NHS Greater Glasgow and Clyde	**Paper No. 24/39**
Meeting:	**NHSGGC Board Meeting**
Meeting Date:	**30 April 2024**
Title:	**NHSGGC Access and Waiting Times Policy**
Sponsoring Director/Manager:	**William Edwards, Chief Operating Officer**
Report Author:	**Susan McFadyen, Director of Access**

1. Purpose

The purpose of the attached paper is to:

- Seek approval for the changes to the NHS Greater Glasgow and Clyde Access and Waiting Times Policy in line with the updated National Waiting Times Changes 2023 including revised National guidance and National Policy.

2. Executive Summary

Key changes to the policy can be summarised as follows:

- A reasonable offer of appointment will now require patients to be given 10 calendar days' notice, previously 7 calendar days.
- A reasonable offer of appointment will now be at any appointment across NHSGGC, Golden Jubilee National Hospital (GJNH) and NHS Forth Valley National Treatment Centres.
- Three stage waiting list validation should be progressed for all patients on a waiting list on a regular and continuous basis and should not exceed 6 months where possible.
- The timeline for patient focussed booking has been increased from 14 calendar days (7 days after initial communication and a further 7 days from reminder) to 21 days (14 calendar days after initial communication and a further 7 days from reminder).
- Implied acceptance has been included, indicating that where an appointment date is sent to a patient and there has been no response within 10 calendar days then it is assumed the patient has accepted the appointment.
- AHP MSK unavailability should be applied when a registered medical or healthcare practitioner indicates the patient needs a period of time before AHP MSK rehabilitation/intervention is undertaken.
- Patients waiting times clocks are now fully adjustable regardless of the patient's length of wait.

- Following presentation at Corporate Management Team Board Meeting on 7th March 2024 the following changes were made to the policy.

- The policy now references Realistic Medicine (RM) and Value Based Health and Care (VBH&C) having been a key consideration during the review and update of the policy *(Section 1.6, page 3).*
- Support for travel arrangements to sites both within and outwith the board have been expanded, detailing options available to patients *(section 5.3 page 8).*

Other points to note:
NHSGGC are required to submit an implementation plan to Scottish Government detailing timelines, actions and risks in relation to the implementation of the national changes. The implementation plan has been tabled for reference. It details challenges in relation to the following areas.

- National changes are required to TrakCare by InterSystems to support the changes listed below. there is currently no plan or timeline for the implementation of these changes;
  - System change to allow patients clocks to be reset or adjusted where the 12 weeks treatment time guarantee has passed.
  - System change to allow the resetting of patients clocks for urgent patients where appropriate.
  - System change to allow recording of all clock adjustments so that patient waits can be reported accurately and fully. Without a national solution to manage the flow of information across boards, this will impact the accuracy of reporting of patient waits to the Waiting Times Datamart for all NHSGGC patients who are seen/treated out with the board.

3. Response Required

This paper is presented for approval.

4. Impact Assessment

The impact of this paper on NHSGGC's corporate aims, approach to equality and diversity and environmental impact are assessed as follows: *(Provide a high-level assessment of whether the paper increases the likelihood of these being achieved.)*

- **Better Health** **Positive impact**
- **Better Care** **Positive impact**
- **Better Value** **Positive impact**
- **Better Workplace** **Neutral impact**
- **Equality & Diversity** **Positive impact**
- **Environment** **Neutral impact**

5. Engagement & Communications

The changes highlighted in this paper were subject to the following engagement and communications activity:

- Communication with; Acute Directors, General Managers and Chiefs of Medicine and Nursing. Corporate Management team members. Reviewed across eHealth directorate.
- Presented at the Primary/Secondary Care Interface Group.
- Presented at Directors Access
- Presented at Acute Strategic Management Group.
- Presented to CMT
- Presented at Finance, Planning and Performance Committee.
- Reviewed with Public Engagement team and Comms.

6. Useful Links

- NHS Scotland: national access policy 2023
- NHS Scotland waiting times guidance 2023
- NHS Scotland Waiting Times Guidance DL (2023) 32
- NHS Scotland Waiting Times Patient Information Leaflet 2024
- NHSGGC Financial Operating Procedure, Patients Travelling Expenses Scheme.

Access and Waiting Times Policy

DRAFT 15/04/2024 V12.0

Policy Lead	Chief Operating Officer, Acute Services	
Responsible Director	Director of Access	
To be approved by:	Directors Access	19th February 2024
	Acute Strategic Management Group	29th February 2024
	Corporate Management Team Board Meeting	7th March 2024
	Corporate Management Team Board Meeting	4th April 2024
	Finance, Planning & Performance Committee	9th April 2024
	NHSGGC Board Meeting	30th April 2024
Date for Review:	Approval Pending	
Replaces Previous Version	NHSGGC Access Policy (approved 2015)	

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1 Policy Statement and Rationale

1.1 The NHS Greater Glasgow and Clyde's (NHSGGC) Access and Waiting Times Policy has been developed to provide a common vision, direction and understanding of how NHSGGC will ensure equitable, safe, clinically effective, and efficient access to services for their patients.

1.2 The policy sets out key principles that will help ensure that required systems and processes are in place to optimise the use of facilities and available capacity to deliver high quality and safe patient care in a timely manner.

1.3 NHSGGC is committed to ensuring patients receive treatment in accordance with national objectives and targets.

1.4 The policy is designed, considering the Patient Rights (Scotland) Act 2011, to ensure fair and equitable access to services within national waiting times standards. Current national waiting times standards are:

- 6 weeks for the eight key diagnostic tests and investigations.
- 12 weeks from referral to first appointment for 95% of patients.
- 18 weeks from referral to beginning treatment for 90% of patients.
- 12 weeks from the patient agreeing treatment with the clinician to treatment for inpatient or day case treatment starting (Treatment Time Guarantee).
- 62 days from referral to beginning treatment for 95% of patients referred urgently with a suspicion of cancer.
- 31 days from decision to treat to beginning treatment for 95% of patients diagnosed with cancer.

1.5 The policy is set out to act as an operational guide for all staff involved in the management of patients on a consultant waiting list. It outlines roles and responsibilities and processes to be followed to ensure the effective management of patients who need to attend hospital as an outpatient, inpatient or day case or to access diagnostic services.

1.6 The principles of Realistic Medicine (RM) and Value Based Health and Care (VBH&C) have been considered whilst developing this policy. Our aim is to continue to ensure that the practice of RM enables the delivery of VBH&C across NHSGGC. Our approach will focus on areas such as, clinical sustainability, shared decision making, and future care planning and further growing the practice of RM which underpins VBH&C. We recognise the importance of the Scottish Government VBH&C Action Plan and associated vision and will continue to ensure local work is aligned to those principles.

2 Key Principles

2.1 Patient Need

- The needs of the patient should be paramount.
- Patients should be offered care according to clinical priority and within agreed waiting time standards.
- Improvements in waiting times should be delivered through an effective partnership between Primary and Secondary Care, with appropriate systems, processes and documentation in place.

2.2 Operational

- NHSGGC will work collaboratively to match capacity with demand as much as possible, to ensure patients are seen as quickly as possible.
- As far as possible, patients should be seen within agreed waiting times standards, and those with the longest wait will be prioritised, along with those who are most clinically urgent.
- All urgent cancer referrals should be seen as soon as possible within the cancer waiting times standards.
- Referrals should be managed effectively, using Active Clinical Referral Triage (ACRT) within agreed timescales, recording outcomes electronically.
- Referrals should be made to a clinical team and will be seen by an appropriate member of that team rather than a named individual.
- Sufficient capacity should be optimally utilised to deliver waiting times.
- There are only two reasons why a patient may be unavailable for treatment: medical reasons or patient advised reasons. Patient advised unavailability can only be applied at the request of the patient and must not be prompted by NHSGGC staff.
- Patients should only be added to a waiting list when they are deemed fit, ready and able to attend appointment and/or treatment dates. Services may consider deploying a pre-listing procedure to ensure patients are fit to proceed to treatment, however this is not a requirement.
- Reasonable offers will be made as soon as possible after receipt of referral and patients will receive a minimum of ten calendar days' notice before the date of the appointment or admission.
- Three stage waiting list validation should be embedded across all specialties.
- The provision of day case and short-stay surgery should be maximised.
- Admissions to hospital should be actively managed through pre-assessment services.
- Effective patient booking practices and systems should be in place to maximise capacity.
- All patients must be advised of any delay to their outpatient appointment as soon as possible. If there is a delay caused by the service, which is longer than the patient could be reasonably expected to wait, this would be classed as 'cancelled by service'. A reasonable wait would be anything up to 30 minutes.

2.3 Accessibility

- While the vast majority of NHSGGC patients will be seen within their local area, care may also be delivered through another Health Board, National Treatment Centre or suitable alternative provider.
- Patients should be advised as early as possible if they need to travel for their appointment or treatment.
- Patients should be advised that they may be eligible for reimbursements of costs reasonably incurred for travel to an appointment and/or treatment within NHSGGC in line with the NHSGGC Financial Operating Procedure, Patients Travelling Expenses Scheme.
- Scottish Ambulance Service criteria will be applied to support eligible patients to attend appointments.
- NHSGGC should aim to achieve inclusive and equal access for all service users.
- A reasonable offer for first outpatient assessment and inpatient/day case admission is;
  - when at least 10 calendar days' notice is given
  - An offer of appointment within NHSGGC, Golden Jubilee National Hospital and NHS Forth Valley National Treatment Centres (NTCs). Patients will be offered an appointment that is closest to them geographically that will allow them to be seen in the quickest time
  - when the mode of contact used for the appointment is accepted by the patient e.g., face to face, video, phone call
  - regardless of whether it is offered pre or post guarantee date; and
  - when a short notice offer is verbally accepted by the patient.

2.4 Improvement

- NHSGGC will work to understand the reasons why patients do not attend their appointments, and what support can be provided to reduce non-attendance of agreed appointments.
- Reduce follow-up appointments that are not clinically necessary.
- Feedback should be used to facilitate improvements in service provision.

3 Communicate Effectively with Patients

NHSGGC will ensure that:

- Patients are provided with sufficient information about their treatment to facilitate an informed discussion in the decision-making process.
- Patients are provided with clear, accurate and timely information about how processes will operate as close to the beginning of their journey as possible.
- Patients are provided with information they can easily understand, and that appropriate support is put into place as required.
- Communication with patients is in a format appropriate to their needs e.g., large print, community language, and in a method agreed by them i.e., letter, phone or digitally.
- Patients are given clear instructions on how and when to contact the hospital to either accept or decline an appointment and/or admission date, and the timeframe in which to do this.
- Communication is sent to all patients who are added to an inpatient/day case waiting list for treatment advising that they have been added to the waiting list and identifying

the expected wait time for treatment presented as “9 out of 10 patients have been seen in (x specialty) within (x weeks) in the last 3 months”.

- Where it is anticipated that NHSGGC will be unable to meet the patient’s treatment time guarantee (TTG) the patient will be offered an apology with the reason(s) for the delay and the expected wait time as described above.
- Patients listed for TTG eligible procedures will receive an information leaflet on the Patient Rights (Scotland) Act 2011, which includes details on how to give feedback, make a complaint and how to access the Patient Advice and Support Service (PASS).
- Where treatment occurs outside of the NHSGGC area, or where clinics are held infrequently, it is particularly important that the arrangements and the reasons for this are made clear to patients at the beginning of their care journey including processes of organising their appointment and/or admission to hospital.
- Patients are advised that the costs associated with travelling to an appointment out with NHSGGC and agreed named NTCs, including accommodation, and any other relevant expenses, for the patient and their carer (if necessary), can be covered by the NHSGGC. If a patient incurs costs less than those they would have incurred if their treatment was undertaken within NHSGGC this will not be considered a ‘cost reasonably incurred’ Consideration is given as to whether it may be appropriate to provide transport to support a patient to attend an appointment.
- Patients are given clear and accurate information on how their waiting time is calculated, including when clock adjustments are made and how these affect their treatment time clock.
- Patients are made aware that they must inform the hospital of any changes to their details, e.g., name, address, postcode, telephone number or referrer as soon as possible.
- Any communication being issued to the patient should also be sent to the referrer.
- Where patients are referred back to their GP, the Primary Care team should have arrangements in place to follow up with the patient prior to re-referral.

4 Manage Referrals Effectively

4.1 Referrer

- Prior to referral, the clinician should explain to patients the range of options to be considered. This should include that patients may not need to access specialist or consultant-led services.
- Referrers should advise patients of why they are being referred and the expected waiting time, and outline to patients their responsibilities for keeping appointments and the consequences of not attending.
- Referrers should ensure that patients are available to commence treatment. When the referrer is aware that the patient will be unavailable for a period of time, the referrer should either delay sending the referral until they know the patient is available, or clearly note the patient’s unavailability period on the referral form/letter.
- Referrals should be made electronically and as per local protocols.
- Referrals should be made to a clinical service and not a named consultant.
- Wherever possible patients should be referred directly for diagnostic tests prior to the referral being made for the first outpatient appointment, if applicable and available.

- The referring clinician should advise patients that they may be offered an appointment/treatment in any NHSGGC hospital or any NHS Scotland hospital where appropriate.
- Referrers are aware of their obligation to advise patients of their own responsibilities in the waiting times pathway. To this end, patients will be made aware:
  - They are required to attend their agreed appointment and where the appointment is not required, or they are unable to attend, they should inform the hospital at the earliest available opportunity.
  - It is their responsibility to inform their referrer and the hospital if their medical condition improves and no longer require an appointment or deteriorates in a way which may affect their attendance.
  - They need to advise when they will not be available to attend or be admitted to hospital for any periods of time (e.g., holiday or work commitments). If circumstances change after the referral is made, they must inform the hospital at the first opportunity.
  - They must advise the referrer and/or the hospital if they no longer wish to have their appointment or admission, for any reason.

- Referrers must check that they are providing accurate, timely and complete information within their referral including:
  - CHI identifier (unless they don't have one).
  - Unique Care Pathway Number (UCPN).
  - Full demographic details including, name, address, ethnicity, postcode, up to date mobile and home telephone numbers and email address.
  - Preferred method of contacting patient i.e., letter, phone, or e-mail.
  - Patient's unavailability period if applicable.
  - Patient's ability to attend an appointment at short notice.
  - Armed forces/veteran status if applicable.
  - Additional support needs e.g., visual impairment, hearing impairment etc.
  - An indicator of 'vulnerability' if applicable.
  - Category e.g., routine, urgent, suspicion of cancer, veterans, or other priority groups
  - Patients referred with suspected cancer must be marked as 'URGENT-SUSPICION OF CANCER'

4.2 Receiving Location

- All electronic referrals will be vetted using Active Clinical Referral Triage within three working days to ensure that patients are on the optimal pathway for them.
- All paper referrals will be date stamped, scanned, and entered on to Patient Management System TrakCare within one working day of receipt of the referral letter. The referrals will then be triaged electronically as above.
- The date of receipt of all referrals must be recorded.
- Patients should be booked as close to the date of receipt of referral as reasonably possible.
- Patients referred with suspected cancer must be marked as 'URGENT – SUSPICION OF CANCER'. All urgent cancer patients are required to be seen as soon as possible within cancer waiting time standards.
- Where the treatment cannot be provided locally, and the patient needs to travel elsewhere, the patient should be made aware of as soon as possible.
- Armed Forces personnel, veterans and their families who move between areas retain their relative point on the pathway of care within the national waiting time targets.

- No veteran (including those who have served as a reservist) or their family should be disadvantaged as a result of their membership of the armed forces, when accessing NHS Services.
- The 18 Week clock start date is the date the referral was received by NHSGGC.

4.3 Receiving Clinician

- Receiving clinicians must ensure that waiting lists properly reflect their clinical priorities and are managed effectively.
- It is the receiving clinician's responsibility to communicate with the referrer to advise if a referral is not suitable. Including referrals from outside NHSGGC, where that service already exists in the referring board, unless there is a current agreement in place with NHSGGC (e.g., any regional services). In some cases this may be managed by administrative staff within service and/or referral management centre where referral criteria has not been met.
- Any referrals received for a service that is not delivered in NHSGGC will be returned to the original referrer with advice.
- Where it is found that a referral received would be more appropriately managed by another service provided by NHSGGC, the referral will be passed to that service internally and where appropriate, the referrer informed.
- If the patient has been referred internally for the same condition by a consultant to another consultant and is still awaiting treatment, the waiting times clock continues from the original referral date.

4.4 Self-Referrals

- Many NHSGGC specialties now include outpatient 'opt-in' pathways. If deemed appropriate at vetting, patients can be placed on an opt-in pathway, at which point they are removed from the outpatient waiting list. If a patient, then opts-in within the specified timeframe this is classed as a self-referral and the waiting time clock starts from the date of the self-referral.

5 Manage Waiting Lists Effectively

5.1 'Reasonable Offers'

- A 'reasonable offer' package is the offer of two or more different dates of appointment for each stage of the patient pathway.
- A reasonable offer is a package of:
  - An offer of at least two dates for all new outpatient appointments and day case/inpatient treatment, where 10 calendar days' notice is given.
  - A short notice appointment (less than 10 calendar days) if verbally accepted by the patient during a telephone conversation.
  - An offer of appointment within NHSGGC, Golden Jubilee National Hospital and NHS Forth Valley National Treatment Centres (NTCs). Patients will be offered an appointment that is closest to them geographically that will allow them to be seen in the quickest time.
  - NHSGGC will also recognise Independent Sector facilities across Scotland, National Health Service in England, Wales or Northern Ireland in situations of

extremis. In all circumstances where this clause is required, the authority of the Chief Executive will be sought prior to any such patient treatments taking place.

5.2 Exceptions to a 'reasonable offer'

- Urgent referrals, where short notice appointments/admissions are clinically required.
- Where clinics are held infrequently (every four weeks or less frequently) NHSGGC recognises waiting times may be impacted. NHSGGC will endeavour to ensure that patients are seen as quickly as possible.
- Where patients are waiting for diagnostics tests they should expect short notice appointments. Where patients are beyond the maximum wait times for diagnostic tests and have been given a package of 'reasonable offers' patients will be returned to the referring clinician.

5.3 Appointment location

- Patients may be offered an appointment at any NHSGGC location including agreed National Treatment Centres in order to match demand with capacity across all available locations. This will ensure that patients are seen in the quickest time possible.
  - An offer of an appointment at any location in NHSGGC, Golden Jubilee National Hospital and NHS Forth Valley National Treatment Centres is considered reasonable. Appendix 1 outlines NHSGGC locations and all other non NHSGGC sites where treatment is routinely provided.
  - Patients will be advised as early as possible if they need to travel for their appointment and/or treatment.
  - A request for a specific location will only be allocated by NHSGGC to ensure continuity of care, patient safety or other clinical or exceptional reasons.
- Patients and their carers may be able to access support to attend appointments.
  - Patients and their carers may be eligible for reimbursements of costs reasonably incurred for travel to an appointment and/or treatment within NHSGGC in line with the NHSGGC Financial Operating Procedure, Patients Travelling Expenses Scheme.
  - Scottish Ambulance Service criteria will be applied to support eligible patients to attend appointments.
- Patients who have commenced outpatient treatment in the private sector who wish to transfer to NHSGGC must be referred as a new outpatient by their GP following the principles set out in this policy.
- Where patients admitted to the private sector for an inpatient/day case procedure become unmanageable and require transfer to an NHSGGC hospital, these will be managed in line with locally agreed processes.
- Appropriate documentation and information should be provided to the receiving Health Board or Private Sector where appropriate.
- Any transfer of data must comply with standards in relation to data security and confidentiality.

5.4 Named Consultant

- Patients will be referred to a clinical team and seen by an appropriate member of that team rather than to an individual consultant.
- A patient may request to be seen by a specific named consultant. This may be agreed, taking into account the patient's health and wellbeing, and if it deemed reasonable and clinically appropriate to do so.
- A request for a specific location will only be allocated by NHSGGC to ensure continuity of care, patient safety or other clinical or exceptional reasons.
- If a patient is to be managed by a specific consultant, the period between the date of the original offer and the date of the alternative offer, does not count towards the calculation of waiting time.

5.5 Patient refuses a 'Reasonable Offer'

- Following the refusal of two reasonable offers of a new outpatient appointment, patients may be referred back to the referring clinician. Communication will be sent to the patient and referrer advising of their removal. If a further referral is required, following review, this will be managed by the referring clinician.
- Following the refusal of two reasonable offers of an inpatient/day case date, an administrative review will be carried out, applying the principles within this policy followed by a clinical review where necessary. Patients will be removed as appropriate. Communication will be sent to patients and referrers advising that a review has been undertaken and the decision taken to remove the patient from the waiting list.
- Where a clinical decision is made to retain the patient on the waiting list, a maximum of one further appointment/admission date will be made. If the patient is given a further appointment/admission date they will remain on the waiting list and the clock may be reset to zero from the date the patient advised they were not accepting their second offer of appointment.

6 Waiting List Validation and Removal

6.1 Waiting List Validation

A programme of validation should be progressed for all patients on a waiting list on a regular and continuous basis. Where possible this should not exceed 6 months from previous review. The three stage validation set out below, provides the optimum arrangement for the management of waiting lists. Further information can be found in the NHSGGC Validation and Development of Patient Management Plan Standard Operating Procedure.

6.1.1 Administration and Clerical Validation

- There will be a routine review of the waiting list to quality check the data. This includes removal of duplicate entries, correspondence in clinical letters and identifying that the principles of the policy have been applied.

6.1.2 Patient Validation

- Communication will be sent to patients to confirm if they wish to remain on the waiting list. This will also identify patients who require to be escalated for review by a clinical team.
- NETCALL may be used to engage patients digitally, empowering patients to be involved in their care.
- At this stage it should be established if patients have been seen via another route, for example at an Emergency Department or via private healthcare.

6.1.3 Clinical Validation

- Clinical teams will regularly review patient's records and identify any appropriate actions, including attendance at a virtual clinic, patient management plans or treatment options.

6.2 Waiting List Removal

- Following waiting list validation, if the outcome is to remove a patient from the waiting list, this should be communicated to both the patient and the referrer.
- The communication should include the reason for removal and an appropriate contact name/number should the patient wish to discuss treatment/management.

7 Active Clinical Referral Triage

- Following a new outpatient referral, a clinician will review a patient's clinical record and carry out enhanced vetting using Active Clinical Referral Triage (ACRT) to ensure patients are managed in the most appropriate way.
- All referrals should be vetted using ACRT within three days of receipt of referral.
- Following ACRT patients are likely to:
  - Remain on the waiting list, waiting for a Patient Focussed Booking contact/appointment.
  - Remain on the waiting list, with clinical advice for early management shared with referring clinician.
  - Be provided with information through an opt-in pathway.
  - Returned to referring clinician with feedback following ACRT.
  - Returned to referring clinician with clinical advice for patient management.

- All ACRT outcomes should be recorded electronically on the Patient Management System TrakCare.

8 Booking Methods

8.1 Patient Focused Booking

Patient Focussed Booking (PFB) is a scheduling process whereby a communication is sent to a patient inviting them to contact the booking centre to arrange an appointment at a time suitable to them.

- An initial communication inviting patients to get in contact is sent by NHSGGC.
- A reminder must be sent after 14 calendar days, if the patient has not made contact.
- At this point PFB unavailability will start for new outpatients.
- If there is no appointment made after a further 7 calendar days from the reminder being issued (totalling 21 calendar days):
  - Communication will be sent to new outpatients and their referring clinician advising them that they have been removed from the new outpatient waiting list.
  - TTG patients (excluding diagnostic tests/procedures and diagnostic imaging) **must** be provided a reasonable offer of appointment where the patient has been consented and passed pre-operative assessment. At which point the guidance for reasonable offers and patient refusals should be followed.

8.2 Implied Acceptance

- Implied Acceptance is a scheduling process whereby an appointment is made on behalf of a patient and is issued to them. This is a reasonable offer and should follow the criteria set out for reasonable offers.
- If no response has been received from the patient within 10 calendar days of the appointment being issued, it is then assumed that the patient has accepted the appointment.
- It is the responsibility of the service to ensure that every attempt has been made to contact the patient prior to the date of appointment/treatment.

9 Non Attendance

9.1 Could Not Attend

- If a patient has accepted a 'reasonable offer' of appointment/treatment but gives notice that they will not attend, it should be classed as Could Not Attend (CNA). NHSGGC may reset the patients waiting time clock to zero where it is reasonable and clinically appropriate to do so.
- If a patient cancels three agreed appointment/treatment the patient will be removed from the waiting list. Communication will be sent to the patient and referrer advising them that they have been removed from the new outpatient waiting list.
- If following a clinical review it is not reasonable to refer the patient back to their referring clinician, a further appointment/treatment should be offered.
- NHSGGC may reset the patients clock to zero from the date the patient advised they could not attend their third agreed appointment/treatment.
- If a patient informs NHSGGC that they have an illness, which they feel may prevent them from attending an appointment/treatment on an agreed date clinical advice should be sought where booking centre staff are unable to determine the best course of action.

- If it is deemed that a patient's illness will prevent their attendance at an agreed appointment or treatment, a known period of medical unavailability should be applied. This should be applied for a short period e.g. up to two weeks.
- If it is deemed that a patient's illness will not prevent their attendance at an agreed appointment or treatment, the appointment/treatment should go ahead as planned.

9.2 Did Not Attend

- If after a 'reasonable offer' a patient does not attend an agreed appointment/treatment and has not given any notice of this, it should be classed as Did Not Attend (DNA).
- When a patient does not attend, NHSGGC may refer the patient back to their initial referrer, or where it is reasonable and clinically appropriate to do so, offer one further date and reset the patient's clock to zero from the date of the missed appointment/treatment.
- If a patient does not attend for a second time, they will be recorded as DNA and will be removed from the waiting list.
- Communication will be sent to the patient and their referring clinician advising them that they have been removed from the waiting list and the reason for the removal.
- If a patient contacts NHSGGC within seven calendar days of their missed appointment/treatment the patient's original waiting list entry can be reinstated with a further offer of appointment/treatment made.

9.3 Was Not Brought (applying to children and young people aged 0 – 18 years)

- Was not brought (WNB) applies to children and young people aged 0 – 18 years (who require the presence or support of a parent or carer to attend appointments) who did not attend a planned appointment and had not cancelled the appointment.
- All staff are asked to follow the pathway outlined in the NHSGGC Was Not Brought Guidance for Children and Young People.
  - Where a child is not brought to a first appointment the responsible healthcare professional should make an informed decision regarding the need for a 2nd or 3rd if necessary, offer of appointment based on clinical need/risk.
  - Where a child is not brought to a 3rd appointment the child should then be discharged back to the care of the initial referrer with communication sent to the parents/guardians and all relevant professionals.

9.4 Could Not Wait

- It is important that patients are advised prior to attending their appointment of the expected duration of their appointment. If the appointment is planned to consist of more than one consultation the patient must be made aware of this in advance.
- On arrival or as early as possible all patients must be advised of any delays to their appointment on the day.
- It is reasonable to expect patients to wait up to 30 minutes from the time of the appointment for an outpatient appointment. However, there may be occasions where the patient has registered their arrival for an appointment but cannot wait to be seen.
  - If there is a delay caused by service, where the patient is unable to wait more than 30 minutes this should be recorded as 'cancelled by service'. The patient must be given another 'reasonable offer' of appointment as soon as possible.

- If there is a delay caused by service that is less than 30 minutes where the patients is not willing to wait, this should be recorded as CNA. If this is the patients first or second CNA, the patient should be made another reasonable offer of appointment. However, if they have cancelled three of more agreed appointments previously, the CNA guidance should be followed.

9.5 Cancelled By Service

- Patients should not be disadvantaged as a result of cancellations resulting from operational circumstances. Should this occur, there should be no change to the patients waiting time clock and the patient should be made a further reasonable offer as soon as possible.
- Where possible, this should be within the waiting time standards and treatment time guarantee. However the prioritisation to the start of treatment must not be to the detriment of another patient with a greater clinical need for treatment.
- If, having been admitted, a planned treatment is unexpectedly cancelled, the patient cannot be recorded as having started treatment. Where possible, the patients must still undergo treatment within the waiting time standards and treatment time guarantee.
- A minimum of six weeks' notice is required from all clinicians, in all but exceptional circumstances, to cancel or reduce any outpatient clinic, diagnostic or inpatient/day case session for reasons of annual leave, study leave or on-call commitments.
- If it is necessary, in exceptional circumstances to cancel or reduce any session, the General Manager for that specialty must discuss with the relevant Consultant and agree re-provision of lost capacity to ensure patients are not disadvantaged and wait times do not increase. All short notice (less than six weeks) clinic cancellations must be authorised in writing by the appropriate General Manager.
- If a visiting practitioner service cannot be provided in the Commissioning Health Board area, this should be managed the same as any other service cancellations with no clock impact for patients and a further offer of appointment made.

10 Unavailability

Unavailability is a period of time when a patient would not be in a position to accept an offer of appointment/treatment. All unavailability should have a specified start and end date.

10.1 Patient Advised Unavailability

- Patient advised unavailability is a period of time when it is known that the patient would not be in a position to accept an offer of appointment due to reasons advised by the patient.
- Reasons for patient advised unavailability are:

  - Academic commitment
  - Carer commitment
  - Jury Duty
  - On holiday
  - Minor ailment
  - Personal commitment
  - Work commitment

- Patients can have a maximum of 12 weeks unavailability applied if required, however, patients are encouraged to be available for their treatment as soon as possible and should advise of the minimum period of unavailability.
- A review should be conducted at the end of the period of unavailability, and if required one additional period of up to 12 weeks can be applied. Again, patients are encouraged to be available for their treatment as soon as possible and should advise of the minimum period of unavailability.
- Following the second period of patient advised unavailability, a clinical review must be completed to advise whether the patient should now be offered an appointment or returned to their referring clinician. The clinical review should be completed within the receiving service.
- If the patient is to be referred back to their referring clinician, NHSGGC must record why this was appropriate. Patients and their referring clinician must be informed when the patient has been removed from the waiting list.
- NHSGGC should not estimate a period of patient advised unavailability – the patient should be clearly asked when the period of unavailability will start and end. Good communication with the patient is essential to ensure the appropriate information is provided to the service.

10.2 Medical Unavailability

- This is when a registered medical practitioner has advised that a patient has another medical condition which will prevent the agreed treatment from proceeding for that period of time.
- If a patient is not fit for treatment once on an inpatient/day case waiting list the clinician will ascertain the likely nature and duration. If the reason is that they have a condition that itself requires active treatment then they will be discharged back to the care of their referring clinician or will be referred on to the appropriate specialty. Either action results in removal from the waiting list.
- The start of the period of medical unavailability is the date the registered medical practitioner/clinician made the decision that the patient was medically unavailable. The end date is when the registered medical practitioner/clinician decides the patient is now fit and ready to undergo their treatment.
- Allied Health Professional (AHP) Musculoskeletal (MSK) unavailability is when a registered medical or healthcare practitioner indicates that a patient needs a period of time before AHP MSK rehabilitation/intervention is undertaken. A period of unavailability will be applied for 6 weeks regardless of the 4 week waiting times standard as patients are effectively immobile. AHP MSK unavailability will be applied to a patient's clock only.
- AHP MSK unavailability relates to the patient and should not be used to describe unavailability of the clinical service.

10.3 Patient Focused Booking Unavailability

- Patient-Focussed Booking (PFB) unavailability should begin to be applied 14 calendar days after the issue of the initial communication to the patient, inviting them to make an appointment. Upon issue of the reminder communication one day of unavailability should be added every day until the patient makes an appointment.
- There should be up to a maximum of 7 calendar days of PFB unavailability. When the maximum unavailability has been reached, the patient may be removed from the waiting list. Communication will be sent to the patient and their referring clinician advising them that they have been removed from the waiting list and the reason for the removal.
- In cases where referring back to the referring clinician is not appropriate, NHSGGC may reset the patient's clock to zero (regardless of whether any waiting time standard has been breached), and offer the patient another appointment.

11 Waiting Time Calculation

11.1 New Outpatients

- **Clock start** is the date when the referral is received.
- **Any clock adjustments**. Examples of adjustments can be found in Appendix 2. Patient's clocks are fully adjustable regardless of the patient's length of wait.
- **Clock stop** is the date of the new outpatient appointment, or the date a patient is removed from the outpatient waiting list

- For patients with a Long-Term Condition with an exacerbation or recurring symptoms, a new waiting time clock must be started for new referrals for the same condition. This does not apply to patients who are on Patient-Initiated Review (PIR) or Patient Initiated Follow-Up (PIFU).
- For patients waiting for sequential bilateral treatment the waiting time for the second outpatient appointment is measured as a separate, second pathway with a new waiting time clock. The waiting time clock for the second outpatient appointment should not start until the clinician and patient agree to the treatment. The sequential treatment must not be managed as a Planned Repeat.
- For consultant-to-consultant referrals a new waiting time clock will be started on receipt of the referral by the new consultant-led service if the referral is for a new condition or speciality.
- For patients transferred to a planned service via an urgent care service e.g. Emergency Department, Rapid Access Service, or a Minor Injuries Unit, a formal referral will not always be sent. The waiting time clock will start on the date of attendance at an urgent care service where the purpose of the appointment is for treatment, not a follow-up to treatment already started within an urgent care service.
- For patients who self-refer or opt in via an Active Clinical Referral Triage (ACRT) pathway, a new waiting time clock starts on the date that the patient contacts the service.
- For patients changing their permanent residence to another Health Board area, whose waiting time clock has already started and who request to be treated within that other Heath Board area (i.e. the Health Board of their new residence), their previous waiting time clock should be taken into account.

11.2 New Inpatient/Day Case Patients (Treatment Time Guarantee)

- **Clock start** is the date when the patient agrees treatment with their clinician.
- **Any clock adjustments**. Examples of adjustments can be found in Appendix 2. Patient's clocks are fully adjustable regardless of the patient's length of wait.
- **Clock stop** is the date that the patient starts to receive the agreed treatment, or the date the patient is removed from the waiting list

- Exceptions to the Treatment Time Guarantee can be found in Appendix 3.
- Most patients will agree treatment at their outpatient appointment. This is when the patient's waiting time clock for their inpatient / day case treatment should start.
- However, before the treatment can be agreed, some patients may be required to undergo a diagnostic test. The patient will be contacted about the test result, normally by phone or at a return outpatient appointment. In such cases, the treatment would be agreed at that time, which would be the start date of the Treatment Time Guarantee.
- Should the patient indicate that they would like to have time to consider whether to proceed with the treatment, in this circumstance the patient's waiting time clock will not start until the patient agrees to proceed with the treatment.
- Normally, the patient will be admitted to hospital on the day of treatment, and the patient's waiting time clock should stop on this day.
- In some circumstances, the patient may be admitted for treatment the day before their surgery. Where this occurs in order to start the initial stages of treatment, for example, to administer medication or to clinically prepare the patient, this date should be recorded as the start of treatment.

- For Referral to a One-Stop Service for patients seen on an inpatient or day case basis, the date the patient agrees treatment and the date of the treatment will be the same. The patient will have a zero-wait recorded against the Treatment Time Guarantee. For any patients for whom treatment cannot be undertaken on the day, the waiting time clock will continue.
- For patients with a Long-Term Condition with an exacerbation or recurring symptoms, a new waiting time clock must be started for new referrals for the same condition. This does not apply to patients who are on Patient-Initiated Review (PIR) or Patient Initiated Follow-Up (PIFU).
- For patients waiting for sequential bilateral treatment the waiting time for the second appointment is measured as a separate, second pathway with a new waiting time clock. The waiting time clock for the second appointment should not start until the clinician and patient agree to the treatment. The sequential treatment must not be managed as a Planned Repeat.
- For patients transferred to a planned service via an urgent care service e.g. Emergency Department, Rapid Access Service or a Minor Injuries Unit, a formal referral will not always be sent. The waiting time clock will start on the date of attendance at an urgent care service where the purpose of the appointment is for treatment, not a follow-up to treatment already started within an urgent care service. NHS Waiting Times Guidance 2023 32.
- For patients changing their permanent residence to another Health Board area, whose waiting time clock has already started and who request to be treated within that other Heath Board area (i.e. the Health Board of their new residence), their previous waiting time should be taken into account

11.3 18 Week Referral-To-Treatment

- **Clock start** is the date when the referral is received.
- **Any clock adjustments**. Examples of adjustments can be found in Appendix 2.
- **Clock stop** is the date that treatment commences, appointments are concluded, or if the patient is removed from the waiting list.

- Exceptions to the 18 Weeks Referral-To-Treatment can be found in Appendix 3.
- For patients with a Long-Term Condition with an exacerbation or recurring symptoms, a new waiting time clock must be started for new referrals for the same condition. This does not apply to patients who are on Patient-Initiated Review (PIR) or Patient Initiated Follow-Up (PIFU).
- For patients waiting for sequential bilateral treatment the waiting time for the second outpatient appointment is measured as a separate, second pathway with a new waiting time clock. The waiting time clock for the second outpatient appointment should not start until the clinician and patient agree to the treatment. The sequential treatment must not be managed as a Planned Repeat.
- For consultant-to-consultant referrals a new waiting time clock will be started on receipt of the referral by the new consultant-led service if the referral is for a new condition or speciality. If the consultant-to-consultant referral relates to the same condition that the patient was initially referred for, then the existing clock will continue, and a new clock should not be started.
- For patients transferred to a planned service via an urgent care service e.g. Emergency Department, Rapid Access Service or a Minor Injuries Unit, a formal referral will not always be sent. The waiting time clock will start on the date of attendance at an urgent care service where the purpose of the appointment is for treatment, not a follow-up to treatment already started within an urgent care service.
- For outpatients that self-refer or opt in via an Active Clinical Referral Triage (ACRT) pathway, a new waiting time clock starts on the date that the patient contacts the service.
- For patients changing their permanent residence to another Health Board area, whose waiting time clock has already started and who request to be treated within that other Heath Board area (i.e. the Health Board of their new residence), their previous waiting time clock should be taken into account

11.4 Eight Key Diagnostic Tests and Investigations

- **Clock start** is the date the responsible Health Board of initial referral area receives the request for the test or procedure.
- **Any clock adjustments**. Examples can be found in Appendix 2.
- **Clock stop** is the date the verified report has been received by or made available to the requester, or the date the patient is removed from the waiting list.

- The Eight Key Diagnostic Tests and Investigations covered by the standard are:

- Upper Endoscopy
- Lower Endoscopy (excluding Colonoscopy)
- Colonoscopy
- Cystoscopy
- Computer Tomography (CT)
- Magnetic Resonance Imaging (MRI)
- Barium Studies
- Non-Obstetrics Ultrasound

- For patients who require more than one diagnostic test, each procedure should be recorded as a separate new request.
- Health Boards are required to have a robust process in place to ensure results are communicated to patients in a timely manner

12 Armed Forces Personnel and Veterans

12.1 Armed forces relocation within the UK

- When a member of the UK armed forces or a member of their family moves into a new location in the UK, their previous waiting time should be taken into account. The expectation is that treatment in their new location will be met within the waiting time standards and Treatment Time Guarantee, according to their clinical need.
- It is important that Health Boards have processes in place to ascertain how long these patients have waited to ensure that these patients continue their waiting time and do not have their clock start from zero at the new location.

12.2 Paying due regard to the armed forces covenant

No veteran (including those who have served as reservists) or their family should be disadvantaged, as a result of their membership of the Armed Forces, when accessing NHS services. It is for Health Boards and clinicians to determine how they ensure that they uphold their responsibilities under the Armed Forces Covenant duty. Further detailed guidance for veterans can be found at Armed_Forces_Covenant_Duty_Statutory_Guidance.pdf (publishing.service.gov.uk). An Armed Forces and Veterans eLearning Programme can be accessed via the Turas learning platform. This resource includes case studies demonstrating application of the Covenant duty.

13 Monitoring and Effectiveness

13.1 Systems and Processes

- Systems, processes and resources:
  - Are in place to make sure all staff are adequately trained to use local systems to help manage access to services.
  - Are developed to review and validate waiting lists to ensure accuracy and that national and local access times are achieved.
  - Are in place to communicate, manage and record all outcomes at clinics, additions or alterations to the waiting list electronically.

- Clinic templates are regularly reviewed to ensure they remain effective and efficient.
- All patients, or as appropriate their parent/guardian or carer, undergoing a procedure have indicated in writing that they consent to treatment.
- Onward referrals are completed to make sure the receiving healthcare provider has the necessary information to manage the patient treatment pathway. Any transfer of data will comply with NHS standards in relation to data security and confidentiality.

13.2 Performance Management

- The factors which influence waiting times, such as changes in referral patterns, will be regularly monitored and management action will be taken in sufficient time to ensure waiting time standards are maintained.
- New to return and DNA ratios will be regularly reviewed and steps will be taken to address any issues as necessary.
- Efficiency and productivity will be effectively monitored and any necessary change will be supported where required.
- Benchmarking information will be used wherever possible to review efficiency.

14 Conclusion

- By following the key principles set out in this Access Policy and defining responsibilities under those principles, NHSGGC will ensure equity of service and reduce variation.
- NHSGGC will use the Access Policy in conjunction with other relevant National and Board Guidance and best practice documentation.
- NHSGGC will ensure that their local procedures reflect the principles laid out in this Access Policy

15 Appendices

15.1 Appendix 1 Planned Care Sites

NHSGGC Planned Care Sites	Address
The Beatson West of Scotland Cancer Centre	1053 Great Western Road, Glasgow, G12 0YN
Gartnavel General Hospital	1053 Great Western Road, Glasgow, G12 0YN
Glasgow Royal Infirmary	84 Castle Street, Glasgow, G4 0SF
Inverclyde Royal Hospital	Larkfield Road, Greenock, PA16 0XN
Queen Elizabeth University Hospital	1345 Govan Road, Govan, Glasgow, G51 4TF
Royal Alexandra Hospital	Corsebar Road, Paisley, Renfrewshire, PA2 9PN
Royal Hospital for Children	1345 Govan Road, Govan, Glasgow, G51 4TF
Stobhill Ambulatory Care Hospital	133 Balornock Road, Glasgow, G21 3UW
Vale of Level Hospital	Main Street, Alexandria, West Dunbartonshire G83 0UA
Victoria Ambulatory Care Hospital	52 Grange Road, Glasgow, G42 9LF
West Glasgow Ambulatory Care Hospital	Dalnair Street, Yorkhill, Glasgow, G3 8SJ

Non NHSGGC Planned Care Sites	Address
Golden Jubilee National Hospital	Agamemnon Street, Clydebank, G81 4DY
NHS Forth Valley Royal Hospital	Stirling Road, Larbert, FK5 4WR

15.2 Appendix 2 examples of clock adjustments

- A patient's clock may be adjusted for reasons such as:
- Periods of unavailability whether they be medical, or patient advised
- If a patient refuses two or more reasonable offers of appointment
- If a patient cancels three or more appointments
- If a patient does not attend an agreed appointment
- During a suspension of the Treatment Time Guarantee

15.3 Appendix 3 Exclusions

- **Treatment Time Guarantee Exclusions**

- Assisted reproduction
- Obstetrics services
- Organ, tissue, or cell transplantation, whether from living or deceased donor
- Procedures covered under Exceptional Referral Protocol
- Mental Health, unless a planned admission to hospital (e.g. feeding tube)
- Mental Health services are not under the standards contained in this guidance, unless this requires planned admission to hospital for inpatient or day case treatment.

- Exceptional Aesthetic Procedures which have been specifically excluded in the CMO(2019)05 - Exceptional Referral Protocol (previously known as the Adult Exceptional Aesthetic Referral Protocol) – refresh April 2019 (scot.nhs.uk) are also excluded from the TTG.

- **18 Weeks Referral-To-Treatment Exclusions**

- Direct referrals to Allied Health Professionals (AHPs). However, AHPs may deliver services that are part of the overall waiting time standard e.g. as part of a consultant-led service.
- Assisted conception services.
- Dental treatment provided by undergraduate dental students.
- Direct access referrals to Diagnostic Services where the referral is not part of a 'Straight to Test' referral pathway as there is no transfer of clinical responsibility to the consultant-led team.
- Exceptional Aesthetic Procedures which have been specifically excluded in the CMO(2019)05 - Exceptional Referral Protocol (previously known as the Adult Exceptional Aesthetic Referral Protocol) – refresh April 2019 (scot.nhs.uk).
- Genitourinary Medicine (GUM).
- Homoeopathy.
- Obstetrics.
- Organ and tissue transplants.
- Mental Health services are not under the standards contained in this guidance, unless this requires planned admission to hospital for inpatient or day case treatment.

15.4 Appendix 5 Supporting Documents

- The Patient Rights' (Scotland) Act 2011
- The Patient Rights' (Treatment Time Guarantee) (Scotland) Amendment Regulations 2014
- NHS Scotland: national access policy 2023
- NHS Scotland waiting times guidance 2023
- NHS Scotland Waiting Times Guidance DL (2023) 32
- NHS Scotland Waiting Times Patient Information Leaflet 2024
- Effective Patient Booking for NHS Scotland 2012
- The Healthcare Quality Strategy for NHS Scotland (2010)
- Armed Forces CEL 39 (2010)
- Statutory Guidance on the Armed Forces Covenant Duty
- The Equality Act (2010)
- Exceptional Referral Protocol SGHC/CMO(2019)5
- The Mental Health (Care and Treatment) (Scotland) Act 2003
- NHSGGC Financial Operating Procedure, Patients Travelling Expenses Scheme.
- NHSGGC Was Not Brought Guidance for Children and Young People.

15.5 Appendix 4 Treatment time GUARANTEE patient communication template

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF
Date: 26/01/2024
Telephone: 0141 451 6047

PRIVATE AND CONFIDENTIAL

Bruce Test

1 Wayne Mannor, Gotham City, G1
Unknown
NK010AA

Dear Bruce Test
CHI Number: TJ00001169

Notification of Addition to General Surgery Waiting List

I am writing to confirm that, as agreed with your consultant, you have been added to the General Surgery waiting list for treatment in NHS Greater Glasgow and Clyde. In line with the Patients' Rights (Scotland) Act 2011, you qualify for the Treatment Time Guarantee.
We have seen significant challenges for our NHS, including severe pressures over winter periods, staffing capacities, and the impact of rising inflation costs. This has affected almost all aspects of NHS care, including the number of planned care procedures the health service has been able to provide. Consequently, this has led to some waiting times that are longer than we would like them to be.

Waiting Times
We would like to be able to give you an indication of how long patients are currently waiting. This is challenging as there are many factors which affect how long a patient may wait including:

- the urgency of the care they need
- the complexity of the surgery and
- number of patients currently waiting

Currently 9 out of 10 patients waiting for General Surgery are waiting less than ( ) weeks. Most patients in General Surgery will be treated long before this, with some patients having much shorted waits.

Updates and Contact Details
We may be in contact with you while you are waiting to check if you still need treatment and that your details are correct. Please make sure you respond to any letters or messages you receive from us. If your address or telephone number changes, or you know of any dates you are unavailable, please contact us:
0141 451 6047
Treatment in other Hospitals
We will try to offer you treatment in your local area, however, you may be treated at another hospital with NHS Greater Glasgow and Clyde or within another Health Board. For example,

this could at the Golden Jubliee National Hospital. It would be helpful if you could be as flexible as possible in considering the potential options for the dates for your surgery.

Change in circumstances
We understand that your situation may change while you are waiting for surgery. Please let us know if you do not wish to go ahead with your planned treatment. If your condition has changed, please contact your consultant's secretary or your GP for advice.

General Health
General Health also can have an impact on how long patients have to wait. Looking after your physical and mental wellbeing in advance of your surgery will give you the best chance of having a good recovery and outcome. It is really important that you try to keep yourself as fit and healthy as possible while you wait for your surgery. This includes being as physically active as you can and having a healthy diet. If you smoke, then think about trying to stop.

Wait Times Information
The Scottish Government has set up a website with waiting times information reflecting all patient groups from Public Health Scotland. This is the link:
https://www.nhsinform.scot/waiting-times.

I appreciate that delays are very disappointing, but want to reassure you that we are doing everything possible to reduce waiting times across NHS Greater Glasgow and Clyde.
Thanks you for understanding during this challenging time.
Yours sincerely

Unit Secretary/Waiting List Co-ordinator

Frances Grainger
SCGC TTG 1 Addition to the Waiting List

NHS Greater Glasgow and Clyde
Equality Impact Assessment Tool

Equality Impact Assessment is a legal requirement as set out in the Equality Act (2010) and the Equality Act 2010 (Specific Duties)(Scotland) regulations 2012 and may be used as evidence for cases referred for further investigation for compliance issues. Evidence returned should also align to Specific Outcomes as stated in your local Equality Outcomes Report. Please note that prior to starting an EQIA all Lead Reviewers are required to attend a Lead Reviewer training session or arrange to meet with a member of the Equality and Human Rights Team to discuss the process. Please contact Equality@ggc.scot.nhs.uk for further details or call 0141 2014560.

Name of Policy/Service Review/Service Development/Service Redesign/New Service:

NHSGGC Access and Waiting Times Policy 2024

Is this a: Current Service ☐ Service Development ☐ Service Redesign ☐ New Service ☐ New Policy ☐ Policy Review ☒

Description of the service & rationale for selection for EQIA: (Please state if this is part of a Board-wide service or is locally driven).

What does the service or policy do/aim to achieve? Please give as much information as you can, remembering that this document will be published in the public domain and should promote transparency.

The overall aim of the NHSGGC Access and Waiting Times Policy is to provide a common vision, direction and understanding of how the board will ensure equitable, safe, effective and efficient access to services for their patients. Specifically to;

1. Ensure that patients receive treatment in accordance to their clinical priority. Patients with the same clinical priority will be treated in chronological order, minimising the time a patient spends on the waiting list and improving quality of care and patient experience.
2. Reduce waiting times for treatment and ensure patients are treated in accordance with agreed targets.
3. Ensure standardised processes are in place to support effective patient communication and engagement at all stages of the patient pathway.
4. Ensure standardised processes are in place to support triaging of all new planned care referrals and continuous review of waiting lists in line with three-stage validation processes.
5. Provide information to support patients to make the right choices for them in relation to their care and treatment.
6. Minimise Did Not Attends (DNAs) and patient cancellations in line with application of National Policy including working to understand

reasons why some patients do not, or cannot attend appointments.

7. Apply the principles of Realistic Medicine and Value Based Health and Care to ensure clinical sustainability, shared decision making and future care planning.

Why was this service or policy selected for EQIA? Where does it link to organisational priorities? (If no link, please provide evidence of proportionality, relevance, potential legal risk etc.). Consider any locally identified Specific Outcomes noted in your Equality Outcomes Report.

The NHSGGC Access and Waiting Times Policy is a core document that determines patient flow through planned care services within the board that are subject to a waiting time guarantee. The management of waiting times within the board remains a key organisational priority to meet waiting time's guarantees and national targets set out by Scottish Government.

This policy acts as a means of ensuring fairness across all planned care services and seeks to ensure that all proportionate measures are taken to identify and remove any unintended discriminatory consequences or implementing this policy.

Who is the lead reviewer and when did they attend Lead reviewer Training? (Please note the lead reviewer must be someone in a position to authorise any actions identified as a result of the EQIA)

Name: To be confirmed – JR advising	Date of Lead Reviewer Training:

Please list the staff involved in carrying out this EQIA
(Where non-NHS staff are involved e.g. third sector reps or patients, please record their organisation or reason for inclusion):

Scott Davidson, Deputy Medical Director
Susan McFadyen, Director of Access
Colette Dryden, Acute Access Manager
Pamela Ralphs, Planning Manager
NHSGGC Access Policy Implementation Group (including eHealth leadership).

		Example	Service Evidence Provided	Possible negative impact and Additional Mitigating Action Required
1.	What equalities information is routinely collected from people currently using the service or affected by the policy? If this is a new service proposal what data do you have on proposed service user groups. Please note any barriers to collecting this data in your submitted evidence and an explanation for any protected characteristic data omitted.	*A sexual health service collects service user data covering all 9 protected characteristics to enable them to monitor patterns of use.*	NHSGGC appreciates the diversity of people accessing acute planned care services. On average NHSGGC will admit 15,000 patients for an inpatient/day case procedure and 25,000 patients for a new outpatient appointment, per month. Based on data published in 2020 it is understood that; • 60% of people accessing care will come from our poorest communities (SIMD 1&2). • 5% will not speak English with 7% unable to read English. • 16% will be deaf or hearing impaired. • 6% will be blind or visually impaired. • 15% will have a physical disability. • 1 in every 250 will have a learning disability. TrakCare, the boards patient management system, allows staff to record a patients age, sex, postcode, religion and belief and whether the patient requires interpreting support. Alerts can be applied to individual clinical records on TrakCare for a number of reasons to identify patients who may require additional support to attend for appointments and/or treatment. When a clinical record is accessed this alert will show and requires the user to click 'okay' to acknowledge the information and be mindful when making decision re: appointments and treatment dates, locations and times.	Information recorded in TrakCare relating to protected characteristics will be dependent on accurate information being provided at the referral stage, information held in TrakCare from previous periods of care or from patients who call the service to highlight any requirements they may have. While TrakCare offers the necessary fields to capture data relating to protected characteristics, not all of these fields are mandatory. The implementation of the policy will include awareness raising sessions as well as training for all relevant staff. The importance of

			This alert can also be used to identify where a person may have no/limited access to the internet to ensure that appropriate forms of communication are used and only suitable appointment types are offered.	capturing this information as quickly and as accurately as possible will be highlighted. The NHSGGC Director of Access will have responsibility for the ongoing monitoring of the policy and ensuring that relevant data is captured and to ensure the appropriate actions are taken to drive a person centred approach to the delivery of planned care.
		Example	Service Evidence Provided	Possible negative impact and Additional Mitigating Action Required
2.	Please provide details of how data captured has been/will be used to inform policy content or service design. Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).	*A physical activity programme for people with long term conditions reviewed service user data and found very low uptake by BME (Black and Minority Ethnic) people. Engagement activity found promotional material for the interventions was not*	The NHSGGC local policy has been reviewed and updated to reflect the change in national policy. The review process of the Scottish Government Policy included a period of consultation with service users across NHS Scotland facilitated by HealthCare Improvement Scotland. The document outlines a number of recommendations based on service user experience. NHSGGC have ensured that patients have been at the heart of the review and update of the local policy. The policy outlines a person-centred care approach right across the planned care pathway. Including;	The NHSGGC Public Health will have responsibility for the ongoing monitoring of the policy and its impact for service users in terms of protected characteristics, particularly those living in poverty. Data will be reviewed

	1) Remove discrimination, harassment and victimisation ☐ 2) Promote equality of opportunity ☐ 3) Foster good relations between protected characteristics. ☐ 4) Not applicable ☐	*representative. As a result an adapted range of materials were introduced with ongoing monitoring of uptake. (Due regard promoting equality of opportunity)*	• Ensuring that a programme of enhanced vetting is carried out for all new referrals to ensure that patients are managed in the most appropriate way. • Patients are communicated with in a format that suits them applying the Scottish Government Digital First Standard. This will ensure patients are at the heart of delivery, and adopting tools and processes to promote flexibility and sustainability. • Utilising a range of appointment types. • Providing information on support available for transport and expenses. • Ensuring that patients are empowered to make the right decisions for them and their care. A programme of engagement has been developed by the Patient Engagement Public Involvement Team to capture feedback from services users across NHSGGC. The feedback gathered will further shape the policy, wider implementation and operational delivery across all planned care services. NHSGGC will ensure that the scheduling of appointments will be managed taking into consideration the barriers experienced by those people living in poverty in NHSGGC.	regularly from TrakCare, Care Opinion and patient complaints to ensure that where any changes are required swift action is taken to mitigate the impact for service users and ensure the smooth delivery of planned care across NHSGGC.

		Example	Service Evidence Provided	Possible negative impact and Additional Mitigating Action Required
3.	How have you applied learning from research evidence about the experience of equality groups to the service or Policy? Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes). 1) Remove discrimination, harassment and victimisation ☐ 2) Promote equality of opportunity ☐ 3) Foster good relations between protected characteristics ☐ 4) Not applicable ☐	*Looked after and accommodated care services reviewed a range of research evidence to help promote a more inclusive care environment. Research suggested that young LGBT+ people had a disproportionately difficult time through exposure to bullying and harassment. As a result staff were trained in LGBT+ issues and were more confident in asking related questions to young people. (Due regard to removing discrimination, harassment and victimisation and fostering good relations).*	The NHSGGC local policy has been reviewed and updated to reflect the change in national policy. The review process of the Scottish Government Policy included a period of consultation with service uses across NHS Scotland facilitated by HealthCare Improvement Scotland. The document outlines a number of recommendations based on service user experience. This included Patient Focussed Booking, highlighting its many benefits like ensuring patients are given options when attending an outpatient appointment. This initiative is being rolled out across the board. Data is regularly reviewed to monitor the impact this is having and identify any unintended consequences as quickly as possible. NHSGGC like all boards across NHS Scotland are working closely with the Centre for Sustainable Delivery to ensure that every effort is made to standardise and streamline planned care across a large number of specialities. This includes local implementation of a range of national pathways of care. Opt-in pathways are also now being rolled out across NHSGGC. This approach provides patients who are not likely to benefit from clinical intervention, with information on how they can manage their symptoms in the community and seek input within a set timeframe if required. Discharge patient initiated review (PIR) is a process applied to patients who typically would have returned to an outpatient	A performance monitoring report is being developed to ensure that the implementation of the policy does not disproportionately benefit those patients from more affluent communities. During the initial stages of the implementation of the policy the reporting will include sampling postcodes from across NHSGGC to monitor variances such as an increase in patients who Do Not Attend appointments or a change in referral patterns.

			appointment for a follow-up but with no expectation of ongoing clinical intervention/management. Patients are now no longer offered a follow-up appointment and are instead given details on how they can contact the speciality should they need an appointment within an agreed timeframe e.g. one year. This ensures that only those patients who may benefit from a return appointment/follow-up have the option of accessing the service. Patient Initiated Follow Up (PIFU) is a similar process applied to patients who are being actively managed for a Long Term Condition (LTC). These patients are now no longer allocated a repeat appointment e.g. annually. PIFU enables patients to have a flexible approach to reviews, arranged when they need it most where it would accelerate engagement with the clinical team managing long term conditions. Suitability for both PIR and PIFU will be discussed with the patient by the Clinician. All of the nationally endorsed initiatives minimise the amount of time a patient spends in the healthcare system, reduces the need to travel and provides them with supportive information to be enable them to make future informed decision.	
		Example	Service Evidence Provided	Possible negative impact and Additional Mitigating Action Required
4.	Can you give details of how you have engaged with equality groups with regard	*A money advice service spoke to lone parents (predominantly women)*	The NHSGGC local policy has been reviewed and updated to reflect the change in national policy. The review process of the Scottish Government Policy included a period of consultation	Data will be reviewed regularly from TrakCare, Care Opinion and patient

	to the service review or policy development? What did this engagement tell you about user experience and how was this information used? The Patient Experience and Public Involvement team (PEPI) support NHSGGC to listen and understand what matters to people and can offer support. Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes). 1) Remove discrimination, harassment and victimisation ☐ 2) Promote equality of opportunity ☐ 3) Foster good relations between protected characteristics ☐ 4) Not applicable ☐	*to better understand barriers to accessing the service. Feedback included concerns about waiting times at the drop in service, made more difficult due to child care issues. As a result the service introduced a home visit and telephone service which significantly increased uptake.* *(Due regard to promoting equality of opportunity)* ** The Child Poverty (Scotland) Act 2017 requires organisations to take actions to reduce poverty for children in households at risk of low incomes.*	with service uses across NHS Scotland facilitated by HealthCare Improvement Scotland. The document outlines a number of recommendations based on service user experience. A programme of engagement has been developed by the Patient Engagement Public Involvement Team to capture feedback from services users across NHSGGC. Feedback will be gathered over a three week period using social media engagement, focus groups and text-based surveys. The feedback gathered will further shape the policy, wider implementation and operational delivery across all planned care services.	complaints to ensure that where any changes are required swift action is taken to mitigate the impact for service users and ensure the smooth delivery of planned care across NHSGGC.

		Example	Service Evidence Provided	Possible negative impact and Additional Mitigating Action Required
5.	Is your service physically accessible to everyone? If this is a policy that impacts on movement of service users through areas are there potential barriers that need to be addressed? Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes). 1) Remove discrimination, harassment and victimisation ☐ 2) Promote equality of opportunity ☐ 3) Foster good relations between protected characteristics. ☐	*An access audit of an outpatient physiotherapy department found that users were required to negotiate 2 sets of heavy manual pull doors to access the service. A request was placed to have the doors retained by magnets that could deactivate in the event of a fire.* *(Due regard to remove discrimination, harassment and victimisation).*	NHSGGC Policy describes a reasonable offer as an offer of appointment and/or treatment at a location anywhere within NHSGGC or associated National Treatment Centres (NTC). While this remains the initial position, there are conditions set out within the policy to ensure that patients have a choice where this will support continuation of care, patient safety or other clinical reason. Patient who will be required to travel will be notified of this as quickly as possible and in some instances notified that the provision of certain specialist services are contained on one hospital site. Every effort will be made to appoint patients in the quickest time at a location closest to them geographically. Eligible patients can access Scottish Ambulance Service hospital transport, while others may be entitled to travel expenses. A range of appointment types will be utilised/offered where appropriate in order to support patients to attend vital appointments e.g. virtual and telephone appointments may be offered where a face to face is not required. This will minimise the need for patients travel.	The NHSGGC Director of Access will have responsibility for the ongoing monitoring of the policy and its impact for service users in terms of socio-economic status, age, disability and sex.

	4) Not applicable ☐			
		Example	Service Evidence Provided	Possible negative impact and Additional Mitigating Action Required
6.	How will the service change or policy development ensure it does not discriminate in the way it communicates with service users and staff? Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes). 1) Remove discrimination, harassment and victimisation ■ 2) Promote equality of opportunity ■ 3) Foster good relations between protected characteristics ☐	*Following a service review, an information video to explain new procedures was hosted on the organisation's YouTube site. This was accompanied by a BSL signer to explain service changes to Deaf service users.* *Written materials were offered in other languages and formats.* *(Due regard to remove discrimination, harassment and victimisation and promote equality of opportunity).*	The NHSGGC Access Policy outlines the need to ensure patients are appropriately informed at all stages of the patient journey. This will help inform patients of when, where and how they are likely to receive care and their own responsibilities while they wait. NHSGGC endeavour to create the infrastructure to ensure that patients are communicated with in a format that suits their needs, with a digital first default to ensure patients receive communication quicker in their journey. Communication will be provided in a format that is appropriate for their needs where possible e.g. community language, larger font. Accepting or refusing a reasonable offer is reliant upon contacting NHSGGC to confirm, decline or change an allocated appointment or by contacting NHSGGC in response to a Patient Focussed Booking Letter and subsequently jointly agreeing a suitable date/time. Patients will be communicated with in a format that suits them applying the Scottish Government Digital First Standard. This will ensure patients are at the heart of delivery, and adopting tools and processes to promote flexibility and sustainability.	The information provided at the point of referral is crucial in identifying those patients where adjustment will be required. The referral mechanisms are not set so that these fields are mandatory. The implementation of the policy will include engagement with key stakeholders to highlight the importance of capturing and sharing this information at the start of the patient's journey.

	4) Not applicable ☐ The British Sign Language (Scotland) Act 2017 aims to raise awareness of British Sign Language and improve access to services for those using the language. Specific attention should be paid in your evidence to show how the service review or policy has taken note of this.		It is the responsibility of NHSGGC staff to provide interpreting support for patients using any of our healthcare services. The provision of interpreters is paid for directly by NHSGGC and is accessed via HR Connect. It is vital that information is captured at referral and updated onto TrakCare to ensure that all necessary arrangements can be made as early as possible to ensure that there are no delays to the delivery of care. All written information shared with patients is developed in line with the NHSGGC Accessible Information Policy. This ensures that there is a consistent, accurate and clear approach to the provision of accessible information to patients and members of the public. This includes providing information in a variety of formats and languages.	
7	Protected Characteristic		Service Evidence Provided	Possible negative impact and Additional Mitigating Action Required
(a)	Age Could the service design or policy content have a disproportionate impact on people due to differences in age? (Consider any age cut-offs that exist in the service design or policy content. You will need to objectively justify in the evidence section any segregation on the grounds of age promoted by the		Approximately 17% of the adult population of NHSGGC is above the age of 65. In line with national and local policy patients will be allocated appointments/receive treatment in accordance with their clinical priority. Patients within the same clinical priority will be seen and/or treated in chronological order, minimising the time a patient spends on the waiting list and improving quality of care	Work is required to further promote appropriate transport options for patients across NHSGGC including public transport and volunteer services. As well as processes for applying for Scottish

	policy or included in the service design). Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes). 1) Remove discrimination, harassment and victimisation ☑ 2) Promote equality of opportunity ☑ 3) Foster good relations between protected characteristics. ☐ 4) Not applicable ☐	and patient experience. The NHSGGC Access Policy will not have a differential impact in scheduling by age of a patient. Where someone is elderly/frail, additional support is available to ensure patients are able to attend for appointments and/or treatment. The principles of Realistic Medicine (RM) and Value Based Health and Care (VBH&C) have been considered whilst developing this policy. Our aim is to continue to ensure that the practice of RM enables the delivery of VBH&C across NHSGGC. Our approach will focus on areas such as, clinical sustainability, shared decision making, and future care planning and further growing the practice of RM which underpins VBH&C. We recognise the importance of the Scottish Government VBH&C Action Plan and associated vision and will continue to ensure local work is aligned to those principles.	Ambulance Service transport and access to expenses.
(b)	Disability Could the service design or policy content have a disproportionate impact on people due to the protected characteristic of disability? Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes). 1) Remove discrimination, harassment and victimisation ☑	Within NHSGGC there are; • Approximately 163,100 deaf and hearing impaired people. Of these 1,250 used British Sign Language (BSL) and 440 are deafblind. • Approximately 188,000 people living with sight problems. Many of these patients are elderly, 90% of blind and partially sighted people are over the age of 60. Research has shown that around 24% of deaf and hard of hearing people have missed appointments due to poor communication. Nearly 50% of deafblind people have a medical procedure without having it explained to them due to them due	NHSGGC will make provisions where required to meet travel, accommodation and any other relevant travel expenses for patients and their carers where appropriate. Work is required to further promote appropriate transport options for patients across NHSGGC

	2) Promote equality of opportunity ☐ 3) Foster good relations between protected characteristics. ☐ 4) Not applicable ☐	to their being no guide/communicator at their appointment, this includes surgery. Evidence from NHSGGC patient groups suggest that disabled people have more difficulties in accessing health services than non-disabled people. The barriers that have been identified are commonly given as; • Difficulty in reading and understanding letters. • Difficulty in using telephones to arrange appointments. • Transport difficulties including costs. • Engagement in health services arising from mental health problems. Due to the lack of disaggregated patient data, identifying disabled patients is not always possible. This makes it challenging to identify the uptake of services. However the policy does outline that; • Communication can be provided in a format appropriate for their needs. • Eligible patients can access Scottish Ambulance Service hospital transport, while others may be entitled to travel expenses.	including public transport and volunteer services. As well as processes for applying for Scottish Ambulance Service transport and access to expenses.
	Protected Characteristic	Service Evidence Provided	Possible negative impact and Additional Mitigating Action Required

(c)	Gender Reassignment Could the service change or policy have a disproportionate impact on people with the protected characteristic of Gender Reassignment? Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes). 1) Remove discrimination, harassment and victimisation ☑ 2) Promote equality of opportunity ☑ 3) Foster good relations between protected characteristics ☐ 4) Not applicable ☐	In 2024 all Gender Identity Clinics across NHS Scotland were instructed to operate in line with national and local access policies in order to ensure that robust and efficient processes are in place, thus reducing variation and waiting times.	
	Protected Characteristic	Service Evidence Provided	Possible negative impact and Additional Mitigating Action Required
(d)	Marriage and Civil Partnership Could the service change or policy have a disproportionate impact on the people with the	No anticipated negative impact.	

	protected characteristics of Marriage and Civil Partnership? Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes). 1) Remove discrimination, harassment and victimisation ☐ 2) Promote equality of opportunity ☐ 3) Foster good relations between protected characteristics ☐ 4) Not applicable ☐		
(e)	Pregnancy and Maternity Could the service change or policy have a disproportionate impact on the people with the protected characteristics of Pregnancy and Maternity? Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes). 1) Remove discrimination, harassment and victimisation ☐	While the policy does not apply to obstetrics, pregnant patients may be required to attend other planned care appointments that are subject to a waiting time guarantee. All appropriate support will be given to patients who are pregnant or on maternity leave to attend appointments.	

	2) Promote equality of opportunity ☒ 3) Foster good relations between protected characteristics. ☐ 4) Not applicable ☐		
	Protected Characteristic	Service Evidence Provided	Possible negative impact and Additional Mitigating Action Required
(f)	Race Could the service change or policy have a disproportionate impact on people with the protected characteristics of Race? Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes). 1) Remove discrimination, harassment and victimisation ☒ 2) Promote equality of opportunity ☒ 3) Foster good relations between protected characteristics ☐ 4) Not applicable ☐	NHSGGC is home to a diverse range of spoken languages and all appropriate measures are in place to provide communication support to people who do not speak English as a first language. Through compliance with NHSGGC policies (Interpreting and Clear to All), all patients will receive appropriate communication support in order to negotiate and attend appointments.	

(g)	Religion and Belief Could the service change or policy have a disproportionate impact on the people with the protected characteristic of Religion and Belief? Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes). 1) Remove discrimination, harassment and victimisation ☑ 2) Promote equality of opportunity ☑ 3) Foster good relations between protected characteristics. ☐ 4) Not applicable ☐	No anticipated negative impact.	
	Protected Characteristic	Service Evidence Provided	Possible negative impact and Additional Mitigating Action Required
(h)	Sex Could the service change or policy have a disproportionate impact on the people with the protected characteristic of Sex? Your evidence should show which of the 3 parts of the	Previous work in NHSGGC identified that men aged 20-29 were most likely to not attend for planned care appointments. In further small group research carried out by NHSGGC's Equality and Human Rights team, young men with SIMD 1&2 categories were asked what barriers there were to attending planned care appointments. The most common reason cited as	Application of the policy will mean scheduled appointments may be offered in NHSGGC sites requiring extended travel. This could have a disproportionate impact

	General Duty have been considered (tick relevant boxes). 1) Remove discrimination, harassment and victimisation ☐ 2) Promote equality of opportunity ☐ 3) Foster good relations between protected characteristics. ☐ 4) Not applicable ☐	potential loss of earnings and easing symptoms prior to appointment date. There is significant evidence to highlight that the gendered natured of care with the primary burden falling on women. This captures child care responsibilities and care for older relatives.	on women with caring responsibilities. NHSGGC continues to develop its approach to supporting access for all patients. Including the use of a range of appointment types e.g. virtual and telephone to minimise travel and time required away from day to day responsibilities.
(i)	Sexual Orientation Could the service change or policy have a disproportionate impact on the people with the protected characteristic of Sexual Orientation? Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes). 1) Remove discrimination, harassment and victimisation ☐ 2) Promote equality of opportunity ☐ 3) Foster good relations between protected characteristics. ☐	No anticipated negative impact.	

	4) Not applicable ☐		
	Protected Characteristic	Service Evidence Provided	Possible negative impact and Additional Mitigating Action Required
(j)	Socio – Economic Status & Social Class Could the proposed service change or policy have a disproportionate impact on people because of their social class or experience of poverty and what mitigating action have you taken/planned? The Fairer Scotland Duty (2018) places a duty on public bodies in Scotland to actively consider how they can reduce inequalities of outcome caused by socioeconomic disadvantage when making strategic decisions. If relevant, you should evidence here what steps have been taken to assess and mitigate risk of exacerbating inequality on the ground of socio-economic status. Additional information available here: Fairer Scotland Duty: guidance for public bodies - gov.scot (www.gov.scot) Seven useful questions to consider when seeking to demonstrate 'due regard' in relation to the Duty: 1. What evidence has been considered in preparing for the decision, and are there any gaps in the evidence? 2. What are the voices of people and communities	Evidence suggests that around 60% of acute inpatient use is by people who live in the poorest areas of NHSGGC. NHSGGC Policy describes a reasonable offer as an offer of appointment and/or treatment at a location anywhere within NHSGGC or associated National Treatment Centres (NTC). While this remains the initial position, there are conditions set out within the policy to ensure that patients have a choice where this will support continuation of care, patient safety or other clinical reason. Patient who will be required to travel will be notified of this as quickly as possible and in some instances notified that the provision of certain specialist services are contained on one hospital site. Every effort will be made to appoint patients in the quickest time at a location closest to them geographically. Eligible patients can access Scottish Ambulance Service hospital transport, while others may be entitled to travel expenses. A range of appointment types will be utilised/offered where appropriate in order to support patients to attend vital appointments e.g. virtual and telephone appointments may be	Application of the policy will mean scheduled appointments may be offered in NHSGGC sites requiring extended travel. NHSGGC continues to develop its approach to supporting access for all patients. Including the use of a range of appointment types e.g. virtual and telephone to minimise travel and time required away from day to day responsibilities. Work is required to explore volunteer transport options and whether there are circumstances in which 'upfront costs' can be supported.

	telling us, and how has this been determined (particularly those with lived experience of socio-economic disadvantage)? 3. What does the evidence suggest about the actual or likely impacts of different options or measures on inequalities of outcome that are associated with socio-economic disadvantage? 4. Are some communities of interest or communities of place more affected by disadvantage in this case than others? 5. What does our Duty assessment tell us about socio-economic disadvantage experienced disproportionately according to sex, race, disability and other protected characteristics that we may need to factor into our decisions? 6. How has the evidence been weighed up in reaching our final decision? 7. What plans are in place to monitor or evaluate the impact of the proposals on inequalities of outcome that are associated with socio-economic disadvantage? 'Making Fair Financial Decisions' (EHRC, 2019)21 provides useful information about the 'Brown Principles' which can be used to determine whether due regard has been given. When engaging with communities the National Standards for Community Engagement22 should be followed. Those engaged with should also be advised subsequently on how their contributions were factored into the final decision.	offered where a face to face is not required. This will minimise the need for patients travel.	
(k)	Other marginalised groups	No specific additional burden identified other than possible costs.	

	How have you considered the specific impact on other groups including homeless people, prisoners and ex-offenders, ex-service personnel, people with addictions, people involved in prostitution, asylum seekers & refugees and travellers?		
8.	Does the service change or policy development include an element of cost savings? How have you managed this in a way that will not disproportionately impact on protected characteristic groups? Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes). 1) Remove discrimination, harassment and victimisation ☑ 2) Promote equality of opportunity ☑ 3) Foster good relations between protected characteristics. ☐ 4) Not applicable ☐	The update of the NHSGGC Access Policy has not been directed by cost savings but rather efficiency and patient care.	
		Service Evidence Provided	Possible negative impact and Additional Mitigating Action

			Required
9.	What investment in learning has been made to prevent discrimination, promote equality of opportunity and foster good relations between protected characteristic groups? As a minimum include recorded completion rates of statutory and mandatory learning programmes (or local equivalent) covering equality, diversity and human rights.	All NHSGGC staff are expected to undertake the statutory and mandatory Equality, Diversity and Human Rights e-leaning module and any mandatory learning and education aligned to professional groups. Compliance with statutory and mandatory e-learning currently sits at 90% of the workforce.	

10. In addition to understanding and responding to legal responsibilities set out in Equality Act (2010), services must pay due regard to ensure a person's human rights are protected in all aspects of health and social care provision. This may be more obvious in some areas than others. For instance, mental health inpatient care or older people's residential care may be considered higher risk in terms of potential human rights breach due to potential removal of liberty, seclusion or application of restraint. However risk may also involve fundamental gaps like not providing access to communication support, not involving patients/service users in decisions relating to their care, making decisions that infringe the rights of carers to participate in society or not respecting someone's right to dignity or privacy.

The Human Rights Act sets out rights in a series of articles – right to Life, right to freedom from torture and inhumane and degrading treatment, freedom from slavery and forced labour, right to liberty and security, right to a fair trial, no punishment without law, right to respect for private and family life, right to freedom of thought, belief and religion, right to freedom of expression, right to freedom of assembly and association, right to marry, right to protection from discrimination.

Please explain in the field below if any risks in relation to the service design or policy were identified which could impact on the human rights of patients, service users or staff.

The right to good health is of paramount importance. The policy has been considered alongside possible risks to human rights and considers NHSGGC has met its duties in relation to all related articles.

Please explain in the field below any human rights based approaches undertaken to better understand rights and responsibilities resulting from the service or policy development and what measures have been taken as a result e.g. applying the PANEL Principles to maximise Participation, Accountability, Non-discrimination and Equality, Empowerment and Legality or FAIR* .

Not applicable.

- Facts: What is the experience of the individuals involved and what are the important facts to understand?
- Analyse rights: Develop an analysis of the human rights at stake
- Identify responsibilities: Identify what needs to be done and who is responsible for doing it
- Review actions: Make recommendations for action and later recall and evaluate what has happened as a result.

Having completed the EQIA template, please tick which option you (Lead Reviewer) perceive best reflects the findings of the assessment. This can be cross-checked via the Quality Assurance process:

☐ Option 1: No major change (where no impact or potential for improvement is found, no action is required)

☐ Option 2: Adjust (where a potential or actual negative impact or potential for a more positive impact is found, make changes to mitigate risks or make improvements)

☐ Option 3: Continue (where a potential or actual negative impact or potential for a more positive impact is found but a decision not to make a change can be objectively justified, continue without making changes)

☐ Option 4: Stop and remove (where a serious risk of negative impact is found, the plans, policies etc. being assessed should be halted until these issues can be addressed)

11. If you believe your service is doing something that 'stands out' as an example of good practice - for instance you are routinely collecting patient data on sexual orientation, faith etc. - please use the box below to describe the activity and the benefits this has brought to the service. This information will help others consider opportunities for developments in their own services.

Not applicable.

Actions – from the additional mitigating action requirements boxes completed above, please summarise the actions this service will be taking forward.	Date for completion	Who is responsible?(initials)
Implementation of a comprehensive performance monitoring framework including analysis of demographic data on patients with protected characteristics.	12 months	Director of Access? Is it me

Further roll out of extended appointment types, including virtual and telephone.	12 months	Sectors/ Directorates
Engagement with HSCPs to understand volunteer driver services available across NHSGGC and how these can be use most appropriately to support patient access in vulnerable groups.	6 months	Director of Access
Explore potential community options for services who provide 'up front costs' for patients living in NHSGGCs poorest areas.	6 months	Director of Access

Ongoing 6 Monthly Review please write your 6 monthly EQIA review date:

November 2024

Lead Reviewer: Name
EQIA Sign Off: Job Title
Signature
Date

Quality Assurance Sign Off: Name
Job Title
Signature
Date

NHS GREATER GLASGOW AND CLYDE EQUALITY IMPACT ASSESSMENT TOOL
MEETING THE NEEDS OF DIVERSE COMMUNITIES
6 MONTHLY REVIEW SHEET

Name of Policy/Current Service/Service Development/Service Redesign:

Please detail activity undertaken with regard to actions highlighted in the original EQIA for this Service/Policy

		Completed	
		Date	Initials
Action:			
Status:			
Action:			
Status:			
Action:			
Status:			
Action:			
Status:			

Please detail any outstanding activity with regard to required actions highlighted in the original EQIA process for this Service/Policy and reason for non-completion

		To be Completed by	
		Date	Initials
Action:			
Reason:			
Action:			
Reason:			

Please detail any new actions required since completing the original EQIA and reasons:

		To be completed by	
		Date	Initials
Action:			
Reason:			
Action:			
Reason:			

Please detail any discontinued actions that were originally planned and reasons:

Action:	
Reason:	
Action:	
Reason:	

Please write your next 6-month review date

Name of completing officer:

Date submitted:

If you would like to have your 6 month report reviewed by a Quality Assuror please e-mail to: alastair.low@ggc.scot.nhs.uk