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Gloucestershire Health and Care
NHS Foundation Trust

CLINICAL POLICY
Patient Access to Services (Physical Health)

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Policy Number	CLP103
Version:	V5
Purpose:	This policy covers booking, notice requirements, patient choice, waiting list management and actions. All patient access and choice issues will be dealt with systematically within the principles and spirit of this policy. The overall intent of this policy is to provide a clear, reliable and transparent standard for patient access. By applying this structure and systematic approach, Gloucestershire Health and Care NHS Foundation Trust (GHC) will ensure that patients receive a high-quality service and increase the likelihood of their choosing GHC for their treatment.
Consultation:	Deputy Service Directors for Countywide Services, Operational Service Leads, Business Intelligence Leads, Heads of Profession, Clinical Policy Group Consultation Distribution List
Ratified by:	Clinical Policy Group
Date Ratified:	16/10/2025
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Review Date:	01/10/2028
Author / Reviewer:	Reviewed by: [redacted], Operational Governance and Performance Lead
Audience:	This policy guides and supports operational staff to effectively manage patient access into physical health services.
Dissemination:	The policy will be published on the GHC intranet, and its update will be listed on the Clinical Policy update bulletin
Impact Assessments:	This policy has been subjected to an Equality Impact Assessment. This concluded that this policy will not create any adverse effect or discrimination on any individual or particular group and will not negatively impact upon the quality of services provided by the Trust.

Version History

Version	Date Issued	Reason for Change

V3.1	01/10/2019	Transferred to new Trust Template and updated Trust Name and details
V3.2	31/03/2020	Extension to review date as advised by Director of Nursing, Therapies and Quality during Trust Prioritisation of Services for Covid19
V3.3	02/07/2020	Minor updates by Service Directors and Extension to review date by 12 months
V3.4	23/06/2021	Extension of 3 months whilst this Policy undergoes a review by the Ops Team
V3.5	07/10/2021	Extension of 3 months, Policy is to be combined with parts of the Assessment and Care Management Policy and will become a Trustwide policy
V3.6	22/12/2021	Work is still ongoing on merging this Policy, extension agreed by Deputy Director of Nursing and Interim Deputy Chief Operating Officer
V4	06/05/2022	Reviewed to align with the development of the Non-Access Policy, which is an integrated policy for both mental and physical health services. Non-access information and actions removed from this policy. RTT methodologies outlined in the policy reviewed and updated to align with SystmOne Simplicity
V5	30/10/2025	Reviewed and update added around scheduling appointments. Onward referral process. Addition added in relation to appointments booked via the NHS App. Definition of a did not attend an appointment added. Information about improvement plans for RTT. Amendment regarding patients who access NHS and private treatment. Amendment in relation to diversity of services. Additional information added relating to patients being ready for treatment. Clarity added in relation to local training. Amendment in relation to the Integrated Urgent Care Service. Clarity added in relation to making reasonable adjustments as appropriate.

SUMMARY

The policy sets out how patients can access physical health services provided by Gloucestershire Health and Care NHS Foundation Trust, following a referral into services. The overall intent of this policy is to provide a clear, reliable and transparent standard for patient access. By applying this structured and systematic approach, GHC will ensure that patients receive a high-quality service and increase the likelihood of their choosing GHC for their treatment.

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1. INTRODUCTION

In England, under the NHS constitution (Update August 2023), patients *"have the right to access certain services commissioned by NHS bodies within maximum waiting times"*. Whilst specific national waiting times relate to consultant-led services only, both GHC and our commissioners, recognise waiting times as a relevant indicator for service quality.

2. PURPOSE

The purpose of this policy is to outline GHC requirements and standards for managing patient access to the services it is commissioned to provide. The length of time a patient waits for their treatment and the notice and choice they have when they book their treatment are indicators of the quality and efficiency of services provided by GHC. This includes those patients who access NHS 111 via telephony or online and then requires an outcome with a GHC service. Therefore, all patient access and choice issues will be dealt with systematically within the principles and spirit of this policy.

There are three main principles that serve as the foundation to this policy:

- GHC will ensure that the management of patient access to services is transparent, fair, and equitable and managed according to clinical priority.
- GHC will ensure that the administrative processes in services where patients can book their own appointments and treatment are simple, efficient and provide a high-quality service to patients.
- GHC will act in the interests of patient safety in the event of non-access contacts to services.

The overall intent of this policy is to provide a clear, reliable and transparent standard for patient access. By applying this structured and systematic approach, GHC will ensure that patients receive a high-quality service and increase the likelihood of their choosing GHC for their treatment.

This policy applies to all administration and clinical prioritisation processes relating to patient

access managed by GHC.

The scope of this policy is from a patient's referral into GHC through to their care and assessment/ treatment. All staff involved in a patient's care and treatment should adhere to this policy.

The Chief Operating Officer within GHC has corporate responsibility for ensuring that the policy is effectively implemented through the Operational Management structure and for updating the policy as and when necessary.

3. SCOPE

The detailed principles of this Access Policy are as follows:

a) This policy applies to **physical health** services only.

b) All patients will experience equity of access and impartiality while waiting for their treatment.

c) Patients will be treated in accordance with their clinical need or priority.

d) Patients will be offered treatment/care in the most suitable setting for their needs following assessment and discussion.

e) Clinical need or priority can only be determined by suitably qualified clinical staff with authority to make those decisions.

f) Patients should be ready and available for treatment at the point at which they are referred into the service, recognising that some patients might still be an inpatient and referral is required for discharge planning. Patients who are assessed/identified as unable to leave their property without considerable support; where care is unsuitable for delivery outside of the home or where there is a predicable detrimental impact on health and wellbeing by leaving the home, will be deemed as housebound and therefore appropriate for GHC to visit a patient within their usual residential setting where these exist.

g) Patients will be able to have choice in the scheduling of their appointments and venues where they exist.

h) Data concerning waiting lists and patient's waiting times will be secure, timely, accurate and subject to regular audit and validation.

i) Communication with individual patients and the wider public about waiting lists and waiting times will be clear, informative and timely.

4. DUTIES

General Roles, Responsibilities and Accountability

Gloucestershire Health and Care NHS Foundation Trust (GHC) aims to take all reasonable steps to ensure the safety and independence of its patients and service users to make their own decisions about their care and treatment.

In addition, **GHC** will ensure that:

- All employees have access to current, evidence-based policy documents.
- Appropriate training and updates are provided to support staff in their roles.
- Staff have access to equipment that meets safety standards and maintenance requirements.

Managers and Heads of Service will ensure that:

- All staff are aware of and have access to relevant policy documents.
- All staff are supported to access training and development as appropriate to individual employee needs.
- All staff participate in the appraisal process, including the review of competencies.

Employees (including bank, agency, and locum staff) must ensure that they:

- Practice within their level of competency and within the scope of their professional bodies where appropriate.
- Familiarise themselves with and adhere to relevant GHC policies and procedures.
- Identify any areas for skill update or training required.
- Participate in the appraisal process.
- Ensure that all care and consent complies with the Mental Capacity Act (2005) – see section on MCA Compliance below.

5. MENTAL CAPACITY ACT COMPLIANCE

Where parts of this document relate to decisions about providing any form of care treatment or accommodation, staff using the document must do the following: -

- Establish if the person is able to consent to the care, treatment or accommodation that is proposed. (Consider the 5 principles of the Mental Capacity Act 2005 as outlined in section 1 of the Act. In particular principles 1,2 and 3) Mental Capacity Act 2005 (legislation.gov.uk).
- Where there are concerns that the person may not have mental capacity to make the specific decision, complete and record a formal mental capacity assessment on the GHC Trust approved MCA forms. These are available as templates on clinical record systems and on the GHC intranet.
- Where it has been evidenced that a person lacks the mental capacity to make the specific decision, complete and record a formal best interest decision making process using the best interest checklist as outlined in section 4 of the Mental Capacity Act 2005 Mental Capacity Act 2005 (legislation.gov.uk). Evidence of Best Interests decision making must be provided on the GHC Trust approved forms. These are available as templates on clinical record systems and on the GHC intranet.
- Where a person is admitted to hospital for the treatment of a physical health condition and is assessed as being unable to consent to admission, care or treatment, an application for an Urgent DOLS Authorisation must be submitted to the Local Authority. This applies in all cases where the person lacks capacity, regardless of their compliance with or objection to their admission. Establish if there is an attorney under a relevant and registered Lasting Power of Attorney (LPA) or a deputy appointed by the Court of Protection to make specific decisions on behalf of the person (N.B. they will be the decision maker where a relevant best interest decision is required. The validity of an LPA or a court order can be checked with the Office of the Public Guardian) Office of the Public Guardian - GOV.UK (www.gov.uk).
- If a person lacks mental capacity, it is important to establish if there is a valid and applicable Advance Decision before medical treatment is given. The Advance Decision is legally binding

if it complies with the MCA, is valid and applies to the specific situation. If these principles are met it takes precedence over decisions made in the person's best interests by other people. To be legally binding the person must have been over 18 when the Advance Decision was signed and had capacity to make, understand and communicate the decision. It must specifically state which medical treatments, and in which circumstances the person refuses and only these must be considered. If a patient is detained under the Mental Health Act 1983 treatment can be given for a psychiatric disorder.

- Where the decision relates to a child under the age of 16, the MCA does not apply. In these cases, the competence of the child must be considered under Gillick competence. If the child is deemed not to have the competence to make the decision, then those who hold Parental Responsibility will make the decision, assuming it falls within the Zone of Parental control. Where the decision relates to treatment which is life sustaining, or which will prevent significant long-term damage to a child under 18 their refusal to consent can be overridden even if they have capacity or competence to consent.

6. WAITING TIME TARGETS

Referral to Treatment (RTT) Targets

Referral to treatment targets have been negotiated locally between GHC and their commissioners. GHC recognises that referral to treatment waiting times are a useful quality indicator. This is reported formally through operational governance performance meetings, to the Trust Board or subcommittee and is reviewed as part of the formal contracting meetings.

Universal services that do not have a waiting list are exempt from reporting Referral To Treatment (RTT) performance. These services either do not provide any first definitive treatment for a clinical condition or the service is deemed as unsuitable due to the responsiveness of the service.

These services include:

- Children's Public Health Nursing Services (Health Visiting and School Nursing)
- The School Aged Immunisation Service
- Community Hospital Inpatient Wards
- Minor Injuries and Illness Units
- Integrated Urgent Care Service.

Any service that is being piloted will also not have an agreed RTT target until it is fully established. However, all services will have internal monitoring of wait times.

7. PRINCIPLES AND PROCEDURES

7.1 Clinical Urgency

All referrals are clinically triaged within service areas, and all referrals are prioritised based on their clinical needs. Patients will be classified as either routine or urgent based upon their needs according to the referral information provided, clinical presentation and level of clinical concern.

Urgent – indicates that any delay in treatment will result in a loss of clinical outcome.
Routine – indicates that no loss of clinical outcome is expected if the patient is treated in waiting time order and within maximum waiting time standards.

7.2 Receiving Referrals

Paper and other non-electronic referrals will be date stamped as received on the date of receipt by the service. This is the Referral to Treatment (RTT) start date.

For electronic referrals the RTT start date will begin as soon as the patient's referral is registered on the relevant service's clinical system, or on the date the patient converts their unique booking reference number (UBRN) either directly from the referral point (i.e. GP practice) or via an Appointments Line service.

All referrals should be registered within 1 working day of receipt by the service.

All referrals should aim to be screened to either accept or reject the referral within two working days, however some specialist services may require longer, for example psychosexual medicine and complex contraception.

If referrals do not contain the relevant information required to identify the patient and/or fully understand the patient's needs, then the referral will either be:

(a) Kept open by the service and returned to the referrer requesting this information is added. In this instance the RTT wait continues.
(b) ***Rejected*** by the service and returned to the referrer. In this instance the referral is closed and will be exempt from RTT reporting.

This decision will be based on the clinical reasoning of the triaging clinician.

7.3 Onward Referrals

Referrals to other specialist services may be appropriate for some patients, for example to a specialist acute hospital service. This could include referrals via Cinapsis (app-based advice, guidance and referral electronic system). Some clinical services provided by GHC can refer a patient directly to a specialist service where local agreements are in place with system partners. Some services will need to signpost patients back to their GP, to request an onward referral is made. The onward referrals process is in place within individual clinical services provided by GHC.

7.4 Booking Appointments

All services will aim to find a date appropriate for a patient's clinical priority and convenient to that patient. With the introduction of the NHS App, there are some GHC services where patients are able to self-book an appointment using the NHS App, however this offer is not in place across all of GHC services.

Next available appointments will be offered to those with an ***urgent*** clinical need. Two attempts to contact the patient will be made via telephone and then an appointment will be made for them and the details sent to them. However, due to the diversity of services provided across GHC, there are exceptions in the way in which patients will be contacted, for example the pregnancy advisory service will explore how to contact the patient based on the patient's consent.

Routine appointments will aim to be offered with reasonable notice. If an appointment is offered at less than a week's notice, then refusal of this appointment will not compromise waiting list position and the RTT wait continues. Methods of booking varies between services; some services will contact patients directly; some services will send an appointment letter, and some will request

patients to book appointments via an online system.

For services which offer a direct response and have no waiting list, these principles do not apply.

All appointments should be entered onto the relevant clinical recording system when the appointment is booked. Appointments may be face to face, virtual or via telephone depending upon the service, the clinical needs identified and a robust risk assessment.

When definitive clinical intervention has been completed and recorded on the clinical system the RTT wait stops. If appropriate clinical intervention cannot be offered at a patient's first appointment, then the RTT wait continues until this treatment becomes available and is accessed by the patient. *See section 6 for full details on RTT methodology.*

Reasonable adjustments may need to be considered for some patients when booking an appointment. A reasonable adjustment is a small change that may mean that an autistic person, person with a learning disability or any individual who would meet the criteria of the nine protected characteristics of the Equality Act 2010 would be able to have more equitable access to healthcare.

Reasonable adjustments can be as such (this is not an exhaustive list):

- Easy Read appointment letters
- Text reminders for appointments
- Longer appointment times if someone needs more time
- Priority appointments for people who may find waiting difficult.

7.5 Did Not Attend (DNA), Non-Access Visits and Cancellations

Patients will be advised at their first contact what to do if they need to change a planned appointment.

A patient is said to have ***cancelled*** their appointment if they give notice prior to the appointment. If a patient cancels an appointment twice then the patient may be discharged back to their referrer. If the patient is a vulnerable adult or child and there are safeguarding concerns, then the patient's GP and any other relevant professional supporting that patient may also be informed in writing. Not attending or not being brought to appointments can be an indicator of neglect or domestic abuse so please contact the Safeguarding team on 0300 421 6969 if you have any concerns.

There is a service specific action card in place within the Integrated Urgent Care Service if a patient or carer cancels an out of hours appointment or does not attend a booked appointment. This includes a process whereby non clinicians will attempt to contact the patient on three separate occasions. However, the final decision to either close the case, or refer on for a welfare check is decided by the senior clinician on duty.

If a patient does not attend their appointment, meaning they do not give any prior notice that they will not attend, it is deemed that they DNA their appointment. In children's services this is referred to as the child/young person ***was not brought*** to the appointment. This includes non-access visits for appointments arranged in the residential setting.

Depending upon the patient's needs and circumstances the service may endeavour to establish

why the patient did not attend/was not brought or was not accessible for domiciliary visits. Further appointments may be booked at the discretion of the clinical/service lead.

Appointment cancellations and appointments where a patient DNA (or was not brought to) the appointment cannot be recorded as the first definitive clinical intervention and the RTT wait continues until appropriate clinical intervention is accessed. (Please refer to CLP160 Did Not Attend (DNA), Was Not Brought (WNB) and Non-Access Policy).

In the event of a patient death, the referral is closed and the patient discharged from the service.

7.6 Timed Visits in the Home Setting

Where a person is identified as housebound, a time for the planned visit may not be given unless the person's treatment requires this.

Where possible, staff will indicate if the planned contact will be a morning or afternoon appointment, but it is not always possible or feasible, to apply timed contacts to certain services, for example community nursing.

For services where timed appointments can be offered accurately, they should work to this approach.

Patients will be advised at their first contact what to do if they need to change a planned appointment or will not be home when a contact is expected to prevent wasted time in non-access contacts.

**On the occasion that visits in the home or community settings cannot be completed because access cannot be gained, please refer to the Did Not Attend (DNA), Was Not Brought (WNB) and Non-Access Policy (CLP160) and associated SOPs and action cards (this is an integrated policy covering both physical and mental health services for children, young people and adults).*

7.7 Vulnerable Patients and Safeguarding Issues

GHC will make every attempt to ensure that where safeguarding issues have been identified or when patients are considered vulnerable, they are supported to attend their appointment. These patients will routinely be offered a second appointment if they DNA a first appointment as outlined in Section 5.4. As mentioned in Section 7.5 you should be alert to the possibility that someone is being prevented from accessing care.

Further guidance is available from the GHC Safeguarding Team on 0300 421 6969 and by reference to GHC Safeguarding Child Protection Guidance: Management of Children and Young People Who Fail to Attend Appointments and the Safeguarding Adults Multi Agency Policy.

7.8 Patients who Need to Leave before their Appointment

Patients who attend for their appointment but have to leave prior to being seen due to the clinic not being able to deliver their appointment within 30 minutes of their scheduled appointment time, the patient will be offered a further date at the earliest opportunity. If this was a first appointment, then the RTT wait continues until the patient has received their first definitive clinical intervention.

7.9 Patients who are Late for Appointments

The service will attempt to see patients who attend late for their scheduled appointment time. However, where it is not possible to see the patient because there would be significant impact on service delivery, or risk to other patients, that patient will be deemed to have cancelled their appointment and managed as section 7.4.

7.10 Patients Transferring from the Private Sector to the NHS

Patients can choose to convert between the NHS and the private sector at any point during their treatment without prejudice, however their treatment will not be expedited other than for clinical reasons.

Patients who are eligible for NHS treatment and have been seen privately and ask to go on to the NHS waiting list must be listed at the time the decision to treat is agreed with no delays. They do not need an NHS reassessment before being added to an NHS waiting list.

For patients transferring either from the private sector or from another provider the RTT start date will be the date that their referral is received by the Trust and registered on the relevant clinical system.

8. RTT – CLOCK START / STOP METHODOLOGY

8.1 Treatment Pathway

The RTT clock stops when the first definitive clinical intervention is given. A patient's first definitive clinical intervention is intended to manage a patient's disease, condition or injury. This can be delivered in a number of ways, including via the telephone (advice and guidance), via a virtual platform or face to face etc. This can be provided in a 1-1 setting or a group setting.

If a patient is unfit for treatment, then they may be discharged back to the original referrer. This referral would be closed and would be exempt from RTT reporting. In some cases, the triaging clinician may choose to uphold the referral until the patient is well enough to access care, for instance if a patient has a short-term illness or if discharge would pose risk. In these instances, the RTT wait continues until the first definitive clinical intervention is completed.

DNA's, non-access and appointment cancellations do not stop RTT waits because definitive clinical intervention has not yet been received.

8.2 Active Monitoring

Active monitoring is where it is clinically appropriate to monitor the patient without clinical intervention or further diagnostic procedures, or where a patient wishes to continue to be reviewed as an outpatient, or have an open appointment, without progressing to definitive treatment. As an example, this could include when a specific treatment pathway needs to be accessed but is not available immediately. The RTT wait would continue until the patient has received their first definitive clinical intervention.

Active monitoring can be initiated by either the patient or the clinician. It is not appropriate to use active monitoring for patients that wish to delay an appointment.

9. ENTITLEMENT TO NHS TREATMENT

It will be assumed that patients that are referred from an external source (e.g. GPs, acute trust etc.) will have had their eligibility to receive NHS treatment confirmed by that external source

and therefore GHC will only check eligibility for those patients that self-refer to a GHC service.

For patients that self-refer to a GHC service and for patients that have no NHS number, GHC will check every patient's eligibility to receive NHS treatment in accordance with and following the guidance contained within the Department of Health website.

For services that receive self-referrals, these will be reviewed and signposted to other appropriate services, if they do not meet the criteria of the service that has received the self-referral.

10. RESPONSIBILITY FOR ACHIEVING WAITING TIMES STANDARDS

It is the responsibility of the Head of each respective service to ensure that patients do not breach the national and locally agreed RTT standards in their service areas. They must liaise with relevant staff to ensure that patients are booked on time, with sufficient notice, and in order and that each patient's treatment status is accurately recorded at every stage in their pathway. Where key performance indicators are in place, improvement plans will be required to support compliance with the RTT.

11. PROCESS FOR MONITORING COMPLIANCE

Are the systems or processes in this document monitored in line with national, regional, trust or local requirements?	YES

Monitoring Requirements and Methodology	Frequency	Further Actions
Access targets are agreed locally with commissioners and reported via the organisation's performance dashboard. Access to services is monitored via Patient Tracking Lists (PTLs), which are managed by Heads of Service and performance leads.	Monthly	Performance exceptions are escalated through operational performance reporting via the Operational Performance and Risk Meeting, and shared at Business Intelligence Management Group (BIMG) with oversight at Resources Committee

12. INCIDENT AND NEAR MISS REPORTING AND REGULATION 20 DUTY OF CANDOUR REQUIREMENTS

To support monitoring and learning from harm, staff should utilise the Trust's Incident Reporting System, DATIX. For further guidance, staff and managers should reference the Incident Reporting Policy. For moderate and severe harm, or deaths, related to patient safety incidents, Regulation 20 Duty of Candour must be considered and guidance for staff can be found in the Duty of Candour Policy and Intranet resources. Professional Duty of Candour and the overarching principle of 'being open' should apply to all incidents.

13. TRAINING

Manager of the team is responsible for ensuring that staff working in the team are familiar with the policy, to ensure that patients are able to access services as required.

14. ASSOCIATED DOCUMENTS

- GHC Discharge Policy (Physical Health Policy CLP121)

- Did Not Attend (DNA), Was Not Brought (WNB) and Non-Access Policy (CLP160)
- Safeguarding Child Protection Guidance: Management of Children and Young People Who Fail to Attend Appointments and the Safeguarding Adults Multi Agency Policy.
- National Institute for Health and Care Excellence (NICE) Guidance - CG138 Patient experience in adult NHS services: improving the experience of care for people using adult NHS services.
- National Institute for Health and Care Excellence (NICE) Guidance - NG204 Babies, children and young people's experience of healthcare.