Access and Waiting List Policy

Emerson Green Hospital and Devizes Surgical Centre

Controlled document

This document is uncontrolled when printed

Reference number	AO 1S
Version	1.3
Author	Operations Manager
Date ratified	February 2019
Committee Responsible for Ratification	Clinical Governance EGD
Ratification / Issue date	August 2023
Review date	August 2025
Target audience	EGD Patient Administration, Clinical Commissioners

Document History

Version	Author	Revision Comments

CONTENTS

1 Objectives

As originally set out in the Revision to the Operating Framework for the NHS in England 2010/1, performance management of the 18 weeks waiting times target by the Department of Health has ceased, however, referral to treatment (RTT) data will continue to be published and monitored.

Standards and quality should be maintained pending the development of more outcomes-focused measures. Patients would not expect a return to long waiting times for operations (http://www.18weeks.nhs.uk/)

The length of time a patient needs to wait for hospital treatment is an important quality issue. Treating patients quickly is clinically beneficial and acts as a visible public indicator of hospital efficiency; all of which is key in making the hospital and surgical centre a surgical facility of choice.

The objective of this policy is to ensure patients are treated as soon as possible and within agreed contracted timescales. It promotes efficiency through the introduction of good practice, waiting list management systems and processes, plus emphasises individual accountability and responsibility.

This policy provides support to staff (medical, nursing, managerial and clerical) in the delivery of effective waiting list management and meeting patient needs and expectations.

This policy provides a framework for Practice Plus Group (as Emersons Green Hospital and Devizes Surgical Centre (EGD)) and the commissioners to work collaboratively to ensure that the Integrated Commissioning Board (ICB) is able to deliver their waiting times targets.

2 Scope & Definition

This policy will apply to all staff within EGD who are involved with waiting list management from referral into the hospital or surgical centre until discharged from the system. The policy will be followed by all clinical and non-clinical staff.

The policy and its application are essential to meeting the 18 week, or any other agreed elective surgical timescale. These are essential targets and form one of the ICB's key priorities and objectives.

EGD also forms an important part of the Two Week Urgent Referral pathway for suspected cancer and as such fulfils its obligation to ensure that relevant patients are referred into the relevant multidisciplinary cancer team within 24 hours of diagnosis/ receipt of histology.

This policy covers:

Access to EGD services for which an appointment is required. The milestones in the pathway from receipt of referral through to completion of investigations and/or elective treatment and discharge back to GP. The management of patients who are unable to attend within a given time, not available for treatment and those who are not medically fit, previous suspends, DNA's in line with national policy outlined within The Referral to treatment consultant-led waiting times: rules suite (October 2022) published by the Department of Health and Social Care in January 2012, last updated on 27th October 2022.

- Guidance derived from the refreshed 18 week rules as shown above.
- Good practice in relation to systems and processes of waiting list management including booking. This policy seeks to standardise & monitor good practice across EGD through the implementation of business processes.
- The 18 week waiting time contractual targets for EGD
- The 6 week national diagnostic targets

(See Appendix 1 for Patient Exclusions.)

3 Responsibilities and Accountabilities

Hospital Director
It is the responsibility of the Hospital Director to have processes in place to oversee, supervise and monitor the application of this policy by staff outside of the booking team environment, so that all patient transactions comply with the policy requirements. The Hospital Director for the EGD has ultimate responsibility for ensuring contractual compliance including waiting time targets.

Operations Manager (also represented at Devizes by General Manager) (OM)
The Operations Manager, assisted by the Administration Manager has the responsibility for developing, applying and monitoring the Standard Operating Procedures (SOPs) on a regular basis. Also has responsibility for preparing reports as requested by the ICB. The Operations Manager is accountable for ensuring that the schedules meet capacity and demand to reduce waiting times and therefore RTT's

The Administration Manager has overall responsibility for the management of waiting times and breach reporting.
The Administration Manager will work with the lead booker to ensure that maximum utilisation of outpatient and theatre lists is achieved which will ensure patients are treated within the 6/18 week RTT dependent upon referral type. They will ensure accurate documentation of clock stop//start within the RTT intervention page of Maxims and will work closely with the Business Intelligence Team (BI) to achieve accurate reporting.
The OM will be responsible for the training of all the administrative staff in the use of the RTT intervention page, achieving and evidencing competence.

Lead Booker
The Lead Booker is responsible for the management and dissemination of the weekly speciality specific waiting work lists. In addition to this they must ensure that all administration staff are competent in the use of the RTT intervention form and the national RTT rules.
Is responsible for fully utilising outpatients and theatre lists and highlighting any issues of under booking/not enough capacity to the OM

All Administration Staff
The application and implementation of this policy is the responsibility of all staff who undertake patient administration activity. The Patient Booking team (PBT) are responsible for their own speciality and they use the weekly speciality specific waiting work lists to prioritise patients booking within RTT. They are expected to accurately capture all variances to the patients pathway within the RTT intervention form on maxims and to escalate any capacity and demand issues to the Lead Booker to prevent patients knowingly being booked outside of RTT

Clinical Staff
All clinical staff will support the treatment of patients within the agreed contracted time frame ensuring that patient choice, clinical priority and length of time waiting are all considered as appropriate for each individual patient.

4 Process

Introduction

EGD will provide clinical services in a manner consistent with the NHS commitment to the application of the rules related to the 18-Week Waiting Times, the contractual 18 week rule (or any other agreed Waiting Time period), the 6 week diagnostic rule and as part of the 2 week urgent referral pathway.

All patients must be managed and treated within the agreed pathway of time. The exception to this rule is if the patient chooses to receive treatment outside the agreed pathway of time.

Any patients who are not managed and treated within the 18 week pathway, or have not got a documented exception, will be reported as breach patients, to the referring ICB. Any patients who are

not managed and treated within the 6 week diagnostic pathway will be reported as breach patients to the referring ICB

The process of waiting list management will be transparent.

- Communication with patients should be informative, clear and concise and documented.
- Patients will have access to this policy and should be aware of their responsibilities.
- The Patient Administration (Maxims) system must be used to administer all waiting lists, both inpatient and outpatient for all patient groups.
- All administration and relevant clinical staff will use the RTT intervention page of maxims to capture any variances to the patient pathway
- BI will use the information recorded within the RTT intervention page to populate the comments section of the RTT work list.
- Training will include technical support training provided for the Maxims patient administration system to all identified administration and clinical staff,

EGD will offer patients a choice of appointments within a reasonable timescale. Reasonableness is defined as:-

- For patients where the decision to admit for treatment has been made they must be offered THREE dates. Two of these should be offered with at least two weeks' notice. These must be recorded. All dates offered should be recorded on the Maxims system under the individual patient.

All correspondence with patients, e.g. appointment letters, will explain how to change appointments and the impact of a cancellation or DNA.

EGD will ensure that all decisions regarding the discharge of patients, including any subsequent clinical decisions are recorded within the patients' notes and on the relevant MAXIMS.

A patient's waiting time is calculated from the date of the new referral from the GP or other referring body as agreed with the commissioners. This starts the clock. The clock will stop once the start of definitive treatment occurs (this may be a course of medication prior to surgery) or the patient is discharged back to the GP.

Treatment is defined as the start of the first treatment intended to manage the patient's disease, condition or injury and includes:

- Drug therapy
- Advice and guidance
- Minor procedure undertaken in outpatients where relevant to the original treatment plan
- The clock will not stop where a diagnostic procedure is performed as part of the treatment plan for example: a Sigmoidoscopy pre HALO procedure
- Inpatient (IP)/Day Case (DC) admission for a treatment procedure.

Direct access for patients with GP referrals is available and the directory of services is maintained with adequate capacity to allow choice.

There are occasions when for clinical reasons the 18/6 week clock may be stopped and this is referred to as 'active monitoring'. This can be appropriate for the EGD environment in certain circumstances, and patients who are temporarily not fit for surgery (up to 4 weeks) can be treated in collaboration with their GP, and the EGD clock for these patients will stop until the GP informs EGD that the patient is fit to proceed. If the period for monitoring is likely to be extensive, the patient will be returned back to their GP with an explanation from the consultant that it is not clinically appropriate to start a prolonged period of monitoring in the EGD environment and patient record will be outcomed as end of care
If there is a clinical reason indicating that it is not appropriate to continue to treat the patient at this stage, but to refer back to primary care for ongoing management, then this is seen as a decision not to treat and should be recorded as a clock stop. This will be documented on the Maxims RTT intervention page.

A patient should be offered a date for surgery if:

- There is a sound clinical indication for surgery
- The patient is clinically ready and available to undergo surgery
- The patient has agreed to undergo the procedure within the interval discussed by the clinician.

National Diagnostic waiting times and activities
Who to include; Include all patients waiting for a diagnostic test/procedure funded by the NHS.

Who to exclude; Exclude the patient who is waiting for surveillance or a planned diagnostic test/procedure. The patient who is waiting for a procedure as part of a screening programme and the patient who is currently admitted to a hospital bed and waiting for an emergency diagnostic procedure as part of an inpatient treatment.

How to count the waiting time; Clock starts when the request for a diagnostic procedure is made.
Clock stops; when the patient receives the diagnostic test /procedure.

If the patient misses or cancels **their procedure** appointment for a diagnostic test/procedure then the waiting time for that test/procedure is set to zero and the waiting time starts again from the date of the appointment that the patient cancelled/missed. Similarly if a patient turns down reasonable appointments, ie two separate dates and three weeks notice, then the diagnostic waiting time for that test/procedure can be set to zero from the first date offered. The RTT intervention form is designed to capture this information.

Patients waiting for more than one diagnostic test/procedure
Patients waiting for two separate diagnostic tests/procedures concurrently should have two independent waiting time clocks, one for each test /procedure.

Referrals for bilateral procedures
Patients can only be booked for surgery for one procedure at any one time. Patients requiring bilateral procedures at separate times (e.g. cataract procedures), will have an 18 week pathway clock start for the first procedure and once this has been completed and the consultant has assessed that they are clinically fit to proceed with the second procedure, then they will commence a new 18 week pathway with a clock start from this decision. The new suitable for surgery date will be the new clock start date.

Once the first procedure is undertaken and the patient is fit and able to proceed, the second operation is booked to occur when clinically indicated or within an interval specified by the consultant.

Multiple Procedures
If a patient requires a number of procedures for the same condition (not a bilateral procedure), then the clock will stop at the time the first treatment occurs. The subsequent treatments will be planned and scheduled when the patient is clinically fit. These procedures will not be measured for waiting times as their treatment had already commenced and the 18/6 week RTT clock stopped.

Patients can only be listed for one procedure at any one time. If patients are on waiting list elsewhere for surgical procedures then the GP must decide (this may be in conjunction with the Consultant) which

is the clinically more urgent and once this procedure is completed, then the GP must re-refer for the next procedure. In this circumstance the RTT clock would be stopped and the RTT intervention form completed

When patients are not fit for surgery

Where patients are identified as not fit for surgery at EGD, during pre-screening / preoperative assessment (POAC) (or at a later stage) they will be returned to the GP. However, in some cases it is reasonable to allow patients with a minor acute illness time to recover, for example:

- When further tests are required pre operatively due to an existing or new condition discovered at POAC
- When a patient is found to be unfit on the day of surgery and is clinically cancelled
- When a patient cancels their theatre appointment due to illness
- When a patient is found to be MRSA positive at POAC, follow MRSA treatment protocol
- When a patient is found to have a UTI at POAC, follow UTI treatment protocol
- When a patient is found to hypertensive at POAC -
- When a patient requires a course of physiotherapy lasting less than 4 weeks (at EGD)

At this point a decision needs to be made to decide weather the patient following treatment/further investigation from their GP will be fit for surgery at EGD under the exclusion criteria. If they will not be then the referral needs to be marked end of care, the clock stopped and a comprehensive letter needs to be sent to the GP and the patient.
If they will be fit for surgery following treatment/further investigation from their GP then the RTT intervention form will be completed appropriately.
When EGD receives confirmation from the GP that the patient is now fit to proceed the Outpatient / Patient Experience Team will be responsible for completing a new fit for surgery assessment in Maxims marking the patient not fit and recording reasons why in the comments box. These patients will be managed weekly using the 'not fit not / suitable work list'. If the patient remains not fit for a period of 4 or more weeks the referral will be returned to the GP with a letter. The referral will be marked end of care within Maxims, the RTT clock will be stopped on the RTT intervention page and the ICP will be closed. Every attempt to gain information from either the patient, GP or other medical professional will be documented within the admin notes in the ICP throughout this time. This is important for audit purposes.

The RTT intervention page has been developed to process map the patients journey from the point of entry to point of exit within the 18 and 6 week pathways. It ensures that agreed outcomes are met and establishes the operational working processes and outcomes required for each of the key stages of the patient's journey.

Clear responsibilities are allocated to individual roles within the EGD team within the process.

Each week a scheduling meeting is held which reviews capacity, demand and waiting times. Any decisions to alter capacity to manage changing demand are made during these meetings. This is a multidisciplinary team meeting to ensure that all relevant personnel are involved in decision making. Departmental representation by an appropriately senior staff member is mandatory.

The Maxims Electronic Patient Record supports a "push" and "pull" workflow through alert screens at time of booking if the booking is made outside agreed timescales. It generates daily "work-lists" for management to ensure referrals are speedily processed.

Referral Management

Referrals for EGD will be received by the EGD Patient Bookings Team (PBT) either as manual referrals or as a Directly Bookable Service through the NHS Electronic Referral System (ERS). Other referrals

may be received manually, by fax, by secure e-mail, by post or phone. Phone referrals must be followed up with a written referral.

Services provided will be listed on the Directory of Services on ERS as either Indirect (IDBS) or Directly Bookable Services (DBS) as directed by the coordinating commissioner.

Manual referrals are loaded onto the Maxims by the PBT. Maxims automatically sends the record of the referral to an "*Awaiting Triage*" work list. Once reviewed and accepted by triage these referrals automatically move onto another work list called "*Awaiting Consultation Appointment*". The PBT review this work list and contact the patients to arrange a first appointment. If the PBT are unable to speak to the patient directly on the first attempt, an appointment letter is sent out to the patient.

Referrals received via ERS will automatically transfer to Maxims and be placed on the "*Awaiting Referral Letter*" work list. The PBT will scan and import the referral letters from ERS and save them against the relevant patient record on Maxims. Once the patient record has been created and the referral letter uploaded to the patient record, the referral will transfer to the "*Awaiting Triage"* work list for triage/acceptance. If no referral letter has been received, the referral will remain on the "*Awaiting Referral Letter*" work list and followed up by the PBT. In the event of the referral letter not been received up to 5 business days before the First Outpatient Appointment, the PBT will escalate the decision to reject the referral to the PBT Lead.

Procedure for Clinical Triage Process

The Triage Nurse is responsible for performing the triage of the patient's referral. The triage nurse works from the Maxims "*Awaiting Triage"* work list to assess the suitability of all referrals (including administrative data and clinical criteria). All referrals will be assessed within 2 business days of receipt. If the referral does not have all the required information, the Triage Nurse will flag the referral for review and contact the Referring Clinician either by phone or by using the 'Request for Information' pro-forma as soon as is practicable and at all times within 2 business days of receipt of the referral.

Second Opinion

If the Triage Nurse is unsure as to the suitability of the referral, he/she will request a second opinion from the Lead Consultant.

Rejection of Referral

The agreed Exclusion Criteria (with the ICB) provides the basis for accepting and rejecting patients. This includes both administrative and clinical parameters for rejecting a patient.

In the event that the patient rejects the facility and no longer wishes to continue with their treatment at EGD, the patient will be cancelled, along with all associated appointment arrangements and be referred back to their referring clinician. EGD will notify the referring clinician by letter.

If administrative information required for the patient is missing then EGD will make reasonable attempts to obtain this from the referrer. If this information is not forthcoming, and based on a risk assessment it is felt that it would not be clinically appropriate to see the patient, then the patient will be rejected.

All rejections at triage are documented and are reported to the Contract Manager at the ICB within the quarterly reports.

Unable to Contact Patient

Where a patient does not respond to a letter to agree a date for an appointment, at any stage of the referral to treatment pathway, the patient will be discharged and returned to the referrer and the clock will stop. The timeframe for applying this rule is 2 weeks. EGD will write to the referrer to request a new referral should treatment be required.

Procedure for OPD Booking Process: for Direct ERS Referrals

The PBT will, on a daily basis, ensure each patient is mailed a First Outpatient Appointment confirmation letter confirming the date, time and location within 2 days of receipt of the referral.

Where a patient's appointment may not leave sufficient time for the letter to reach the patient, the PBT will confirm all instructions telephonically with the patient.

Non ERS or Indirect ERS referrals

Accepted referrals will be placed on the "*Consultation Appointment Required"* work list. The PBT will on monitor and action this work list on a daily basis and ensure each patient on the list has been contacted to arrange for a First Outpatient Appointment.

The PBT will ensure that all patients referred will be contacted either by telephone or in writing within 2 business days of the receipt date to agree a date, time and location for their First Outpatient Appointment. The PBT will offer the patient a choice of 3 First Outpatient Appointment dates, and a choice of times within those dates.
If the patient requests an appointment more than 6 weeks after the receipt of all patient referral information, the First Outpatient Appointment will not take place later than the requested date and the PBT will document this as patient choice.

The PBT will confirm all appointment arrangements with the patient in writing within 2 business days of agreeing the First Outpatient Appointment. If it is not possible to agree the appointment date with the patient within six weeks of EGD receiving the referral, the referral will be cancelled and returned to the Referring Clinician.

Procedure for Re-Schedule / Cancellation of OPD Appointment / Procedure Process – By Patient: Indirect Choose and Book

All patient requests for re-scheduling and cancellation of appointments prior to their First Outpatient Appointment will be dealt with by the PBT. At the time of making their original booking, the patient will be given the PBT contact telephone number – (staffed between 09.00 and 17.00 during weekdays).

The PBT will offer the patient 2 alternative appointment dates. If the appointment date cannot be agreed, the patient will be referred back to their referring clinician. The Referring Clinician will be notified in writing of the cancellation. The patient will also be sent a letter confirming the cancellation and be instructed to contact their Referring Clinician for further advice. If the appointment date is agreed however is not within the appropriate RTT timeline, the PBT must document this in the patient record as patient choice. Any changes made to the original First Outpatient Appointment date will be followed up in writing no later than 2 business days after agreeing the new date.

Procedure for Re-Schedule / Cancellation of OPD / Procedure Appointment Process – By Patient: ERS

As this is an automated system the booking and cancellation of appointment is managed differently to non ERS appointment.
The patients will re-schedule/cancel their First Outpatient Appointment by using one of the following methods:

- ERS website
- Telephone Appointment Line

Patient Scheduled to Attend for First Outpatient Appointment

On the day of the scheduled First Outpatient Appointment, the Reception team will document the patient's attendance in Maxims. Should the patient not attend (DNA), the Reception team will record the patient DNA against the clinic appointment and the RTT intervention page in Maxims. They will attempt to call the patient to understand if the appointment is still required. If they are unable to talk to the patient a DNA letter is sent to the patient asking them to contact the PBT within 7 days to rebook their appointment. Following the First Outpatient Appointment, the patient will either be booked for surgery or recorded as "Unfit/surgery not required". These patients will appear on the not fit not suitable weekly work list supplied by the BI team to ensure that they do not get lost in the system.

The Reception team will monitor and action the "*DNA work list"* daily and attempt to make contact with any patient that did not attend their appointment. The PBT Staff will notify the Referring Clinician in writing within 1 business day of the patient's non-attendance. The Reception team will make reasonable efforts, including not less than 3 attempts over 2 consecutive business days and at different times to contact the patient to re-arrange their appointment. As a minimum one call will be made after 18.00. At all times the reception team will monitor the DNA list to ensure patients do not exceed the 7 business day period from date of letter sent. If contact can be made, the Reception team will offer the patient 3 alternative appointment dates. If the appointment date cannot be agreed, the patient will be cancelled and be referred back to their Referring Clinician. If the appointment date is agreed however is not within the appropriate RTT timeline, the Reception team will inform the PBT to discharge patient back to GP and refer when patient is ready to proceed as patient choice.
In the event that all contact attempts have failed and the patient did not respond to the DNA letter, the patient will be cancelled and notified in writing to contact their Referring Clinician for further advice. The Referring Clinician will also be notified in writing of the patient cancellation due to a DNA.

After a patient has DNA/Cancelled twice they may be discharged back to GP by PBT who will send an email to the Medical Secretaries to write a letter to GP explaining why we could not proceed. This is not a blanket term and each case will be looked at individually. Reception Team to nullify clock in RTT intervention page.

Two week pathway – urgent referral to cancer MDT

Any patient who is reported, whilst attending EGD, as having malignant pathology will have their results immediately faxed to the appropriate multi-disciplinary cancer team headed "fast track". This ensures that the alert is received by the appropriate team within 24 hours of EGD becoming aware.

The Clinician in charge of the case then personally telephones:

- Receiving Clinician
- and Patient

to discuss the case. A fast track referral will be sent to the relevant cancer MDT at the relevant Trust, copied to the referring clinician and/or the patient's GP informing them of the situation. In the event of unexpected malignant histology being received post patient discharge; the consultant will telephone the GP. It is likely that the GP may speak with the patient to inform them of diagnosis but this is only on agreement between GP and consultant, but a fast track referral is made by the EGD consultant in all cases.

Inpatient and Day case Admissions

A patient requiring inpatient or day-case admission will be given at least 2 reasonable offers of an admission date within the appropriate RTT target. A reasonable offer to patients, at the inpatient or day-case admission stage of the pathway, is defined as the offer of any number of appointment dates and times, at least 2 of which must be 2 or more weeks in the future and within the appropriate RTT target. Any appointment within 2 weeks that is mutually agreed between a patient and the Provider is automatically regarded as being reasonable. Where a patient declines, at the inpatient or day-case admission stage, 2 or more reasonable offers of admission date they should be appointed for a date of their choice and the decision details recorded.

Provider Cancellation of Appointment or Procedure

Means the cancellation by the Provider (acting reasonably) of a Patient Procedure Appointment by notice to the NHS Patient more than forty-eight (48) hours before the Appointment is scheduled to take place due to Rejection.

In Direct ERS only the PBT will be allowed to re-schedule Provider Cancellations for First Outpatient Appointments as this will require access to the original ERS referral. Where there is an operational need by EGD to cancel and re-schedule the patients First Outpatient Appointment, the PBT must escalate the request to the Booking Team Lead. The Booking Team Lead will instruct the PBT to action the necessary cancellation and re-booking of the patients First Outpatient Appointment.

In the event of EGD initiating a change of patient appointment, the PBT will contact all patients by telephone in the first instance and rebook the patient. Patients will be rebooked within the agreed timeline. Should the patient not be reached by telephone, the PBT will send a new appointment letter to the patient and provide an explanation as to why the original appointment has been rebooked. The letter will also inform the patient that should this new appointment date and time not be convenient, to contact the PBT to rebook the appointment at a date and time that is convenient to the patient, however always within the agreed timeline.

5 Monitoring Effectiveness & Review

The OM and Lead Booker will conduct a weekly review of the work lists supplied by BI to ensure that patients referrals are being appropriately managed and identified any areas where remedial training is required.
The OM will review all RTT intervention form content bi weekly in a report supplied by BI
EGD will review waiting times, theatre and outpatient utilisation on a weekly basis, to ensure that all patients can be treated if they are fit, willing and able within the 18 week pathway, (6 week pathway for Endoscopy or other diagnostics).

If any changes are made this policy will be updated and the version number changed, with the changes highlighted in a separate document /statement to ensure staff are made aware of all changes made and amend practice as appropriate.

This policy will be reviewed after a period of 2 years or sooner should new evidence for practice become available.

6 Related Policies, Documents and References

1. http://www.nhs.uk/choiceintheNHS/Rightsandpledges/Waitingtimes/Pages/Guide%20to%20waiting%20times.aspx (Last accessed 27.09.13)
2. Diagnostics waiting times and activity
3. RTT intervention user guide
4. NHS constitution
5. Patients charter
6. EGD exclusion criteria
7. RTT national rules suite

7 Appendices

Appendix 1
Patient Exclusions

The right to wait no longer than 18 weeks from initial referral by a General Practitioner to the start of receiving treatment does not apply to:

- Patients who are not on an 18 week pathway.
- Patients who are registered with a GP in Northern Ireland, Scotland or Wales. This policy only applies to England and the right applies to patients referred to a service commissioned by an English ICB.
- Patients who do not attend (DNA) an agreed appointment, or rearranged appointment, without giving prior notice where the date of the original appointment offered was reasonable. While the NHS should make every effort to treat these patients within the waiting time standard and offer redress if this is not met, it is not possible to guarantee this in these cases. Commissioners and providers should ensure local access policies, detailing the consequences of not turning up to appointments, should be available to all patients and published. These policies should be consistent with the national 18 weeks rules suite. Patients who give prior notice when cancelling or rearranging their appointments in advance should not be classed as DNAs.
- Patients who refuse treatment. The reasons for the refusal of treatment by the patient, or someone acting lawfully on their behalf, should be recorded.
- Patients who choose to wait longer than 18 weeks for their treatment, and they had been offered a reasonable date to attend an appointment at the provider.
- Patients who are unable to commence treatment within 18 weeks (for reasons not related to the relevant commissioner or provider) where they had been offered a reasonable date to attend an appointment at the provider. This exclusion should apply in limited circumstances only, for example, a reservist posted abroad who was unable to commence routine treatment.
- Patients for whom it is not clinically appropriate to start treatment within 18 weeks.
- Patients who do not require treatment following clinical assessment.
- Patients who are referred back to primary care services to receive treatment.
- Patients who require active monitoring following assessment.
- Patients who are placed on a national transplant waiting list following assessment.

8 Equality Impact Assessment

		Yes/No	Comments
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:		
	Race	No	
	Ethnic origins (including gypsies and travellers)	No	
	Nationality	No	
	Gender	No	
	Culture	No	
	Religion or belief	No	
	Sexual orientation including lesbian, gay and bisexual people	No	
	Age		
	Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	

		Yes/No	Comments
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	N/A	
4.	Is the impact of the policy/guidance likely to be negative?	No	
5.	If so can the impact be avoided?	N/A	
6.	What alternatives are there to achieving the policy/guidance without the impact?	N/A	
7.	Can we reduce the impact by taking different action?	N/A	