting list

8.6 Harm RAG ratings are allocated to patients based on the potential of clinical harm should the patient continue to wait. The RAG rating takes a holistic approach to each patient, rather than being procedure specific. For example, clinicians may give consideration to the impact on the patient's mental health and education, as well as their physical health.

Harm Rating	Definition
Red	Patient will come to clinical harm should they continue to wait
Amber	Patient will likely come to clinical harm should they continue to wait
Green	Patient is unlikely to come to clinical harm should they continue to wait

8.7 There are no definitive time frames for treatment attached to each harm rating. However, Red patients are most clinically urgent so would be offered the next available TCI. Patients with an Amber RAG rating are assigned Amber 1, Amber 2 and Amber 3 categories. These patients are all at a similar risk of harm, but the further categorisation provides guidance to the waiting list team about the order the clinician would like the patients seen in.

9 Referrals

9.1 The primary route for the receipt of GP referrals will be electronically through the NHS e-referrals System (ERS). However, referrals will also be received electronically through NHS mail for internal referrals, and either through NHS mail or paper letters for referrals from other Trusts.

9.2 If a patient is referred for a procedure that is not routinely commissioned and does not have a completed Individual Funding Request (IFR) attached with the referral, it will be rejected by the clinician.

9.3 It is the responsibility of the referrer to ensure the referral letter contains accurate and up to date demographic information regarding the patient. Referrals must include full demographic details including ethnicity data, as well as including the NHS number and contact telephone numbers. Referrals without this information may be rejected, provided that all attempts to source the required information have failed.

9.4 Within 48 hours from receipt, referrals received in all accepted formats, will be added to Careflow, and electronically sent on to an appropriate clinician for triage via eDMS.

Advice and Guidance

9.5 Primary Care colleagues may contact the Trust to seek Advice and Guidance (A&G). These requests should be made through eRS and actioned by the Trust within 2 working days of receipt of the request.

9.6 A&G requests may result in clinical teams advising tests, a formal referral, or other advice that will help to keep the patient cared for appropriately in the most suitable setting. A referral for A&G does not start an 18-week pathway. If A&G requests require conversion to a referral, then this will start an RTT clock at the point the A&G referral is converted to an outpatient referral within eRS.

9.7 The outcome of a referral into a Referral Assessment Service (RAS), may also be A&G. In this circumstance, an RTT pathway starts when the referral is received, and ends when A&G is given. See sections 9.19-9.20

General Practitioner (GP) Referrals

9.8 All GP referrals must be received via the e-Referral Service (ERS). If a paper referral is received from a GP, this will be rejected by the Booking Team and the GP contacted to re-refer via the e-Referral Service.

9.9 Any GP referral that has been rejected by the clinician, will be rejected on the eReferral Service with an appropriate reason. It is the responsibility of the GP to inform the parent or guardian that the appointment has been cancelled and the referral rejected. The consultant refusing the referral must state the reason for rejection. If no reason is given, the booking team should return the e-Referral to the clinician for this to be done. If the e-Referral is for a service not provided by the Trust the referral will be rejected back to the referring GP advising that the patient needs to be referred elsewhere.

9.10 If a patient is referred via the e-Referral Service and there are no slots available for the selected service they will be deferred to the provider and appear on the Appointment Slot Issue (ASI) work list. When a patient appears on the ASI work list, the patient's referral will be added to Careflow within 2 working days, and the patient will be offered

an appointment when one is available. See links in Associated Documents (Section 26) for links to ASI Standard Operating Procedure and guidance on how this is managed.

Cancer Referrals

9.11 If a GP/GDP refers a patient to the Trust with suspicion of cancer, the patient should be referred on a two week wait referral. The referrer must use the designated two-week wait referral proforma, included in Associated Documents (Section 26). Referrals which do not use the proforma will be accepted to avoid delays for patients, but it is the clinician's responsibility to feedback to the referrer.

9.12 It is the responsibility of the referrer to ensure the nature of the two week wait referral and importance of being seen quickly is communicated to the patient. The referrer should find out if the patient will not be available to take an appointment within the following 14 days, if so they should defer the referral until such time that their patient will be able to attend an outpatient appointment within two weeks of being referred.

9.13 Two-week wait referrals can only be 'downgraded' by the referrer – if a consultant thinks the referral is inappropriate this should be discussed with the referrer, and the referrer asked to withdraw the two-week wait referral status. A referrer should not be asked to downgrade a patient, or withdraw the referral, simply because patient cannot be seen within two weeks.

Referrals outside of eRS

9.14 Referrals will be sent outside of eRS when received from consultants from other trusts, or internal clinicians. Where a referral is received in the consultant's office in the first instance, this must be date stamped and sent to the New Referrals team in Outpatients on the same day as receipt. Referral should be scanned in and sent electronically to avoid delay. This will allow the referral to be processed in line with those sent directly to outpatients, and be passed to a clinician within 2 days of receipt. The RTT clock start date for these referrals is the date they were first received in the consultant's office, for referrals received via email the start date is when the email was sent.

9.15 If a referral has been made and the special interest of the consultant does not match the needs of the patient the consultant should write to the referrer directly so that appropriate treatment can be sought.

Internal Referrals- Referrals outside of eRS

9.16 Where possible, internal consultant-to-consultant referrals will be kept to a minimum and must relate to the referred condition. Consultant-to-consultant referrals will be accepted where the referral is made following an outpatient or Emergency Department (ED) attendance, where a different specialist consultant opinion is needed to advance the management of the condition. If the referral is from ED, the outpatient appointment will be recorded as a new appointment. If the referral is from an outpatient appointment, the resulting appointment will be recorded as a follow up. Any need for treatment not related to the referred condition must be identified back to the GP for onward refer to a different specialist.

Incoming Inter-Provider Transfers - Referrals outside of eRS

9.17 Referrals from other organisations into consultant-led services must be accompanied with an Inter-Provider Transfer Administrative Minimum Data Set (IPTAMDS) to ensure

the correct 18-week information is received. The patient's RTT wait will then be reportable by the Trust, instead of the referring hospital.

9.18 This applies when the clinical responsibility for the patient transfers to the Trust. Therefore, if a patient is referred for a diagnostic test or opinion only, with follow up care to continue at the referring organisation, this is not an IPT.

Referral Assessment Service

9.19 Some specialties utilise Referral Assessment Services (RAS's) on eRS. A new RTT pathway starts when a referral is received by a RAS.

9.20 GP referrals will be triaged by a clinician to ensure it is an appropriate referral, and to determine the best option to manage the patient's condition. In some cases, clinicians may provide A&G to Primary Care in place of accepting the referral (the RTT pathway would stop at this point). Alternatively, the referral may be directed to the most appropriate service within the Trust.

Grading

9.21 Referrals should be graded by a clinician within 3 working days from the clinician receiving the referral from outpatients.

9.22 Generic referrals will be sent to the consultant with the shortest waiting time in that specialty to allow greatest flexibility in terms of the booking of the patient's appointment. Although it is recognised that some referrals may be directed to a specific consultant if their specialised opinion is required.

9.23 Referrals must be prioritised using only the following criteria:

Priority	Timescale for first appointment
Suspected cancer (2 week wait)/ target referral	2 weeks
Urgent	2 weeks
Routine	Next available appointment (within 18 weeks)

Veterans

9.24 The Trust will give due regard and consideration to the families of veterans, in accordance with the Armed Forces Covenant. This may include, but is not limited to, asking families if they have a family member who has service in the Armed Forces, referring patients/families to other services as appropriate, making special consideration in some cases such as for the injured or bereaved.

10 Outpatient Appointments

Booking Urgent and 2 Week Wait Appointments

10.1 GPs and patients cannot book into urgent and 2 Week Wait appointment slots via eRS. Instead, the patient will be telephoned by the Outpatient Booking Team within one working day to mutually agree the appointment date.

10.2 The Cancer MDT Coordinator will identify new 2 Week Wait referrals through regular reports. They will input the patient onto the cancer information system and liaise with staff to ensure patients are offered a first appointment date within 14 days at the Trust's acute site. If an appointment cannot be offered within 2 weeks, it must be escalated to the Care Group Operational Management Team for action and resolution.

10.3 If the Trust is unable to contact a patient to arrange or expedite an urgent appointment following three attempts at different times and days, and confirmation of the patient's contact details with their GP, the patient will be sent a letter with an appropriate appointment to avoid delay.

Booking non-urgent appointments

10.4 Appointments are booked up to 6 weeks in advance to minimise the risk of cancellations. This is in line with national best practice. Patients are allocated appointment times in order of clinical priority and then length of wait.

10.5 Patients waiting for a new appointment are sent a letter with the details of their appointment.

10.6 Patients waiting for a follow up appointment on the review list are prioritised based on how overdue they are, as a percentage of their original review period. The methodology for this is as follows:

$$\text{Calculation: } \frac{\text{Number of days overdue}}{\text{Number of days in the review period}}$$

Priority	Definition
1	Patient overdue by >=200
2	Patient overdue by 150%-200%
3	Patient overdue by 100%- 150%
4	Patient overdue by 75% - 100%
5	Patient overdue by 50% - 75%
6	Patient overdue by 25% - 50%
7	Patient overdue by 0%- 25%
Not yet due	Patient's review date has not yet been reached

10.7 For example:

- Patient A is overdue by 100 days and their review period is 12 months (365 days). The calculation would be 100/365, meaning the patient is shown as 27% overdue
- Patient B is overdue by 100 days and their review period is 4 months (122 days). The calculation would be 100/122, meaning the patient is shown as 82% overdue

- Patient A & B are overdue by the same amount of days but as the review period for patient B is shorter, they would be considered a higher priority as their percentage overdue is greater

10.8 Patients on the review list are booked into appointments using the Netcall system which telephones patients/parents/guardian in the priority order listed above. When the call is answered, the patient/parent/guardian will be put in contact with the Outpatient Booking Team to book an appointment. The Outpatients Out of Hours Team will also contact outlying patients on the review list to try and book them an appointment.

10.9 If a patient needs an outpatient appointment booking following an inpatient admission, the ward clerk will inform Outpatients of all appointments that need to be booked daily via email, and the Outpatients Team will book the appointments.

Telephone and Virtual Clinics

10.10 Telephone and virtual clinics are used as an alternative to face to face new and follow up appointments, in specialties where this is clinically appropriate.

10.11 All parents or guardians must be informed that their child will not be required to attend the hospital and be given instructions for how to attend the non face to face appointment.

10.12 Telephone and virtual consultations will be delivered in line with Trust guidelines and policy.

Appointment Reminders

10.13 Patients will receive notification of an appointment booking via text and/or email, this will then allow them to log into Patient Hub to view their appointment. Patients can request to rebook their appointment on Patient Hub, which will put them in touch with the Outpatient Booking Team. They can also view additional resources, such as clinic specific videos. Patient Hub monitors whether the patient has accessed appointment details, and if not, after 3 days it will generate a letter to be posted instead.

10.14 If a speciality isn't on Patient Hub, a letter is printed and sent to the patient on the same day that the appointment is booked.

10.15 Appointment reminders are sent via text to patients whose mobile telephone numbers are available on the Trust PAS. Reminders are sent 7 and 2 days before the appointment.

Patients who WNB/DNA their appointment

10.16 Adult patients who do not attend appointments without any prior notification are considered as 'DNAs' (did not attend), this is applicable to most patients in the Clinical Genetics service.

10.17 Outside of this service, the vast majority of the Trust's patients are children and young people. Unlike adults, often children do not often take direct responsibility for their own health needs. Therefore, patients who do not attend appointments without any prior notification are considered 'WNB' (was not brought) by their parents/carers. WNB and DNA appointments are both managed in line with the following principles.

10.18 If the patient is not brought to an appointment and the clinician feels there are no clinical implications, then the default position must be that the patient is referred back to their GP. This is provided that the Trust can demonstrate that the appointment was clearly communicated to the patient. The GP will be informed via letter that the patient was not brought to their appointment and has been discharged. Where there are known safeguarding concerns, this should be highlighted to the GP and the allocated Social Worker. A copy of the correspondence should also be provided to the Health Visitor if the patient is under five years of age.

10.19 If a patient is not brought to an outpatient appointment the Trust may offer the patient a second appointment if the clinician feels it is clinically inappropriate to discharge back to referrer or primary care, or there are other considerations which would warrant a second appointment, e.g. health inequality factors. If a patient is not brought to two consecutive appointments, it will be escalated to the operational manager to discuss with the relevant clinician. Consideration should be made to whether the patient has not been brought to appointments with other specialties, as when considered collectively they may raise a safeguarding concern. If there are any safeguarding concerns about the patient, the Trust's Safeguarding procedures will be followed, and advice may be sought from the relevant Safeguarding Team (see sections 10.26-10.29 Safeguarding Considerations).

10.20 If there is a judgment that failure to attend the appointment poses a significant risk to the child's health:

- This must be specified to the GP, Health Visitor and School Nurse
- A referral to Social Care should be considered if the welfare concern is sufficiently great
- Social Care should always be notified if the child is known to be subject to a child protection plan
- Further liaison with referrer should be considered to enable a risk assessment to be completed and a follow up plan discussed

<u>Patient Cancellations</u>

10.21 If parents or guardians cancel their child's appointment, it should be rebooked at the time of cancellation, if there is an appointment available. If an appointment is cancelled through Patient Hub during contact centre opening hours, a staff member will phone the patient to rebook the appointment. If the patient cancels out of hours or there are no staff available in the contact centre, Outpatients will be informed of the cancellation via email. Staff will then ring the patient to rebook when the email is picked up on the next working day.

10.22 If there are no appointments available, the patient will be added to the Review List if it is a follow up appointment, and rebooking will be prioritised in line with the table in section 10.6. If the patient was already on the review list, they will remain on the review list in the same position with the same due date and priority. If a new appointment can't be rebooked following a cancellation, this will be escalated to a booking coordinator, and will be managed and booked through Open Referrals on Careflow.

10.23 If a parent or guardian attempts to cancel consecutive appointments within the same clinical specialty for a second time, they should be advised that this is not possible, unless in exceptional circumstances. If the parent or guardian still wants to cancel the

appointment, the patient's notes should be reviewed by clinical staff. If the clinician does not identify any clinical or safeguarding risks involved in not treating the patient, they should be discharged. If the clinician considers it necessary, the patient may be rebooked.

10.24 If a patient is discharged due to multiple cancellations, a letter must be sent to the GP / referrer informing them the reason for discharge, with a copy to the Health Visitor / School Nurse and Parent/guardian.

10.25 If a parent / carer cancels a follow up appointment and states that they do not need a further appointment, outpatients must inform the responsible clinician through a Patient Query form in eDMS. The clinician should review the patient's notes to ensure there is no clinical or safeguarding risk for the patient. If the clinician is comfortable to discharge the patient a letter should be sent to the child's GP informing them of this (with a copy to the parent and Health Visitor / School Nurse).

Safeguarding Considerations

10.26 If there are safeguarding concerns relating to patient access, including WNBs, consideration should be given to the impact on the child or young person. In order to recognise and respond appropriately to safeguarding concerns in a timely manner, colleagues are required to complete the relevant safeguarding training for their role, in line with the Trust Safeguarding Training Policy.

10.27 Colleagues may access safeguarding supervision to discuss any emerging safeguarding concerns relating to patient access to agree on the most appropriate action to safeguard a child or young person, in line with the Trust's Safeguarding Supervision Policy

10.28 Children/young people who are the subjects of a Child Protection Plan or have been discussed in Multi-Agency Risk Assessment Conferences will have a safeguarding alert on their electronic health record. These should be dealt with in line with the Safeguarding Alert Standard Operating Procedure and guidance.

10.29 Colleagues should use the Patient Access Policy alongside the relevant Trust safeguarding procedures, linked in Associated Documents (Section 26). Colleagues may contact their safeguarding supervisors for advice, support or supervision whenever they identify an actual or potential safeguarding concern relating to patient access. The Trust safeguarding teams covering Acute Services; CAMHS and Community Services are all available to provide specialist safeguarding advice and support.

Hospital Cancellations

10.30 Patients who are cancelled by the hospital should be offered an alternative date, which is as soon as practicably possible. Wherever possible, patients that have been previously cancelled should not be cancelled a second time.

10.31 The only acceptable reason for any clinic to be cancelled is due to the unplanned absence of clinical staff. Clinics should not be cancelled for any other purpose unless there are exceptional circumstances.

10.32 A minimum of six weeks' notice is required for planned annual leave or study leave when a clinic will need to be cancelled or reduced as a result. Any leave requests with less than 6 weeks' notice need to be submitted in writing, including the reason for the

late request, and be signed off by the Associate Director or Clinical Director of the Care Group. When the cancelation of a clinic at short notice is unavoidable, it is the responsibility of outpatients to rebook patients, but the responsibility of the clinician and Care Group to provide the capacity to do so.

10.33 Cancelled sessions should be communicated to the relevant departments as soon as they are known. Cancellations must be communicated through Medi-Rota or clinic cancellation forms, and these forms should be actioned by admin teams as soon as possible after receipt, and within a maximum of five working days.

Reconciling Outpatient Clinics

10.34 All Outpatient Clinic attendances must have a definitive outcome recorded on the relevant patient information system. The e-outcome form should be completed by the clinician in real time and no later than 24 hours after the clinic. The process applies to appointments on the SCFT sites, peripheral clinics, and virtual/telephone appointments. Outpatients can view non-outcomed appointments the day after the clinics, these are clinic appointments with missing attendance indicators although there may be an outcome form on eDMS with this information on. If this information is not available within 3 working days, the outcome is recorded as missing.

Open Appointments & Patient Initiated Follow-Ups (PIFU)

10.35 A clinician may decide a patient doesn't need a further follow up appointment on a set date however, they will give the patient the opportunity to have a further appointment if the patient feels they need one, without requiring a new referral into the Trust. There are two options for this:

- **Open appointments**: the patient can contact the Trust for an appointment within 6 months from the original appointment. Any open appointments that have not had an appointment booked within 6 months will be discharged (except for neuro-disability and pain, which are 12 months)

- **Patient Initiated Follow-up (PIFU)**: the patient can contact the Trust for an appointment within any time period after the original appointment and be given the next available appointment. If this appointment does not suit the patient (e.g. they would like one sooner), then the request will be escalated to the clinical team to decide if this patient should be given an earlier appointment. PIFUs do not expire after a set timeframe, however if the patient books a follow up appointment, the new outcome from this appointment would apply moving forward. Patients on PIFU will be discharged if patients reach transition age and haven't accessed the appointment. There are safety net processes within PIFU for transition and safeguarding, and all PIFU patients are shared routinely with the clinician. See Associated Documents Section 26 for more guidance.

10.36 If a clinician requests that an appointment is booked for a patient (e.g. if a patient has phoned a secretary), an appointment may only be booked if the patient has an open appointment, PIFU, is on the review list or an RTT pathway. If this is not the case, the patient will be directed to their GP to be re-referred into the service.

Outgoing Inter-Provider Transfers

10.37 Where a patient needs to be transferred to another provider for the same condition, an Inter-Provider Transfer Administrative Minimum Data Set (IPTAMDS) form must be

completed and sent with the referral. This details the patient's RTT pathway and waiting time. The inter-provider transfer must be identified and sent by the clinician's secretary; the Performance Team may help complete the RTT details on the IPTAMDS. A copy of the IPTAMDS form must be kept in the patient's record. The patient's RTT 18-week clock will transfer to the new provider at this stage and the RTT pathway will be stopped on the Trust's PAS system.

10.38 Where a patient is transferred to another provider for advice or diagnostic tests only, this is not an inter-provider transfer and the clinical responsibility and the patient's RTT clock will remain with the Trust.

Administrative clock stops

10.39 A patient's RTT pathway may stop outside of a clinic appointment or inpatient admission. For example, if the results of a patient's diagnostic investigations are normal they may be communicated to the patient and GP via letter, rather than in a clinic appointment. If no further action is required, the patient may be discharged provided this is clearly communicated to the patient and GP in the letter.

Unable to contact for outpatient appointment or inpatient admission

10.40 If after 3 attempts at phoning a patient at different days and times, the Trust is unable to contact the patient to arrange an outpatient appointment, a letter should be sent to the patient asking them to make contact within 2 weeks. If the patient does not make contact within two weeks a second letter should be sent, giving the patient another two weeks to make contact. If no response is received to the second letter, this will be escalated to the clinician who should review the patient to decide whether they can be discharged. If the clinician feels the patient cannot be discharged and may be at risk of coming to harm if they are not seen, a referral to Safeguarding should be considered and next steps agreed alongside further attempts at contact.

11 Diagnostics (Radiology)

11.1 This section of the access policy is applicable to the following diagnostic tests, which are delivered by the radiology service. Other diagnostic investigations delivered within an outpatient or inpatient setting, are covered by the outpatient and elective admission sections of the policy.

- General Radiography (X-ray)
- Digital Fluoroscopy
- Computerised Tomography
- Magnetic Resonance Imaging (MRI)
- Ultrasound
- Nuclear Medicine
- DEXA

11.2 Referrals for diagnostic tests must be made electronically using the Order comms system.

11.3 Referrals are allocated to the appropriate clinician for prioritisation according to protocol for each modality. All referrals will be triaged within one working day of the request being received. If an inappropriate referral has been made, or referral protocols were not followed, the radiologist will reject the referral and advise the referring clinician to the reasons why.

11.4 Patients should be telephoned and offered a minimum of two dates with at least three weeks' notice for a routine diagnostic request. Where possible, patients can be offered earlier dates at less than three weeks' notice, however patients who decline short notice offers may do so without any adverse effect on their waiting time. For urgent diagnostic requests, patients must be telephoned and offered an appropriate appointment. A confirmation letter should be sent out to the patient within one working day of the appointment being agreed.

11.5 If after three attempts on different days and times, the patient is unable to be contacted, the patient must be sent a letter asking them to contact the department within 14 days. If the patient does not contact the department within 14 days, then the patient will be discharged back to the referring clinician.

11.6 Patients who cancel a diagnostic procedure and who require another appointment should be offered one in line with booking procedures. If a parent or guardian attempts to cancel another consecutive appointment, the parent or guardian should be advised that this is not possible. If the parent or guardian does not wish to retain the current appointment, then this should be cancelled, removing the patient from the diagnostic waiting list and the referral returned back to the originating referrer.

11.7 If a patient WNB to their diagnostic appointment, they may be offered another appointment. If a patient is not brought on two consecutive occasions for their diagnostic, the patient will be removed from the diagnostic waiting list and referred back to the referrer. The referring clinician will be informed via letter.

11.8 Where any member of staff has concerns about safeguarding of a child whose repeated cancelled or changed appointments cause significant delay, they should liaise and discuss this concern with the consultant in charge of that patient's care.

11.9 Diagnostic tests are prioritised for booking using the D Code Priority ratings listed in section 8.3.

12 Inpatient Admissions

Structure of waiting lists

12.1 The elective waiting list should consist of patients who are waiting for a procedure; they should be available to attend for an admission or may have already accepted a “To Come In” (TCI) date. These patients are monitored through the waiting lists on Careflow and RTT PTL.

12.2 Planned admissions are where a patient needs to wait a set period of time for their procedure, due to clinical reasons. This includes planned surveillance diagnostic tests carried out at set intervals (e.g. check cystoscopy) or a series of procedures carried out as part of a treatment plan which are required for clinical reasons to be carried out at a specific time or repeated at a specific frequency. These patients are added to a planned waiting list, which is subject to the same monitoring as the elective waiting list.

12.3 Planned patients are outside the scope of RTT until they are due their procedure. New RTT pathways will be started for planned patients 4 weeks after their due date, should the patient not have had their procedure by this time. The 4-week period gives time for patients to be booked in and clinical review to take place.

12.4 All waiting lists are to be maintained and managed on the electronic patient record used by the service (e.g. Careflow). In no circumstances should duplicate manual waiting list records be held.

Adding patient to a waiting list

12.5 The decision to add a patient to a Waiting List must be made by a consultant, or under an arrangement agreed with the consultant.

12.6 Patients who are added to a waiting list must be fit, willing and able to attend for admission on the day the decision is made i.e., if there was a bed available tomorrow in which to admit a patient, they would be medically fit to receive treatment and able and willing to come in.

12.7 Every patient and their GP should receive a letter confirming that they have been put on a waiting list. This should include details of how the patient can contact the Trust if they will not be able to accept an admission date during a particular time period.

12.8 An electronic booking form must be completed by the clinician listing the patient. This must include the clinical priority of the patient (both RCS Priority and clinical risk harm rating as detailed under section 8), which must be input onto the waiting list entry on Careflow.

12.9 Where prior approval for treatment is required, this must be obtained via the Care Group process before adding a patient to the active waiting list. The patient’s RTT clock will continue to tick whilst approval is sought.

Arranging Dates for Admission

12.10 Patients will be allocated TCIs according to the booking prioritisation criteria agreed at Corporate Harm Panel, and detailed under section 8, which takes into account patients’ clinical harm ratings and length of wait. The most clinically urgent patients (Red, P1a & P1b) will be allocated a TCI as soon as possible as a priority.

12.11 When it is time for a patient to be offered a TCI, they will be contacted by phone to agree a TCI date. This should be followed up with a confirmation letter detailing any explicit instructions.

12.12 If patients declines 2 reasonable offers of TCI dates, they should be reviewed by a clinician. The clinician should consider whether the patient should remain on the waiting list or be removed and either discharged or be placed on active monitoring, with the option of relisting the patient in in future.

12.13 Whilst all TCI offers should to be reasonable, some patients may be willing to attend at short notice, often to fill gaps caused by late cancellations that may otherwise mean an available space on a theatre list is lost. However if a patient declines such an offer, this should not be detrimental to the patient, their waiting time must continue.

12.14 If after 3 attempts at phoning a patient, at different days and times, the Trust is unable to make contact to arrange a TCI, the unable to contact process, as detailed under section 10.40 will be followed.

Patient Initiated Delays

12.15 Once on a waiting list, a patient may contact the Trust to request their procedure is delayed. Examples for doing so include, but are not limited to, exams, medical treatment of parent/carer, and making necessary adjustments to the patient's home to support their recovery. The patient must provide a date for when they would be willing to accept a TCI from. The responsible clinician will be informed of any patient-initiated delays to ensure that no harm is likely to result from the patient waiting longer for treatment. The outcome of the review may be that:

- The request is acceptable, patient will remain on the waiting list, prioritised as a P6
- The patient is removed from the waiting list, and either referred back to the GP or placed on active monitoring as deemed clinically appropriate. This option is to be considered if the delay is over 12 weeks, or the family cannot provide a date for when they would be willing to accept a TCI. A new RTT pathway would start if the patient was relisted in future.
- The clinician does not think the delay is appropriate, and they may wish to meet with the patient to review their options. The clinician should consider a referral to Safeguarding if there is a risk to the patient

12.16 A patient can choose to wait for their procedure to be undertaken by a specific clinician, with no effect to their RTT pathway. It should be explained to the patient that they are delaying their treatment if there is another clinician available to undertake the procedure sooner.

Patients who are unfit

12.17 At the time of listing, patients should be fit, ready and able to come in, however patients may become unfit for admission while on the waiting list.

12.18 If the patient is unfit due to a short-term ailment (e.g. patient has a cold), and declines an admission date as a result of this, they should remain on the waiting list and offered a further TCI date once recovered.

12.19 If it is discovered that the patient has underlying comorbidities or medical conditions that will prevent the patient having the admission they have been listed for, they should be removed from the waiting list. The clinician should then decide the next steps for the patient, this may be a referral back to primary care for the patient to be re-referred if they are considered fit for the procedure in future. Alternatively, the patient may be placed on active monitoring to be reviewed regularly by the Trust and re-listed if they become fit for the procedure in future. In both cases, the RTT pathway would be stopped, and a new RTT pathway would be started if the patient is relisted in future.

Patient Cancellations

12.20 If a patient cancels a TCI date, they will be offered a further TCI date when one is available. However, if a second consecutive TCI date is cancelled by the patient, they will be reviewed by a clinician to decide if another date should be offered to the patient, or whether they could be removed from the waiting list.

12.21 If a parent or guardian decides that they no longer wish to proceed with their child having the procedure undertaken, the clinician must be informed of this decision who will then review the patient to confirm whether they can be removed from the waiting list. If the clinician discharges or places the patient on active monitoring, the RTT clock will stop. If the clinician does not agree to remove the patient from the waiting list, the reasons for this should be discussed with the parent or guardian in clinic. The clinician should give consideration to whether a safeguarding referral is required.

Patients who are not brought to a TCI date

12.22 Where a patient is not brought to a reasonably offered TCI date the patient should be reviewed by the clinician and if there are no safeguarding or clinical implications, they should be removed from the waiting list and returned to the care of their GP. A letter must be sent to the parent or guardian and the GP informing them that the patient has been removed from the waiting list and discharged.

Hospital Cancellations

National Target	Standard
100%	All patients whose procedure is cancelled by the hospital on the day of the procedure, for a non-clinical reason, must be rebooked within 28 days.

12.23 Patient admissions should not be cancelled for non-clinical reasons at any stage. TCI dates should not be given further ahead than the Trust Annual Leave Policy to minimise the risk of non-clinical TCI cancellations. If, in unavoidable circumstances, a patient admission is cancelled on the day of admission for a non-clinical reason then they must be admitted within 28 days from the date of cancellation.

12.24 If a patient's TCI date is cancelled on the day of the admission due to a clinical reason, then the patient must be offered another TCI date based on the clinician's decision. These patients are not subject to being seen within 28 days.

12.25 If a TCI date needs to be cancelled before a patient is admitted, the patient must be telephoned and given a reason. An alternative date should be agreed at the time of cancellation where possible unless complex planning is required to arrange a new date.

13 Transition to Adult Services

13.1 Consideration will be given to patients who may require transition to adult services, with plans made in line with guidelines for the relevant services. Transfer of care usually occurs between 16 years and 18 years at a time of relative stability. Patients who are transitioning to adult services must have a live transition plan on eDMS. Care Groups will monitor compliance to ensure patients have appropriate plans in place.

13.2 As per national guidance the young person's care remains within the children's services until they have had their first appointment in the adult service.

13.3 The Trust's Transition Policy provides a structured, equitable and co-ordinated pathway for specialties to transfer care of young people and their families to primary, secondary or tertiary adult health care services with a long-term healthcare need. http://nww.sch.nhs.uk/documents/4-corporate-policies/1525-transition-from-children-s-to-adult-services-policy

13.4 If a clinician feels it is most appropriate for the Trust to continue to manage a patient who is 18 years and older then an "Over 18 Form" need completing and submitting within eDMS for sign off by the Executive Medical Director.

13.5 Young people 16 years and over can access the Trust Emergency Department for a physical health reason, providing they still being seen by the Trust for active follow up. An electronic Yorkshire Ambulance Service form can be completed within eDMS for complex young people over the age of 16 who are likely to attend the emergency department, to ensure they are bought to the paediatric services. Young people under the CAMHS service are required to attend the adult Emergency Department from 16 years and above.

14 Children and Adolescent Mental Health Services (CAMHS)

Standards

National Target	Standard	National Guidance
50%	Within a maximum of two weeks of referral, more than 50% of people with suspected First Episode Psychosis (FEP) should receive a NICE-approved package of care.	https://www.england.nhs.uk/mental-health/resources/access-waiting-time/
92%	Children and young people (up to the age of 19) referred for assessment or treatment for an eating disorder should receive NICE-approved treatment with a designated healthcare professional within one week for urgent cases and four weeks for every other case.	https://www.england.nhs.uk/mental-health/resources/access-waiting-time/

Local Target	Standard
92%	Non-urgent patients should start their first treatment within 18 weeks from referral into the service. First treatment is considered to be the second appointment.

14.1 The principles in sections 1-13 of this policy apply to the CAMHS service, where relevant, unless stated otherwise.

Community CAMHS Referrals

14.2 All new referrals will be entered on to the electronic patient record system within two working days of receipt of the referral. The date is entered on to the system is the date the referral was first received by the service. Referrals are reviewed by clinicians daily in the duty referrals meeting. If rejected, a letter is sent to the referrer (with the patient copied in) to inform them and provide any relevant signposting.

14.3 Following triage, referrals will be accepted on the electronic patient record system and a letter sent to the patient informing them that they are on the waiting list. Referrals are graded in the priorities listed below, although some patients initially graded as routine may be expedited to the next available appointment if there are clinical concerns while the patient is waiting.

Priority	Definition
Urgent	Patient requires an appointment within 2 weeks.
Routine	Patient requires an appointment at the earliest available opportunity.

Community CAMHS Appointments

14.4 When an appointment slot becomes available, an opt-in letter will be sent to the parent/guardian inviting them to contact the Booking Office to book their appointment.

14.5 If there is no response to the letter within 14 days, the patient will be removed from the waiting list. A letter will be sent to the patient and the GP informing them. If the patient makes contact within the next 7 days, the referral would be reopened with no change to their waiting time. If safeguarding concerns had been identified at triage, the clinician will decide the most appropriate next steps for the patient.

14.6 If a patient cancels their appointment once, they will be able to rebook. If the patient cancels a second consecutive appointment, the clinician will review the patient's notes. They may discharge the patient if this will not put them at risk of harm. If discharge is not appropriate, the clinician will contact the patient to ascertain the reasons for non-attendance and ensure compliance to attend the rescheduled appointment.

14.7 If a patient is not brought to their appointment, the clinician will review the patient's notes and decide on next steps. The patient may be discharged, rebooked, or have an enquiry letter sent asking them to make contact if they still require the service. If a patient is not brought to the re-booked appointment, the patient will be discharged unless the clinician thinks this would put the patient at risk of harm. The Safeguarding principles in section 10.26-10.29 apply to CAMHS, and patients identified with safeguarding issues can be identified on the high risk register if required.

14.8 Clinicians should give a minimum of six weeks' notice of annual leave. If leave is taken when patients are already booked in, the clinician and booking team should work to reschedule the patients for as soon as possible. Compliance will be managed by the Care Group to ensure minimal disruption to patient care.

14.9 Where a patient requires further therapeutic treatment following their first treatment, they will be added to the waiting list for the specific therapy. The patient will remain on the caseload of the responsible clinician while they wait. Once a clinician becomes available to start therapy, the patient will be telephoned to agree an appointment date. The patient will be added onto the new clinician's caseload when allocated.

<u>Suspected First Episode Psychosis (FEP) & Eating Disorders</u>

14.10 The waiting time clock for the FEP and Eating Disorder standards starts from the date the referral is received. The primary reason for referral should be Suspected First Episode Psychosis or Eating Disorder.

14.11 Where a primary reason for referral is not recorded as Eating Disorder or FEP, but this is identified during triage/single point of access, the clock start date is the date of initial referral. If this is not suspected during triage but at a subsequent assessment, then the date the clock starts is when suspicion is first raised. If a patient is already in contact with mental health services, the clock starts when suspicion of FEP or Eating Disorder is first raised.

14.12 The patient will be telephoned and offered an appointment within 7 days for urgent Eating Disorder appointments, 14 days for First Episode Psychosis appointments or 28 days for non-urgent Eating Disorder appointments. If the patient is unable to attend the offered date, a further date within the aforementioned timeframe must be offered. Where there is no available appointment within these time periods it will be immediately escalated to the Duty Lead and Service Manager.

14.13 Non-attendance or cancellations will not stop or pause the clock for the referral to treatment waiting time. However, If the patient is repeatedly WNB to appointments then the referral can be discharged provided that:

- The Trust can demonstrate that the appointment was clearly communicated to the patient

- Discharging the patient will not cause further harm and is agreed with CAMHS clinicians

- Any outstanding safeguarding actions are formally communicated with clear onward accountability identified

14.14 Clock stops occur for FEP and Eating Disorder pathways when the first definitive treatment starts i.e., on the day the first session of NICE-approved treatment is delivered. The NICE-approved treatments are:

FEP	Eating Disorders
Patient is assessed by the EIP (early intervention in psychosis) service, and if appropriate: • Have been accepted onto the EIP service caseload. • Have been allocated an EIP care coordinator who has actively engaged with the person to develop a plan of care and commence treatment in line with NICE recommendations	• Family Therapy • Cognitive Behavioural Therapy • Guided Self-Help • Interpersonal Psychotherapy • Focal Psychodynamic Therapy

14.15 Clock stops may also occur for non-treatment when it is communicated to the patient and GP that:

- A clinical decision has been reached not to treat as ED or FEP / possible 'at risk' mental state is not evident following assessment. In this case the patient should be discharged back to primary care with advice about next steps

- If there is suspicion of a different condition, the patient should be referred to the appropriate service to include risk assessment of safeguarding. If the receiving service has an access and waiting time standard the clock will continue and the pathway information must be forwarded with the onward referral

- The patient declines assessment / treatment and the decision is made to discharge back to referrer / GP

15 Physiotherapy and Occupational Therapy

Standards

Local Target	Standard
92%	Non-urgent patients should start their first treatment within 18 weeks from referral into the service. First treatment is considered to be the patient's first appointment.

15.1 The principles in sections 1-13 of this policy apply to the Physiotherapy and Occupational Therapy (PTOT) service, where relevant, unless stated otherwise.

Referrals

15.2 The PTOT service accepts referrals from clinical colleagues from any SCFT speciality and Primary care.

15.3 Referrals to the PTOT inpatient services are accepted for any aged child during their admission and are received via ward rounds, handover meetings, written referral forms or verbally form medical, nursing or therapy colleagues.

15.4 Referrals, via a referral letter, MDT clinic or verbally from a health, education, or social care professional, to PTOT outpatient services are accepted for children up to their 16th birthday. There are some exceptions to this;

- Children who have their corrective scoliosis surgery performed at the Trust
- Trauma and Orthopaedic patients, over the age of 15, who have their surgery performed at the Trust
- Burns patients up to their 18th birthday if they are not expected to need adult care after that
- Young adults up to the age of 18 years attending the Pain MDT clinic

15.5 The service aims to transition patients to adult services at age 16, except for pupils in special schools who may remain in the service for longer.

15.6 Patients under certain acute specialities will automatically receive a referral to the PTOT service so they can access the service if and when they need it e.g., every child with Cystic Fibrosis, JIA/rheumatological conditions, Metabolic Bone. These referrals may be received verbally. When an open referral is received, the service will contact the family to make an appointment. Pupils in a Special School who have an existing or previous referral into the service will also have open access to PTOT, those who are not already known the service would need a new referral from a consultant.

Booking Appointments

15.7 All referrals received into the service will be date stamped and graded by a qualified therapist within the relevant team. Accepted referrals are added to the appropriate electronic system and designated onto the appropriate waiting list. For those services on

a referral to treatment pathway, the clock start date is the date the referral is received within the Trust.

15.8 If the referral is to be placed on a waiting list, a letter is sent to the referrer and parents / carer to advise that the referral has been received and the child has been placed on a waiting list and the service will make contact when an appointment is available.

15.9 At an appropriate time, the parent / carer will be sent a letter asking them to contact the service within 14 days to book an appointment (unless they have made a telephone referral themselves). If parents or guardians do not contact the service within 14 days of their letter being sent, the patient is discharged; the referrer is notified and asked to re-refer where necessary. There may be exceptions to this based on the clinicians' safeguarding concerns or if the therapist feels that their condition requires a further opportunity to engage.

15.10 The initial appointment offered may be at the clinicians out-patient setting in the Trust premises, the child's school setting or be a virtual telephone / video appointment. Therapists are discouraged from arranging the initial appointment for a child not previously known to the service in the child's home setting unless there are extenuating circumstances meaning that the child cannot travel.

15.11 Wherever possible the appointment will be confirmed by letter, email or text message. The confirmation will include the time and location of the appointment and the method to be used (telephone / video / face to face).

15.12 Appointments arranged in the child's school setting will go ahead even if parents do not attend, so long as prior consent to see the child has been given by the parent.

15.13 For children who need re-referring to the service because of clinical need, a re-referral can be accepted using existing referral paperwork that is less than six months old. These patients will be treated like new referrals and treated accordingly, unless of extenuating circumstances.

15.14 All follow-up appointments are arranged with the practitioner and client at a mutually convenient time.

15.15 If the clinician makes the decision to re-appoint a telephone appointment, this should be offered as a further telephone appointment. A face-to-face appointment should only be offered as a re-appointment if new information has been received that this is the only appropriate medium.

15.16 If a patient is not brought to their appointment, the Trust's WNB/DNA policy applies (see sections 10.16-10.20).

16 Clinical Genetics

Standards

Local Target	Standard
92%	Non-urgent patients should start their first treatment within 18 weeks from referral into the service. First treatment is considered to be the patient's first appointment.

16.1 The principles in sections 1-13 of this policy apply to the Clinical Genetics service, where relevant, unless stated otherwise.

Referrals

16.2 All referrals received into the service will be date stamped, added to the appropriate electronic system and given to an appropriate clinician within two working days of receipt. Referrals into Clinical Genetics start a new RTT pathway.

16.3 The clinician will triage the referral within a week of its receipt into the department and return it to the department's booking team.

Booking Appointments

16.4 Where required patients will then be sent a family history questionnaire to complete and return within 28 days. If this is not appropriate, they will receive a telephone call, letter, or appointment. Once the questionnaire has been completed and returned, the patient's case will be assessed and they will receive a letter, telephone call or appointment as appropriate. If the patient does not respond within 28 days, they are sent a reminder.

16.5 If the patient does not respond, they will either be discharged back to the referring clinician and their 18-week clock will stop, or they will be contacted for information.

16.6 If a patient cancels an appointment, they will be contacted by the Booking Team and the timescale for rebooking will be explained. If they still wish to cancel, the reason for this will be noted and forwarded to the relevant clinician, and they will be re-booked. Every effort will be made to find a suitable time, location and medium for the appointment. If they cancel for a second or subsequent time, they will be advised that the clinician may wish to discharge them as per the Trust policy. The information will be forwarded to the clinician who will make a clinical decision about whether to discharge or offer a further appt. If discharging, they will write back to the referrer.

16.7 If a patient is not brought to their appointment, the Trust's WNB/DNA policy applies (see sections 10.16-10.20).

16.8 First treatment is considered to be the patient's first consultation appointment where they are given information about the genetics of their condition and what this means for them. The patient may have other appointments prior to this, but these are to help of gather family history information and clinical background.

17 Speech and Language Therapy

Standards

Local Target	Standard
92%	Patients should start their first treatment within 18 weeks from referral into the service. First treatment is considered to be given at the patient's first appointment.

17.1 The principles in sections 1-13 of this policy apply to the Speech and Language Therapy (SLT) service, where relevant, unless stated otherwise.

Referrals

17.2 Speech and Language Therapy (SLT) accepts referrals from health, education and social care colleagues. Whilst referrals directly from families are accepted, joint referrals with schools are encouraged.

17.3 Once the referral is received, it is date stamped and added to SystmOne, the patient administration system used for managing SLT pathways. The clock start date is the date the referral is received within the Trust.

17.4 Generally, all SLT referrals are considered routine, unless the patient has significant feeding issues. In this case the referral is prioritised as urgent, and the patient is seen more quickly.

Booking appointments

17.5 For children who are not yet in school, the patient will be sent a letter asking them to contact the service within 14 days to book an appointment. If they do not contact the service within 14 days of their letter being sent, the patient is discharged, the referrer is notified and asked to re-refer if required.

17.6 For children who are school-aged, their initial appointment will be offered in their school setting. Appointments will be confirmed with the school and parents notified and invited to attend. The appointments will go ahead even if parents do not attend if prior consent to see the child has been given.

17.7 Ward patients and urgent feeding referrals are contacted in person or by phone and visited as soon as possible.

Cancellations & non-attended appointments

17.8 Patients who are not brought to their initial SLT appointment will be discharged back to the referrer. Patients who are not brought to follow up appointments may be discharged, or a further appointment may be offered if the therapist feels it is appropriate. If a patient is not brought for a second consecutive appointment, they will be discharged.

17.9 If an initial SLT appointment is cancelled by the patient, the service will aim to rebook the first appointment within 18 weeks of the original referral. Depending on the pathway, this may be agreed over the phone, or a new date may be issued to the patient via letter. The cancellation does not stop the waiting time clock.

17.10 If a first appointment is attempted to be cancelled for a second time, the cancellation request will be declined, and the patient will need to either attend the agreed appointment or be discharged from the service.

17.11 If a patient is discharged due to non-attendance or cancellations, a discharge letter will be sent to the child's GP, originating referrer and other, relevant professionals significant to the care of that child. In the event of safeguarding concerns, the discharge letter will also be sent colleagues in social care.

17.12 For patients who need re-referring to the service a re-referral will be accepted using the existing referral paperwork, providing it is no more than six months old.

18 0-19 Service

18.1 All children and young people aged 0-19 years, and up to 25 years for SEND, who reside or attend a school in Sheffield sit within either the Health Visiting or School Nursing units on SystmOne, dependent on age. When patients start school, they will move from the Health Visiting to the School Nursing service.

18.2 Appointments and contacts with clients can be in the home, clinic, school, youth centre, children's centres or other settings within the community.

18.3 A child or young person is only discharged from services when they reach the age of 19 or if they transfer out to another area outside of Sheffield in which case the care is transferred.

18.4 When services are made aware an intervention is required, the request will be addressed by the Duty Health Visitor/School Nurse within the same day and an appropriate practitioner will be allocated the request. Requests for interventions can be received from all agencies and partners (including GPs, social care and schools), and can be received in any format (e.g. email, phone call and Early Help Meetings).

18.5 The allocated practitioner will then arrange the contact in an appropriate time frame. This should be in accordance with service specifications and the need and priority of the child or young person, and should not exceed one month. The appointment would be made with the parent / carer or young person directly via telephone/SMS or letter.

18.6 Should a patient cancel an appointment this would be rearranged directly with the practitioner. Should in exceptional circumstances an appointment be cancelled by the service the individual practitioner would reschedule the appointment.

18.7 Where there is non-access, clinicians follow the Failed Visits Protocol or Parents who decline 0-19 Health Visiting Services in Sheffield Protocol.

18.8 All follow-up appointments are arranged with the practitioner and client and a mutually convenient time.

19 Psychology

Standards

Local Target	Standard
92%	Non-urgent patients should start their first treatment within 18 weeks from referral into the service. First treatment is considered to be the patient's first appointment.

19.1 The principles in sections 1-13 of this policy apply to the Psychology service.

20 Dietetics

Standards

Local Target	Standard
92%	Non-urgent patients should start their first treatment within 18 weeks from referral into the service. First treatment is considered to be the patient's first appointment.

20.1 The principles in sections 1-13 of this policy apply to the Dietetics service, where relevant, unless stated otherwise.

Referrals

20.2 The Dietetic service accepts referrals from clinical colleagues from any SCFT speciality and Primary Care.

20.3 Referrals to the Dietetic inpatient services are accepted for all inpatients at SCFT, regardless of age, and are received via ward rounds, handover meetings, written referral forms, through Careflow, or verbally from clinical colleagues.

20.4 Referrals to Dietetic outpatient services are accepted for children up to and including their 18th birthday (in line with 0-19 services). The service aims to transition patients to adult services from age 16, except for pupils in special schools, however on occasion there is no adult service to accept before the age of 18.

20.5 Certain specialities will receive open dietetic referrals automatically to their service e.g. every child with Cystic Fibrosis, inherited Metabolic diseases or Type 1 Diabetics. When an open referral is received, the service will contact the family to make an appointment.

20.6 All referrals received into the service will be date stamped, then screened by a qualified clinician. Accepted referrals are added to the appropriate electronic system and designated onto the appropriate waiting list.

Booking Appointments

20.7 At an appropriate time, the parent / carer will be contacted by letter asking them to contact the service within 14 days to book an appointment. If parents or guardians do not contact the service within 14 days of their letter being sent, the patient is discharged; the referrer is notified and asked to re-refer where necessary. There may be exceptions to this based on the clinicians' safeguarding concerns or if the therapist feels that their condition requires a further opportunity to engage.

20.8 Wherever possible booked appointments will be confirmed by letter, email or text message. The confirmation should include the time and location of the appointment and the method to be used (telephone / video / face to face).

20.9 If a patient is not brought to their appointment, the Trust's WNB/DNA policy applies (see sections 10.16-10.20).

21 Hearing Services (Audiology)

Standards

National Target	Standard
99%	Audiology Assessments are applicable to the DM01 standard. Therefore, patients must undergo audiology assessments within 5 weeks and 6 days (or 41 days) from the date of decision to refer to appointment date. This excludes planned diagnostic investigations.

21.1 The principles in sections 1-13 of this policy apply to the Hearing Services (Audiology) service, where relevant, unless stated otherwise.

Referrals

21.2 Audiology referrals are made directly to Hearing Services (Audiology) department. Referrals are accepted from Health, Education, Social Care and Clinical Colleagues - by email, paper or via GP e-Referral Service (ERS).

21.3 Referrals are date stamped, graded by an Audiologists and then added to Careflow.

21.4 A letter is sent to parents requesting they telephone Hearing Services or contact the department by email to arrange an appointment.

21.5 If no response from parents after 10 working days, the referral is will be passed to Audiologist to decide on the next steps. Parents may be contacted by phone or sent an appointment by post, or the referral may be discharged, and a letter sent to referrer and GP.

Appointments

21.6 Appointments made by post will be offered with at least 3 weeks' notice. Appointments accepted by parents by phone or email with less than 3 weeks' notice are deemed acceptable.

21.7 Parents who phone to decline any appointment will be put through to an Audiologist – if the decision is agreed to discharge then a letter will be sent to the referrer/GP informing them of this.

21.8 Hearing Services (Audiology) use Patient Hub and text messaging for appointment reminders.

Cancellations

21.9 Parents will be offered another date if they cancel their appointment. If no appointments are available this is escalated to the Office Manager or a Senior Audiologist. If parents cancel for a third time, they will be put through to an Audiologist for their decision on whether to offer another appointment or discharge.

Patient Pathways

21.10 The majority of children diagnosed with permanent congenital hearing impairment should be offered follow up until the age of 16 years, when the process of transition will be considered. Failure to attend long term care may present a clinical risk to the patient and attempts should be made to encourage attendance. In a small minority of patients, it may be appropriate to offer patient initiated follow up. Specific populations of patients may be at risk of developing a hearing loss, and these groups would normally be offered follow up until an appropriate stage. Local guidelines for the current patient pathways in Hearing Services are available for reference.

21.11 If a patient is not brought to their appointment, the Trust's WNB/DNA policy applies (see sections 10.16-10.20).

22 Neurodisability

22.1 The principles in sections 1-13 of this policy apply to the Neurodisability service.

23 Private and Overseas patients

23.1 Please see the separate Trust Policies for Private, Overseas and Cross Border Patients. These patients are not applicable to the national standards.

23.2 Where a patient has been seen by a clinician privately but then decides to transfer their care to the NHS and they are transferring onto an 18-week pathway, the 18-week clock starts at the point at which clinical responsibility for the patients care transfers to the NHS (i.e., when the Trust accepts the referral for the patient). Private patients transferring in this way will be treated in turn within the terms of this policy.

23.3 If first treatment has already started or been given, a referral from private to NHS care would not start a new clock unless the patient requires a substantially new course of treatment. In this case, the clock would start at the point clinical responsibility for the patient is accepted and received.

24 Governance

24.1 Contributors to this policy have been included under Appendix 1. This document has been seen by all Care Groups, Corporate Harm Panel, Waiting List Management Board and Performance Committee prior to approval.

24.2 Care Groups are expected to ensure management of patients and pathways is done in accordance with this policy. Internal assurance will be provided through a through a range of forums. These include, but are not limited to, Patient Tracking List Meetings (PTLs) and Operational Performance and Planning Meetings (OPPMs). For the full governance structure, see Appendix 2, and refer to the Trust's Performance Improvement Framework.

24.3 Compliance with the standards and processes outlined in this policy is monitored through a range of KPIs, these are also monitored in the meetings outlined in Appendix 2.

24.4 Training required on any aspect of this policy will be provided by the Planning and Performance Team. See Appendix 3.

24.5 This policy will be reviewed annually, taking into consideration national planning guidance, or where there is significant variance to national guidance which would warrant an immediate review and updating of the Patient Access Policy.

25 References

- National RTT Guidance: https://www.england.nhs.uk/rtt/
- National cancer waiting times guidance: https://www.england.nhs.uk/statistics/statistical-work areas/cancer-waiting-times/
- Diagnostic waiting times guidance: https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/diagnostics-waiting-times-and-activity-dm01
- Children and Adolescent Mental Health Services Waiting Times: https://www.england.nhs.uk/mental-health/resources/access-waiting-time/

26 Associated Documents

- Management of Appointment Slot Issues
    - Managing Appointment Slots Issues User Guide V7.docx
    - GP Referrals received through eRS but booked outside eRS.docx
- Cancer Referrals
    - Appendix 2WW referral proforma.docx
- Patient initiated follow up (PIFU)
    - Intranet page
    - Admin process
    - Clinician process
    - Patient leaflet
- Safeguarding
    - Safeguarding Training Policy
    - Safeguarding Supervision Policy
    - Policy for Safeguarding Children
    - Guide to Safeguarding Alerts
    - Safeguarding Alerts Standard Operating Procedure
- Transition to Adult Services
    - Transition from Children's to Adult Services Policy
- 0-19 Service
    - Failed Visits Protocol
    - Parents Who Decline 0-19 Health Visiting Services Protocol
- Performance Framework
    - Performance Improvement Framework
- Private and Overseas Visitors
    - Private Patients Policy
    - Overseas and Cross Border Patients Policy

27 Equality and Health Inequality Impact Assessment

27.1 This policy applies to all Trust employees irrespective of age, race, colour, religion, disability, nationality, ethnic origin, sexual orientation or marital status, carer status, social and employment status, HIV status, gender reassignment, political affiliation or trade union membership. All employees will be treated in a fair and equitable manner.

27.2 This policy applies to all patients and their families irrespective of age, race, colour, religion, disability, nationality, ethnic origin, sexual orientation or marital status, carer status, social and employment status, HIV status, gender reassignment, political affiliation or trade union membership. All patients and their families will be treated in a fair and equitable manner, for some families this may require some additional support in order to minimise the potential impact of any health inequalities which might exist.

27.3 The Trust will take account of any specific access or specialist requirements (e.g. BSL interpreter, documents in large print) for individual employees, patients and their families during the implementation of this policy.

27.4 The Equality and Health Inequality Impact Assessment tool is included as Appendix 4.

28 Version Control

Version	Date	Author	Status	Comment
9	September 2022	Killian Burke Head of Planning and Performance	Approved	Complete rewrite of the policy has occurred

29 Appendices

- Contributors to the Policy
- Governance Structure
- Communication and Training Plan
- Equality and Health Inequality Impact Assessment Tool

Appendix 1 – Contributors to the Policy

The whole document has been reviewed by:

Chief Operating Officer
Deputy Operations Director
Head of Information
Head of Planning and Performance
Safeguarding Team: Community Services Safeguarding Named Nurse, Acute Safeguarding Named Nurse, CAMHS Safeguarding Named Nurse
Corporate Harm Panel
Data Quality Group

Subject Matter Experts have reviewed the following:

10. **Outpatients Appointments:** Head of Outpatients, Outpatients Service Manager, Senior Programme Manager (Modernising Outpatients)

11. **Diagnostics (Radiology):** Radiology Manager

12. **Inpatient Admissions:** Senior Operational Manager and Waiting List Team Leader

13. **Transition to Adult Services:** Transition Lead Nurse

14. **Children and Adolescent Mental Health Services (CAMHS):** Community CAMHS Service Manager, Community CAMHS Deputy Service Manager, CAMHS Operational Manager, CAMHS Operational Support Manager and CAMHS Service Delivery Manager

15. **Physiotherapy & Occupational Therapy:** Head of Physio & OT and Team Leader for Community Physio & OT

16. **Clinical Genetics:** Clinical Genetics Service Manager and Deputy Manager

17. **Speech and Language Therapy:** Deputy Head of Service and CWAMH Service Manager

18. **0-19:** Head of 0-19 Community Service

19. **Psychology:** CWAMH Service Manager and Psychology Admin Manager

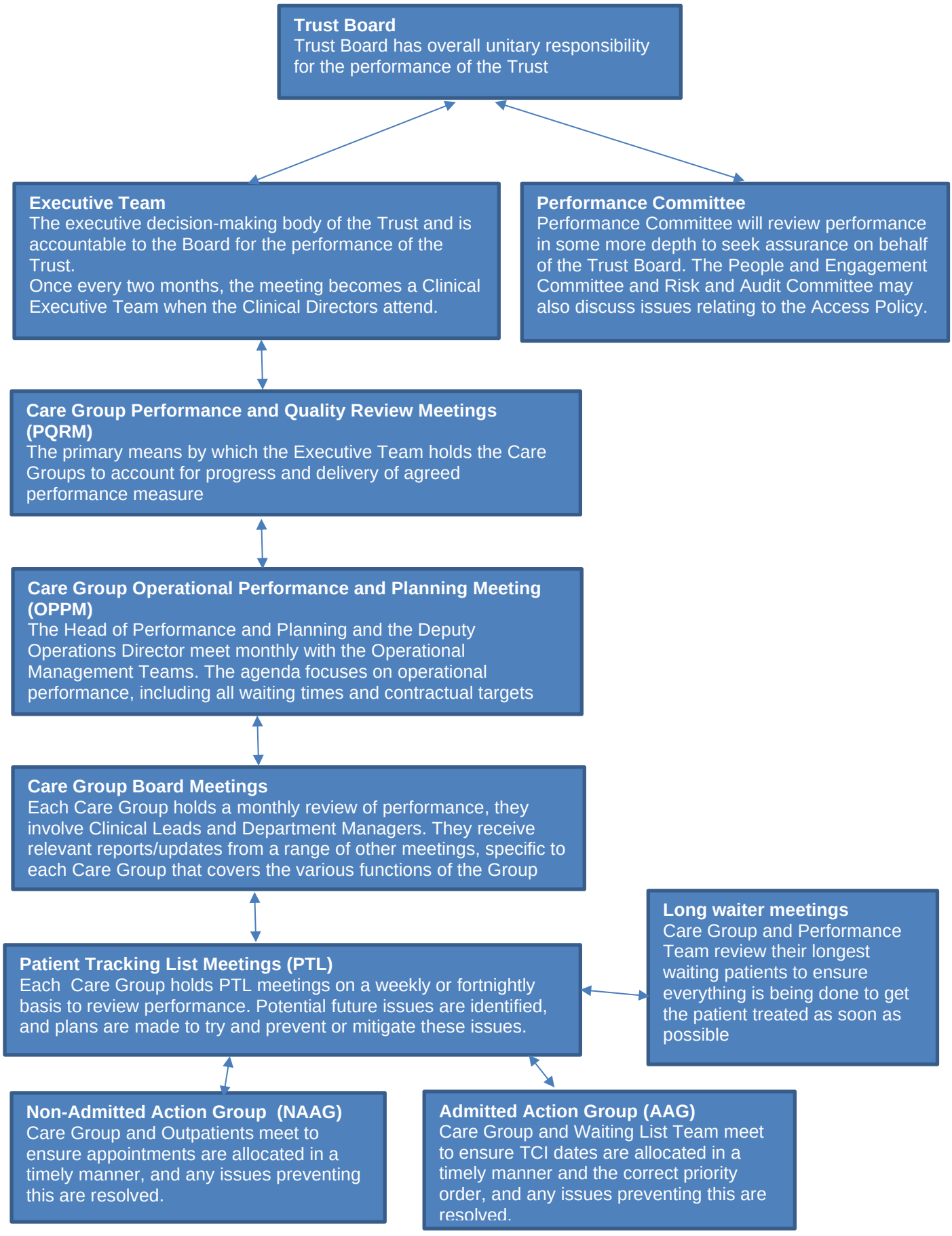
20. **Dietetics:** Head of Dietetics

21. **Audiology:** Head of Hearing Services

22. **Neurodisability:** Associate Director of MEDicine and Deputy Divisional Manager MEDicine

27. **Equality and Health Inequality Impact Assessment:** Senior Programme Manager (WNB Intervention Project Lead)

Appendix 2 – Governance Structure



Appendix 3 – Communication and Training Plan

- The policy will be presented at all Care Group Boards by the end of Q3 2022 so Care Groups understand the changes which have been made the key areas they will need to manage
- Training will be available, provided by Planning and Performance, for all colleagues, including Consultants and clinical staff, who are currently involved in the administration or management of outpatient and/or elective care
- For new staff who are to be involved in the administration or management of outpatients and/or elective care, training on the Access Policy will be included within the role specific training for these colleagues as part of their local Trust induction
- Planning and Performance will work alongside Communications to present a Trust wide communication highlighting the refreshed policy during Q3 2022
- Additional brief summaries will be produced for key staff groups to support both training and ongoing adherence to the Access Policy. These will be produced by Planning and Performance during Q3 2022
- Summary headlines for patients and their families on key areas will be produced and managed through the Waiting Well programme of work, with support provided by Communications

Appendix 4 – Equality and Health Inequality Impact Assessment Tool

Equality/Health Inequality Impact				
Dimension	Notes	Positive Impact	No Impact	Negative Impact
Sex			X	
Race			X	
Sexual orientation			X	
Gender reassignment			X	
Disability			X	
Marriage and Civil Partnership			X	
Pregnancy and maternity			X	
Religion or belief			X	
Age			X	
Deprivation			X	
Health Literacy			X	
Carers (unpaid family members)			X	
Ability to Speak English	Mitigations in Place		X	
Digital Poverty	Mitigations in Place		X	