WHC Access, Booking and Choice of Date Policy: Outpatient Services

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Status		Ratified	
Target Audience (who does the document apply to and who should be using it)		Wiltshire Health and Care staff working with Outpatients/clinics	
Accountable Director		**Managing Director**	
Policy Author/Originator - **Any comments on this document should, in the first instance be addressed to whc.policyqueries@nhs.net**		**Head of Service for MIU, Wheelchairs, Continence, Orthotics**	
If developed in partnership with another agency, ratification details of the relevant agency			

Equality Impact and Parity of Esteem

Wiltshire Health and Care strive to ensure equality of opportunity and parity of esteem for all service users, local people and the workforce. As an employer and a provider of health care, we aim to ensure that none are placed at a disadvantage as a result of its policies and procedures. This document has therefore been equality impact assessed in line with current legislation to ensure fairness and consistency for all those covered by it regardless of their individuality. This means all our services are accessible, appropriate and sensitive to the needs of the individual.

References: ***NHS England 'Everyone Counts: planning for patients 2014-15 / 2018-19' and The Mental Health Crisis Care Concordat (DH 2014).***

Safeguarding

Wiltshire Health and Care have a strong commitment to care that is safe, of a high quality and that upholds our patients' rights. All our patients have the right to live lives free from abuse or neglect and, where they are able, to make or be supported to make informed decisions and choices about their treatment, care and support. Where patients are not able to make their own decisions, Wiltshire Health and Care staff are committed to ensuring that treatment, care and support is undertaken in accordance with the person's best interests. In order to fulfil these commitments, Wiltshire Health and Care follow the Safeguarding principles and responsibilities laid out in sections 42-46 of the Care Act (2014) and are informed by, and apply, the guiding principles and provisions of the Mental Capacity Act (2005) (refer to Wiltshire Health and Care Safeguarding Adults Policy and Procedure, and Mental Capacity Act Policy and Procedure).
Regarding children, WHC is responsible for providing services in accordance with Section 11 of the Children's Act (1989) and works under the principles of Working Together to Safeguard Children (2018).

Special Cases
This document is only applicable to patients attending Outpatient (clinic-based) services.

Contents

Instant Information

The policy sets the parameters for referral to treatment pathways. It provides guidance on access and booking of appointments for specialist services,

1. Document Details

1.1 Introduction and Purpose of the Document

The aim of this policy is to ensure that patients accessing an outpatient appointment within Wiltshire Health and Care (hereinafter referred to as WHC) are managed in line with national access and choice guidance (Ref 1 and 3 in section 1.2 below).

The overall aim of the policy is to ensure patients are treated in a timely, equitable and effective manner.

1.1 Purpose of the Document

The aim of this policy is to:

- Ensure that patients accessing an outpatient appointment are managed in line with national waiting list guidance and access requirements appropriate for their referral route.
- Ensure patients are treated in a timely and effective manner with fair and equitable access to community health services.
- Support proactive management of waiting lists and ensure clear guidance on booking rules to ensure compliance with condition-specific waiting time requirements.

The policy is based on nationally mandated guidance and local interpretation of these rules, to provide both clarity and consistency for all patients and staff.

1.2 Document Description

This is a policy document.

1.3 Scope

All staff involved in the administration of patient activities and healthcare professionals involved in the delivery of that healthcare need to understand and ensure that their practices are consistent with the content of this policy; and that systems are in place to support effective schedule management.

This document applies to all patients.

1.5 Allied Health Professional Services

The standards in this policy apply to non-consultant led services only.

1.6 Regulatory Position

This policy is based around core principles established within the NHS Constitution (Ref 3), which states the rights to which patients, the public and staff are entitled. The NHS Constitution is a document enshrined in law, and as such all NHS providers are bound to take account of the document in all aspects of their operations.

In addition to the NHS Constitution, individual acts of parliament shall dictate the approach NHS Trusts must take in providing access to public services. In particular the 2010 White Paper *Equity and Excellence: Liberating the NHS* reaffirmed the commitment to provide patients with more choice in NHS systems.

Any future guidance about the patient access or patient choice from the Department of Health or commissioners will supersede any guidance in this document.

1.7 Exclusions

The following activity is excluded from the 18 week Referral to Treatment (RTT) standard:

- Patients receiving on-going care for a condition whose first definitive treatment for that condition has already occurred.

- Patients whose 18 week clock has stopped for active monitoring and has not yet restarted, even though they may still be followed up by the service.

1.8 Consultation Process

The following is a list of consultees in formulating this document:

Job Title / Department.	**Date Consultee Agreed Document Contents**
Advanced Information Analyst	22/05/18
Advanced Systems Manager	07/08/18
Head of Development and Performance	06/06/18
Head of Podiatry, Dietetics, Diabetes and SALT	21/05/18 – comments made/included
Head of Service/Administration Manager, MSK Physiotherapy Service	03/04/2018

1.10 Glossary/Definitions

The following terms and acronyms are used within the document:

ASI	Appointment Slot Issue - When patients or professional users of Choose and Book are unable to book an appointment. The most common reason for this is a lack of appointment slots being made available to Choose and Book
CAB	Choose and Book - An online tool which patients (and their GPs) may use to determine where they would like to be seen, at what time, within the outpatient setting.
CCG	Clinical Commissioning Group
DNA	Did Not Attend

DoH	Department of Health
DoS	Directory of Services
DTT	Decision To Treat
GP	General Practitioner
GWH	Great Western Hospital
IPC/IP&C	Infection Prevention and Control
KPI	Key Performance Indicator
MATS	Musculo-skeletal Assessment and Treatment Service
MDS	Minimum Data Set. A specific set of information required to be provided at the point of referral or transfer.
MDT	Multi-disciplinary Team
NHS	National Health Service
OPD	Outpatient Department
PAS	Patient Administration System (such as SystmOne/Medway)
Prior Approval	The procedures that commissioners have either prohibited or restricted, and funding request / authorisation processes apply. In some health economies they are called "Procedures of Limited Clinical Value" or "Planned Procedures within Threshold."
PTL	Patient Tracking List. Used to record the current 18 week waiting status of patients referred to but not yet discharged from WHC.
RMS	Referral Management Service
RTT	Referral to Treatment. The point of referral (usually from the general practitioner) to WHC, measured in weeks and days from the point of receipt of referral
SOP	Standard Operating Procedures
S1	SystmOne – patient database
TATs	Turnaround times
UBRN	Unique booking reference number
Virtual Clinic	A clinic where a patient case is reviewed without the patient being physically present (i.e. not a face to face consultation).
WHC	Wiltshire Health and Care

1.11 Document Author

The document author is responsible for identifying the need for a change in this document as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or

clinical standards and local/national directives, and resubmitting the document for approval and republication if changes are required.

1.12 Target Audience

The target audience has the responsibility to ensure their compliance with this document by:

- Ensuring any training required is attended and kept up to date.
- Ensuring any competencies required are maintained.
- Co-operating with the development and implementation of policies as part of their normal duties and responsibilities.

2. Main Policy Content Details

2.1 Overview of National Standards

The Operating Framework for the NHS in England 2012-13 identified a series of performance measures these are included as part of the framework, and are applicable to WHC's provision of its services.

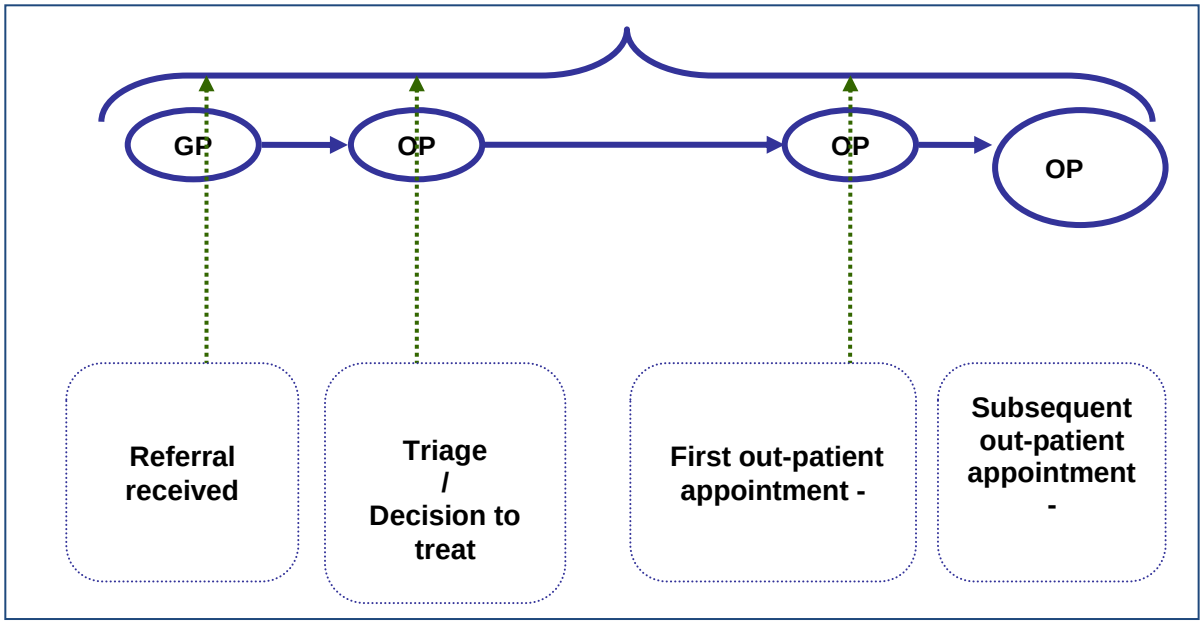
The operational standards are as follows:

- **18 weeks pathway**

92% of patients on an incomplete pathway should have been waiting no longer than 18 weeks.

2.2 Internal Operating Standards for non-urgent 18 week Pathways

- The phases of the patient pathway are outlined below: Initial referral in to WHC from GP or another provider – or from within WHC.
- Referral to triage
- First outpatient appointment
- Subsequent outpatient appointment phase.



WHC must deliver non-urgent pathways within the time periods outlined in section 2.1. In addition, WHC will work towards reducing the waiting time for a first outpatient appointment as follows:

The following activities are excluded from the 18 week RTT standard:

- Patients receiving ongoing care for a condition where the first definitive treatment for that condition has already occurred.
- Patients whose 18 week clock has stopped for active monitoring, and who have not yet had a pathway started after this event, even though they may still be followed up

2.3 18 week 'Clock' Terminology

The following section refers to booking rules and processes, along with the impact on patient waiting times. To aid interpretation of these, the following national definitions around waiting times should be used for all routine and urgent referrals. Full guidance is available in the DoH publication Referral to treatment consultant-led waiting times Rules Suite (April 2014) (Ref 9).

2.3.1 Clock Starts

A) A waiting time clock starts when any care professional or service permitted by an English NHS commissioner to make such referrals, refers to:

- A Specialist Community 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;
- An interface or 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.

B) A waiting time clock also starts upon a self-referral by a patient to the above services, where these pathways have been agreed locally by commissioners and providers and once the referral is ratified by a care professional permitted to do so.

- Upon completion of a referral to treatment period, a new waiting time clock only starts:
- Upon a patient being re-referred into a service; interface; or 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 that they did not attend (DNA) that stopped and nullified their earlier clock.

2.3.2 Clock Pauses

These do not apply to non-admitted services.

2.3.3 Clock Stops

A patient's RTT clock will be stopped for a number of reasons which are outlined below.

a) ***First definitive treatment starts***. This could be:
   - clinical intervention, if this is what the clinician decides is the best way to manage the patient's disease, condition or injury and avoid further interventions (e.g. community physiotherapy) with the exception of Wheelchair and Orthotic services where clocks stops at the point of handover of equipment/discharge.

b) Decision not to treat

c) Decision to embark on a period of watchful waiting or active monitoring i.e. where it is judged to be clinically appropriate to start a period of active monitoring in secondary care without clinical intervention. The patient declines treatment when offered it.
d) A patient does not attend 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.
e) A patient does not attend any other appointment and is subsequently discharged back to the care of their GP, provided that:
   - The provider can demonstrate that the appointment was clearly communicated to the patient;
   - Discharging the patient is not contrary to their best clinical interests;
     Discharging the patient is carried out according to local, publicly available/published, policies on DNAs;
   - These local policies are clearly defined and specifically protect the clinical interests of vulnerable patients (e.g. children) and are agreed with clinicians, commissioners, patients and other relevant stakeholders.

2.4 Inappropriate Referrals

If at clinical triage it is felt the patient does not meet the specified criteria for the service.

2.5 Locally Agreed Commissioner Requirements

WHC has no additional locally agreed contractual arrangements with local Clinical Commissioning Groups (CCG) in addition to national access goals set by the Department of Health / NHSE.

3. WHC's Values, Principles and Governance

This section identifies the values, principles and governance that underpin the delivery of the Elective Access, Booking & Choice Policy.

3.1 WHC Values

WHC's values are:

- Quality: Quality care for all
- Integrity: Demonstrating integrity in all that we do
- Partnership: Building and strengthening partnerships
- Changing: Adapting in a changing community

Each value has associated behaviours and skills to ensure that each member of staff provides the same high quality care and level of customer service.

3.2 Application of, and compliance with, this policy

This policy applies to all clinical and administrative staff and services relating to elective patient access managed by WHC, including outpatient, therapies and diagnostic services.

All staff involved in the management of patients' access to the service are expected to follow this policy. Each clinical service must follow this policy to deliver high quality, consistent care to patients across the organisation as a whole.

Key performance indicators (KPIs) have been identified to monitor compliance with the policy, and where performance is below the expected thresholds corrective action will be taken (e.g. further training and support.)

3.2.1 Escalation

In accordance with a training needs analysis, staff involved in the implementation of this policy, both clinical and administrative, must undertake appropriate training. It is the responsibility of all members of staff to understand the principles and definitions which underpin delivery of all elective access performance measures; referral to treatment (18 weeks) and diagnostics. All staff involved in managing or administering patients' pathways for elective care must not carry out any action about which they feel uncertain, or that could contradict this policy. They should escalate their concerns / uncertainties to their manager in the first instance.

3.3 Performance Monitoring and Reporting Structures

Performance of the RTT targets will be monitored and reported monthly at WHC Executive Committee.

In the event that WHC does not meet the monthly RTT or diagnostic targets as set out in section 2, the Informatics Team will inform the Managing Director of WHC, and a detailed breach report with lessons learnt will be submitted.

3.4 Statutory Reporting

WHC complies with the statutory reporting requirements for elective access and all external reports must be signed off by the Managing Director before submission. The reports are supplied to commissioners.

3.5 Recording the Status of Patients

Alongside patient and referrer communications all staff (clinical and non-clinical) must be aware of their responsibility to accurately and contemporaneously record interactions with patients which impact on their 18 week pathway.

This includes the recording of the outcomes of the clinic attendance within 24 hours of that activity occurring, completion of clinical outcomes for every patient-clinician interaction in every outpatient clinic and for any clinical decision made out of an outpatient environment (i.e. virtual clinics, telephone clinics, office-based reviews etc.).

3.6 Validating the Status of Patients

The activity viewer which supports the delivery of all access targets must also be validated at key intervals or time points to ensure that the status of each individual patient is recorded correctly.

Any patient with an open pathway which has been inactive for six months or more (note: annual review patients are active) will be validated and discharged back to their GP. A letter will be sent to the patient and copied to their GP.

3.7 Communication

3.7.1 Communication with WHC Patients

The rules and principles within which WHC will operate to deliver care to all patients on an 18 week pathway. This must be made clear and transparent to patients at each stage of their pathway within WHC.

All communications with patients, whether verbal or written, must be informative, clear and concise. The patient's GP will have access to all correspondence. Copies of all correspondence with the patient must be kept in the patient's clinical notes; these will be available electronically for auditing purposes.

3.7.2 Communication with Referring Organisations or Individuals

Similarly, all communications with referring organisations and individuals (e.g. the patient's general practitioner or consultant) will make clear the rules and principles being applied at each stage of the patient's pathway or as their status may change (e.g. from active wait to planned care). Where clinical responsibility for a patient's care is discharged back to that referrer (e.g. after treatment is completed or where a patient has failed to attend a number of appointments), this must be made clear in any communication. Copies of all correspondence with the referrer must be kept in the patient's clinical notes or available electronically for auditing purposes.

3.8 Access to Health Services for Military Veterans

In line with the December 2007 guidance from the Department of Health, all veterans and war pensioners should receive priority access to NHS care for any conditions which are related to their

service, subject to the clinical needs of all patients. Military veterans should not need first to have applied and become eligible for a war pension before receiving priority treatment. GPs should notify WHC of the patient's condition and its relation to military service when they refer the patient so that WHC can ensure that it meets the current guidance for priority service over other patients with the same level of clinical need. In line with clinical policy patients with more urgent clinical needs will continue to receive clinical priority.

3.9 Overseas Visitors

Patients who are identified as, or possibly are, overseas visitors will be registered on PAS. The Department of Health Guidance on implementing the overseas visitors charging regulations (ref 8) should be followed. If staff are unclear about what they should do they should contact line management in the first instance.

4 Referral Management

This section of the policy details the principles under which WHC will govern access and choice within the outpatient setting. It is intended to provide an outline of core rules established and an overview of procedures to be followed. It should be read in tandem with the relevant Standard Operating Procedures.

4.1 Urgent and Routine New Patient Referrals

4.1.1 Referrals

- Referrals should be made to a service rather than a named clinician, wherever possible, and be aligned with the Patient Choice national agenda.
- Referrals must be registered and stored onto WHC's electronic system within **3 working days** of receipt of referral by WHC, unless otherwise specified in the KPI's for a specific service
- Clinical review must take place within **3 working days** of receipt of routine referrals, unless otherwise specified in the KPI's for a specific service

4.1.2 Paper Referrals

All referrals should be sent to the relevant department for processing.

For recording purposes, and the start of the 18 week clock, the date of referral **is the date received** by WHC, (except for referrals mentioned in section 4.1.4 below) and all referrals should be clearly date stamped by each department upon receipt.

If the patient is referred internally for the same condition, then it is a continuation of the original clock until first treatment is commenced. If the patient has been internally referred for a new problem, one that is separate to the original referral, whether or not they are being seen by the original specialty, a new 18 week clock will start when the receiving department date stamps the referral and a new treatment pathway commences.

4.1.3 Refer Management Centre or interface service to consultant Referrals

4.1.4 Clinic Templates on SystmOne

Clinic templates are crucial to ensuring that new and follow-up clinic capacity is managed and utilised in the most efficient manner possible, and should be maintained robustly. The core principles are:

- The speciality clinical lead and Head of Service will review their outpatient clinic templates at least yearly in order to reflect the changing demands of the service.

- Any requests to change an existing template must be made to the S1 support team and will have been approved / supported by the service manager.

- Any template changes (including reductions and cancellations) require a minimum notice period of six weeks. If requests for changes are less than six weeks' notice, they should be escalated to the relevant Head of Service for approval with an explanation of why circumstances are exceptional.

5 Outpatient Booking Management

This section of the policy details the principles under which WHC will govern access and choice of date within the outpatient setting. It is intended to provide an outline of core rules established and an overview of procedures to be followed.

5.1 Booking Rules

A number of basic booking rules apply to managing outpatient capacity, to ensure patients are able to be treated in a clinically appropriate way, and so that WHC can provide a sustainable service:

- All patients will be offered appointment dates in chronological order, unless there is an appropriate clinical decision that patients need to be treated more urgently to prevent deterioration in their clinical condition. At the point of offer, patients need to be willing and able to attend an appointment.

- No patient waiting for an outpatient appointment can have their RTT clock suspended or paused for any reason.

- Patients should wherever possible be offered a choice of appointment dates, in line with national policy and good customer service principles.

- Each clinical speciality should be aware of the target first-to-follow-up appointment outpatient ratios associated with their service and manage activity accordingly.

- Each clinic will be set up with a template defining the number of available new and follow-up slots.

- Agreed limits of over bookings may be locally agreed with specialty clinicians.

- WHC adopts a zero tolerance approach to any patients waiting more than 52 weeks from referral to treatment

5.2 Reasonable Offer of New and Follow Up Appointments

A 'reasonable' offer is a date that is **at least three weeks** from the time of the offer being made and a choice of two dates. This does not preclude offering patients earlier dates.

Patients who decline one reasonable offer must be offered at least one further reasonable date. If two reasonable offers (i.e. with three weeks' notice) are declined for either a new or follow-up outpatient consultation, the patient will be discharged back to their GP or referring clinician.

All appointments will be confirmed in writing unless there is insufficient time to post a letter and the patient has agreed the date on the telephone.

5.3 Upgrading and Downgrading of Referrals

Referrals cannot be downgraded without discussion and agreement by the receiving clinician with the original referrer. Any joint decision to downgrade a referral must be documented in the health records and the patient must be communicated with. The referral can only be downgraded before the patient attends their first outpatient appointment.

5.4 Patient Initiated Cancellations

- When the patient cancels any (new or follow-up) agreed outpatient appointment, the next available appointment will be offered.

- If slots are not available within the 18 week RTT pathway, this needs to be escalated to the relevant Head of Service.

- All appointment letters must have all required information and advice on how to change an appointment and the impact of a cancellation or DNA.

- Where a patient on an 18 week pathway makes themself unavailable to be seen within 18 week RTT timeframes they will be discharged back to the care of their GP for re-referral when they are available. This will stop the clock, and a new clock starts when patient is re-referred by GP.

- In addition, patients (those currently on an 18 week pathway) who cancel their outpatient appointment for reasons other than sickness of themselves or a dependant at less than 24 hours' notice, after receiving reasonable notice (interpreted as at least three weeks) of this date, will be reviewed by the clinician prior to removal from the waiting list and discharged back to their GP for further action in primary care or re-referral when ready, willing and able to proceed. Exceptions can be applied for personal circumstances that are beyond the patient's control by showing compassion and care.

- Where a patient has cancelled and rescheduled two outpatient appointments and wishes to cancel and rearrange a third, the patient will be discharged and referred back to their GP unless the clinician believes this to be clinically inappropriate.

5.5 Did Not Attend (DNA) Patients – Outpatients

A Did Not Attend (DNA) refers to a patient who has failed to attend their appointment when reasonable notice of the appointment was communicated to the patient or carer.

Any patient who does not attend their "agreed" appointment (new or follow-up) will be **discharged** back to their GP unless it is agreed by the clinician after reviewing the notes, that this is contrary to their best clinical interest, or it is agreed that the patient is considered to be vulnerable (see section 5.7 below).

All first appointment patients will be discharged unless they fall within those categories listed in section 5.7.

All follow up appointment patients deemed safe following the clinical review of their notes will be discharged to their GP with a letter which, if the patient is known to the clinician will include a detailed management plan.

- Low risk, no further action is required other than a discharge letter.
- Medium risk, a letter will be sent to the GP advising of both the discharge and the clinicians risk analysis.
- High risk, a new appointment or re-referral is required.

WHC must offer a further appointment following a DNA to any patient where it is clear that administrative error has led to the patient not attending their appointment (or where it is not clear that the date has been communicated to the patient).

Examples of administrative errors will be where:

- Patient claims he/she did not receive appointment letter at all/ on time.
- Patient was not given choice of appointment at time of booking.

If upon review the Clinician feels it would be detrimental to the patient's health if an appointment is not re-booked, then the patient must first be contacted to ascertain the reasons for DNA and ensure compliance to attend a rescheduled appointment.

In the event that a patient is discharged, both patient and referrer will be notified of this in writing to ensure the referring clinician is aware and can action further management of the patient if necessary. It will also be made clear to the referrer whether the DNA appointment is a first or follow up booking. For 18 week pathways this will stop the 18 week clock.

WHC will make every effort to reduce the amount of DNAs by:

- Telephoning patients booked at less than two weeks in advance of the clinic date offering choice of appointment time wherever possible.
- Encouraging patients to update their contact details at every visit to ensure WHC is always able to contact them.
- Send Text message reminders, if available for the service concerned, at least one week prior to appointment.
- Service leads will carry out quarterly DNA audit to understand the reasons and take remedial actions where appropriate.

5.6 Exceptions to DNA Policy

Patients who fall into the categories below will be reviewed by a clinician and a decision made with regard to whether to discharge back to the referrer or offer another appointment.

- Children up to the age of 16 years.
- Urgent referrals (as above).
- Other clinical exceptions as denoted by /clinicians. This may include vulnerable adults and/or children where discretion will be needed in how the service deals with DNAs
- Patients who missed their appointment due to an inpatient stay.

5.7 New Appointments

- All patients once registered on PAS (within **3days**) and agreed to be appropriate referrals following vetting (within **3 days**).

5.8 Follow-Up Appointments

Follow-up appointments are appropriate when a patient's condition requires continued intervention of specialist clinical expertise.

In situations where there is no evidence that a further specialist clinical intervention is required the patient should be discharged to the care of their GP. This clinic outcome documentation must be completed to reflect this decision, by the clinician seeing the patient.

To ensure time to process e.g. manufacturing or sourcing of equipment, follow-up appointments should be booked at an appropriate interval.

If results are negative, consideration should be given to the need for the subsequent outpatient appointment. A suitable letter to the patient and GP may be sufficient as would a telephone consultation. The patient must be discharged on PAS via a "virtual clinic" review only for external. This will stop the 18 week clock. Every opportunity should be taken to follow up patients virtually to ensure timely follow up, reduce New-to-follow-up ratios and prevent unnecessary journeys to the hospital for patients.

6 Duties and Responsibilities

6.1 Referrer

WHC relies on all referring clinicians ensuring that patients understand their responsibilities and potential pathway steps and timescales when being referred. This will help ensure that patients are referred under the appropriate clinical guidelines, aware of the speed at which their pathway may be progressed, and are in the best position to accept timely and appropriate appointments. Therefore WHC expects that, before a referral is made, the patient is ready, willing and able to attend for an appointment and undergo any treatment that may be required. This will include being both clinically fit for assessment and possible treatment of their condition. This is the responsibility of the referring clinician, e.g. the GP.

- Referrers must provide accurate, timely and complete information within their referral.
- Wherever possible, referrals should be made electronically
- After a referral has been made, the referrer must inform the hospital service if the patient no longer wishes or requires to be seen.
- The referrer must appropriately manage any patients who are discharged by WHC following a DNA or cancellation(s) of their appointment(s).
- Where there are repeat referrals with no clear change, a request will be made to the referrer to provide a reason why the patient has been referred again.

6.2 Patient

- Patients must inform WHC of any changes to their name, address, telephone numbers or GP.
- Patients should keep their appointment, and make every effort to arrive on time.
- Patients who cannot attend should cancel or rearrange their appointment with as much notice as possible
- Patients must inform their GP if their medical condition improves or deteriorates in a way that may affect their attendance, including short term illness which prevents acceptance of an appointment.
- Patients who no longer wish to have their outpatient appointment, for whatever reason, must advise the referrer and the service immediately.
- Patients who are unaware of the reason for their referral should receive an explanation; patient can then confirm if they wish to go ahead. Feedback (discharge summary) should be provided to the referrer/GP.

6.3 WHC

- Whilst responsibility for achieving targets lies with WHC**, the Executive** and ultimately the **Board**, all staff with access to, and a duty to maintain, referral and waiting list information systems are accountable for their accurate upkeep.
- If we have to cancel an appointment or clinic (e.g. due to staff sickness), an alternative will be offered within 2 weeks. This may be at a different site from the original appointment.

6.3.1 Heads of Service

Heads of Operational teams, through the senior management team, are responsible for achieving access targets, and for ensuring that appropriate capacity is in place to meet demand.

Supported by expertise from the Informatics Team**,** they are responsible for ensuring that data is accurate and the reporting against targets reflects the true position.

6.3.2 Administrative Staff

Administrative staff including back office staff, receptionists and booking officers, are responsible and accountable through the WHC management structure, for compliance with all aspects of this policy. Staff will attend appropriate training tailored to their role.

6.3.3 All Clinical Staff

All Clinical staff are responsible for ensuring they comply with their responsibilities as outlined in this policy.

Staff involved in managing patients' pathways for elective care must not carry out any action about which they feel uncertain, or that could contradict this policy. They should escalate their concerns / uncertainties to their manager in the first instance.

6.3.4 Ward/Service Managers, and Managers for Non Clinical Services

All Ward/Service Managers, and Managers for Non Clinical Services are to ensure that the list of new or revised policies, competencies, clinical guidelines, strategies, plans, protocols or procedural documents published each month is on the agenda at meetings to ensure that the documents are drawn to the attention of managers and general users. All Ward/Service Managers, and Managers for Non Clinical Services must ensure that employees within their area are aware of the document; able to implement the document and that any superseded documents are destroyed.

7. Monitoring Compliance and Effectiveness of Implementation

The arrangements for monitoring compliance are outlined in the table below: -

Measurable Policy Objectives	**Monitoring / Audit Method**	**Monitoring Responsibility** (individual / group /committee)	**Frequency of Monitoring**	**Reporting Arrangements** (committee / group to which monitoring results are presented)	**What Action Will be Taken if Gaps are Identified?**
Performance of WHC against the national RTT standards in line with national policy and reporting requirements	Review performance in RTTviewer and Performance report	Senior management	Regular monitoring of RTT viewer	WHC Management Team meeting Executive Committee Board	Action plan to be agreed between the Executive and operational managers

The Managing Director is ultimately responsible for the implementation of this document.

8 Review Date, Arrangements and Other Document Details

8.1 Review Date

This document will be reviewed in one year's time or sooner as required, then subsequently every three years in accordance with WHC's agreed process for reviewing documents.

9 References, Further Reading and Links to Other Policies

The following is a list of other policies, procedural documents or guidance documents to which staff should refer for further details:

Ref. No.	**Document Title**	**Document Location**
1	Referral to treatment consultant-led waiting times Rules Suite (April 2014)	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/255582/RTT_Rules_Suite_April_2014.pdf
2	NHS Operating Framework 2012/13	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216590/dh_131428.pdf
3	NHS Constitution 2010	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170656/NHS_Constitution.pdf

Ref. No.	Document Title	Document Location
4	Equity and Excellence: Liberating the NHS 2010 (DH)	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213823/dh_117794.pdf
5	Monitor Risk Assessment Framework	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/421204/RAF_update_revmar15.pdf
6	Child Protection and Safeguarding Policy	T.Drive
7	Allied Health Professional Referral to Treatment Revised Guide 2011	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215248/dh_131969.pdf
8	Guidance on Implementing The Overseas Visitors Hospital Charging regulations	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/418634/Implementing_overseas_charging_regulations_2015.pdf

10. Consultation Process

The following is a list of consultees in formulating this document and the date that they approved the document:

Job Title / Department.	Date Consultee Agreed Document Contents
Advanced Information Analyst	22/05/18
Advanced Systems Manager	04/08/18 – comments made
Head of Development and Performance	06/06/18
Head of Podiatry, Dietetics, Diabetes and SALT	21/05/18 – comments made
Head of Service/Administration Manager, MSK Physiotherapy Service	03/04/2018

Appendix A – Equality Impact Assessment

Protected Characteristic	For employees	For patients
Age	Employment practices including recruitment, personal development, promotion, entitlements and retention encompass employees with protected characteristics.	Services are provided, regardless of age, on the basis of clinical need alone.
Disability -	Reasonable steps will be taken to accommodate the disabled person's requirements, including: • Physical access • Format of information • Time of interview or consultation event • Personal assistance • Interpreter • Induction loop system • Independent living equipment • Content of interview of course etc.	Reasonable steps are taken to accommodate the disabled person's requirements, including: • Physical access • Format of information • Time of consultation /event • Personal assistance • Interpreter • Induction loop system .
Gender reassignment -	There is equal access to recruitment, personal development, promotion and retention. Confidentiality about an individual's status is maintained.	There is equality of opportunity in relation to health care for individuals irrespective of whether they are male or female. Confidentiality about an individual's status is maintained and supported by a specific policy.
Marriage and Civil Partnership	There is equal access to recruitment, personal development, promotion and retention for individuals irrespective of whether they are single, divorced, separated, living together or married or in a civil partnership	There is equality of opportunity in relation to health care for individuals irrespective of whether they are single, divorced, separated, living together or married or in a civil partnership.
Pregnancy and Maternity -	There is equal access to recruitment, personal development, promotion and retention for female employees who are pregnant or on maternity leave. A woman is protected against discrimination on the grounds of pregnancy and maternity. With regard to employment, the woman is protected during the period of her pregnancy and any statutory maternity leave to which she is entitled. • There is a Flexible Working Policy.	There is equality of opportunity in relation to health care for women irrespective of whether they are pregnant or on maternity leave. A woman is protected against discrimination on the grounds of pregnancy and maternity.
Race - including Nationality and Ethnicity	There is provision for interpreter services for people whose first language is not English. Documents can be made available in alternative languages/formats Written communications are in plain English and the use of language particularly jargon or colloquialisms is avoided. Religion, belief and culture is respected.	There is provision for interpreter services for people whose first language is not English. Documents can be made available in alternative languages/formats Written communications are in plain English and the use of language particularly jargon or colloquialisms is avoided. Religion, belief and culture is respected.
Religion or Belief	HR policies cover consideration of: • Prayer facilities	Equality and Diversity guidelines enable consideration of:

	• Dietary requirements. • Gender of staff when caring for patients of opposite sex. • Respect for requests from staff to have time off for religious festivals and strategies. • Respect for dress codes	• Prayer facilities • Dietary requirements. • Gender of staff when caring for patients of opposite sex. • Respect for religious festivals • Respect for dress codes • Chaperone Policy
Sex	HR policies cover consideration of: • Equal access to recruitment, personal development, promotion and retention. • Childcare arrangements that do not exclude a candidate from employment and the need for flexible working. • The provision of single sex facilities, including toilets	The majority of toilets within public areas are unisex.
Sexual orientation	HR policies cover consideration of: • Recognition and respect of individual's sexuality. • Recognition of same sex relationships in respect to consent. • The maintenance of confidentiality about an individual's sexuality. • Consider the effect on heterosexual, gay, lesbian and bi-sexual people	There is: • Recognition and respect of individual's sexuality. • Recognition of same sex relationships in respect to consent. • The maintenance of confidentiality about an individual's sexuality. • Chaperone Policy

Appendix B – Quality Impact Assessment Tool

Purpose To assess the impact of individual policies and procedural documents on the quality of care provided to patients by Wiltshire Health and Care		
Process The impact assessment is to be completed by the document author. In the case of clinical policies and documents, this should be in consultation with Clinical Leads and other relevant clinician representatives. Risks identified from the quality impact assessment must be specified on this form and the reasons for acceptance of those risks or mitigation measures explained.		
Monitoring the Level of Risk The mitigating actions and level of risk should be monitored by the author of the policy or procedural document or such other specified person. High Risks must be reported to the relevant Executive Lead.		
Impact Assessment Please explain or describe as applicable.		
1.	Consider the impact that your document will have on our ability to deliver high quality care.	*The policy will assist staff to deliver high quality care within local and national guidelines*
2.	The impact might be positive (an improvement) or negative (a risk to our ability to deliver high quality care).	
3.	Consider the overall service - for example: compromise in one area may be mitigated by higher standard of care overall.	*This document will not compromise care in any other area*
4.	Where you identify a risk, you must include identify the mitigating actions you will put in place. Specify who the lead for this risk is.	
Impact on Clinical Effectiveness & Patient Safety		
5.	Describe the impact of the document on clinical effectiveness. Consider issues such as our ability to deliver safe care; our ability to deliver effective care; and our ability to prevent avoidable harm.	*The policy is designed to provide maximum clinical effectiveness within a local clinic setting*
Impact on Patient & Carer Experience		
6.	Describe the impact of the policy or procedural document on patient / carer experience. Consider issues such as our ability to treat patients with dignity and respect; our ability to deliver an efficient service; our ability to deliver personalised care; and our ability to care for patients in an appropriate physical environment.	*The policy allows patients to access clinic-based provision at a number of sites across Wiltshire, meaning that most patients can access provision close to home.*

Impact on Inequalities, and Parity of Esteem		
7.	Describe the impact of the document on inequalities in our community. Consider whether the document will have a differential impact on certain groups of patients (such as those with a hearing impairment or those where English is not their first language).	*There should be no negative impact on any groups of patients. Exclusion from the procedure would only be based on clinical risk, as set out in the policy. Reasonable adjustments and support can be made available.*