

Patient Access Policy

November 2013

This procedural document supersedes the previous procedural documents for Policy for the Management of Patients/Clients Access to Services

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Version Control Sheet

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1.0	6/11/13	AD Operational Support Service	Final	Policy Ratification Group approved on 29 th October 2013

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1. Introduction

This Patient Access Policy is designed to ensure that all patients (adults and children) who are referred and treated within Hounslow and Richmond NHS Trust (HRCH) are responded to efficiently, equitably and in line with NHS national access targets for patients. It must be read in conjunction with the Department of Health's 18 Week Rules & Definition Policy and with the guidelines suggested in the NHS Executive document "NHS Waiting Times: Guidelines for Good Administrative Practice".

It is intended that this policy will form part of more comprehensive waiting list management guidance and procedures to include management of those patients/clients who do not attend (DNA) and for managing patients on an 18 week pathway and replace all previous access policies. It will support local operational procedures across HRCH and within all departments, and all staff will ensure that their practices are consistent with it. Although each service will have its own individual care pathways and guidelines, staff will ensure that local, individual service operational procedures reflect the rules laid out in this document. The only exception to this will be services who have agreed standard response times based on clinical priorities and will have tighter time frames due to the nature of the service.

It is recognised that patients/clients who do not attend (DNA) for their community out patient treatment or there is a 'failed home visit' represent a significant cost in terms of reduced utilisation of facilities and additional workload for those staff dealing with the admission procedures to services.

It should be noted that waiting times need to reflect commissioner's service specifications.

Safeguarding

Where there are children or adults for whom there are any safeguarding concerns who fail to attend an appointment the referrer should be contacted to advise of the non-attendance as this may result in further action.

The clinician may be required to offer a degree of flexibility with regard to re-booking appointments where this may affect a Child Protection Plan or a Vulnerable Adult Plan - whilst working within the respective waiting times for the service area.

2. Aims and objectives

These guidelines, which reflect existing good practice, should be applied across all services in order to ensure a consistent and fair approach to the management of patient flows through the services.

The main objectives are as follows:

- In most circumstances, patients should not be referred to community services unless they are fit, ready and willing to access services within the waiting times as recorded in the service specification. The referral for an assessment will be available within a maximum of 18 weeks for treatment. Definitions of being 'fit' for service will be defined at the service level.
- The management of new referrals and associated waiting lists will be consistent with the NHS 18 week referral-to-treatment target and within waiting times within service specifications. All national milestones required for diagnostic and treatment pathways will be met and the relevant guidance for these targets will be applied.
- The management of new referrals and waiting lists will be clear, transparent and equitable. Patients will be seen and treated according to their clinical priority. Those patients of similar clinical priority will be seen in turn, usually in order of administrative receipt and/or patient availability.
- All communication from providers to patients will be supportive, informative and open.
- Appointments will be made with reasonable choice and adequate notice. All efforts will be made to ensure that patients are aware of this policy and understand the information contained within the referral and appointment process.

- To establish a framework which promotes the exercise of sound clinical judgment, thereby ensuring DNAs, cancellations and failed home visits are managed appropriately.
- To ensure targeted and efficient use of resources to maximise use, and minimise waits.
- To encourage attendance, effective intervention and improved clinical outcomes.

Scope

This policy is intended to be used by all clinical and administration staff within the provided services of HRCH. The scope will also cover the use as a source of reference by other HRCH commissioned services, agency staff and independent contractors.

3. Definitions and explanation of any terms used.

These definitions are based on the Department of Health's "Referral to Treatment, Frequently Asked Questions", Version 5, March 2008.

Active Monitoring: An 18 week clock may be stopped where it is clinically appropriate to start a period of monitoring. A new 18 week clock will start when a decision to treat is made following a period of watchful waiting/active monitoring.

Consultant Led: Services where a consultant retains overall clinical responsibility for the service, team or treatment. The consultant will not necessarily be physically present for each patient's appointment but he/she takes overall clinical responsibility for patient care.

Diagnostic Wait: The 6 weeks from the referral received date in which to make a diagnosis of the patient's condition. In the context of community services, this will mainly be represented by a patient assessment, but it may include diagnostic tests such as hearing tests, X rays or MRI scan.

DNA includes all non-contacts with patients where the patient does not give any advance notice that they will not be attending or available for the planned appointment. In the context of 18 weeks, this is defined as where a patient fails to attend an appointment/admission without prior notice or arrives after more than 25% of the time of their appointment has already elapsed.

Cancellation refers to situations where notice is given by the patient of their intention not to attend for a planned appointment.

Failed home visits include those occasions where a planned visit cannot take place due to the absence of the patient or where entry is prevented by the patient and/or relatives.

Exceptional circumstances: Circumstances of individual risk (clinical or other) which cause clinician to judge that the Access policy should be overridden.

Reasonable justification: Circumstances outside the patients' control, which prevent them from attending and notifying service.

First Definitive Treatment: An intervention intended to manage a patient's disease, condition or injury and avoid further intervention. What constitutes First Definitive Treatment is a matter for clinical judgment, in consultation with others as appropriate, including the patient.

Interface Service: The national definition is for all arrangements that incorporate any intermediary levels of clinical triage, assessment and treatment between traditional primary and secondary care. In terms of 18 weeks, the term "interface service" does not apply to non consultant-led mental health services run by Mental Health Trusts or referrals to 'practitioners with a special interest' for triage, assessment and possible treatment, except where they are working as part of a wider interface service type arrangements as described above.

Minimum Data Set: The minimum amount of data with patient information in order to manage the patient's referral and monitor the 18 week clock

New Clock Starts: The 18 week referral to treatment clock will start again for patients who have a clocked stopped, in the following circumstances:

- When a decision is taken to start a substantively new or different treatment that does not already form part of that patient's agreed care plan
- When a patient is re-referred 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 DNA that stopped and nullified their earlier clock.

Patient: Includes both adults and children accessing services.

Reasonable Offer: A reasonable offer of an appointment will include, if necessary, a choice of two appointment days and with a minimum of 2 -3 weeks advance notice, unless the patient accepts an earlier appointment date as convenient to them.

Clock Stop: If a patient DNAs their first appointment following the initial referral that started their 18 week clock, provided that the provider can demonstrate that the appointment was clearly communicated to the patient.

Follow up appointment: any appointment following the initial appointment.

Partial bookings: The patient is given a choice of when to attend. The patient is advised of the total waiting time during the consultation between themselves and the health care provider/practitioner. The patient is able to choose and confirm their appointment approximately 4 – 6 weeks in advance of the time given.

Full bookings: The patient is given an opportunity to agree a date at the time of, or within one working day of, the referral or decision to treat. The patient may choose to agree the date when initially offered or defer their decision until later.

High risk/vulnerable patients: The definition of 'vulnerable' is taken from the Civil Contingencies Act 2004, which states that vulnerable people are those 'who are less able to help themselves in the circumstances of an emergency' and should 'be given special consideration in plans'.

Discharge: When the responsibility for the patient/clients care is transferred back to the referrer or other party. The service no longer has responsibility for that patient either on the waiting list or caseload.

Clinical decision: A decision taken by a clinician or other qualified care professional, in consultation with the patient, and with reference to local access policies and commissioning

Referral Management Centre: A referral management centre or assessment service is a specific type of interface service that does not provide treatment, but accepts GP (or other) referrals and provides advice on the most appropriate next steps for the place or treatment of the patient.

4. Duties

Board

The Board has overall responsibility for ratifying and approving all policy documents produced within the trust. They will also require to be assured of the monitoring, reporting and reviewing processes in association with this policy in light of Department of Health Key Performance Indicators.

Chief Executive

- The Chief Executive is accountable for all services to ensure that they act consistently with respect to the access that patients receive from HRCH.

Service Managers: The role of all managers is to:

- Monitor and report on compliance to the policy.
- Support clinicians in the application and interpretation of the policy.
- To ensure distribution of this policy and associated information leaflets to all referrers to services
- Provide training packages to ensure competency for the level of clinical decision making and risk assessment required.
- Ensure inclusion of topic at local induction level.
- Provide internal communication.
- Ensure regular review process for the policy with regard to the relevance, equality and inclusion issues and incorporation of new guidance and legislation.

All Clinical Staff : Staff members are expected to:

- Apply the policy to current practice.

- Record, audit compliance and provide feedback.
- Ensure their own practice is clinically effective to enable safe clinical judgments of risk are undertaken.
- Ensure any access issues are highlighted to the attention of the service manager.

Referrers:

- Patients should be assessed for availability to be seen in line with waiting times noted in service specifications and maximum a of 18 weeks for definitive treatment before referral. Exceptions to this include vulnerable children and adults; in these cases, the referrer will send the referral with a note to the service explaining the reason for the referral.
- Referrers are required to complete a referral form, preferably in electronic or typewritten format, that contains all relevant information on the patient's condition, requirements and identity to enable the receiving service to process the referral in accordance with local operational protocols. For example, requirements may include language and transport needs, NHS number and daytime telephone contact numbers and ethnicity.
- Referrers are also required to ensure that patients understand the reasons for their referral and understand the appointment process, including any implications of delay for treatment if the appointment is not attended or cancelled by the patient.

Administrative and Clinical Responsibilities of the Receiving Service:

- Referrals received by email, post or fax will be opened and date stamped on the day of their receipt into HRCH at the point of entry. All referrals will be registered on the clinical database within one working day. If a referral does not include all relevant information (as a Minimum Data Set), it will be returned to the referrer and the clock will not start until a completed referral form is received.
- A clinical review of paper and fax referrals, including triage where required, will be undertaken within 3 working days of the receipt of referral, depending on the clinical urgency of the referral. Those referrals which are not clinically appropriate will be returned to the referrer with explanations for the return and/or further advice for the management of the patient. The referral closure decision will be recorded on the Service's clinical database.

Principles:

The national rules allowing for a maximum of 18 weeks from referral to first definitive treatment will apply for all patients using:

- 'Interface' services or services accessed through a referral management service. This is defined as "all arrangements that incorporate any intermediary levels of clinical triage, assessment and treatment between traditional primary and secondary care."
- 'Consultant led' services defined as a consultant (member of a Royal College or Faculty appointed by a consultant appointment committee) who retains overall clinical responsibility for the service team or treatment even if they are not physically present for each patient's appointment.
- Audiology services.

The over-riding factor in the management of any DNA, cancellation or failed home visit will be the patient's best interests, maximising therapeutic benefit and minimising clinical risk. All DNAs, cancellations and failed home visits should be reviewed on an individual basis and any subsequent action influenced by the needs of the individual patient. Where an individual clinician is in any doubt as to the level of risk presented by an individual patient, advice should be sought from the patient's G.P. or other senior colleagues.

The effective management of DNAs, cancellations and failed home visits for first appointments is reliant upon the provision of adequate information by the referrer. Where services feel it is practical and appropriate, they may wish to agree local standards/guidelines on information to be provided

on referral. Where this is the case, liaison between services is recommended to ensure a standardised approach where possible.

Each clinical service should have in place procedures to minimise the frequency of DNAs, cancellations and failed home visits e.g. require confirmation of attendance for first appointments, provide clear information to patients of how to cancel/change appointments.

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.

Where there are children or adults for whom there are any safeguarding concerns who fail to attend an appointment the referrer should be contacted to advise of the non-attendance as this may result in further action.

The clinician may be required to offer a degree of flexibility with regard to re-booking appointments where this may affect a Child Protection Plan or a Vulnerable Adult Plan - whilst working within the respective waiting times for the service area.

All decisions regarding the follow-up of patients who DNA, cancel or where the home visit fails will be notified to the GP, the referrer, and to any other involved parties/agencies.

Whenever a patient DNAs, this should be recorded both on the relevant computer system and in the patient's medical notes.

Procedures:

Onward Referrals:

- Referrals may be transferred to other services; either after the patient has been seen for the first time or at clinical triage/review, in line with the Service's operational procedures.
- An onward referral must be accompanied by a Minimum Data Set so that the patient's progress on the 'still ticking' 18 week clock can continue to be monitored.
- The receiving and referring providers are jointly responsible for ensuring the 18 week target is met.
- Any transfers into or out of a service must be recorded appropriately on the service's management information system / clinical database.

Offer of an Appointment:

- Offers of an appointment will be made in line with individual service operational protocols by letter, telephone, text or email.
- Patients will be offered appointments within a reasonable notice period. Appointment letters will also include contact details for the patient to re-arrange the appointment if necessary.
- Patients who are unable to attend an appointment within 4 weeks will usually be referred back to the care of their GP/referrer. This means that the GP/referrer retains the clinical risk for the patient, until patients attend their first appointment. Patients should then be re-referred when they are ready to attend within a 4 week period.
- An offer of an appointment date will be considered reasonable by HRCH if the clinic/service is held at any of HRCH sites under the supervision of an appropriate clinical team. Exceptions to this may include patients who need transport or a home visit, the vulnerable and the frail and elderly.
- Once the patient's appointment is agreed, the Service will send a letter to the patient confirming their appointment. As noted above, this will provide information on how to change their appointment if necessary.

Management of Follow-Up Appointments:

- Follow-up appointments should be agreed prior to the patient leaving the clinic / service, where possible and clinically necessary. Where this is not possible, an appointment should be arranged with the patient within 15 working days of the original appointment or in line with individual service operational protocols.

- Follow up appointments include appointments which are deemed 'active monitoring' (aka 'watchful waits') and these will be re-scheduled at the interval required, e.g. for annual reviews. The 18 week clock is paused during this period.

Cancellations by the Service – Clinic / Service Cancellations

Unplanned Cancellations:

The only acceptable reason for any clinic / appointment to be cancelled is due to the unplanned absence of clinical staff, for example due to sickness absence. Clinics / appointments will not be cancelled for any other purpose unless exceptional circumstances arise e.g. as part of a major incident/business continuity plan. Clinic / service cancellations can only be authorised by the appropriate Service Manager.

Planned Cancellations or Rescheduling of Clinics:

- A minimum of two weeks notice is required to reschedule or reduce a clinic / appointment. Patients will be re-booked in order to provide a timely appointment or, where possible, locum cover will be arranged to prevent disruption to the normal service / clinic schedule. Similarly, a minimum of two weeks notice is required to *add* a clinic, to allow adjustments to be made to the clinical management information system.
- Wherever possible a patient who has had their appointment rescheduled by the Service will not be subsequently rescheduled.
- Where cancellations are initiated by the Service, patients will be contacted and offered a new appointment date and time within a maximum of 4 weeks of the cancelled appointment. The clinician will ensure that the referral and any related case notes of cancelled patients are reviewed to prioritise patients with high clinical risk.
- If an appointment is rescheduled with less than 2 weeks notice, telephone, email and first class mail will be used to ensure the patient is contacted and given as much notice as possible.

Patient Cancellations and Rescheduling

- A patient cancellation or rescheduling request occurs when the patient contacts the Service in advance of their appointment stating that they are unable to attend. This includes cancellation on the day, where the patient calls prior to the time of their appointment.
- Patients who attend but who are delayed more than 30 minutes by the Service and who are unable to wait for their appointment should not be included in the category of a patient cancellation. These appointments should be treated as appointments which have been rescheduled by the Service; staff must endeavour to agree another appointment time with the patient before they leave the premises.
- The Service will ensure that the cancellation and rescheduling process is clearly stated in the appointment letter (or other communication methods of confirming appointments) with contact details listed.
- When a patient requests to reschedule their appointment, a further appointment date and time will be offered. *Their 18 week clock continues from their original date of referral (although the diagnostic 6 week clock can be adjusted for patient cancellations of the first appointment).*
- For first appointments this new date will be either prior to the original appointment or within 6 weeks of the original referral date. If there is no available appointment slot to offer within the timeframe, the appropriate Service Manager may be able to make alternative arrangements e.g. with over-bookings or an additional clinic / appointment sessions.
- For follow-up appointments of patients on an 18 week pathway, a new date will be agreed which allows treatment still to be made within the 18 week timeframe.
- HRCH policy is to accommodate one cancellation by the patient for each referral. On the second cancellation, the patient will usually be discharged back into the care of their referrer. The referrer (where different from the GP) and the GP will be sent a letter indicating the reason for the discharge. Exceptions to this will be made for:
- Patients on long-term follow-up or patients in vulnerable groups.

- Cases where the patient is genuinely unable to attend an appointment e.g. illness, caring for a sick relative.
- If the patient has had their appointment rescheduled several times by the Service

In all circumstances, details must be recorded on the clinic database.

On discharge back to the referrer the 18 week clock will stop. If the patient is re-referred, a new 18 week clock will start.

PATIENTS WHO DO NOT ATTEND (DNA) THEIR APPOINTMENT

A patient DNAs when they do not attend their appointment without informing the Service in advance, or they arrive after more than 25% of their appointment time has elapsed and cannot be seen. It is up to the discretion of the service whether patients arriving late can be fitted in or not.

First Appointments

HRCH policy is that patients who do not attend their first appointment, without contacting the Service, will be discharged back to the care of their referrer, unless the patient contacts the service within 10 working days of the appointment and asks to be re-instated. If the patient then DNAs a second time, this will result in discharge to the referrer, without the capability of self re-instatement.

In the event of a DNA at the first appointment, the 18 week clock is stopped. If a patient does not attend their first appointment and are offered a further appointment, their original 18 week clock is nullified when they DNA. A new clock starts at the point from which they agree a new appointment with the Service.

Exceptions to this are as follows:

- For vulnerable patients and those who are unable to make informed decisions, the Service will attempt to contact the patient/parents/carers to arrange another appointment. If the Service fails to arrange an appointment, the clinician and Service Manager will review the patient's case within 5 working days of the DNA and decide appropriate next steps.
- If the clinician expecting the appointment is able to assess from the referral form that the patient is high risk, the Service will take steps as outlined above for vulnerable patients.
- If there is evidence that a Service initiated administrative error has led to the patient's non-attendance, the patient concerned will be contacted to arrange another appointment to take place within 4 weeks of the DNA and the Service will follow the policy for appointment cancellations.
- Safeguarding. Where there are children or adults for whom there are any safeguarding concerns who fail to attend an appointment the referrer should be contacted to advise of the non-attendance as this may result in further action.

The clinician may be required to offer a degree of flexibility with regard to re-booking appointments where this may affect a Child Protection Plan or a Vulnerable Adult Plan - whilst working within the respective waiting times for the service area.

DNA at Follow-up Appointments (for the same treatment)

HRCH policy is that patients who do not attend their follow-up outpatient appointment, without informing the Service, will be discharged back to their referrer and GP with a letter of explanation.

However, patients who contact the service after the DNA within ten working days of the appointment will be treated sympathetically and reinstated. *If a patient is re-instated, the clock continues from the original referral receipt date.*

Patients who DNA a second consecutive appointment will be discharged back to the care of their GP. The patient may be re-referred at the discretion of the GP *and this will start a new 18 week clock.*

Exceptions to this are the same as outlined above for DNA at the first appointment.

- **Patients who become unable to attend follow-up appointments due to long term reasons.**
- **Medically Unfit Patients**

Some patients may become medically unfit after their first appointment and before they have been able to receive treatment. For patients who are medically unfit for a period of 2 months or longer, the patient will be referred back to their GP/referrer with a letter of explanation. *In this case the clock will be stopped.* When the patient is fit to be seen, the GP/referrer may make a new referral.

Patients who develop conditions which can be expected to resolve within 2 months will remain on the waiting list. *In this situation the 18 week clock will continue and the start time will not be reset.* These patients may not receive treatment within the 18 week period and in such cases will be included within the 5% tolerance level allowed.

House Move

Patients who move house during the course of treatment have the option to remain on the waiting list of the Service or be added to the waiting list at a new local Trust, after a new referral from their new GP/referrer. *In the latter circumstances, a new clock will start.* It is important that the two options are clearly explained to the patient to enable an informed decision.

Other Long-Term Deferral Reasons

In exceptional circumstances, some patients may have to postpone their treatment after the first appointment due to other reasons, such as the need to return to their home country, if this is not the United Kingdom, and will not be able to be seen within the normal period of time allocated to a patient re-scheduling request. In this case, the decision of whether to offer the patient a later appointment date will be made by the Service Manager. However, if the deferral is for more than 2 months, the patient will be referred back to their GP/referrer with a letter of explanation, unless the local protocols state otherwise, as in the case of vulnerable patients. When the patient is available to be seen, the GP/referrer can make a new referral.

5. Consultation Process

The HRCH Adults Senior Management Team, HRCH Children's senior managers, HRCH senior Support service managers and the members of the HRCH Quality & Safety Committee provided oversight into this policy's development and comments incorporated as appropriate.

6. Approval and Ratification Process

The initial draft of this policy was sent to Directorate Management Team on 1st May 2013. This initial draft updated policy was sent to the performance team for review and comment on 1st May 2013.

Final approval was given by the Policy Ratification Group on 29th October 2013.

7. Dissemination and Implementation

This document will be placed on the intranet by the QCE team. The QCE team will provide a reference number for the policy.

It will be therefore be available to all staff via the HRCH NHS Trust intranet. Furthermore the document will be circulated to all managers who will be required to cascade the information to members of their teams and to confirm receipt of the procedure and destruction of previous

procedures/policies which this supersedes. Managers will ensure that all staff are briefed on its contents and on what it means for them.

8. Archiving

The QCE team will undertake the archiving arrangements.

9. Training requirements

On ratification this policy will be circulated by the Service Managers for information and implementation.

For training requirements please refer to the Trust's Training and Development Policy and the Training Needs Analysis. The report author will ensure that the Training and Development Policy is updated (if needed) with details of relevant training for the procedural document.

10. Monitoring and Auditing Compliance with the Procedural Document

See Appendix A

11. Review

This procedural document will be reviewed in 3 years' time in 2016. It will be reviewed by AD Operational Support Service and Children's Specialist Services Manager.

12. References

None

13. Associated Documentation

Individual Service Specifications for bespoke waiting times agreed with Commissioners.

14. Appendices

Appendix A – Monitoring and compliance tool.

Appendix B - Equality impact assessment tool

Standard - Compliance Monitoring Table

Element to be monitored <i>(NHSLA minimum requirements must be listed– if you need advice on these please contact the QCE team)</i>	Lead	How Trust will monitor compliance <i>(Data and audit)</i>	Frequency of monitoring	Reporting arrangements	Acting on recommendations and Lead(s) <i>Who/what committee will act on recommendations</i>	Change in practice and lessons to be shared <i>How will changes be implemented and lessons learnt/ shared</i>
18 week waits	Performance / Service Managers	Performance Reports	Monthly	Directorate Management Team Meeting	Service Managers	Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders including the operations manager, responsible managers and duty holder.

Equalities Impact Assessment Pro Forma**This MUST be completed if new policy or strategy.****NAME OF POLICY OR STRATEGY**

Manager's name	AD Operational Support Service and Children's Specialist Services Manager.
Directorate	AD Operational Support Service and Children's Specialist Services Manager.
Date	1 st May 2013
Function, strategy, policy or service	Policy
Main aims, purpose and outcomes of the function, strategy, policy, service or work	Access to Services
How will these aims affect our statutory duty to: 1. Advance equality of opportunity? 2. Eliminate unlawful discrimination, harassment and victimisation? 3. Foster good relations between different groups? 4. Protect and promote human rights?	Fully endorsed Fully endorsed Fully endorsed Fully endorsed
Associated frameworks/NHS Operating Framework mention e.g. national targets NSF's	Yes
Who does it affect? <i>e.g. staff, patients, carers</i>	All groups
Engagement and consultation process carried out (<i>state who was involved, how and when they were engaged and the key feedback</i>)	N/A
What aspects of the policy, including how it is delivered, or accessed, could contribute to inequality?	N/A
What different needs, experiences or attitudes are particular communities or groups likely to have in relation to this policy?	N/A

Please complete the screening assessment grid below for equality groups listed within the Equality Act (2010) and highlight the evidence underlying your assessment. For further help on this please contact the equalities lead Jane Bailey jane.bailey@hrch.nhs.uk or 020 8973 3000

Equality group	Positive impact	Neutral impact	Negative impact	Reason/comment/evidence/necessary action planning following equality analysis screening
Age <i>Consider and detail (including any source of evidence) across age ranges on old and younger people. This can include safeguarding, consent and child welfare.</i>		X		
Disability <i>Consider and detail on attitudinal, physical and social barriers.</i>		X		
Gender Reassignment <i>Consider impact on transgender and transsexual people. This can include issues such as privacy of data and harassment.</i>		X		
Marriage and civil partnership		X		
Pregnancy and maternity <i>Consider and detail on working arrangements, part-time working, infant caring responsibilities</i>		X		
Race <i>Consider and detail on difference ethnic groups, nationalities, Roma gypsies, Irish travellers, language barriers.</i>		X		

Religion/belief (including lack of belief) <i>Consider and detail on people with different religions, beliefs or no belief.</i>		X		
Sex (i.e. gender) <i>Consider and detail (including the source of any evidence) on men and women (potential to link to carers below).</i>		X		
Sexual Orientation <i>Consider and detail on heterosexual people as well as lesbian, gay and bi-sexual people</i>		X		
Others (e.g. carers, homeless people, sex workers)		X		
Human rights considerations	The Human Rights Act contains 15 rights, all of which NHS organisations have a duty to act compatibly with and to respect, protect and fulfil.			
	Yes	No	Neutral	Reason/comment/evidence/ necessary action planning following equality analysis screening
Does the subject of this EIA contribute to encouraging respect for human rights?	X			
Is there any evidence that the subject of this EIA is at risk of unlawfully restricting an individual's human rights?		X		
If so please suggest how these actions will be mitigated				