Mersey Care NHS
NHS Foundation Trust

TRUST-WIDE CLINICAL POLICY DOCUMENT

Managing Community Access and the management of appointments

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TRUST-WIDE CLINICAL POLICY DOCUMENT

2016 – Version 3

Quality, recovery and wellbeing at the heart of everything we do

Mersey Care NHS
NHS Foundation Trust

TRUST-WIDE CLINICAL POLICY DOCUMENT

Managing Community Access and the management of appointments

Further information about this document:

Document name	**SD08 Managing Community Access and the management of appointments**
Document summary	**This Policy provides detailed descriptions of how appointments, did not attends, and cancelled appointments will be managed by the Trust, in conjunction with National Guidance and standards.This Policy document clearly identifies the expected response times that service users should expect to be seen by and what will happen if an appointment is cancelled or a service user fails to attend.**
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Version Control:

		Version History:
Version 1.0	Policy Review Group	13/02/2016
Version 1.3	Policy Review Group	/12/2017
Version 3	Policy Review Group Executive Committee	Dec 2016 Jan 2017

SUPPORTING STATEMENTS

This document should be read in conjunction with the following statements:

SAFEGUARDING IS EVERYBODY'S BUSINESS

All Mersey Care NHS Foundation Trust employees have a statutory duty to safeguard and promote the welfare of children and vulnerable adults, including:

- being alert to the possibility of child/vulnerable adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child/vulnerable adult;
- knowing how to deal with a disclosure or allegation of child/adult abuse;
- undertaking training as appropriate for their role and keeping themselves updated;
- being aware of and following the local policies and procedures they need to follow if they have a child/vulnerable adult concern;
- participating in multi-agency working to safeguard the child or vulnerable adult (if appropriate to your role);
- ensuring contemporaneous records are kept at all times and record keeping is in strict adherence to Mersey Care NHS Foundation Trust policy and procedures and professional guidelines. Roles, responsibilities and accountabilities, will differ depending on the post you hold within the organisation;
- ensuring that all staff and their managers discuss and record any safeguarding issues that arise at each supervision session

EQUALITY AND HUMAN RIGHTS

Mersey Care NHS Foundation Trust recognises that some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the *protected characteristics* of age, disability, gender, race, religion or belief, sexual orientation and transgender. The Equality Act also requires regard to socio-economic factors including pregnancy /maternity and marriage/civil partnership.

The trust is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in our role as a major employer. The trust believes that all people have the right to be treated with dignity and respect and is committed to the elimination of unfair and unlawful discriminatory practices.

Mersey Care NHS Foundation Trust also is aware of its legal duties under the Human Rights Act 1998. Section 6 of the Human Rights Act requires all public authorities to uphold and promote Human Rights in everything they do. It is unlawful for a public authority to perform any act which contravenes the Human Rights Act.

Mersey Care NHS Foundation Trust is committed to carrying out its functions and service delivery in line the with a Human Rights based approach and the FREDA principles of **F**airness, **R**espect, **E**quality **D**ignity, and **A**utonomy

Contents

1. PURPOSE AND RATIONALE

1.1. The NHS Plan (2000) highlighted the need for Trusts to ensure service users and carers have fast, convenient access to appropriate treatment and support, offering service users and carers real choice in when, where and how their care is provided. The NHS is using new technology to enhance access processes.

1.2. A modern and effective service needs to be:

- Quick and easy to get into.
- Provided by the right team, at the right time and in the right place.

1.3. This Policy and Procedure document explains why the policy is necessary, to whom it applies to, the underlying beliefs behind the policy, the standards to be achieved and how the policy standards will be met through working practices.

2. OUTCOME FOCUSED AIMS AND OBJECTIVES

2.1. This policy explains:

- why the policy is necessary (rationale)
- to whom it applies and where and when it should be applied (scope)
- the underlying beliefs upon which the policy is based (principles)
- the standards to be achieved (policy)
- how the policy standards will be met through working practices (procedure)

2.2. The purpose of this policy and procedure is to ensure:

- We provide an excellent service that reflects Trust values and aims. A service that is responsive to service user and carer feedback and within the framework of service governance.
- The safety and well being of service users who miss an appointment or home visit.
- The safety and well being of the general public. It is recognised that some service users may pose a risk to themselves or others if they do not maintain contact with mental health services.
- We comply with Department of Health guidance and meet relevant targets.
- We adopt best national practice.

3. SCOPE

3.1. This policy applies to:

- All clinical services within the Local Services Division.
- All professional groups, departments and teams who offer appointments or assessments or visits; i.e. doctors, nurses, social workers, occupational therapists, psychologists, physiotherapists, support staff. For example this policy applies to doctors working in outpatient departments as well as

nurses, social workers and occupational therapists working in community teams.

This policy does not apply to inpatient services and high secure services.

4. DEFINITIONS

4.1. For the purposes of this policy, the following terms have the meanings given below:

- **Appointment / Visit:** An arrangement (in writing, on the telephone) has been made to see a service user at a certain time and place.

- **Waiting List*:*** Service users who are awaiting assessment / treatment and are currently available to attend an appointment / visit.

- **Did Not Attend (DNA):** Service users who have been informed of or agreed their appointment / visit date and who without notifying the department / service did not attend for their appointment / visit.

- **Service User Cancellation:** Service users who have been informed of or who have agreed their appointment / visit date and who have subsequently informed the department / service that they are unable to attend.

- **Trust Cancellation:** Service users who have been informed of or who have agreed their appointment / visit date and who have subsequently had their appointment / visit cancelled by the department / service.

- **Full Booking:** The service user is given the choice of when to attend an appointment / visit. The service user is given the opportunity to agree an appointment date at the time of, or within one working day of the decision to treat.

- **New appointment:** An appointment lasting approximately 1 hour, given to service users who are not known to the service.

- **Follow up appointment:** A shorter appointment given to known service users who are receiving on-going support / treatment

- **Visit:** An appointment arranged by a doctor, nurse, social worker, occupational therapist, and support worker that often takes place in the service user's home.

- **Care Programme Approach (CPA):** A framework for integrated access, care co-ordination and resource allocation in mental health care.

5. DUTIES AND RESPONSIBILITIES

5.1 **CHIEF EXECUTIVE:**

As accountable officer, the Chief Executive must ensure that responsibility for managing community access processes and service user appointments is delegated to an appropriate executive lead, as outlined in the executive portfolios.

5.2 **EXECUTIVE DIRECTOR**

The Executive Director has responsibility to ensure there is an appropriate and effective system in place for managing community access processes and service user appointments

5.3 **CHIEF AND DEPUTY OPERATING OFFICERS**

Will be responsible for ensuring that their staff complies with this policy and resources are available to support this process. If more resources are required they should take action to support this.

5.4 **TEAM MANAGERS**

Have a responsibility to ensure that the standards set out within this policy are being followed and will take the appropriate action if required following the annual audit.

5.5 **ALL CLINICAL STAFF**

All clinical staff within the Trust that are involved will ensure that they participate in implementing this policy and that they comply with all elements of this policy specifically around managing the risk for patients who miss their appointments.

5.6 **ADMINISTRATION/APPOINTMENT STAFF**

All administration staff that have responsibility for managing service user outpatient appointments need to comply with this policy and follow all the processes identified to ensure that there is an effective and safe management of community access processes in place.

We know from local service user, carer and referrer feedback, local service redesign and from best practice in other parts of the country that by managing the “way in” to our services in an efficient way we will deliver teams and departments that are easy to access to all members of a community, responsive to national changes, and cost effective.

Perfect Care is always at the top of our trust agenda. That‘s why we are doing everything we can to make our services match with people’s lifestyles and the technology they use, to give more people easy access to the services they need.

6. PROCESS

This policy only relates to routine appointments. When dealing with urgent or emergency situations the clinician or clinical team can decide to bypass these procedures. However if possible the procedures described in this policy should be used in urgent or emergency situations.
This policy is to ensure that:

6.1. Each clinical service has in place local procedures and management arrangements that support the standards in this policy.

- The overriding factor in the management of any access process will be the service users' best interest and satisfaction, maximising therapeutic benefit and minimising clinical risk.
- Services have good communication processes in place with referrers and service users; e.g. timely response times, agreed referral pathways, regular discussion.
- All staff will treat service users, carers and referrers as they would expect to be treated.
- Providing clear, concise communication.
- Being welcoming, helpful and friendly.
- Offering them choice where ever possible.
- Keeping them informed and updated.

6.2. Services are aware of local did not attend and cancellation rates and have management processes that regularly monitor and review them.

- Services only cancel clinics / appointments / visits in exceptional circumstances; e.g. sickness, etc.
- Service user feedback is aggregated and used across the service to improve processes. Services develop efficient processes that put service user need first.

6.3. **REFERRALS**

6.3.1. Clinical Services within Mersey Care NHS Foundation Trust operate different referral and access systems and processes. However, the main principles below are applicable to all services and should be followed as soon as they receive a new referral.

- All written referrals must be date-stamped as soon as they are received.
- Referrals must be put on electronic clinical record system immediately and no later than one working date from being received, with the Referral Received Date completed as per the date stamp.
- Verbal referrals followed by a letter should be recorded as the date that the letter arrives. If no letter is sent, the date of the verbal referral should be recorded
- Referrals received via Choose and Book should be printed and date stamped as soon as the patient has contacted the service to convert their unique booking reference number (UBRN).
- All Referrals received via post, fax or Choose and Book should be added to the Service User's record on electronic clinical record system.

6.3.2. Referrals need to be recorded on electronic clinical record system even if the Team has not seen the referral yet, or has not agreed to see the patient. This is so that the service user is included on the waiting list from the beginning, but is also important as all referrals form part of the service user's care record at the Trust

6.3.3. Any referral letters received elsewhere in the organisation will be date stamped and faxed or emailed to the relevant service within 24 hours of receipt. Referral letters must not be sent in the internal post in order to avoid delays.

6.3.4. Once a Referral has been logged on electronic clinical record system, it should be sent to the relevant staff for triage, or discussion at a multi-disciplinary Team meeting. Referrals will be prioritised accordingly and recorded on the electronic records system.

6.4. CHOOSE AND BOOK REFERRALS

6.4.1. Referrers will continue to send referrals in a variety of ways (e.g.) via the post, fax, telephone, email, etc. Choose and Book referrals should be treated the same way as all other types of referrals.

6.5. GENERAL PRINCIPLES

6.5.1. Following the receipt of a new referral and the decision by the service to offer an assessment to a service user, Appointments staff within each service will be responsible for managing the Booking process from the start until completion.

6.5.2. When arranging a first appointment, every effort must be made to contact all service users regardless of specialty or referral source, by telephone to agree an appropriate appointment date and time.

6.5.3. All first appointments in the Trust will be booked with choice of date and time. Service Users should be offered a choice of at least two appointments on different days, with at least three weeks notice for routine referrals before the first of these appointments.

6.5.4. When booking an appointment, the Appointments staff will initially make a reasonable attempt to contact the service user by telephone. If they are contactable, the clinic appointment will then be booked on the telephone.

6.5.5. If the Appointments staff are unable to contact the service user by telephone, then an appointment letter will be sent out asking the service user to contact the Service to confirm the appointment date. If the appointment is not convenient then an alternative date can be arranged.

6.5.6. All unsuccessful attempts to contact a service user should be recorded on electronic clinical record system.

6.5.7. Where the Appointments staff are unable to book a first appointments within the agreed maximum waiting target for the service, this should be escalated to the appropriate Manager or Clinician.

6.5.8. Where sufficient capacity is not available for new patients and there is the potential of a breach in the waiting time, staff should escalate this to the appropriate manager.

6.6. APPOINTMENTS REMINDERS

6.6.1. It should be standard practice that all patients are reminded about their outpatient appointments. Although different reminder systems may exist in different teams, all Appointments staff must ensure the following as a minimum:

- Patients are sent a reminder letter 1 week before their appointment is due
- Service Users are contacted by phone 1-2 days before their appointment. If Service Users telephone details are not available, staff should obtain this information directly from the referrer.
- All reminders or attempts to remind the service users must be recorded in the service user's record on electronic clinical record system.
- The use of automated appointment reminder systems (eg SMS reminders) may be introduced by the Trust in the future.

6.6.2. The Local Division is subject to a number of waiting time performance indicators, set both locally and nationally. All waiting time indicators are included in the Trust's Performance Assurance Framework.

6.6.3. The management of waiting lists should be based on clinical priority and treatment provided according to clinical need, within the target time frame of six / four weeks for all referrals. Service users not classified as a priority will be treated on a "first come first served" basis.

6.6.4. It is vital that services manage their Assessment and Interventions Waiting Lists correctly.

6.7. RECORDING OF REFERALS

6.7.1. All new referrals should be entered onto electronic clinical record system within one day of being received by the service. The electronic clinical record system must be used to record referral details, episodes (when appropriate), contacts and the result of these. The information held on electronic clinical record system also needs to match the information held in the service user's case notes and any other manual records used e.g. paper based waiting list records.

6.8. CALCULATIONS OF WAITING TIMES

6.8.1. The table below shows all waiting time performance indicators for the Trust by service as at April 2015.

Local waiting time indicators

Mersey Care currently operates a local six week maximum waiting time target for new referrals into service.
This six week target is applicable to **all** staff groups, (e.g.) not just doctors, for new (first) face to face contact/assessment for the following;

- Adults
- Older Adults
- Asperger's

Mersey Care currently operates a Commissioner defined maximum four week waiting time target for assessment by **Brain Injury Services**.

Mersey Care currently operates a Commissioner defined maximum six week waiting time target for assessment to **Psychological Therapy Service** for:

- Liverpool older adults community teams,
- Rotunda Day Service
- Learning Disability Psychological Services

Mersey Care operates a Commissioner defined maximum six week waiting time target for assessment to **Specialist Psychotherapy Service** and also follow an established 18 week referral to treatment (intervention) waiting time target

Mersey Care operates a Commissioner defined maximum six week waiting time target for assessment to **Eating Disorder Service** and also follow an established 18 week referral to treatment (intervention) waiting time target

Mersey Care operates a Commissioner defined maximum four week (28 day) waiting time target for assessment and commencement of treatment to **Talk Liverpool** (IAPT service)

Early Intervention in Psychosis Service with a suspected first episode of psychosis will be seen and commenced on treatment following NICE guidance within two weeks (14 days) or receipt of referral.

6.8.2. The assessment waiting time is the time in weeks that the service user has waited for their first assessment appointment.

It is usually calculated as follows:

First Assessment Appointment Date – Referral Received Date = Waiting Time in Weeks

6.8.3. The treatment / intervention waiting time is the time in weeks that the service user has waited for their first intervention appointment and is usually calculated as follows.

First Intervention Appointment Date – Referral Received Date = Waiting Time in Weeks

6.8.4. The **Referral Received Date** is the date that the referral request was received by the Service.

6.9. **WHEN DOES THE WAITING TIME START?**

6.9.1. For a letter or electronic referral the waiting time starts from the date the original provider service i.e. any team or Clinician in Mersey care, receives the referral.

6.9.2. For a verbal referral if the verbal request is followed by a letter, the referral received date is counted as the date the letter was received. If no letter is to follow, the referral received date is the date of the verbal referral.

6.9.3. For Choose and Book referrals (please refer to section 10) the waiting time starts from the date the unique booking reference number (UBRN) is converted i.e. the service user has called the Service to activate their referral).

6.9.4. It is therefore very important that all clinical services date stamp all paper referrals on the day they arrive at the service.

6.9.5. If a referral contains insufficient information and is returned to the referrer for clarification or more information the waiting time remains the same, i.e. the original date the referral was received by the provider service.

7. APPOINTMENTS

7.1. When the service is in the process of arranging an appointment with the service user, the Referral Received date needs to be checked to ensure that the service user is seen before they breach the waiting times target for assessments. If the service user chooses not to be seen before the “breach” date then this needs to be clearly recorded within the local waiting list records.

8. MANAGEMENT OF THE WAITING LIST

8.1. On a daily basis the Appointments Staff will be responsible for monitoring the outpatient waiting list for any potential breaches, by using the "Current Outpatient Waiting List Report" in the BiT Portal.

8.2. It is the responsibility of Mersey Care staff arranging the appointment to ensure that no service users are booked beyond the maximum waiting time target.

8.3. Any service users waiting longer than 2 weeks without an appointment date should be escalated to the appropriate manager.

8.4. Where it is not possible to book patients within their breach date this will be immediately escalated to the relevant Team Manager or a Senior Manager.

8.5. It is good practice for all clinicians and clinical teams to review and validate their waiting lists once a week.

9. REMOVING SERVICE USERS FROM THE WAITING LIST

9.1. Generally, a service user will stay on the waiting list until the date that they are seen in clinic. However, there are exceptions:

- **Signposting referrals:** If the referral has insufficient information, the Service may decide to ask for further information from the referrer or decide to reject the referral. In the case of requesting further information, the waiting time continues to clock up for the service user so it is important that the additional information is received and reviewed promptly. When the decision is taken to reject the referral, the referral will be returned to the referrer with a letter explaining the decision. Similarly, the Service may decide that the service user actually requires input from a different service eg TALK Liverpool, and will forward the referral on advising the original referrer accordingly. The referral screen on electronic clinical record system should be updated with the 'Referral closed date', and a note explaining what has happened. A record should also be kept in the service user's case notes and in local waiting list records. The service user should then be removed from the waiting list.

- **Service User refuses services offered:** If the service user refuses to be seen or decides that they no longer require the appointment, they can be removed from the waiting list at the Service's discretion and/or based on assessment of risk by the multi-disciplinary team. The referral screen should be updated as before so as to close the referral, and if an episode has been opened for the Service, this should also be closed.

- **Service user is unavailable:** The service user may be unavailable for a period of a few weeks or more, and therefore unable to attend. This may be due to them working away from home, being unwell with a different medical condition, or due to other personal circumstances. In these situations, the Service should refer the patient back to the referrer and ask them to re-refer once the service user is available again. As before, the referral and episode (if open) should be closed.

- **Service user is deceased:** If notification is received that a service user on the waiting list has died, any future appointments that had been arranged for them must be cancelled. The referral and episode must be closed as before. The date of death should be entered on the third page of the Patient Registration screen on electronic clinical record system. This will remove the service user from the waiting list, but also prevents their family being contacted in error by staff trying to arrange an appointment.

10. CANCELLED APPOINTMENTS

10.1. If an appointment is cancelled and another appointment date arranged for the service user, this has an impact upon the waiting time. There are two types of cancelled appointment:

- **Cancelled by provider:** If the Service cancels an appointment, the waiting time continues to clock up for the service user. It is therefore important that service users are rebooked as soon as possible and care should be taken when rebooking, so that the service user does not breach the waiting times target while they are being offered their new appointment date. If there are no appointments available before the service user breaches, then management must be informed immediately so that action can be taken and arrangements made for the patient to be seen. A contact with a result of 'Cancelled Provider' must be entered onto electronic clinical record system to show that the Service (Provider) cancelled the appointment.

- **Cancelled by patient:** If a service user notifies the Service that they wish to change or cancel their appointment (first assessment or first intervention), their waiting time is reset to zero (provided that they were given reasonable choice, see Section 8). The service user can contact the Service to cancel an appointment up to 24 hours before their agreed appointment time. The waiting time restarts from the appointment date that was cancelled. A contact with a result of 'Cancelled Pat/Client' must be entered on electronic clinical record system to show that the service user cancelled the appointment.

11. MANAGING DID NOT ATTEND (DNA) AND CANCELLED APPOINTMENTS

11.1. Service users that do not keep their outpatient appointments and do not cancel them cost the NHS millions of pounds a year. DNA refers to the number of service users with an appointment who did not attend and failed to give advance warning to the mental health outpatient appointment clinics (OPA), on that day. This includes patients who cancelled their outpatient appointment on the same day on which the appointment was scheduled. Missed appointments can cause serious delays in treatment for other servicer users; therefore, it important that people realise that not turning up to appointments can have a big impact on the care and treatment we are able to provide other service users. The main effects of these DNA's are:

- An increase in waiting time for appointments
- Frustration for both staff and service user.
- A waste of clinical and clerical resources
- A potential risk to the service users health

11.2. There is a perception that the workload capacity of outpatient clinics is being pushed to overloading and that's why we want to ensure that OPA clinics are offering the safest and highest possible quality care to our service users.

11.3. The purpose of this document is to set out the guidelines for a standardised approach to reduce DNA's within the local division. The primary aim is to:

- Reduce the number of DNA's for both new and ongoing OPA's.
- Provide advance notification of cancelled appointments that can be reused by other patients on the waiting list
- Improve the patient's experience
- Reduce costs
- Reduce outpatient waiting lists and enhance more responsive services
- Ensure the Trust makes best use of its staff and facilities.

11.4. **DID NOT ATTEND (DNA) APPOINTMENTS**

11.5. **NEW APPOINTMENT**

11.6. When a Service User fails to attend their new appointment (DNA), the service will contact the service user or any other potential sources of information to find out why they did not attend. It may also be useful to liaise with the referrer.

This information will help the clinician or clinical team decide what to do next.

11.7. If a service user fails to attend or decides to cancel their routine first (new) appointment / visit, then the clinician or clinical team must decide whether to refer the service user back to the referrer (often primary care) or to offer a second appointment. This decision must be made by the clinician or clinical team (Multi-disciplinary Team), assessing all the information available to them; e.g. clinical risk assessment.

This is particularly important where there is a known history of suicidality or previous suicide attempts, as the risk of such individuals going on to make further suicide attempts or complete suicide is greatly increased.

Depending on the outcome of the MDT assessment the next course of action can be determined. This could be another appointment, a visit by staff to the service user's address, a discussion with the GP, or discharge.

11.8. **FOLLOW UP APPOINTMENT/ VISIT**

11.8.1. If a service user fails to attend a follow up appointment or home visit, the clinician / clinical team will assess the risk factors associated with non-attendance in their individual care plan and take action in accordance with the risks identified.

11.9. **SERVCE USERS ON CPA**

If a service user on CPA does not attend a follow up appointment / visit, then the clinician or clinical team who offered the appointment / visit needs to assess the case involving the care co-ordinator, and if necessary other members of the team and key stakeholders. Such an assessment will need to

take place within a reasonable time frame and can be incorporated into other regular MDT meetings.

This is particularly important where there is a known history of suicidality, as the risk of such individuals going on to make further suicide attempts or complete suicide is greatly increased.

11.10. Service users should not be discharged back to primary care simply because they have missed an appointment. Service users may DNA or cancel appointments for good reasons. Any discharge should follow the CPA process.

11.11. Decision making processes need to be timely to minimise risk and also keep waiting times to a minimum.

11.12. All decisions regarding the follow-up of service users who did not attend (DNA) or cancelled their appointment, will be notified to the GP (and / or referrer where this is not the GP), and the service user, and any other involved parties in a timely manner; i.e. within a maximum of five working days.

11.13. **APPOINTMENT CANCELLATION BY SERVICE USERS**

11.14. Where the patient cancels an appointment, a further appointment must be offered. If a patient cancels their appointment they must agree another appointment either prior to the original or within two weeks of the original appointment. When a patient cannot agree a new appointment within the reasonable timeframe, every effort should be made for the patient to be seen as soon as possible and prior to the maximum waiting time date.

11.15. When patients cancel their appointments for a second time in a row, a Clinician or Clinical team (MDT) must be informed in order to decide if another appointment will be offered or if the service user will be returned to the care of the referring GP. A further appointment should not be offered until advice has been received by a Clinician or Clinical team. The Clinician or Clinical Team is expected to provide such advice promptly in order to avoid delays in offering a further appointment if required.

11.16. Patients are able to cancel their outpatient appointment up to 24 hours before their agreed appointment time. If a patient cancels on the day of their appointment, it will be recorded as a Did Not Attend (DNA) appointment.

11.17. **APPOINTMENT CANCELLATION BY THE TRUST**

11.18. The Trust should only cancel clinics / appointments / visits in exceptional circumstances; e.g. sickness, etc. If the cancellation is unavoidable, it will be the responsibility of the service to ensure that appropriate action is taken in order that patients are treated in accordance to clinical priority and within guaranteed waiting times.

11.19. Clinicians need to give as much notice as possible before taking annual leave or study leave; i.e. more than six weeks notice. The Clinical Director for each Clinical Business Unit or other senior managers must give written authorisation for cancellations under six weeks.

11.20. When cancelling clinics, appointments or visits a minimum of six weeks notice must be given for all planned absences.

11.21. The only acceptable reason to cancel at short notice (less than six weeks) is due to exceptional circumstances, such as sickness, is the unforeseen absence of clinical staff. Appointments should not be cancelled for any other purpose unless there are exceptional circumstances.

11.22. Wherever possible, service users that have been previously cancelled should not be cancelled a second time.

11.23. Service users should be informed as to the reason their appointment / visit has been cancelled and clinicians or clinical teams need to arrange an alternative appointment as soon as possible.

11.24. Where patients have to be cancelled at short notice, the case notes must be reviewed by medical staff.

11.25. Wherever possible, patients that have been previously cancelled should not be cancelled a second time.

11.26. **RECORD KEEPING**

11.27. All information needs to be recorded accurately in a timely manner in the health record and/ or information system as appropriate in accordance with the approved electronic clinical record system training programme delivered by the Informatics Merseyside Clinical Information Systems Trainers.

11.28. All staff need to ensure they are inputting and updating data on the electronic clinical record system in accordance with the standards defined within the Trust's Data Quality Policy.

11.29. A delay in data inputting will affect DNA, cancellation rates and waiting times and may result in incorrect reporting of performance against relevant key performance indicators.

11.30. Information needs to be accurate, timely, transparent, and auditable and truly reflect the services we are providing.

11.31. Agreed audit reporting undertaken through existing Governance structures.

11.32. Monitoring of KPI's by Board and its committee via the Care at a Glance Performance Report.

12. CONSULTATION

- This policy has been developed through consultation with team managers, admin managers, administration & appointment staff and service users within Mersey Care NHS Foundation Trust.

13. TRAINING AND SUPPORT.

13.1. All staff who are responsible for arranging and managing appointments will be appraised of the details within this policy and any changes or updates shared through group training sessions or 1:1 supervision.

14. MONITORING

- Team managers or senior managers in the Trust have a responsibility to ensure that audits of referrals should be completed on a regular basis.

- Staff must audit a sample of 10 referral letters per Community Team (or Service) every quarter to check the following:

1) That every referral is date stamped by the receiving person and that the date on the stamp matches the one entered on electronic clinical record system.
2) The clock Start and Stop dates for each referral should be checked in order to ensure that they have been recorded as per the policy.
3) For all referrals that are closed off on electronic clinical record system, there should be a corresponding letter advising the referring GP of this.

- It is the responsibility of the managers in each area to ensure that the audits take place every quarter and that the outcome of the audits is communicated to the relevant staff and training/learning needs are identified.

- monthly monitoring of KPI's by Board and it's committee via the Care at a Glance performance report.

15. HUMAN RIGHTS AND EQUALITY

15.1. Mersey Care NHS Foundation Trust recognises that all sections of society may experience prejudice and discrimination. This can be true in service delivery and employment. The Trust is committed to equality opportunity and anti-discriminatory practice both in the provision of services and in our role as a major employer.

15.2. The Trust believes that all people have the right to be treated with dignity and respect. The Trust is working towards and is committed to the elimination of unfair and unlawful discriminatory practices. All employees have responsibility for the effective implementation of this policy. They will be made fully aware of this policy and without exception must adhere to its requirements.

15.3. Mersey Care NHS Foundation Trust is also aware of its legal duties under the Human Rights Act 1998.

15.4. All public authorities have a legal duty to uphold and promote human rights in everything they do. It is unlawful for a public authority to perform any act which constitutes discrimination.

15.5. Mersey Care NHS Foundation Trust is committed to carrying out its functions and service delivery in line with Human Rights principles of dignity, autonomy, respect, fairness and equality.

- Consultation involved team managers, admin managers, administration and - appointment staff within Mersey Care NHS Foundation Trust.

16. Equality and Human Rights Analysis

Title: Managing Community Access
Area covered: Trust Wide

What are the intended outcomes of this work? *The policy ensures that service users receive appropriate care. It also contains a link to NHS North of England.*
Who will be affected? *e.g. staff, patients, service users etc* Staff and Service Users.

Evidence

What evidence have you considered? The standards for practice within Mersey Care NHS Trust have been drawn from, ' The Royal College of Psychiatrists of London Coroners and Justice Act 2009 Human Rights Act (1998) Mental Capacity Act(2005)
Disability (including learning disability) Any service user whose first language isn't English an interpreter or other mediums as requested would be provided. A service user who is deaf a person able to use BSL would be provided. The policy can also be provided in large text. As part of the trust's mandatory training all staff must complete Equality, Diversity, & Human Rights training at the appropriate level commensurate with their job role. *If the service user lacks mental capacity to take part in the discussion and make any necessary decisions then relatives, others close to the service user or recognised carers would be consulted as per policy.*
Sex Policy SD08 applies to all staff and service users regardless of sex. Staff should always be mindful of maintaining dignity where ever possible throughout any clinical procedure.
Race Policy SD08 applies to all staff and service users regardless of race. If an interpreter or other medium was requested this would be provided by the Trust.
Age *Policy SD08 relates to adults only.*

Gender reassignment (including transgender) *Policy SD08 applies to all staff and service users regardless of gender reassignment(including transgender) on transgender and transsexual people. This can include issues such as privacy of data and harassment.*
Sexual orientation Policy SD07 applies to all staff and service users regardless of sexual orientation. .
Religion or belief **This policy applies to all staff and service users regardless of religion or belief**
Pregnancy and maternity *Not applicable.*
Carers *Not applicable*
Other identified *Not applicable.*
Cross Cutting Policy SD08 applies to all staff and service users without discrimination.

Human Rights	**Is there an impact?** **How this right could be protected?**
Right to life (Article 2)	Not applicable
Right of freedom from inhuman and degrading treatment (Article 3)	This policy ensure that the Trust responsibility in relation to article 3 is met. To include reference the Human Rights Act responsibilities and considerations in the principle.
Right to liberty (Article 5)	Not applicable
Right to a fair trial (Article 6)	Not applicable
Right to private and family life (Article 8)	Not applicable
Right of freedom of religion or belief (Article 9)	Not applicable
Right to freedom of expression **Note: this does not include insulting language such as racism (Article 10)**	Not applicable
Right freedom from discrimination (Article 14)	Not applicable.

Engagement and Involvement *detail any engagement and involvement that was completed inputting this together.*

Not applicable.

Summary of Analysis *This highlights specific areas which indicate whether the whole of the document supports the trust to meet general duties of the Equality Act 2010*

Eliminate discrimination, harassment and victimisation

This policy is implemented in line with the policy content irrespective of any protected characteristics.

Advance equality of opportunity

Staff will implement the policy when required.

Promote good relations between groups

All relevant staff will have access to the appropriate training.

What is the overall impact?

Not applicable.

Addressing the impact on equalities

There needs to be greater consideration re health inequalities and the impact of each individual development /change in relation to the protected characteristics and vulnerable groups
All efforts during any clinical intervention will be made to maintain dignity where ever possible for all individuals irrespective of protected characteristics.

Action planning for improvement

At review included the specific reference to our responsibilities regarding the Human Right Act 1998

For the record

Name of persons who carried out this assessment:

Date assessment completed:

Name of responsible Director:

Date assessment was signed:

Action plan template

This part of the template is to help you develop your action plan. You might want to change the categories in the first column to reflect the actions needed for your policy.

Category	Actions	Target date	Person responsible and their area of responsibility
Monitoring			
Engagement			
Increasing accessibility			