To: Health and Wellbeing Board Circulation

Dear Sir/Madam

Health and Wellbeing Board – 24 July 2013

Please find attached the undermentioned items, which were marked “To Follow” on the Agenda for the above meeting.

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<th>Item</th>
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<td>8.</td>
<td>Winter Pressure Deferment Scheme</td>
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Yours faithfully

K. Dunne

Kelley Dunne
Democratic Services Officer
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**Report to Governing Body**

**Date of meeting:** 19th November 2015

**Governing Body Member Lead:** Dr Hilary Flett

**Accountable Director:** Director of Commissioning

**Report title:** Winter Pressure Deferment Scheme

**Report prepared by:** Chrissie Cooke, Interim Director of Commissioning.

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### Strategic Objectives

This report supports the following CCG Strategic Objectives. Please insert ‘x’ as appropriate.

1. Commissioning effective, safe, high quality services (Supporting delivery of the NHS Constitution for patients). **x**
2. Delivery of St Helens CCG Strategic Commissioning Priorities **x**
3. Achieving sustained financial balance **x**
4. Improving the quality and safety of commissioned services **x**
5. Improving the quality of Primary Care Services

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### Governance and Risk

**Does the report support the CCG’s governance compliance?** **x**

**Does this report provide the Governing Body with assurance against any of the risks identified in the Assurance Framework? (please specify)**

*Risks identified regarding managing winter and financial balance** **x**

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### Purpose of the Report

To seek approval for delays to the CCGs elective care programme

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### Recommendations to the Committee

Provide options if appropriate – committee to agree if the report is to be approved elsewhere, approve if Committee has the authority; avoid ‘not’ ‘committee is asked to review and discuss …’ is the preferred for information only items)

**Action / Decision required:**

It is recommended that the Governing Body approve the following

- Delaying the elective programme to help manage ‘winter’ and deliver the CCGs financial recovery plan
- The methods set out in this paper are enacted
- The monitoring of clinical and quality impact is reported via the SRG and the financial and activity impact is monitored via the Recovery plan group
- An evaluation of the impact of this scheme is reported back to Governing Body in September
2016 in advance of winter planning.

- Note the EIA and approve the recommendations

If the decision of the Governing Body is not to approve the scheme, the meeting is requested to discuss the alternatives for managing winter pressures and delivering the recovery plan.

### Background

_Limited this section unless a major strategy or complex proposal, provide key information in support of the recommendations and analysis and/or justification – describe briefly the consultation undertaken if appropriate_

This paper sets out the need to assist the health system to manage winter pressures and to achieve financial savings by implementing a 6 week delay in elective referrals over a three month period. This will reduce demand for secondary care over winter, and reduce re-imbursement in year.

The proposal builds on an approach used by Warrington PCT/CCG in previous years. This scheme will be applied in conjunction with other measures designed to achieve recovery savings for the CCG and assist the Acute Provider with reducing their forecast deficit.

### Financial/Resource Implications

_Please provide list of any financial risks/implications associated with this report_

St Helens is a challenged economy with a history of financial pressures associated with St Helens and Knowsley hospitals PFI scheme and significant Local Authority social care budget cuts. Following early recognition of emerging financial challenges, the CCG took a pro-active approach to highlighting the issues through NHS England locally and instigated an internal recovery process. Options for mitigating actions were discussed and agreed by the Governing Body, one of which was delaying elective referrals. The recovery measures are focussed initially on containing the position for 2015/16, with longer term transformation projects to deliver sustainable change in future years in line with the CCG’s commissioning strategy.

Officers of the CCG have completed an analysis on the possible financial impact of different options for deferment, based on estimated activity. The activity assumptions have been made using historical referral patterns and performance of specialities in year. The team have also excluded the savings from procedures where it is extremely likely that patient would get referred, i.e. paediatrics, and all urgent referrals. This has been further developed using a 75% reduction, 60% reduction and 50% reduction in referrals during the period

Assuming a most likely scenario is 60% of referrals will be deferred for 6 weeks, the cost saving is £923,619.

It is important to note that this will only mean a delay of re-imbursement for the provider until after the end of March 2016. There is expected to be an attrition rate but it is expected to be minimal, probably only 1 or 2%. Therefore there is a requirement to find an additional £905,146 savings in addition to next year’s QIPP.
National Policy, Guidance, Standards or Legislation relevant to the Report *(please provide a list of all relevant publications or standards)*

18 weeks standard - NHS Constitution

Equality and Diversity and Human Rights *(Are there any E&D or HRA implications? If not, please put N/A, if so what are they and how are they being addressed? Explain any equality impacts and the positive population outcomes expected from the decision)*

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, The CCG has

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

Detailed assessments are included in the appendices

Stakeholder consultation *(has appropriate consultation taken place e.g. public; overview and scrutiny committee; health and wellbeing boards; local authority; MPs, CCG sub-Committees)*

Informal discussions have been held internally and with key stakeholders to gauge reactions, to identify concerns or risks that may still be present.

Governing Body members have had discussions with Health watch, the Local Medical Committee, St Helens and Knowsley Trust, Knowsley and Halton CCGs and the Local Authority.

Whilst concerned about the impact this scheme could have on patients there was recognition that the CCG is in a difficult position and they were broadly supportive of the pans and safeguards proposed. Officers have carefully considered each issue and has ensured that mitigating actions are included in the plan.

The scheme was extensively debated at Members Council on the 18th November. *(a verbal update will follow)*

Quality Impact *(please describe any quality improvements expected to be delivered)*

This paper sets out how the quality impact of this proposal has been assessed. A detailed assessment is included in the appendices. The importance of clinical quality is paramount in times of financial challenge and to ensure clinical focus is maintained key savings schemes have agreed clinical leadership, this proposal has been extensively consulted upon and quality concerns addressed via the documentation to support the plan.
### Risks

**Risks** *(please provide information on any risk e.g. patient safety, service delivery, finance, legal or reputational risk and the actions that are being taken to mitigate against the risk to include patient safety, regulatory and statutory issue – if appropriate describe risk if action is not taken)*

The risks that have been identified through this process are:

1. Patient who needs urgent treatment could potentially not get referred
2. Patient who needs urgent treatment agrees to a deferment because they don’t understand the implications
3. Patients hear about the scheme, think that they won’t get referred and don’t go to see their GP.
4. Negative publicity
5. Actions do not assist in managing winter
6. Actions do not lead to savings

We have considered all of these issues and reasonable mitigating actions are included and described in the paper.

### Legal Implications

**Legal Implications** *(if legal advice has been sought explain here)*

Not relevant at present - advice has been sought over challenge to PSED and issues are covered in the paper.

### Communication issues

**Communication issues** *(is there a need to convey the decision to a specific group or promote the implications of the decision widely e.g. a new service or campaign)*

Communications materials are included in appendix 5.

### Conclusion

**Conclusion** *(a brief supporting statement by the author)*

The purpose of this scheme is two-fold. Firstly to enable capacity over winter to cope with emergency and urgent care. Secondly to enable management of the financial position so that the CCG does not lose funding. The plan has various safeguards to ensure that people who need urgent treatment get access to it in the same way they have always done. It is likely that this scheme will mean that people who need urgent care have better access to acute services. Those who need urgent treatment or emergency treatment are less likely to be cancelled during these months because of the delays to non-urgent referrals.

Based on the analysis and evaluation of all aspects of impact it is clear that this plan could adversely affect people who do not need urgent treatment during December, January and February. This will mainly be in terms of patient experience if the guidance to GPs is followed, and should not have an impact on patient safety. There may be a level of indirect or direct discrimination by reason of peoples protected characteristics; however the materials and plans detailed in this paper set out the safeguards that will be in place to minimise this likelihood.

There will be a mid-term review to evaluate any complaints, claims or challenges during the life of the scheme. In addition a more detailed evaluation of the scheme will be completed in case the CCG wishes to re-run it in future years.

There is a quantifiable impact in savings that will be extremely helpful to the CCGs financial position in year.
Introduction

This report sets out the way that St Helens CCG wishes to manage some of the system resilience pressures that are likely to happen during winter 2015/16. It describes how the proposed Winter Pressures Deferral Scheme will work and the recommendations to the Governing Body that will ensure system resilience over the winter months, with as little negative impact on patients as possible and a reduction on the negative impact on future health and social care provision in the borough.

Executive Summary

St Helens CCG, like many other CCGs, is experiencing significant financial pressures and is at significant risk of not achieving its statutory duty of a 1% surplus at the end of this financial year. The 1% surplus counts towards the total budget of 2016-2017, as it has done in previous years. If the CCG does not achieve its financial plan, funding from NHS England will be reduced by 1%. This will have a significant negative impact on the health and social care economy next year, as not only will the CCG received a reduced total budget, but this year’s deficit is added to the QIPP challenge of 2016-2017, and quality payments, which are made only if statutory financial targets are met, will also be lost.

To deal with this financial challenge, the CCG has worked with NHSE on a recovery plan, which includes a series of strategies to minimise the deficit in this financial year and also longer term strategies to improve system resilience. The Winter Pressures Deferment Scheme is one of these strategies. It aims to reduce non-elective activity in the acute trusts for a three month period from 1st December 2015 to 29th February 2016, which will in term allow the acute Trusts to manage its emergency patients or non-elective activity more effectively.

It will require significant GP support and engagement for its success. However, without such a scheme NHSE will reduce the allocation of money of the CCG next year which will mean we cannot invest in primary care in the same way as the last 2 years.

Key Aims of the Winter Pressure Deferment Scheme

- GPs will be asked by St Helens CCG to defer non-urgent elective referrals to all acute providers for 6 weeks, between 1st December 2015 until 29th February 2016.
- This request will not affect sick children, people with possible cancer, patients whose condition the GP considers is urgent or patients where the GP considers there is any clinical uncertainty or risk of deterioration.
- This is a decision made in partnership with the patient, if at any time the patient or the GP does not agree, the referral should be made as usual.
- The patient will only be asked if they are prepared to wait for 6 weeks for their referral to be made if the GP thinks that their condition is not urgent.
- If a patient’s condition deteriorates, the GP can refer the patient as an urgent case.
- An equality impact assessment and safeguards have been put in place to protect people who may otherwise be disadvantaged. GPs need to be sure that a patient who consents to a deferment is able to participate fully in the discussion and is not being discriminated against. The scheme has been approved by St Helens CCG Quality Committee.
St Helens Healthwatch has been consulted and is supportive of the Scheme. Further patient Group liaison is planned prior to the launch.

The Scheme will enable Trusts to focus on Non-elective activity at a time of greatest need.

The NHS referral to treatment target of 18 weeks is unlikely to be breeched even with the 6 week deferral period, as most non elective cases are seen before 11 weeks at Local Trusts.

The scheme will make a significant contribution towards managing health costs in St Helens and has been approved by St Helens CCG Finance and Performance Committee.

Context- The local healthcare system

1. The CCG commissions healthcare for the population of St Helens, which is approximately 195,000 people. One aspect of this healthcare is emergency care (known as non-elective) such as Accident and Emergency service and emergency admission to hospital. The other aspect of healthcare is the planned type (known as elective). This is pre-arranged, non-emergency care that includes scheduled operations. When a patient takes a problem or condition to the GP, that isn’t a medical emergency but that requires treatment that can’t be delivered by the practice, the GP will refer the patient to a hospital or other service for treatment.

2. The emergency care services that operate in St Helens have seasonal pressures, particularly throughout the winter period. This time of year, when the weather is colder and wetter, often sees an increase in people being unwell from colds, flu and accidents. There is a corresponding increase in calls for urgent care, and an increase in older people, in particular, needing more support. The NHS has a universal standard of ensuring that people who need to be seen in A&E are seen and treated or admitted within four hours. Whilst this is a nominal target, it is also a quality marker for patients and the public. Waiting for assessment and treatment in urgent care is often detrimental to a patient's condition and therefore should be avoided.

3. Parts of the elective care system in the NHS operate to a similar target, known as 18 weeks. Basically it means that a patient should not wait more than 18 weeks from the time they are referred by their GP to the time their treatment is commenced, unless they choose to wait longer. It is a standard set out in the NHS constitution. In elective care the GP is responsible for deciding on the urgency of the patient's condition. In some cases a patient may need urgent surgery but it is not a medical emergency where they should be sent to A&E. There are processes in place that mean that if a patient needs to be seen urgently, for example with suspected cancer, they are prioritised and seen more quickly than others.

4. When the 18 weeks target was introduced, it had a dramatic effect on the time that patients wait for a service, and also the numbers of people waiting. The elective system is so efficient now that several years later St Helens patients do not wait for very long for treatment and most services perform very well in this regard. Many patients are seen and treated in well under 18 weeks, in some specialities the wait can be under 8 weeks.

5. Whilst this is very good for patients who need to have planned care not to wait, it has a knock on effect on the capacity that services have to cope with urgent care. This is felt particularly in winter.

6. There is a finite amount of resource allocated to the CCG to buy healthcare for patients. In the main this money is invested in services at St Helens and Knowsley NHS Trust, Bridgewater
Community FT and 5 Boroughs Partnership, as well as funding GP practices. The CCG has a fund that is kept aside to pay for extra services during winter, but this is limited. There is also no real opportunity for the CCG to find extra hospital beds, or extra doctors and nurses. Even if the money was there the physical space and the trained professionals are not available.

7. This means that we have to manage with what we have got over winter. Inevitably when patients need urgent care planned procedures can get cancelled to make room. Patients see this every year as winter pressures mean operations and clinics are cancelled or delayed. Acute services are under pressure to make sure that the chances of this happening is reduced and often put on extra clinics or run their services at weekends to make sure patients are not adversely affected. This is places an additional burden on hospital and community services, which can, at times, lead to over stretched resource and poor care.

All of St Helens health services with patients and the public need to work together to make sure that

- Urgent care is given to patients who need it as soon as they need it
- Planned care is delivered to those who need it in a timely way
- The quality of care is not damaged or under-mined by pressures on the healthcare system

The Proposal- delaying or slowing down elective referrals over winter.

8. As described above GPs are responsible for determining the urgency of a patient’s condition, and to make a referral based on this. As described before there are processes in place for urgent referrals to be prioritised so that these patients are seen more quickly than non-urgent. To make the best use of health services in St Helens it would be sensible to stop non-urgent work at a time when urgent and emergency work is known to be increased. However elective procedures are set out as a right in the NHS Constitution so stopping elective work completely would not be appropriate.

9. To make room for the additional demand on hospital services over winter, therefore, the CCG is proposing that referrals for non-urgent planned treatments over winter are ‘slowed’ down. This will apply to every planned treatment or procedure that is not classed as urgent by the GP.

10. A much more austere approach was used by NHS Warrington/Warrington CCG in 2010, 2011 and 2014. The results were not analysed in detail however there were reported negative impacts and benefits associated with their plan. There was a definite impact each time, both in terms of creating care capacity and financial savings. Officers of the CCG have consulted with officers of Warrington CCG to understand these issues and have used Warrington’s experience to shape the way this plan is being proposed, especially to avoid some of the problems they identified.

11. To implement this, the CCG is requesting that on the date that the GP decides a patient should be referred, the actual referral is not made for 6 weeks. The CCG is also proposing that this policy commences on 1st December 2015 until 29th February 2016.

12. Because this may appear controversial it is important for everyone to understand some important principles of this proposal.
The GP remains the person responsible for determining clinical urgency. This proposal does not change the GPs duty to refer patients who need urgent treatment.
The decision to delay the referral will be made in partnership between the patient and the GP.
GPs must ensure that they take account of the patient’s ability to contribute to a meaningful discussion about delaying their treatment and are not discriminated against because they are vulnerable or disabled.
If at any time the patient’s condition deteriorates, they must be able to activate that referral before the end of the deferment period and see their GP if necessary.
Patients who have agreed to delay a referral for treatment will not be disadvantaged by having to attend the GP for a subsequent appointment to make the delayed referral, unless they wish to.
13. The CCG has discussed the options around delaying elective referrals and has considered the impact of each. Historical elective activity was analysed to evaluate how many patients were being referred, and to which speciality and what the usual waiting time was for each speciality. The intelligence gained from this information was then used to identify what approach the CCG should recommend.

14. The options that have been considered are:
   - Stopping all referrals for specified ‘cold’ procedures
   - Delaying all referrals that are non-urgent
   - Delaying all procedures that have a waiting time of less than 10 weeks

15. The options were considered using two main principles – quality impact and equality impact.

16. Assuming that 60% of referrals are delayed over this period it is estimated that 2,229 patients would be affected by the delay.

Financial impact

17. Officers of the CCG have completed an analysis on the possible financial impact of the three options above, based on estimated activity. The activity assumptions have been made using historical referral patterns and performance of specialities in year. The team have also excluded the savings from procedures where it is extremely likely that patient would get referred, i.e. sick children, and all urgent referrals. This has been further developed using a 75% reduction, 60% reduction and 50% reduction in referrals during the period. The most likely scenario has been factored into the table below.

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<th>Option</th>
<th>Quality impact</th>
<th>Equality impact</th>
<th>Should this option be pursued?</th>
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<td>Delaying all referrals that are non-urgent</td>
<td>Limited quality impact - would only apply if patient &amp; GP agree</td>
<td>Please see Equality report attached</td>
<td>YES</td>
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<td>Recommendations must be approved to meet Public sector Equality Duties</td>
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<td>Delaying all procedures that have a waiting time of less than 10 weeks</td>
<td>Limited quality impact - would only apply if patient &amp; GP agree</td>
<td>Please see Equality report attached</td>
<td>NO</td>
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<td>Stopping all referrals for specified cold procedures</td>
<td>Some of the procedures may still be required even if they are not life threatening because of their impact in a different aspect of a patient’s life; For example cataract treatment where both eyes are impaired and increase the risk of falls. Patient may agree but it may not be safe.</td>
<td>Please see Equality report attached</td>
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<td>Recommendations must be approved to meet Public sector Equality Duties</td>
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1 ‘cold’ procedures refers to procedures that treat non-life threatening conditions, includes but is not limited to procedures of limited clinical priority.
18. Assuming a most likely scenario is 60% of referrals will be deferred for 6 weeks, the cost saving is £923,619.

19. It is important to note that this will only mean a delay of re-imbursement for the provider until after the end of March 2016. There is expected to be an attrition rate but it is expected to be minimal, probably only 1 or 2%. Therefore there is a requirement to find an additional £905,146 savings in addition to next year’s QIPP.

**Implementation & Monitoring**

20. If this proposal is accepted there are a number of steps that CCG officers will take to implement this approach which will be overseen by the elective Programme steering group. This group includes a managerial and a clinical lead as well as finance, commissioning and performance staff. The clinical impact and system resilience performance and impact will be reported to the System Resilience Group as part of the overall winter plan. The financial and activity impact will be reported to the Recovery Plan oversight group.

21. This scheme will be implemented over a four month period, with a mid-term review and a formal evaluation over the summer. The table below sets this out.

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Communications Strategy

22. To ensure maximum success with this plan a communications strategy has been developed that will ensure that the right messages are being reported to the health and social care system and to the public. The elements of the communications strategy are to ensure these messages, frequently asked questions and briefings are given to different groups of people/services which are described below.

- **Internal to the CCG:** a summary of this paper will be shared internally via team meetings to ensure that the key messages are consistent and managed. This is in recognition that all our staff are in contact with other organisations and will need to ensure that key messages are passed on correctly, and in recognition that all our staff are patients, many of them St Helens patients.

- **General Practice:** will include a briefing regarding the purpose of delaying referrals, the draft letters and information leaflets that GPs could give to patients, a model process for activating referrals that can be used at practice level and frequently asked questions for clinicians.

- **Patients & Public:** will include Healthwatch and MPs. Posters and leaflets to be displayed in waiting rooms and clinical areas, press releases and interviews for radio etc.

- **Service Providers:** will include briefing to be disseminated via provider comms systems and requirements for reporting adverse events clarified.

- **Third party stakeholders:** these will include the Local Authority OSC, LMC, local councillors; local authority colleagues and other CCGs and will be prepared individually.

Conclusion

23. The purpose of this scheme is two-fold. Firstly to enable capacity over winter to cope with emergency and urgent care. Secondly to enable management of the financial position so that the CCG does not lose funding. The plan has various safeguards to ensure that people who need urgent treatment get access to it in the same way they have always done. It is likely that this scheme will mean that people who need urgent care have better access to acute services. Those who need urgent treatment or emergency treatment are less likely to be cancelled during these months because of the delays to non-urgent referrals.
24. Based on the analysis and evaluation of all aspects of impact it is clear that this plan *could* adversely affect people who *do not need* urgent treatment during December, January and February. This will mainly be in terms of patient experience if the guidance to GPs is followed, and should not have an impact on patient safety. There may be a level of indirect or direct discrimination by reason of peoples protected characteristics; however the materials and plans detailed in this paper set out the safeguards that will be in place to minimise this likelihood.

25. There will be a mid-term review to evaluate any complaints, claims or challenges during the life of the scheme. In addition a more detailed evaluation of the scheme will be completed in case the CCG wishes to re-run it in future years.

26. There is a quantifiable impact in savings that will be extremely helpful to the CCGs financial position in year.

**Appendices**

- Quality Impact analysis
- Equality Impact analysis
- Financial Impact Analysis
- Frequently asked questions for patients
- Letter for patients
- GP practice guidance
- Process map
Equality Analysis Report (interim):

Elective Treatments and extending time lines for referral

1) Introduction:

The Equality Act 2010 contains within it a statutory requirement known as ‘public sector equality duty’ (PSED). PSED requires that service provider examine ‘all functions’ and test these against three aims:

(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Redesigning and changing how a service is provided is a service ‘function’ and there must examine how the change and redesign meets the above aims. The purpose of this analysis is to test whether any change would directly (section 13 of the Equality Act 2010) or indirectly discrimination (section 19) by creating untoward and unacceptable barriers preventing individuals from access the service based on their protected characteristics and thus causing greater health inequality.

This equality analysis report will look at the circumstances for the change proposed below, what potential barriers could arise and any potential mitigation or change to policy that may need to be undertaken.

Whilst the Equality Act 2010 is a primary piece of legislation (all other legislation must adhere and comply to it), it helps support and clarify the Heath and Social Care Act 2012 section 14T:

14TDuties as to reducing inequalities

Each clinical commissioning group must, in the exercise of its functions, have regard to the need to—

(a) Reduce inequalities between patients with respect to their ability to access health services, and

(b) Reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.

With this there is a clear need to examine health inequalities and any discriminatory forces that may be in play with and new or current service provision, policy and criteria.

2) The proposed policy.

Currently contained within the Health and Social Care Act 2012, is the instruction that GPs must make referrals to specialist, in relation to elective treatments, within 18 weeks.
GP services within St Helen’s CCG control have a ‘turnover rate’ of 8 week for referrals for elective treatments.

Hospital Trusts have highlighted that, with the oncoming winter demand, that they are/will be ‘overstretched’ and cannot meet emergency and urgent treatments as well as elective treatments within currently formed time frames. The CCG in considering how to ‘ease the pressure’ wants to instruct GP to ‘stall’ any ‘elective treatment’ by 6 weeks. Thus extending the time frame, from a current 8 weeks before referral, to a minimum of 13 weeks before referral.

The CCG in instructing GPs to extend referrals timescale by 6 weeks, offers some safeguarding principles such that:

“Because this may appear controversial it is important for everyone to understand some important principles of this proposal.

1. The GP remains the person responsible for determining clinical urgency. This proposal does not change the GPs duty to refer patients who need urgent treatment.
2. The decision to delay the referral will be made in partnership between the patient and the GP.
3. If at any time the patient’s condition deteriorates, before the delayed referral is activated, they must be able to see their GP for a reassessment.
4. Patients who have agreed to delay a referral for treatment will not be disadvantaged by having to attend the GP for a subsequent appointment to make the delayed referral, unless they wish to.”

3) What is changing?

The change is a criteria change, in that:

- A rule will be applied by GPs to in effect extend the referral by 6 weeks on all elective treatments, thus making the patient wait for a further six weeks (regardless of any further delay in treatment once seen by the specialist.)
- GPs are being asked to consider other factors, other than clinical need, which will impact on their decision making.

Effects of the change (in addition to delay):

1) Patients may or may not know that there is in fact an ‘added delay’
2) The patients may not be able to fully express their need for treatment as soon as possible (and simply go along with the GPs recommendation)
3) Patients may inadvertently be indirectly discriminated in the faulty application of the 6 week rule
4) Patients may be deterred from returning to the GP if they think that the appointment they are given (with the +6 weeks) is the very earliest that they can be seen, despite their condition worsening.
5) Patients may have consternations about the delay but feel inhibited in expressing them and challenging the GPs view.

Items (2),(3),(4) and (5) are high risk situations that have a propensity for inherent discrimination

|----------------------------------|---------------|--------------------------|----------------------------------------|
| Disability: (learning disability) | A patient may have a learning difficulty and fails to understand that an objection can be raised with the GP, or has the capacity to raise an objection over the addition of the extra 6 weeks to the time line. Patients may be deterred from returning to the GP if they think that the appointment they are given (with the +6 weeks) is the very earliest that can be seen, despite their condition worsening. | Direct discrimination | Section 13  
Section 149  
1(a), (b), (c)  
Section 149.  
3(a), (b) |
| Disability Physical              | The GP sees two patients with similar issues and extend both treatment time lines by 6 week due to ‘CCG & Hospital trust pressure’. The second patient has a disability on which the elective treatment is not connected but has a contributing impact on their overall | Indirect discrimination | Section 19  
“A person (A) discriminates against another (B) if A applies to B a ‘provision, criteria or practice’ in relation to a relevant protected characteristics……if ‘it puts or would put B at [a] disadvantage  
PSED section 149 (1a) |
<table>
<thead>
<tr>
<th>Disability</th>
<th>Definition</th>
<th>Indirect Discrimination</th>
<th>Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability causing a greater disadvantage.</td>
<td>A GP makes a recommendation to add the additional 6 weeks, the female patient does not feel able to challenge. Patients may be deterred from returning to the GP if they think that the appointment they are given (with the +6 weeks) is the very earliest that can be seen, despite their condition worsening.</td>
<td>Indirect discrimination</td>
<td>Section 19 “A person (A) discriminates against another (B) if A applies to B a ‘provision, criteria or practice’ in relation to a relevant protected characteristic...if it puts or would put B at [a] disadvantage” PSED section 149 (1a)(1b)</td>
</tr>
<tr>
<td>Age (younger patients and older patients)</td>
<td>Patients may have consternations about the delay but feel inhibited in expressing them and challenging the GPs view. Patients may be deterred from returning to the GP if they think that the appointment they are given (with the +6 weeks) is the very earliest that can be seen, despite their condition worsening.</td>
<td>Indirect discrimination</td>
<td>Section 19 “A person (A) discriminates against another (B) if A applies to B a ‘provision, criteria or practice’ in relation to a relevant protected characteristic...if it puts or would put B at [a] disadvantage” PSED section 149 (1a)(1b)</td>
</tr>
</tbody>
</table>
| Ethnicity (language) | A patient may have a communication difficulty and fails to understand that an objection can be raised with the GP, or has the capacity to raise an objection over the addition of the extra 6 weeks to the time line. | Indirect discrimination | Section 19 “A person (A) discriminates against another (B) if A applies to B a ‘provision, criteria or practice’ in relation to a relevant protected characteristics……if ‘it puts or would put B at [a] disadvantage

PSED section 149 (1a)(1b)

| Trans-gender | Additional delay in treatment may have a destabilizing effect on the patient (either physically and mentally) | Indirect discrimination | Section 19 “A person (A) discriminates against another (B) if A applies to B a ‘provision, criteria or practice’ in relation to a relevant protected characteristics……if ‘it puts or would put B at [a] disadvantage

PSED section 149 (1a)(1b)

| 4) Legitimate Aim?  
The CCGs wish to extend the referrals time period to utilise the maximum time allowed of 18 weeks in order to alleviate pressure on hospital trust is a legitimate aim and not discriminatory in and of itself. However the application of the rule and the ‘safeguarding principles’ do not remove potential discrimination and therefore further work need to be produced before the CCG can state compliance with the Equality Act 2010 and PSED in particular.  

5) Actions needed to bolster safeguarding and to ensure this proposal complies with PSED:  

Evidence (to establish base line and authenticate proposal):  

a) Evidence to demonstrate that elective treatment are running at the 8 week time scale and to demonstrate that the addition of 6 week would not push certain cases beyond the 18 week limit
b) Evidence of current elective requests and treatments disaggregated by issues that affect different protected characteristics (e.g. male and female) and their associated time lines.

Mechanisms:

1) Clear **guidelines and examples** to GPs on applying the 6 week rule and the necessary adjustments that have to be made to avoid indirect discrimination and proof that they GPs ‘taken these messages on board’

   **CCG response** – **guidelines have been set out in the comms. materials to GPs, plus will be covered in detail during the Members Forum meeting in November.**

2) Mechanisms for patients to object and these be handled in a timely manner to be in place and knowingly available.

   **CCG response** This is set out in the comms materials- open letter to patients and key messages

3) Mechanism to monitor the application of the rule and to analysis and test the results within a short term time frame to identify any discriminatory trends.

   **CCG response**- There is a mid-term review built into the scheme that will cover this.

4) No additional financial reward, from the CCG, given to GPs in lieu of delaying referrals

   **CCG response** There is no financial reward to GPs for application of this deferment scheme

5) Consultation needs to be considered:
   - Inform the public/ interested parties of ‘the policy shift’, the effects of the policy shift
   - Inform public of their position as ‘partner in the decision to delay’.

   **CCG response** This is included in the comms plan

End....
**WINTER PRESSURES DEFERMENT SCHEME - FREQUENTLY ASKED QUESTIONS FOR PATIENTS**

**Why am I being asked to defer my referral for treatment?**
NHS St Helens CCG is asking all patients, who need to be referred for non-urgent treatment, if they would be happy for their treatment to be deferred for a period of 6 weeks to enable the local NHS to manage winter pressures better.

**What does deferring mean?**
All patients requiring non-urgent elective care such as hip operations, gall bladder surgery, knee replacements etc, are required by the NHS to be treated by the NHS within 18 weeks of being referred. Many patients are seen much quicker than this. Agreeing to defer your referral means you will still be treated by the NHS in exactly the same way but your referral letter from your GP will not be sent for 6 weeks.

**How does deferring help the NHS to do this?**
During the winter months the local NHS is under increased pressure as more patients than usual require treatment for respiratory conditions, flu or slips, trips and falls. When these pressures mount the NHS often has to cancel routine operations if there are no spare beds because patients have been admitted for treatment urgently or unexpectedly. Deferring your treatment allows doctors to focus on these patients and reduces the risk of your operation being cancelled.

**Is this about saving money?**
No. The local NHS will still be required to pay for your treatment; this is about helping us to manage pressures over the busy winter months.

**What if I don’t want my treatment to be deferred?**
If you and your GP discuss deferring treatment and as a patient you would prefer not to defer, then you don’t have to. This is about patient choice. Some patients will prefer to defer their treatment because they don’t want to be admitted over Christmas or perhaps they are going on holiday but we understand other patients will want to be referred as normal.

**My neighbour also requires hospital treatment but he wasn’t asked to defer - why is that?**
GPs are still being asked to process urgent referrals in the same way. So if the GP felt that waiting to refer your neighbour for 6 weeks could make their condition worse, they were in pain or he might have cancer, then it wouldn’t be safe to defer treatment. We are only asking patients, where it is clinically safe, if they would be happy to defer.

**What happens if my condition becomes worse?**
If your condition becomes worse or you are in pain during the deferral period please speak to your GP straight away and they will ensure you are referred. We don’t want any patients to be adversely
affected by this process but your GP cannot help you if they are not aware you are in pain or your condition has got worse.
Supporting the QIA process

Advising and supporting the process (Quality & Safety Team)
The Quality & Safety Team will support an effective application of this procedure by:

- providing advice to all staff on all aspects of the process
- leading on ensuring information is provided to staff to report concerns about projects and schemes and their potential negative impact on quality, patient experience or safety or indeed on staff. This advice to staff will be both on how they can engage with the Team on an individual Plan along with how to confidentially report their concerns regarding quality on any initiative.
- advising and supporting the Governing body to consider the final QIAs

Further development and review of this process
This process will be transferred into the standard template regarding policies and procedures. The process itself will be reviewed on an on-going basis with required revisions being made. QIA process will formally review it at least annually.

Please include a Brief paragraph to describe the purpose of the change or service development being assessed

To make room for the additional demand on hospital services over winter the CCG is proposing that referrals for non-urgent planned treatments over winter are ‘slowed’ down. This will apply to every planned treatment or procedure that is not classed as urgent by the GP.

To implement this the CCG is requesting that on the date that the GP decides a patient should be referred, the actual referral is not made for 6 weeks. The CCG is also proposing that this policy commences on 1<sup>st</sup> December 2015 until 31<sup>st</sup> January 2016.
Date: 07.10.15

Completed by: Chrissie Cooke

<table>
<thead>
<tr>
<th>Area of Quality</th>
<th>Impact Question</th>
<th>Positive/ Negative/ Neutral</th>
<th>Impact and mitigation and Action Required</th>
<th>Guidance notes</th>
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<tbody>
<tr>
<td>Duty of Quality</td>
<td>How does the proposal impact on any of the following:</td>
<td></td>
<td>There is a risk even though it is small in likelihood that patients may be disadvantaged the mitigating actions are that patients will be able to go back to their GP to activate the referral if their condition worsens, there is also an appeals and complaints option included in the patients letter.</td>
<td></td>
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<tr>
<td></td>
<td>• Compliance with the NHS Constitution</td>
<td>Positive impact on 4 hour target Neutral impact on 18 weeks Neutral</td>
<td></td>
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<td></td>
<td>• Partnerships</td>
<td>Neutral</td>
<td></td>
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<tr>
<td></td>
<td>• Safeguarding children or adults and the duty to promote equality</td>
<td>Neutral</td>
<td></td>
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<td></td>
<td>The ongoing quality impact will be reviewed via SRG, which includes managerial and clinical staff from providers LA and CCG.</td>
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<tr>
<td><strong>Patient Experience</strong></td>
<td>Does the proposal impact on any of the following – positive survey results from patients, patient choice, personalised &amp; compassionate care?</td>
<td></td>
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<td></td>
<td>• What is the impact on race, gender, age, disability, sexual orientation, religion and belief for individual and community health, access to services and experience?</td>
<td>Positive or neutral impact - this will be carried out n consultation with the patient and may improve their feeling of involvement and exercising choice</td>
<td></td>
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<td></td>
<td>• What impact is it likely to have on self-reported experience of patients and service uses?</td>
<td></td>
<td></td>
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<td></td>
<td>• How will it impact on the choice agenda?</td>
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</table>

We believe that we have put some safeguards in place to protect patients against this

There may be adverse impact on patients experience as patients will be actually waiting for longer (even though it will not affect the constitutional target of referral to treatment in 18 weeks), this is likely to be no worse than being cancelled due to winter pressures and may be better.

Communications to patients and the public
Advice and support to GPs and other clinical staff.

Monitoring of patient complaints via CQPG & SRG
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<td></td>
<td>• How will it impact on the compassionate and personalised care agenda?</td>
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<tr>
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<tr>
<td><strong>Patient Safety</strong></td>
<td>Does the proposal impact on any of the following - safety, systems in place to safeguard patients to prevent harm, including infection control</td>
<td></td>
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<tr>
<td></td>
<td>• What is the impact on partner organisations and any aspect of shared risk?</td>
<td>Neutral</td>
<td>As above</td>
<td>As above – expected to be neutral</td>
</tr>
<tr>
<td></td>
<td>• Will this impact on the organisations duty to protect children, young people and adults?</td>
<td></td>
<td></td>
<td>May improve patient safety due to increased likelihood of access to secondary care for emergency patients at best it will be neutral if GPs continue to use clinical judgment and refer urgent patient as usual</td>
</tr>
<tr>
<td></td>
<td>• Impact on patient safety?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Impact on preventable harm?</td>
<td></td>
<td></td>
<td>Neutral- IPC practice should be business as usual</td>
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<td></td>
<td>• Will it affect the reliability of safety systems?</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• How will it impact on systems and processes for ensuring that the risk of healthcare acquired infections to patients is</td>
<td></td>
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August 2013
Version 1.2 revised June 2014
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<td></td>
<td>reduced?</td>
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<td></td>
<td>• What is the impact on clinical workforce capability care and skills?</td>
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<tr>
<td><strong>Clinical Effectiveness</strong></td>
<td>Does the proposal impact on delivery of evidence based practice, clinical leadership, clinical engagement and/or high quality standards?</td>
<td></td>
<td></td>
<td>As above</td>
</tr>
<tr>
<td></td>
<td>• How does it impact on implementation of evidence based practice?</td>
<td>Positive/ Negative/ Neutral</td>
<td>Clinicians would be applying evidence based practice to determine if a patient should be referred. This may improve adherence to guidance regarding the criteria for referral.</td>
<td></td>
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<td></td>
<td>• How will it impact on clinical leadership?</td>
<td>Neutral</td>
<td>Neutral</td>
<td></td>
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<tr>
<td></td>
<td>• Does it reduce/impact on variation in care provision?</td>
<td></td>
<td>We expect that this will lead to a reduction in variation as all electives that are not urgent will be delayed.</td>
<td></td>
</tr>
<tr>
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<td></td>
<td>• Does it impact on ensuring that care is delivered in most clinically and cost effective setting?</td>
<td></td>
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<td></td>
<td>• Does it lead to improvements in care pathway?</td>
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<tr>
<td>Prevention</td>
<td>• How does the proposal promote self-care and reduce health inequality?</td>
<td>This will improve the opportunity for self-care, patients are more likely to have a say in their referral and decision to take up treatment or try self-care alternatives</td>
<td>As above</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Does it affect supporting people to stay well?</td>
<td>This may have an adverse impact on people who would benefit form a secondary care intervention to prevent a condition worsening where it isn’t urgent- this is probably no worse than the normal impact over winter however.</td>
<td></td>
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<td></td>
<td></td>
<td>This will improve the opportunity for self-care, patients are more likely to have a say in their referral</td>
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<tr>
<td></td>
<td>- Does it promote self-care for people with long term conditions?</td>
<td>and decision to take up treatment or try self-care alternatives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Productivity and Innovation</td>
<td>Does the proposal support delivery within the best setting to deliver best clinical and cost effective care; eliminating any resource inefficiencies; low carbon pathway; improved care pathway? Does it eliminate inefficiency and waste by design?</td>
<td>Yes</td>
<td>Yes- this is likely to limit the rate of 18 weeks performance</td>
<td>As above</td>
</tr>
</tbody>
</table>
Enclosure 5 practice guidance

ST HELENS CCG - ELECTIVE DEFERMENT SCHEME
GP PRACTICE GUIDANCE

With effect from 1st December 2015 until 29th February 2016 St Helens CCG is seeking General Practitioners’ support to defer acute referral activity (apart from those patients categorised as ‘urgent’) and to ensure that no ‘routine’ referrals into secondary care are generated.

‘Secondary Care’ includes all NHS acute trusts and other acute / secondary care providers as listed on Choose and Book.

As stated above, urgent referrals can still be processed as normal.

Urgent referrals are categorised as:-

1. Urgent Clinical Referrals that will not wait for referral without significant clinical risk to the patient
2. Cancer 2 week waits / Suspected Cancers

- If in any doubt at all e.g whether a cancer is suspected, an “urgent” referral would apply and General Practitioners should generate an urgent referral in the usual way

- If a patient needs to be referred to secondary care and the General Practitioner has decided that the patient’s condition is not urgent the GP should discuss the option of delaying activating the referral for 6 weeks. The standard letter on the clinical system should be used. This letter will auto-fill with the patients data and the referral information. This should be printed and given to the patient as confirmation that they have agreed to a delay. The patient should be verbally advised to return to the practice in 6 weeks to activate their referral.

- Patients who have agreed to a delay in their referral being activated should hand their letter into the practice reception at or after the date stated on the letter. Practice reception will then need to activate the referral.

- Where a General Practitioner has categorised a patient’s potential referral as ‘routine’ for primary care management and ‘watchful waiting’ for the suspension period but is concerned that the condition is indicating an escalation to ‘urgent’ e.g. under criteria (1) above, the General Practitioner should use their clinical judgement to re-categorise as ‘urgent’ and refer as appropriate.
• Where a General Practitioner considers referral is the only option, but does not deem it ‘urgent’ under the above criteria, practices will need to establish a system for when the patient returns with their referral form.

• Where a General Practitioner considers referral is the only option, but does not deem it ‘urgent’ under the above criteria, practices may wish to explore whether there are Choose and Book slots available 8 weeks hence for the particular specialty, and manage the deferred referral in this way.

• This is a deferment of referrals into secondary care for the specified period only 1st December 2015- 29th February 2016

• All General Practitioners (including any sessional/locum General Practitioners employed during this time) must be made aware of this “elective deferment period”

• Patients could forget about their referral, lose their letter or deteriorate clinically. Practices will need to establish a system for ensuring that patients who have agreed to a delay and who do not bring their letter back for activation are followed up within 2 weeks of the delay date.

St Helens CCG appreciates your support and co-operation
Managing winter in St Helens

Dear ...(auto-fill)..................

You have been asked to delay your routine treatment by your GP to help local healthcare services manage better over winter. Your GP has been asked to do this by St Helens CCG who are responsible for all healthcare services in the area.

In the winter period (December to February) we always find that more people need urgent and emergency treatment. To help avoid last minute cancellations of surgery and out-patients appointments the CCG has asked General Practitioners to delay referring patients for non-urgent hospital treatment for 6 weeks, during 1st December 2015 and 29th February 2016. This request will not affect people with possible cancer or patients whose condition is urgent, they will be referred as usual.

Your GP has decided that your treatment is not urgent and you have agreed to have your referral for treatment delayed by 6 weeks.

You should bring this letter back to the practice on ......(auto-fill).......................... The practice receptionist will then activate your referral. If you feel at any time in the interval that your condition has deteriorated you should ask to speak with your GP and discuss if your referral needs to be brought forward. Your referral information is set out below.

Date of consultation with GP: ............. (auto-fill)..................

Procedure to be referred for: ............. (auto-fill)..................

Provider to be referred to: ............. (auto-fill)..................
This delay of non-urgent treatment will mean that all the Hospitals serving the people of St Helens will be able to concentrate on urgent and emergency cases.

If you wish to discuss the contents of this letter any further or wish to complain please contact sthelensccg.complaints@nhs.net or ring 0800 218 2333

Thank you for your cooperation and for helping the health service during the winter months.

************************************************************************************

READ CODES

9R58 On suspended waiting list
9N6m Reason for delayed referral
671F Discussed with patient
661m Clinical management plan agreed