Directorate of Health Workforce and Performance
Access Support Team

The Scottish Government

CEL 33 (2012)

August 2012

Dear Colleague

DELIVERING WAITING TIMES

1. This letter attaches the NHSScotland Waiting Time Guidance; the NHS Scotland National Access Policy and Effective patient booking for NHSScotland, which are intended to provide additional guidance for Boards to assist them in the delivery of the national waiting times standards.

2. These documents each relate to 18 weeks Referral to Treatment, NEW WAYS Stage of Treatment Standards, the 6 week standard for key diagnostic tests and the Treatment Time Guarantee which was contained in the Patient Rights (Scotland) Act 2011. As such these should be read in conjunction with the Treatment Time Guarantee Guidance, the Act and the Regulations and Directions.

3. The NHSScotland Waiting Time Guidance replaces previous '18 weeks: The Referral To Treatment Standard: Principles and definitions' (January 2009), and 'NEW WAYS of Defining and Measuring waiting times' (December 2007). It is written for the use of all staff in NHSScotland and particularly those involved in collecting and recording information for patients.

4. The National Access Policy aims to ensure consistency of approach in providing access to services. This policy should be supported by a Local Access Policy developed by each Board setting out the details of how these principles apply to their local services.

5. Effective patient booking for NHSScotland sets out good practice in booking and management of patient appointments.

Action

4. Chief Executives must ensure that this letter, the attached documents and all other relevant supporting documents are brought to the attention of all appropriate staff. In particular ensure that:

- staff are trained to ensure that they fully understand the implications of this guidance and its application.
- that local policy on waiting times reflects the requirements set out.
- that your Local Access Policy is developed to support these principles and is made widely available. This includes publication on the Board's website.

Addresses

For action
Chief Executive, NHS Boards
Chief Executives, Special Health Boards
Chief Executive, NHS National Services
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Yours sincerely

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Director of Workforce and Performance

NHSScotland Waiting Time Guidance:

18 weeks Referral to Treatment Standard
NEW WAYS Stage of Treatment Standards
and incorporating Treatment Time Guarantee Guidance

July 2012

Document purpose	Guidance for NHS Boards on application of Treatment Time Guarantee, 18 weeks Referral to Treatment Standard and NEW WAYS Stage of Treatment Standards
Title	NHSScotland Waiting Time Guidance
Author	Scottish Government (Access Support Division)
Issue Date	July 2012
Target audience	NHS Staff involved in implementing The Patient Rights (Scotland) Act 2011 Treatment Time Guarantee, New Outpatient and Inpatient/Day case Stage of Treatment and 18 weeks Referral to Treatment waiting times
Circulation list	NHS Board Chief Executives
Description	NHSScotland Waiting Times Guidance: Treatment Time Guarantee, 18 weeks Referral to Treatment Standard and NEW WAYS Stage of Treatment Standards
Cross references	The Patient Rights (Scotland) Act 2011 The Patient Rights (Treatment Time Guarantee) (Scotland) Regulations 2012 The Patient Rights (Treatment Time Guarantee) (Scotland) Directions 2012 Patient Rights (Scotland) Act 2011 Treatment Time Guarantee Guidance NHSScotland National Access Policy: Treatment Time Guarantee, 18 weeks Referral to Treatment Standard, NEW WAYS Stage of Treatment Standards Effective Patient Booking for NHSScotland ISD Health & Social Care Data Dictionary Armed Forces CEL 8 (2008); Armed Forces CEL 3 (2009); Armed Forces CEL 39 (2010) Adult Exceptional Aesthetic Referral Protocol CEL 27 (2011)
Superseded documents	18 Weeks: The Referral To Treatment Standard: Principles and Definitions Issue 2.0 (January 2009) NEW WAYS of defining and measuring waiting times: Applying the Scottish Executive Health Department Guidance, Version 3.0 (December 2007)

Contents

1. Introduction

Waiting times for treatment in Scotland are shorter than they have ever been before, and embrace more people than ever before. As a minimum 90% of patients accessing acute secondary care services can now expect to be treated within 18 weeks from the receipt of their referral to the start of their treatment. This is underpinned by standards for the maximum length of wait for a first outpatient appointment and also for an inpatient or day case appointment for admission. For the first time, the Patient Rights (Scotland) Act 2011 enshrines in law that, once a patient has been diagnosed as requiring inpatient or day case treatment, and has agreed to that treatment, that patient's treatment must start within 12 weeks of the treatment having been agreed with the Health Board.

This approach firmly supports NHSScotland's Quality Ambitions, which put Quality at the heart of our NHS. The shared ambition is to deliver world-leading person-centred, safe and effective healthcare services; these will impact on every single person working with or for NHSScotland in supporting or providing treatment.

Person Centred: There will be mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making.

Safe: There will be no avoidable injury or harm to people from healthcare they receive, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times.

Effective: The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated.

Furthermore, timeliness is internationally recognised as one of the six dimensions of quality, as an equal pillar with effective; efficient; safe; equitable and person centred. The intention, therefore, of the Treatment Time Guarantee is to assure timely access to care at the point of treatment, so that patients do not have the added worry of waiting too long. The Treatment Time Guarantee will apply to all planned inpatient and day case treatments (with very few exceptions which are set out in the Regulations). The Treatment Time Guarantee operates within the 18 weeks Referral To Treatment standard, to support timely access to high quality care at each point of the patient journey.

The current waiting times standards are:

- 18 weeks Referral to Treatment for 90% of patients;
- 12 weeks for new outpatient appointments;
- 6 weeks for the eight key diagnostic tests and investigations; and,
- the legal 12 week Treatment Time Guarantee.

To deliver the 18 weeks Referral to Treatment standard, all stages of the patient's pathway need to be as short as possible. This is why there are waiting times standards for the stages of treatment. Consequently the vast majority of patients will be seen in less than 12 weeks for outpatients and less than 12 weeks for the Treatment Time Guarantee.

2. Purpose of This Document

This guidance document should be used in conjunction with the Patient Rights (Scotland) Act 2011, The Patient Rights (Treatment Time Guarantee) (Scotland) Regulations 2012, The Patient Rights (Treatment Time Guarantee) (Scotland) Directions 2012, Treatment Time Guarantee Guidance, NHSScotland National Access Policy and Effective Patient Booking for NHSScotland guidance.

The NHSScotland National Access Policy aims to ensure consistency of approach in providing access to services. The Effective Patient Booking for NHSScotland guidance aims to set out good practice in booking and management of patient appointments.

This document sets out the high level principles that should be adhered to. This guidance is to ensure that patients who are waiting for appointments are managed fairly and consistently across NHSScotland and that NHSScotland has clear and consistent guidance.

This document is for the use of all staff in NHSScotland, and particularly those involved in collecting and recording information for patients on the following:

- 18 weeks Referral to Treatment for 90% of patients;
- 12 weeks for new outpatient appointments;
- 6 weeks for the eight key diagnostic tests and investigations; and
- the legal 12 week Treatment Time Guarantee.

The Scottish Government Directorate for Health Workforce and Performance Access Support Division are the owners of this guidance. The Information Delivery Team are responsible for managing guidance and authorising changes.

Any enquiries regarding national guidance should be addressed to Information Services Division at NSS.isdWAITINGTIMES@nhs.net in the first instance.

3. Access to Services

Patients may access health services in a variety of different ways, which could include the following:

- **Referral to a consultant-led service or Direct Access Service for Audiology**. Examples include a GP, AHP, Optometrist or General Dental Practitioner referring to a consultant-led service; a GP referring to a direct access Audiology service; Consultant to Consultant referrals.

- **Referral to Direct Access or Open Access Diagnostics**. This is where patients are referred to a diagnostic service to inform a primary care clinician of the most appropriate way to manage the patient's condition.

- **Referral to a One-Stop Service**. This is where the patient receives a consultation, diagnosis and treatment at one appointment during the same visit.

- **Referral to a 'Rapid Access' service**. These are services which must be provided within a short time period due to clinical need.

- **Referral to a General Practitioner with Special Interest (GPwSI)**. This is where a GP undertakes patient care which would normally be performed by a Consultant.

- **Re-referrals of patients with a Long Term Condition with an exacerbation or recurring symptom**. A Long Term Condition is defined as a condition that cannot at present be cured, but can be treated and controlled over a long period of time by medication and other therapies. Examples include chronic obstructive pulmonary disorder (COPD), epilepsy, asthma and diabetes mellitus. Patients may have more than one long term condition.

- **Referrals for Sequential Bilateral Surgery**. This is where a patient is referred for bilateral surgery to be carried out sequentially, for example, cataract surgery on both eyes.

- **Planned Repeats**. These patients are distinguished from other patients given an advanced date of appointment by their requirement for regular surveillance or treatment planned over a series of appointments. For planned repeat patients, only the first treatment in the required series of appointments are subject to waiting time standards and Treatment Time Guarantee as all subsequent appointments are return appointments.

- **Patients transferred to a planned service via Accident & Emergency, Minor Injury Unit or Walk-in centres**. This is where a patient is referred to a planned service as a result of attending Accident & Emergency, Minor Injury Unit or Walk-in centre. A formal referral will not always be sent in these cases.

- **Self-referral by a patient where the referral is accepted by a care professional**. There are certain services where a patient may self-refer.

- **Visiting practitioner service**. This is where one Health Board (the original Health Board) has an arrangement with another Health Board (the Commissioning Health Board) to provide a service in the commissioning Health Board's area. This often occurs in remote and rural areas, where services are relatively infrequent.

4. Communication with Patients

It is important that patients are provided with clear, accurate and timely information about how processes will operate for arranging for them to be seen.

The principles of effective patient booking practice are detailed in the Effective Booking for NHSScotland guidance.

Health Boards must introduce effective processes for delivering and accepting or rejecting offers of appointments.

The patient should be given clear instructions on how and when to contact the hospital to either accept or decline offers of appointments, and the timeframe in which to do this. This can be by telephone, electronically or in writing.

All patients should be given clear information on the consequences of not responding quickly to communications and the impact this could have on their waiting time. All patient literature should make sure that the patient can understand their responsibilities. This should be set out in each Health Board's Local Access Policy.

Communications with patients should be in a format appropriate to their needs e.g. large print, community language. It may be necessary to contact the referring clinician or patient/patient's carer to clarify communication requirements such as different formats, languages or interpreter.

Health Boards must advise the patient (or where appropriate the patient's carer) in writing when:

- the patient does not attend an agreed appointment and has not given the Health Board reasonable notice of this (Did Not Attend);
- the patient has been removed from the waiting list, for example, because the patient Did Not Attend or Could Not Attend; or
- the responsible Health Board is unable to meet the waiting time standard within its own area.

4.1 Treatment Time Guarantee Patients

Health Boards must advise Treatment Time Guarantee patients (or where appropriate the patient's carer) in writing when:

- the patient is eligible for the Treatment Time Guarantee;
- the patient has been deemed indefinitely unavailable for treatment;
- the patient is unavailable for treatment for a known period, noting the start and end date of that known period and, where appropriate, noting the anticipated date when the patient will be reviewed;
- the patient has refused two or more offers of an appointment;
- the patient does not attend an agreed appointment and has not given the Health Board reasonable notice of this (Did Not Attend);
- the patient has accepted a reasonable offer of appointment but then the patient has on three or more occasions cancelled an appointment (Could Not Attend);
- the patient has been removed from the waiting list, for example, because the patient Did Not Attend or Could Not Attend;
- to confirm the patient's request to be treated in a different Health Board; or

- the responsible Health Board is unable to meet the Treatment Time Guarantee within its own area.

If the Health Board breaches the Treatment Time Guarantee, then the Health Board must provide the patient (or where appropriate the patient's carer) with an explanation in writing of why the Health Board did not deliver the Treatment Time Guarantee, details of the advice and support available and details of how feedback, comments or complaints can be raised.

Any communication which is required in law for the Treatment Time Guarantee is to be made to the patient (or where appropriate the patient's carer) in writing. This may be electronically if:

- this has been consented in writing; and
- such consent has not been withdrawn in writing.

"In writing" includes any communication sent by electronic means if it is received in a form which is legible and capable of being used for subsequent reference.

5. Additional Support Needs

Health Boards have a duty to ensure that patients are provided with information they can easily understand, that appropriate support is put in place as required and additional needs are taken account of where these have been communicated by the patient, the patient's carer or a medical practitioner.

Additional Support Needs are areas in which health services are required to provide assistance to the patient to facilitate their access to health services.

Patients who have additional needs should be identified on Health Board information systems so that appropriate support can be put in place, along the entire patient pathway, for those who need it.

The Examples of Information on Additional Needs table overleaf provides examples of information that should be collected to support patients who have additional needs. Other information may be required. An option of 'requires more time in appointment' may be required for patients with additional support needs.

Examples of Information on Additional Needs

Literacy issues	Requires information verbally Requires written information in large font Requires words and pictures version
Learning Disability	Requires easy to read Requires words and pictures Using Makaton sign language Requires a carer present Requires an advocate present
English as a second language	Requires interpreter Requires information verbally Requires information translated
Speech impairment	Requires to write response Using Makaton sign language Requires a carer or advocate present
Using lip-reading	Requires lip speaker Requires information verbally
Using British sign language	Requires British Sign Language interpreter
Using Makaton sign language	Requires to staff to understand
Deaf/Blind	Requires a guide communicator Uses a tape recorder Requires a loop Requires to bring a guide dog
Visual impairment	Requires written information in large font Requires information verbally Requires easy to read Uses email
	Requires to bring a guide dog Requires information in Braille Requires communication by phone Uses Email
Hearing impairment	Requires to bring a hearing dog Requires written information Uses Text Phone Uses Email
Mobility issues	Requires Ambulance/car/taxi Requires two person escort Requires transport Carer will attend Requires NHS helper/Volunteer assistance with wheelchair
Faith/belief	Prefer Female/Male consultation Prefer non Friday appointments Requires access to Prayer Room
Socio Economic	Lack of bus/train services Money to travel to appointments Family constraints (eg Gender Based Violence, caring responsibilities) Getting time off work Early discharge implications
Other	Requires appropriate chaperone

6. Waiting Time Calculation

6.1 Waiting Time Clock

The patient's waiting time is referred to as a waiting time clock, using the following terms:

- **Clock start**
  The date at which the calculation of waiting time starts.

- **Clock adjustments**
  Where it is reasonable and clinically appropriate, the waiting time clock may be adjusted for a number of reasons, including: the patient has given the Health Board reasonable notice that they can not attend an appointment; where the patient is unable to attend or did not attend an appointment; when the patient refuses a reasonable offer; and periods of time when the patient is unavailable for treatment.

  These periods do not count towards the calculation of waiting time.

- **Clock stop**
  The date at which the calculation of waiting time stops.

6.2 18 Weeks Referral to Treatment

The Health Board of receipt of initial referral is responsible for ensuring that the patient is treated within 18 weeks, irrespective of the Health Board of treatment.

- **Clock start** is the date when the referral is received.

- **Clock stop** is the date that treatment commences.

For patients with a Long Term Condition with an exacerbation or recurring symptom, a new waiting time clock must be started for new referrals for the same condition.

For patients waiting for sequential bilateral treatment the waiting time for the second treatment is measured as a separate, second pathway. It may be that the agreement for the need for both treatments is made at the same time. However, normally the agreement to commence the second treatment is only made on or after the post-operative review for the first treatment. The waiting time for the second treatment should not start until that agreement is reached. The sequential treatment must not be managed as a Planned Repeat.

For consultant to consultant referrals a new waiting times clock will be started on receipt of the referral by the new consultant-led service if the referral is for a new condition only. 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 Accident & Emergency, Minor Injury Unit or Walk-in centre a formal referral will not always be sent. The waiting times clock will start on the date of attendance to A&E/Minor Injury Unit/Walk-in Centre where the purpose of the appointment is for treatment, not a follow-up to treatment already started in A&E/Minor Injury Unit/Walk-in Centre.

For patients that self-refer the waiting time clock starts on the date that the patient self-refers.

6.3 New Outpatients

The Health Board of treatment is responsible for ensuring that the patient is seen within 12 weeks.

- **Clock start** is the date when the referral is received.
- **Clock stop** is the date of the new outpatient appointment.

For patients with a Long Term Condition with an exacerbation or recurring symptom a new waiting time clock must be started for new referrals for the same condition.

For consultant to consultant referrals a new waiting times clock will be started on receipt of the referral by the new consultant-led service if the referral is for a new condition.

For patients transferred to a planned service via Accident & Emergency, Minor Injury Unit or Walk-in centre a formal referral will not always be sent. The waiting times clock will start on the date of attendance to A&E/Minor Injury Unit/Walk-in Centre where the purpose of the appointment is for treatment, not a follow-up to treatment already started in A&E/Minor Injury Unit/Walk-in Centre.

For patients that self-refer the waiting time clock starts on the date that the patient self-refers.

6.4 Treatment Time Guarantee

The Health Board who agrees the treatment is required in law to ensure that patients access their treatment within 12 weeks.

- **Clock start** is the date when the clinician and patient agree to the agreed treatment (which will be the date when the decision is made by the clinician to put the patient on the waiting list).

For the vast majority of patients agreement will be the date of the outpatient appointment. It is therefore essential there is no delay between the agreement to treat and the patient's waiting time clock starting.

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 they would like to have time to consider whether to go ahead with the treatment, then the calculation of the Treatment Time Guarantee will not start until the patient agrees to proceed with that treatment. Good practice would be to ascertain from the patient how long they wish to take to consider the treatment and agree a date when the hospital will contact them to discuss this further and agree treatment.

In such circumstances the contact date should be noted and the patient should be contacted on that date. If the patient agrees the treatment at that point, then that is the clock start date for the Treatment Time Guarantee. Should the patient wish for more time to consider the treatment, then good practice would be for a discussion to be held with the appropriate clinician to determine if a further contact date should be agreed, or if the patient should be referred back to the GP (i.e. the referring clinician).

Pre-operative assessment cannot be taken as the date of agreement to treatment as the clinician and the patient will have previously already agreed to the agreed treatment. The pre-operative assessment appointment is intended to ensure that the patient is fit for treatment which has already been agreed, and does not constitute agreeing to treatment. The start date, based on agreement to treat, is clear in legislation and this must be applied at all times.

- **Clock stop** is the date that the patient starts to receive the agreed treatment.

Normally the patient will be admitted to hospital on the day of treatment, and the treatment time end point will be recorded as such.

In some circumstances, the patient may be admitted for treatment the day before their actual surgery. Where this occurs in order to start to the initial stages of treatment, for example, to administer medication or to clinically prepare the patient, this date should be recorded as the end date i.e. 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, and the patient will have a zero-wait recorded against the Treatment Time Guarantee. For the small number of patients where treatment can not be undertaken on the day, the waiting time clock will continue.

For patients waiting for sequential bilateral treatment the waiting time for the second treatment is measured as a separate, second pathway. It may be that the agreement for the need for both treatments is made at the same time. However, normally the agreement to commence the second treatment is only made on or after the post-operative review for the first treatment. The waiting time for the second treatment should not start until the clinician and patient agree to the agreed treatment. The sequential treatment must not be managed as a Planned Repeat.

For patients transferred to a planned service via Accident & Emergency, Minor Injury Unit or Walk-in centre a formal referral will not always be sent. The waiting times clock will start on the date when the clinician and patient agree to the agreed treatment.

For patients changing their ordinary residence to another Health Board area whose waiting time clock has already started and that patient requests to be treated within that other Health Board area (i.e. the Health Board of their new residence) the new responsible Health Board may reset the calculation of waiting time to zero where that is reasonable and clinically appropriate to do so.

A suspension of the Treatment Time Guarantee will only be granted by Scottish Ministers in very exceptional circumstances for a period of up to 30 days. A longer period will require approval in the Scottish Parliament. Scottish Government Health Directorate processes should be followed when seeking a suspension.

6.5 Exceptions to the Treatment Time Guarantee

The Health Board who agrees the treatment is required in law to ensure that patients access their treatment within 12 weeks.

Exceptions to the Treatment Time Guarantee are set out in the Regulations. These are:

- assisted reproduction;

- obstetrics services;
- organ, tissue or cell transplantation whether from living or deceased donor;
- designated national specialist services for surgical intervention of spinal scoliosis;
- the treatment of injuries, deformities or disease of the spine by an injection or surgical intervention.

The latter exception around spinal treatment is intended to be a temporary exclusion for a period of one year, and will be removed from the list of exceptions from 1 October 2013. This means Health Boards should now be working to ensure that there is the necessary capacity to deliver the Treatment Time Guarantee for patients who require such planned inpatient and day case spinal treatment from 1 October 2013.

It is also intended to review the designated national scoliosis service with the aim of bringing it within the Treatment Time Guarantee at a later date.

- **Clock start** is the date when the clinician and patient agree to the agreed treatment (which will be the date when the decision is made by the clinician to put the patient on the waiting list).

- **Clock stop** is the date on that the patient starts to receive the agreed treatment.

6.6 Eight Key Diagnostic Tests and Investigations

The Health Board of receipt of the request for the test or procedure is responsible for ensuring that the verified report is received by or made available to the requester within 6 weeks.

Diagnostic tests and investigations are used to identify a patient's condition, disease or injury to enable a medical diagnosis to be made. The Eight Key Diagnostic Tests and Investigations are:

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

- **Clock start** is the date when the request for the test or procedure is received within the department.

- **Clock stop** is the date the verified report has been received by or made available to the requester.

7. Offers of Appointment

It is good practice that prior to making a referral the referring clinician should use a booking fact sheet to discuss the process of referral with the patient, in line with the recommendations in Effective Patient Booking for NHSScotland.

Health Boards must ensure that their Local Access Policy includes their reasonable offer policy. The details of each Health Board's reasonable offer policy should be clearly set out in their Local Access Policy and published on their website. A Health Board may choose to adopt a policy whereby more than two offers of appointment can be routinely made to accommodate further patient focus when agreeing a suitable appointment date.

7.1 Reasonable Offer

A reasonable offer of appointment is the offer of two or more different dates of appointment for each stage of the patient's treatment pathway, with a minimum of seven days notice from the date each offer of appointment to the date of the appointment.

Offers should be made as soon as possible after receipt of referral or when the clinician and the patient agree to the agreed treatment.

If the patient accepts the first appointment date offered then this will be deemed as accepting a reasonable offer of appointment and a further date need not be offered.

Short notice appointment dates (i.e. those offered with less than seven days notice) can be offered. If the patient accepts such an offer, then this would be deemed to be a reasonable offer of appointment. However, if the patient declines such a short notice offer, they must not be disadvantaged, and must be made a reasonable offer of a further two or more different dates of appointment within the waiting time standards and Treatment Time Guarantee. Clearly cases of clinical urgency will require an early alternative appointment.

When making a reasonable offer it is good practice for appointment offers to be made as soon as possible after the patient agrees treatment, and ideally at least fourteen days before the proposed treatment date. (The minimum period of notice for a 'reasonable offer' of appointment is seven days.)

Health Boards must ensure that patient additional needs are taken into account and that appropriate support is put in place as required when offering an appointment date.

In offering appointment dates by letter, ideally (as a matter of good practice) the patient should receive the letter at least fourteen days prior to the appointment date. The letter should be in a format appropriate to the patient's needs and should clearly set out details of how the patient can request an alternative date and a reasonable timescale to do so.

Urgent appointments, where the waiting time should be determined by clinical need, are excluded from the reasonable offer timescale of seven days notice. However, every effort should be taken to agree a date suitable for the patient taking account of the urgency and availability of clinical services.

Appointments offered must be within the Treatment Time Guarantee or the waiting time standard which applies to each patient for that part of their journey. If the patient has not been seen within waiting time standard or Treatment Time Guarantee this must be clearly reported as exceeding waiting time standard or Treatment Time Guarantee (taking account of periods where the waiting time clock has been adjusted).

The Health Board must ensure that if it breaches the Treatment Time Guarantee, then the patient should be offered the next available appointment having regard to the patient's availability and other relevant factors. It is also important that the patient is provided with an explanation in writing of why the Health Board did not deliver the Treatment Time Guarantee, details of the advice and support available and details of how feedback, comments or complaints can be raised. In arranging the next available appointment the Health Board must not prioritise the start of the patient's treatment if that would be detrimental to another patient with a greater clinical need for treatment.

Communication with patients should be in a format appropriate to their needs, for example, letters that are large print, easy to read or in the patient's primary language, or verbal. Please see the 'Additional Support Needs' section for further guidance.

Each Health Board should have a reminder/confirmation system in place for patients who do not confirm their appointment. This will ensure patients are given a second notification of their appointment date and time.

Where the process of Implied Acceptance is used, the patient's waiting times clock must not be adjusted if they do not attend the offered first appointment date because they have not yet accepted a reasonable offer of two or more different dates of appointment.

It is not considered a reasonable offer of appointment if the patient is offered a treatment location without an offer of date for appointment.

7.2 Appointment Location

It is expected that most patients will be seen and treated locally wherever possible and appropriate, based on clinical need and operational effectiveness. However, it may not always be possible for Health Boards to provide access locally for all patients and for all services where Health Boards are, for example, constrained by geography or specialist services.

Consequently Health Boards have agreements in place for other Health Boards or other providers to provide additional capacity. The details of each Health Board's service locations where treatment may be reasonably undertaken should be clearly set out in their Local Access Policy and published on their website. Possible and reasonable service locations should also be explained to each patient from the outset.

If specified in their Local Access Policy, it is a reasonable offer where the Health Board offers the patient an appointment at any of the following locations:

- Any site within that Health Board area providing the required service, unless the Health Board specifies in their Local Access Policy arrangements for remote and rural settings.
- Any site outwith that Health Board area where treatment is routinely provided for that Health Board, for example another Health Board, the Golden Jubilee National Hospital or a national or regional service centre.
- In certain circumstances limited use of alternative providers, within or without the Health Board area, including Independent Sector providers, may be required in response to capacity constraints and would also constitute a reasonable offer.

Where the Health Board is unable to meet the waiting time standards or Treatment Time Guarantee within its own area and has arranged for treatment by another suitable alternative provider outwith the Health Board, the Health Board must be responsible for the cost of any transport and accommodation arrangements necessarily and reasonably incurred by the

patient and their carer (if necessary). This would not apply, however, if the patient has requested to be treated elsewhere for personal reasons.

It is important that patients are advised as early as possible of the likely need to travel for treatment. If an offer is to be made for treatment out of the Health Board area, or at a location not listed in the Health Board's Local Access Policy, then the provision of clear and accurate communication to patients is essential; each Health Board should set out a good practice approach and 'script' for staff's use in these circumstances. Health Boards may find it helpful to record the willingness to travel of patients at the start of the process.

A small number of patients may wish to request a specific appointment location. Accommodating a request for a specific appointment location cannot be guaranteed in any case. Where the patient would prefer to wait for treatment at a specific location, rather than receive treatment at another location, and the Health Board does agree to accommodate this request, the patient's wait might be longer than the waiting time standards or Treatment Time Guarantee. The patient should be made aware of the length of the wait they will experience in writing. It must be clear that this is at the patient's request and that they are fully aware of the consequences. A request for treatment in a specific location cannot be prompted by the Health Board.

7.3 Named Consultant

Patients are referred to a clinical team and seen by an appropriate member of that team rather than to an individual consultant. Each Health Board's Local Access Policy should set out that a reasonable offer of appointment relates any competent clinician who is part of the consultant-led service which the Heath Board provides in that specialty or subspecialty. A named consultant will only be allocated to ensure continuity of care, patient safety or for other clinical or exceptional reasons. The Local Access Policy should also set out the Health Board's position on whether or not the same clinician who carried out the outpatient assessment would normally undertake the inpatient/day case treatment.

A small number of patients may wish to request a named consultant. Accommodating a request for a specific named consultant cannot be guaranteed in any case. Where the patient would prefer to wait for an appointment with a named consultant, rather than an appointment with another consultant, and the Health Board agrees to accommodate this request, the patient's wait might be longer than the waiting time standards or Treatment Time Guarantee. The patient should be made aware of the length of the wait they will experience in writing. It must be clear that this is at the patient's request and that they are fully aware of the consequences of their decision. A request for an appointment with a named consultant cannot be prompted by the Health Board.

7.4 Patient Refuses a Reasonable Offer

If the patient refuses a reasonable offer (i.e. two or more different dates of appointment), then advice on next steps should be sought from the relevant clinical team. As part of this process, systems should be in place to record relevant information.

On refusal of a reasonable offer the Health Board may:

- refer the patient back to their referring clinician;
- reset the treatment time clock to zero if it is not reasonable and clinically appropriate to refer the patient back to their referring clinician.

A period of unavailability must not be applied in circumstances when the patient refuses a reasonable offer of appointment.

Health Boards must inform patients of the consequences of refusing a reasonable offer of appointment. Also, for patients under the Treatment Time Guarantee, if the patient is referred back to their referring clinician, the Health Board must write to the patient, the patient's referring clinician and, where appropriate, the patient's carer to inform them of this.

It is important that the date the patient declined the reasonable offer is recorded and the actions taken i.e. refer back to referring clinician or reset the waiting time clock to zero. The patient's waiting clock is reset to zero from the date on which the last offer was declined, not the date of the offered appointment.

As part of its Local Access Policy, a Health Board may choose to adopt a policy whereby more than two offers of appointment dates can be routinely made to accommodate further patient focus over agreeing a suitable appointment date.

7.5 Offers of Appointment Beyond the Treatment Time Guarantee

Where a Health Board has not complied with the Treatment Time Guarantee the Health Board must make such arrangements as are necessary to ensure that the agreed treatment starts at the next available opportunity, having regard to the patient's availability and other relevant factors. However, this prioritisation to the start of treatment must not be to the detriment of another patient with a greater clinical need for treatment.

Short notice appointment dates can be offered. If the patient declines such a short notice offer, they should be offered the next available appointment for treatment. If the patient refuses this offer, then the patient should be offered the next available appointment without resetting the waiting time clock to zero.

The Health Board must provide the patient with an explanation why their Treatment Time Guarantee did not start within 12 weeks. The patient must be given details of the advice and support service available and how to give feedback, comments or raise concerns.

7.6 Booking Methods

There are a number of different approaches to booking appointment and admission dates used across NHSScotland. Each Health Board is responsible for ensuring that, whatever the method(s) selected for use locally, it meets the waiting time standards or Treatment Time Guarantee described for a reasonable offer and takes account of guidance under 'Communication with Patients' and 'Additional Support Needs'. For further information please refer to Effective Patient Booking for NHSScotland.

8. Non Attendance

8.1 Could Not Attend

If the patient has accepted a reasonable offer of appointment but then gives the hospital reasonable notice that they will not attend that appointment (CNA), then advice on next steps should be sought from the relevant clinical team. As part of this process, systems should be in place to record relevant information. The Health Board may reset the patient's waiting time clock to zero, where it is reasonable and clinically appropriate to do so. This would be effective from the day that the patient informs the Health Board that can not attend rather than the appointment date.

Health Boards are not required to reset the clock to zero. For example, should a patient requiring urgent treatment cancel an agreed appointment with the Health Board (giving reasonable notice to the Health Board), it is unlikely that it would be considered reasonable and clinically appropriate for the Health Board to reset the clock to zero. Generally, in such circumstances, it is likely that the Health Board would offer another appointment to the patient within the waiting time standards or Treatment Time Guarantee without resetting the clock to zero.

When the patient informs the Health Board that they have a minor illness such as a cold, which may prevent them from attending the appointment on the agreed date, clinical advice must be sought as to the clinically appropriate course of action.

- If the clinician has advised that the patient's minor illness will prevent the agreed appointment or treatment from proceeding on the agreed date, a known period of medical unavailability should be applied. This would normally be for a short period only, for example up to two weeks.

- If the clinician has advised that the patient's minor illness will not prevent the agreed appointment or treatment from proceeding on the agreed date, the appointment should go ahead as planned.

- If the clinician has advised that the minor illness will not prevent the agreed appointment or treatment from proceeding on the agreed date but the patient can not attend (CNA) the agreed appointment, the patient's waiting time clock is reset to zero, where it is reasonable and clinically appropriate to do so.

If the patient cancels an agreed appointment for the third time then the patient would normally be referred back to their referring clinician, where it is reasonable and clinically appropriate for the Health Board to do so. The waiting time standards and Treatment Time Guarantee will cease to apply. If it is not reasonable or clinically appropriate to refer the patient back to their referring clinician, then the clock may be reset to zero once again. The clock should be reset to zero from the date the patient advised they were cancelling their agreed appointment.

If the patient is to be referred back to their referring clinician, the clinical advice must be sought to confirm it is appropriate and clinically reasonable to do so. The date of the decision to refer the patient back to their referring clinician must be recorded on the patient administration system.

Health Boards should inform patients of the consequences of cancelling an agreed appointment. Health Boards must inform patients (or where appropriate the patient's carer) and the patient's referring clinician when the patient has been removed from the waiting list.

Where a Health Board has not complied with the Treatment Time Guarantee the Health Board must make such arrangements as are necessary to ensure that the agreed treatment starts at the next available opportunity, having regard to the patient's availability and other relevant factors. If the patient cancels an agreed appointment, then the patient should be offered the next available appointment without resetting the clock to zero. However, this prioritisation to the start of treatment must not be to the detriment of another patient with a greater clinical need for treatment.

8.2 Did Not Attend

If the patient does not attend an agreed appointment and has not given the Health Board reasonable notice of this (DNA), then advice on next steps should be sought from the clinical team to which the patient was referred. As part of this process, systems should be in place to record relevant information.

The Health Board may reset the patient's waiting time clock to zero or refer the patient back to their referring clinician, where it is reasonable and clinically appropriate. The waiting time standards and Treatment Time Guarantee will cease to apply where the patient is referred back to their referring clinician.

Health Boards are not required to reset the clock to zero or refer the patient back to their referring clinician. For example, should a patient requiring urgent treatment not attend an agreed appointment with the Health Board, it is unlikely that it would be considered reasonable and clinically appropriate for the Health Board to reset the clock to zero or refer the patient back to their referring clinician. Generally, in such circumstances, it is likely that the Health Board would offer another appointment to the patient within the waiting time standards and Treatment Time Guarantee without adjusting the clock to zero.

The date of the patient's non attendance must be recorded. If the patient is being referred back their referring clinician, the Health Board must record why this was reasonable and clinically appropriate.

Health Boards must inform patients of the consequences of not attending an agreed appointment. Also, for patients under the Treatment Time Guarantee, if the patient is referred back to their referring clinician the Health Board must write to the patient, the patient's referring clinician and, where appropriate, the patient's carer to inform them of this.

Where a Health Board has not complied with the Treatment Time Guarantee the Health Board must make such arrangements as are necessary to ensure that the agreed treatment starts at the next available opportunity, having regard to the patient's availability and other relevant factors. If the patient does not attend an agreed appointment and has not given the Health Board reasonable notice of this, then the patient should be offered the next available appointment without resetting the clock to zero. However, this prioritisation to the start of treatment must not be to the detriment of another patient with a greater clinical need for treatment.

8.3 Could Not Wait

There may be occasions where the patient has registered their arrival for an appointment but cannot wait to be seen. What should be recorded will vary dependent on whether it is a patient- or service-induced situation. Therefore, local judgement will be necessary. This should be included in the Health Board's Local Access Policy.

- If the delay is caused by the late running of an appointment and that delay is much longer than the patient could reasonably be expected to wait then this should be

recorded as 'Cancelled by Service' and the patient given another reasonable offer of appointment within the waiting time standards and Treatment Time Guarantee.

- If there is a minor delay in the appointment, providing the patient has been given information on the delay, but the patient is not willing to wait even a short length of time, then the outcome should be recorded as a CNA. The patient should be made another reasonable offer of appointment but because this is a CNA their waiting time clock may be reset to zero, where it is reasonable and clinically appropriate to do so.

It is important that patients are advised prior to attending their appointment of the expected duration of their attendance. If the appointment is planned to consist of more than one consultation, the patient should be recorded as a CNA if the patient is not willing to wait for all consultations within the appointment. The patient should be made another reasonable offer of appointment but because this is a CNA the patient's waiting time clock may be reset to zero, where it is reasonable and clinically appropriate to do so.

8.4 Cancelled by Service

Patients must not be disadvantaged as a result of changes such as cancellations resulting from operational circumstances. Should this occur, the patient's waiting time clock should continue ticking and the patient should be made a further reasonable offer as soon as possible and within the waiting time standards and Treatment Time Guarantee.

If, having been admitted, a planned treatment is unexpectedly cancelled, the patient cannot be recorded as having started treatment. The patient must still undergo treatment within the waiting time standards and Treatment Time Guarantee.

In relation to Treatment Time Guarantee patients, if a visiting practitioner service cannot be provided in the Commissioning Health Board area due to severe weather that prevents the visiting consultant (from the original Health Board) from travelling to the commissioning Health Board area, then the patient must be offered an appointment outwith the Commissioning Health Board area within the Treatment Time Guarantee (i.e. meaning in practice that the patient would have to travel for such an appointment).

However, if the patient decides, rather than to attend an appointment for the agreed treatment outwith the Commissioning Health Board area, to wait until the next scheduled visiting practitioner service, then the period from the date the Commissioning Health Board is made aware of the patient's decision to wait to the date of the next scheduled visiting practitioner service will not count towards the calculation of the Treatment Time Guarantee.

Where the patient does prefer to wait to the date of the next scheduled visiting practitioner service, resulting in a waiting time longer than the Treatment Time Guarantee, then the patient may request for a period of unavailability to be applied. It must be made clear that this is at the patient's request and that they are fully aware of their decision. That is, it is the patient choosing to wait longer than the Treatment Time Guarantee in order to wait to the date of the next scheduled visiting practitioner service and this cannot be prompted by the Health Board.

9. Patient Unavailability

There are only two reasons why a patient may be unavailable for treatment, medical reasons or patient-advised reasons:

- a registered **medical practitioner** has advised that the patient has another medical condition which prevents the agreed treatment from proceeding; or
- because **the patient** has advised the Health Board that they are unavailable for treatment. The application of patient advised unavailability can only be made at the request of the patient.

These are the only circumstances where unavailability may be applied.

Where the patient is unavailable for treatment, this will have an impact on the calculation of waiting time. This period of time is not included in the patient's waiting time.

Patients may be unavailable for a known period of time or be indefinitely unavailable.

As part of the Health Board's obligation to provide patients with clear and accurate information about how waiting time is calculated, the Health Board must record clear and accurate information about the reason for the patient's waiting time unavailability. The reason for all unavailability must be recorded using the national reference file for waiting time unavailability.

Health Boards must advise Treatment Time Guarantee patients in writing when they have been deemed indefinitely unavailable for treatment or when they are unavailable for treatment for a known period, noting the start and end date of that known period and, where appropriate, noting the anticipated date when the patient will be reviewed. The Health Board must also inform the patient of how this will affect their Treatment Time Guarantee clock.

Where a Health Board has not complied with the Treatment Time Guarantee the Health Board must make such arrangements as are necessary to ensure that the agreed treatment starts at the next available opportunity, having regard to the patient's availability and other relevant factors. If the patient is unavailable for a known period then the next available appointment offered should be the next available appointment following the period of unavailability. However, this prioritisation to the start of treatment must not be to the detriment of another patient with a greater clinical need for treatment.

9.1 Indefinite Unavailability

Indefinite unavailability is when the likely period of unavailability (whether that be for medical or patient advised reasons) cannot be determined.

If treatment has not been agreed between the patient and the Health Board, and the patient is indefinitely unavailable for such a treatment, the waiting times clock will not start. Patients should not be added to the waiting list if there is no known end date to their unavailability.

It is good practice for the Health Board to advise the patient that they have been deemed indefinitely unavailable and the date when they will be reviewed.

The patient may become indefinitely unavailable once the waiting times clock has already started. In such a case the waiting times clock will stop and the waiting time standards or Treatment Time Guarantee cease to apply to that patient.

If the patient is then deemed to be available after a period of indefinite unavailability, then a new waiting time standards clock starts from zero from the date that the patient becomes available. A new Treatment Time Guarantee clock starts from zero from the date that the clinician and the patient agree to the agreed treatment.

The Health Board must ensure the availability of the patient for the agreed treatment is reviewed within 12 weeks from the date the patient became indefinitely unavailable for treatment and record the outcome of the review.

If the patient is still indefinitely unavailable following such a review, a second review must be undertaken within 12 weeks of the date of the first review. If, following the second review the patient is still indefinitely unavailable, the Health Board must refer the patient back to their referring clinician.

If the patient is then deemed to be available after a review, then a new waiting time standards clock starts from zero from the date that the review. A new Treatment Time Guarantee clock starts from zero from the date that the clinician and the patient agree to the agreed treatment.

In circumstances when the patient is indefinitely unavailable for the appointment or treatment (whether that is prior to calculation of waiting starting or otherwise), the Health Board must record the start date and reason for the indefinite unavailability and the review date.

9.2 Known Unavailability

Known 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 medical or patient advised reasons.

9.2.1 Medical Unavailability

This is when the patient is unavailable for the appointment or treatment for a known period of time because a registered medical practitioner has advised that the patient has another medical condition which prevents the agreed treatment from proceeding for that period of time.

Medical unavailability may only be applied by a clinician working under a protocol as part of a consultant lead service. In relation to the Treatment Time Guarantee medical unavailability can only be applied because a registered medical practitioner has advised that the patient has another medical condition that prevents the agreed treatment from proceeding.

The start date of the period of unavailability is the date the registered medical practitioner/clinician made the decision that the patient was medically unavailable.

The end date when the registered medical practitioner/clinician decides the patient is now fit to undergo their treatment.

Medical unavailability relates to the patient and should not be used to describe unavailability of the clinical service.

9.2.2 Patient Advised Unavailability

This is when the patient is unavailable for the appointment or treatment for a known period of time when the patient has advised the Health Board that they are unavailable for the appointment or treatment for that known period.

Health Boards are not to estimate a period of patient advised unavailability – the patient should be clearly asked when the period of unavailability should start and end. Good communication is essential here to ensure the patient provides the appropriate information to the service.

The start date of the period of unavailability is the date when the patient has advised the period of unavailability will start.

The end date will be the date when the patient has advised the period of unavailability will stop.

9.2.3 Patient Advised Unavailability (appointment location)

Each Health Board must specify in their Local Access Policy the locations where the appointment or treatment may reasonably be undertaken (including planned capacity outwith the Health Board area, and in some instances the Independent Sector).

A small number of patients may, however, prefer, rather than to accept an appointment or treatment outwith their Health Board area, to wait locally for an appointment even though that may make the waiting time longer than the waiting time standards or Treatment Time Guarantee. This would be unusual and one would not expect large numbers of patients to request treatment at a particular location. Accommodating a request for a specific location of appointment or treatment cannot be guaranteed in any case.

Where the patient does prefer to wait locally for an appointment or treatment, resulting in a waiting time longer than the waiting time standards or Treatment Time Guarantee, then the patient may request for a period of unavailability to be applied. It must be made clear that this is at the patient's request and that they are fully aware of their decision. That is, it is the patient choosing to wait longer than the waiting times standards or Treatment Time Guarantee in order to have the appointment or treatment in a specific location and this cannot be prompted by the Health Board.

The application of patient advised unavailability in this case would be used only when it is clear that the delay would be time limited and the offer of appointment or treatment at the requested location could be made within a specified period of time. The start date of the period of unavailability will be the date when the earliest waiting time standard or Treatment Time Guarantee would have otherwise come to an end. The end date of the period of unavailability will be the date of the appointment.

The application of patient advised unavailability can only be made at the request of the patient and must not be prompted by the Health Board.

9.2.4 Patient Advised Unavailability (named consultant)

Each Health Board must specify in their Local Access Policy that patients will be booked to a clinical team rather than referred to an individual consultant. However, a small number of patients may wish to request a named consultant even though that may make the waiting time longer that the waiting time standards or Treatment Time Guarantee. This would be unusual and one would not expect large numbers of patients to request a specific consultant. Accommodating a request for a specific consultant cannot be guaranteed in any case.

Where the patient does prefer to wait for a specific consultant, resulting in a waiting time longer than the waiting time standards or Treatment Time Guarantee, then the patient may request for a period of unavailability to be applied

Some patients may wish to decline (at their own request) an offer of appointment or treatment within the waiting time standards or Treatment Time Guarantee, carried out by an alternative or unspecified consultant and prefer to wait to for an appointment or treatment by a named consultant.

Where the patient has requested a named consultant, resulting in an overall waiting time of more than the waiting time standards or Treatment Time Guarantee, and with the agreement of the Health Board, a period of known patient advised unavailability may be applied. The patient must be made fully aware of the implications of their request on the length of wait they will experience. It must be made clear that this is at the patient's request and that they are fully aware of their decision. That is, it is the patient choosing to wait longer than the waiting times standards or Treatment Time Guarantee in order to have the appointment with a specific consultant and this cannot be prompted by the Health Board.

The application of patient requested unavailability in this case would be used only when it is clear that the delay would be time limited and the offer of appointment or treatment by the named consultant could be made within a specified period of time. The start date of the period of unavailability will be the date when the earliest waiting time standard and Treatment Time Guarantee would have otherwise come to an end. The end date of the period of unavailability will be the date of the appointment.

The application of patient requested unavailability can only be made at the request of the patient and must not be prompted by the Health Board.

10. Clinic Outcome

The 'clinic outcome' is information from the clinic that indicates the status of the patient's waiting time clock.

A clinic outcome must be recorded for every new, return and DNA patient appointment.

A clinic outcome should also be recorded where a decision is made outwith an outpatient clinic setting that directly effects status of the patient's waiting time clock.

The nationally defined set of clinic outcome codes (see Appendix 3) should be used.

11. Access to Health Services for Armed Forces Personnel and Veterans

11.1 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 and according to their clinical need.

It is important that Health Boards have processes in place to ascertain how long these patients have waited already to ensure that these patients continue their waiting time and do not have their clock start from zero.

11.2 Priority Access for Veterans

All veterans (including those who have served as reservists) should receive priority access to NHS primary, secondary and tertiary care for any conditions which are likely to be related to their armed forces service, even when they are not in receipt of a war pension, subject to the clinical needs of all patients.

It is for clinicians to determine, on the balance of probabilities, whether it is likely that a condition is related to service.

12. Appendices

Appendix 1
Exclusions from 18 Weeks Referral To Treatment Standard

Appendix 2
Inclusions in 18 Weeks Referral To Treatment Standard

Appendix 3
18 weeks RTT Outpatient Clinic Outcome Recording

Appendix 1 – Exclusions from 18 Weeks Referral to Treatment Standard

Referrals to the following services or some specific procedures are currently excluded and therefore do not trigger clock starts:

- 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;
- Designated national specialist service for Scoliosis;
- 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 CEL 27 (2011) Adult Exceptional Aesthetic Referral Protocol;
- Genitourinary Medicine (GUM);
- Homoeopathy;
- Obstetrics;
- Organ and Tissue transplants;
- Mental health Services.

Appendix 2 – Inclusions in 18 Weeks Referral To Treatment Standard

To ensure consistency in reporting for the 18 weeks Referral To Treatment pathway across the service, the following also apply:

For reporting purposes, patients on a Cancer pathway should also be reported through the 18 weeks Referral To Treatment pathway.

All patients added to a waiting list for planned treatment should be included in the 18 weeks Referral To Treatment data submission

All Outpatient appointments, New and Return, are required to have a Clinic Outcome code applied.

Appendix 3 – 18 weeks RTT Outpatient Clinic Outcome Recording

One Outcome Code must be selected for every patient seen at the Outpatient Clinic (New or Return appointment).

All codes on the left hand side of the form have an outcome which will cause the patient's clock to stop i.e. the patient has reached the end of his/her patient pathway.

This is the date on which the patient starts the treatment that is most appropriate for the patient's disease, condition or injury.

All codes on the right hand side of the form have an outcome where the patient's clock continues to tick, pauses or is adjust to zero waiting time.

Code	Outcome for Patient – Clock Stopped	Code	Outcome for Patient – Clock still Ticking / Paused / Zeroed
01	Therapeutic treatment commenced / Medical treatment prescribed by clinician today	101	Add to Waiting list for admission / OP procedure – for treatment (includes for admission today)
02	Medical treatment to be prescribed by GP	102	Admit today for diagnostic Tests / diagnostic OP Procedure carried out today – awaiting results
03	Patient fitted with a medical device today	103	Refer for diagnostic test
04	Decision taken to start active monitoring / watchful waiting	104	Refer for treatment to Nurse / AHP
05	Patient declined treatment	105	Refer for investigation / treatment to another clinician - same condition Retain responsibility for patient care
06	No treatment required / Patient Discharged	106	Refer for investigation / treatment to another clinician - same condition Transfer of care to another clinician
07	Patient DNA – no further appointment	107	Return OP Appointment – continuing management pre treatment
08	Return OP Appointment - treatment already started / complete	108	Patient considering options
		109	Patient DNA – further appointment

NHSScotland National Access Policy:

Treatment Time Guarantee
18 weeks Referral to Treatment Standard
NEW WAYS Stage of Treatment Standards

July 2012

Document Control Sheet

Document purpose	To outline overarching principles of Scotland-wide Access Policy for use by all NHS Boards.
Title	NHSScotland National Access Policy: Treatment Time Guarantee, 18 weeks Referral to Treatment Standard, NEW WAYS Stage of Treatment Standards
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Superseded docs	None

Contents

1. Introduction

The NHSScotland National Access Policy: Treatment Time Guarantee, 18 weeks Referral to Treatment Standard, NEW WAYS Stage of Treatment Standards (National Access Policy) has been developed to provide a common vision, direction and understanding of how Boards should ensure equitable, safe, clinically effective and efficient access to services for their patients.

This policy sets out principles that will help ensure that systems are in place to optimise the use of facilities and available capacity in order to deliver high quality, safe patient care in a timely manner.

Boards should ensure that they have systems, processes and resources in place to deliver the responsibilities described in the National Access Policy and that Standard Operating Procedures (SOPs) are established to ensure delivery of the requirements of this Policy.

Each Board will also provide a Local Access Policy, setting out the details of how these principles apply to their local services, eg possible and reasonable service locations.

Each Local Access Policy must be developed with patient participation, be open and transparent, be approved by the Board in open session and be made widely available. This includes publication on the Board's website.

2. Background

Waiting times for assessment and treatment in Scotland are shorter than they have ever been before, and embrace more people than ever before. For the first time, the Patient Rights (Scotland) Act 2011 enshrines in law that, once a patient has been diagnosed as requiring inpatient or day case treatment, and has agreed to that treatment, that patient's treatment must start within 12 weeks of the treatment having been agreed with the Health Board. The treatment time guarantee operates within existing Stage of Treatment and 18 weeks Referral to Treatment standards, to support timely access to high quality care at each point of the patient journey. This represents a mutual partnership between each patient and their Health Board, with responsibilities on either side.

NHS Scotland's Efficiency and Productivity Programme Delivery Framework (June 2009) set out a commitment to achieve evidence based clinical practice by improving consistency of care, reducing variation and creating the right culture and organisational conditions required to support transformational change.

It is essential that NHSScotland uses resources in a cost effective way. It is recognised that a culture of continual service redesign and improvement is necessary to achieve transformational change. The need to improve consistency of care and reduce variation across NHSScotland is part of an explicit ongoing commitment to evidence based clinical practice.

The National Access Policy aims to ensure consistency of approach in providing access to services and as such it underpins The Patient Rights (Scotland) Act 2011.

The National Access Policy also firmly supports NHSScotland's Quality Ambitions, which put quality at the heart of our NHS. The shared ambition is to deliver world-leading person centred, safe and effective healthcare services.

3. Waiting Time Standards

Boards are required to ensure that there is equitable and sustainable delivery of waiting time standards, and systems are in place to ensure sufficient capacity is available and there is optimal use of this capacity to deliver all waiting time requirements. This will involve working collaboratively with other healthcare providers and will ensure patients receive the most appropriate treatment with the shortest wait.

4. Key Principles of the NHSScotland National Access Policy: Treatment Time Guarantee, 18 weeks Referral to Treatment Standard, NEW WAYS Stage of Treatment Standards

There are a number of key principles that underpin the achievement of the aims of the National Access Policy and delivery of waiting time standards.

- The patients' interests are paramount.
- Patients are offered care according to clinical priority and within agreed waiting time standards.
- There is partnership working with stakeholders in primary, secondary and social care.
- Referrals are managed effectively through electronic triage.
- Boards should provide a common pathway for electronic triage which includes the option of providing advice to the referrer or an appropriate appointment.
- Variations in referral patterns are identified and reduced.
- Waiting lists are managed effectively using electronic systems where possible.
- Patients are referred to a clinical team and seen by an appropriate member of that team rather than a named consultant. The Local Access Policy for each Board should set out that a reasonable offer of treatment relates to any competent clinician who is part of the consultant-led service which the Board provides in that specialty or subspecialty.
- Whilst the vast majority of patients are seen at their local hospital, services may also be delivered through another Board or suitable alternative provider. The Local Access Policy for each Board should set out the locations where treatment may be reasonably undertaken.
- Offers are made as soon as possible after receipt of referral, and with a minimum of seven days notice from the date the offer is made to the date of appointment. (Good practice would be that the offer be made at least fourteen days before the appointment date).
- A reasonable offer is where a patient must be offered two or more dates of appointment for first outpatient assessment and inpatient/day case admission.
- The details of what constitutes a reasonable offer should be set out in each Board's Local Access Policy. This includes the details of each Board's service locations.

- If a patient refuses a reasonable offer of appointment as set out in the Local Access Policy, the Board should refer the patient back to the referring clinician where it is reasonable and clinically appropriate to do so, or reset the waiting time clock to zero.

- There are only two reasons why a patient may be unavailable for treatment: medical reasons or patient advised reasons.

- Patients should not be added to a waiting list if they are not yet ready for treatment.

- Patient advised unavailability can only be applied at the request of the patient and must not be prompted by the Board.

- Boards should work to reduce non-attendance.

- Sufficient capacity should be available and optimally utilised to deliver waiting times.

- The provision of day case and short-stay surgery is maximised.

- Admissions to hospital are actively managed through pre-assessment services.

- Unnecessary follow up appointments are reduced.

- Information is used to facilitate improvements in service provision.

- Boards aim to achieve inclusive and equal access for all service users.

- Leadership and accountability for the improvement of waiting times and achieving waiting times standards should be explicit within each Board area.

- Each Board must publish a Local Access Policy based on the principle of 'reasonableness' from both the NHS and patients. As a guide, this should cover in detail, the Board's local policy on:

    - Communication processes
    - Reasonable offer
    - Suitable alternative providers
    - Possible and reasonable service locations
    - Travel costs
    - Referral to a service or clinical team
    - Patient booking systems
    - Clock adjustments for unavailability, "CNAs" and "DNAs"
    - the recording process which should be clear and transparent.

5. Responsibilities under the NHSScotland National Access Policy: Treatment Time Guarantee, 18 weeks Referral to Treatment Standard, NEW WAYS Stage of Treatment Standards

This Policy details the responsibilities that will ensure equity and a consistency in approach to access to services both within Boards and across NHSScotland as a whole.

Boards are required to ensure that their Local Access Policies and procedures reflect the principles laid out in this National Access Policy. Boards are encouraged to implement this Policy in a manner that best meets the needs of their patients.

The four key responsibilities under the National Access Policy are:

1. To communicate effectively with patients.
2. To manage referrals effectively.
3. To manage waiting lists effectively.
4. To use information to support improvements in service provision.

5.1. To communicate effectively with patients

There is a need to ensure that patients are appropriately informed at all stages of the patient journey. Communicating effectively with patients will help to inform them of when, where and how they are to receive care and their responsibilities in helping to ensure that this happens.

- Each patient must be provided with sufficient information about their treatment to facilitate their informed discussion in the decision making process.

- It is important that patients are provided with clear, accurate and timely information about how processes will operate for arranging for them to be seen or to be admitted to hospital.

- Where possible, GP Practice staff should advise patients of the possible locations for their appointment/treatment, as described in the Local Access Policy. If a patient does not accept a reasonable offer of appointment or admission, this may have implications for the time they have to wait and may result in patients being returned to the care of their GP.

- Where treatment occurs outside the Board 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 the process of organising their appointment or admission.

- GPs should advise patients that they are required to attend their agreed appointment: where the appointment is not required or they are unable to attend, they should inform the hospital at the earliest available opportunity.

- Patients must inform the hospital if their medical condition improves and no longer requires an appointment, or deteriorates in a way which may affect their attendance.

- Patients should be made aware that they must 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 earliest opportunity.

- Patients should be made aware that they must inform the hospital of any changes to their details, e.g. name, address, postcode, telephone number or GP as soon as possible.

- Each Board must have clear processes and procedures in place to ensure that patients can inform the Board of any changes in their personal circumstances and/or their ability to attend appointment.

- The patient should be given clear instructions on how and when to contact the hospital to either accept or decline an appointment or admission date, and the timeframe in which to do this.

- Patients should be given clear and accurate information in writing about how their waiting time is calculated, including when clock adjustments are made and how these affect their treatment time clock.

- Patients should be given clear information on the consequences of not responding quickly to hospital communications, and the impact this could have on their waiting time. Any patient literature should make sure that the patient can understand their responsibilities. Communications with patients should be in a format appropriate to their additional support needs e.g. large print, community language.

- Patients should be made aware that if they no longer wish to have their outpatient appointment or admission, for whatever reason, they must advise the referrer and / or the hospital.

- Where patients do not attend for appointments, and are referred back to their GP, the primary care team should have in place arrangements to follow up with the patient prior to re-referral.

5.2. To manage referrals effectively

Improvements in waiting times should be delivered through an effective partnership between Primary and Secondary Care, with appropriate protocols and documentation in place.

5.2.1 Referrer

- Prior to referral, the clinician should explain to the patient the range of options to be considered. It should explained that patients may not need to access specialist or consultant-led services.

- The referring clinician should advise patients of why they are being referred, the expected waiting time and outline to patients their responsibilities for keeping appointments and the consequences of not attending.

- Where treatment cannot be provided locally and the patient needs to travel elsewhere, the patient should be made aware of that as early as possible.

- The referring clinician should ensure that the patient is 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 where possible and as per local protocols.

- GPs should make referrals to a clinical service and not a named consultant.

- Wherever possible patients should be referred for diagnostics tests prior to the referral being made for the first outpatient appointment.

- Referrers must provide accurate, timely and complete information within their referral including:

    - CHI identifier (unless they don't have one)
    - Full demographic details including:
    - Name
    - Address
    - Ethnicity
    - Postcode
    - Up to date mobile and home telephone numbers
    - e-mail address
    - Preferred method of contacting patient i.e. letter, phone or e-mail
    - Patient's unavailability period if applicable
    - Armed forces/veteran status if applicable
    - Additional Support Needs.

5.2.2 Receiving location

- There should be a structured and transparent approach to the management of referrals, scheduling and booking for all patients. 'Effective patient booking for NHSScotland' identifies actions that underpin best practice in the booking and management of patient appointments.

- Referrals should be triaged electronically where possible.

- 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.

- A common pathway that allows advice or an appointment as appropriate should be in place.

- Systems and procedures should be put in place to triage and prioritise referrals in accordance with referral category (e.g. URGENT).

- 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.

- 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. Refer to Access to NHS Care for Armed Forces Personnel CEL 8 (2008) and CEL 3 (2009).

- Special exemptions that exist for Armed Forces veterans enable them to receive priority treatment if the condition is directly attributable to injuries sustained during the war periods. Refer to HDL 2006 (16) – 'Priority Treatment for War Pensioners' and to 'Access to Health Services for Armed Forces Veterans – Extension to Priority Treatment' CEL 8 (2008).

5.2.3 Receiving Clinician

- It is the receiving clinician's responsibility to communicate with the referrer to offer advice on whether a referral is suitable. This will avoid unnecessary outpatient appointments.

- Any referrals received for a service that is not delivered in that Board area should be returned to the original referrer with advice. Where it is judged that the referral would be more appropriately managed by another service provided by the Board, the referral will be passed to that service and the referrer informed.

- Receiving clinicians must ensure that waiting lists properly reflect their clinical priorities and are managed effectively.

5.2.4 Patient Transfer

- The transfer of any part of a patient's health care to another Board area or to the private sector must always be with the consent of the patient. The transferring consultant should be notified of this decision.

- Appropriate documentation and information should be provided to the receiving Board (or Private Sector provider where appropriate). There should be an agreed minimum data set between Boards.

- If the patient does not wish to be transferred, the original provider must ensure the patient is made a reasonable offer of appointment as set out in the Board's Local Access Policy.

- Private patients opting to transfer to NHS treatment must be referred back to the GP to discuss their options and if appropriate referred to local NHS provider.

5.3. To manage waiting lists effectively

To support delivery of waiting times standards there is a need for Boards to manage their waiting lists effectively. This includes triaging of referrals, management of both new and return patients and accurate recording of clinic outcomes.

- Systems, processes and resources should be in place to ensure that all staff are adequately trained to use local systems to help manage access to services.

- All new referrals should be triaged electronically with all new appointments having a corresponding waiting list entry.

- Patients should be seen within maximum waiting times standards and booked in turn, taking clinical priority into account.

- Ensure that details of patients on the waiting list who are admitted as emergency admissions are communicated for recording on the Patient Administration System.

- Patients should only be added to a waiting list if they are available to commence treatment.

- Systems and procedures should be in place to ensure that waiting list managers are aware of any patient cancelled on the day of or after admission.

- Systems and procedures should be developed to review and validate waiting lists to ensure accuracy and delivery of national and local access times.

- Boards should ensure that they maintain a Directory of Services.

- Ensure that new outpatients only receive a return appointment if there is a clinical need.

- Ensure systems and procedures are in place to monitor and manage the amount of return appointments.

- Ensure that all patients undergoing a procedure have indicated in writing that they consent to treatment.

- Ensure effective communication is in place to notify the referring clinician on the decision to treat e.g. treatment to be provided, treatment delayed because medically unavailable.

- Ensure systems and procedures are in place to communicate, manage and record all outcomes at clinics, additions or alterations to the waiting list electronically.

- Patients who require treatment for different conditions may be on two separate pathways. Boards should have arrangements in place to identify what condition should take precedence.

- Regularly review clinic templates to ensure they reflect changing demand patterns.

- Onward referral processes should be completed to ensure the receiving healthcare provider has the necessary information to manage the patient treatment pathway. Any transfer of data must comply with standards in relation to data security and confidentiality.

5.4. To use information to support improvements in service provision

The ability to effectively monitor and manage services requires good quality data. This helps to inform performance and identify areas for future improvement.

- The factors which influence waiting times, such as changes in referral patterns, should be regularly monitored and management action taken in sufficient time to ensure waiting time standards are maintained.

- Review new to return and DNA ratios and take necessary steps to address any issues as necessary.

- Ensure the effective monitoring of efficiency and productivity and support necessary change where required.

- Benchmarking information should be used wherever possible in reviewing clinic templates and efficiency.

6. Conclusion

Following the key principles of the National Access Policy and following the responsibilities under those principles will ensure equity of service and reduce variation. Boards should use the National Access Policy in conjunction with other relevant national guidance and good practice documentation.

Boards are required to ensure that their local policies and procedures reflect the principles laid out in this National Access Policy. Boards are required to implement this policy in a manner that best meets the needs of their patients.

NHS SCOTLAND

Effective patient booking for NHSScotland

Best practice in the booking and management of patient appointments

healthier scotland
SCOTTISH GOVERNMENT

The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

Contents

Background

The way that appointments are booked can have a profound effect on the efficiency of hospital processes and ultimately the delivery of safe and reliable services for patients. As waiting times in NHSScotland have reduced, models of patient booking practice have had to evolve to accommodate reducing waits and to embed the principles of New Ways of Defining and Measuring Waiting Times (V3.0 issued in December 2007).

Booking polices have continued to develop. This document identifies actions that underpin best practice in the booking and management of patient appointments and is commended to NHS Boards.

Booking Models in Operation across NHSScotland

There are currently three main models of booking in operation across Scotland:

- **Patient Focussed Booking** where a letter is sent to patients' inviting them to make contact to make arrangements for their appointment.
- **Implied Acceptance** where patients' are sent a letter offering them an appointment date where the patient's acceptance of that date is assumed (implied) unless the patient makes contact to advise that they are not available.
- **Telephone Booking** where arrangements for the appointment are made by telephoning the patient to make the appointment or by writing to the patient asking them to phone in to make arrangements. This method is most commonly used where there are very short waiting times such as in Diagnostic services.

Did Not Attend

When a patient does not attend an appointment this is known as a Did Not Attend (DNA).

DNAs occur for a variety of reasons. Patients' may experience difficulty with transport, weather or home circumstances which make it difficult to keep appointments. There is found to be a link between deprivation and DNA rates and the NHS Boards in Scotland with the highest DNA rates have the highest deprivation indices.

DNAs vary by specialty, with Psychiatry and Mental Health having the higher DNA rates in comparison acute specialties such as General Surgery or Orthopaedics. Age is also a factor in patient attendance with those between the ages of 15–49 being the most likely to DNA.

Managing Did Not Attend

Booking systems allowing patient choice and flexibility have been linked to reduction in DNA rates. The Planned Care Improvement Programme found marked decrease in DNA rates when PFB was implemented in full.

An example of how DNAs reduce with PFB is shown in Table 1, Figure 1 and 2 where PFB was introduced in October 2009.

Clinic type	Calendar Year	
	2008	2009
New Attends	4390	4633
New Attends—Did Not Attend	336	221
New Planned Attends	4726	4854
DNA Rate (%)	7.1%	4.6%

Table 1 DNA Rate—PFB Only New Outpatient Appointments
Practitioner Base—Raigmore Hospital (Old Highland—Raigmore and Peripheral Sites)

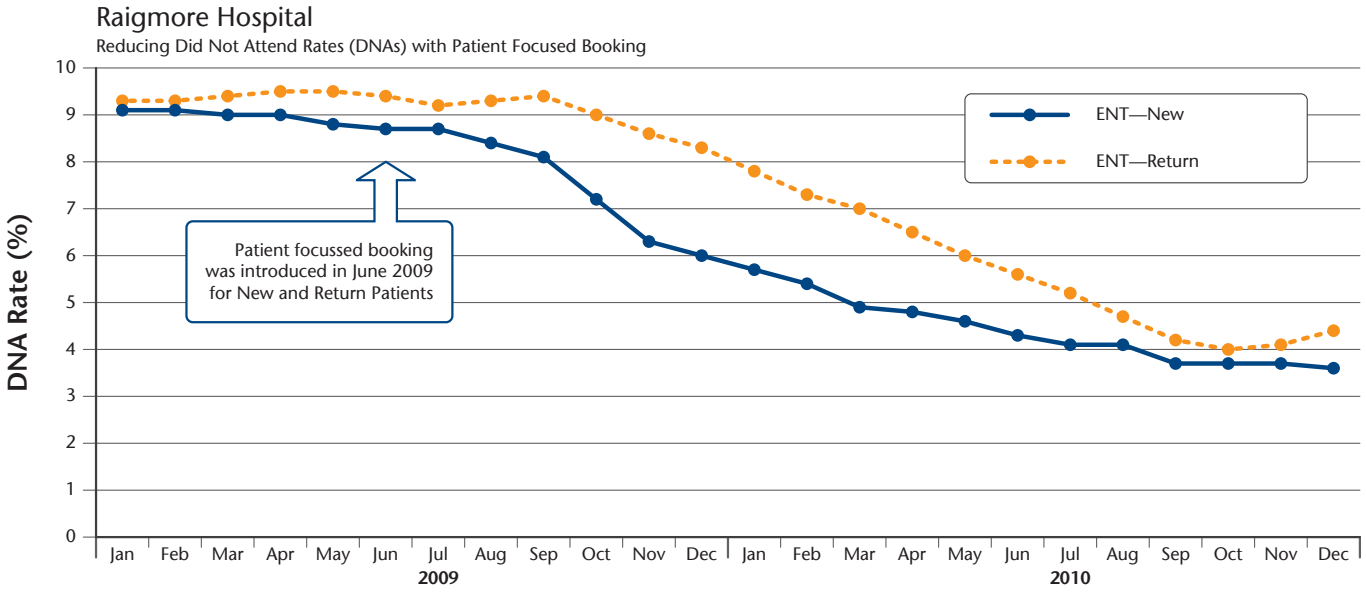


Figure 1 Trend of Rolling Year DNA rates for ENT Out Patients (New and Return, Raigmore Hospital), Jan 2009 to Dec 2010

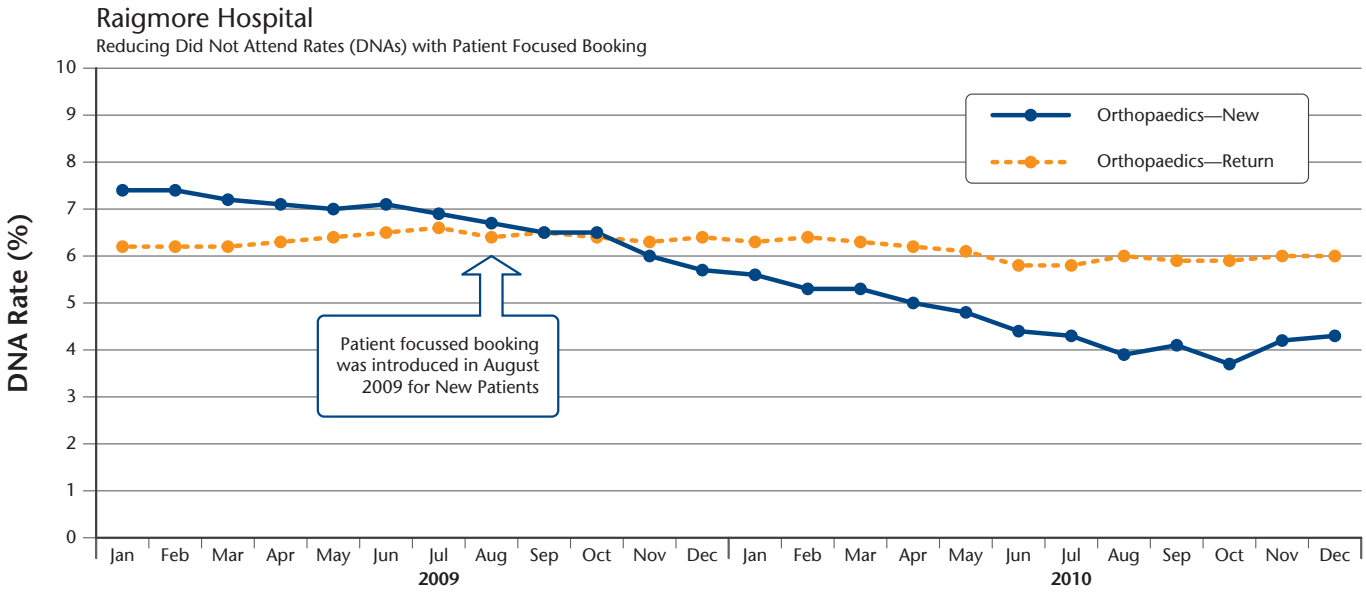


Figure 2 Trend of Rolling Year DNA Rates for Orthopaedic Out Patients (New and Return, Raigmore Hospital), Jan 2009 to Dec 2010

DNA reductions achieved in NHS Boards which have adopted patient focussed booking in full over the last five years has contributed significantly towards the delivery of their local Health improvement, Efficiency, Access and Treatment (HEAT) target for DNAs.

Patient Focussed Booking

The Centre for Change and Innovation (CCI) published guidance on the implementation of patient focussed booking across NHSScotland in 2006. This guidance was updated in 2007 by the Planned Care Improvement Programme in their publication Patient Pathway Management: Approaches to Booking and Access. The programme found that Patient-Focused Booking (PFB) puts patients at the heart of the booking process by engaging them in a dialogue about their appointment and benefits both patients and the NHS.

> "PFB is about creating a good appointments and waiting list management system, for patients it is about better information and being involved in choosing a convenient appointment that they are more likely to attend."

Patient Pathway Management: Approaches to Booking and Access (May 2007)

Commitment to Equality

The Healthcare Quality Strategy for NHSScotland (May 2010) makes a commitment to understanding the needs of different communities, eliminating discrimination and reducing inequality. To meet this commitment there is a need to ensure that information about equality needs is collected and shared to improve the care of individuals and the efficiency of services. For example, by meeting an individual's equality need to receive information in a format or language that can be understood contributes to reducing missed appointments.

Eight Principles of Effective Patient Focussed Booking Practice

It is proposed that NHS Boards should apply the following eight principles of effective PFB consistently to all outpatient and one-stop clinics to promote attendance and offer choice to patients for the mutual benefit of patients and NHS Boards.

1. Clear communication with patients from the outset, outlining their responsibility for their appointment including booking, attending and advising of any changes to their availability. This should take place at the point of referral and within any booking dialogue between the patient and service.
2. A referral process which facilitates the transfer of information about the patients' equality needs and availability to attend.
3. All staff involved in booking and appointing working to standard operating procedures to ensure equity in appointing patients.
4. Booking processes must facilitate timely engagement and offer a single, reliable point of contact for patients.
5. Booking processes must offer patients real choice through active dialogue including dates and times of available appointments, following Treatment Time Guarantee and Waiting Times guidance.
6. Patients must be reminded of their appointment close to the date of agreed attendance.
7. The process must order the waiting list so patients are seen in turn, allowing for clinical priority.
8. The process must ensure ongoing validation of the waiting list to reduce wasted slots.

Recommendations

NHS Boards should consistently apply the eight principles of effective PFB practice to all new and return outpatient appointments to offer choice to patients and promote attendance. A recommended booking process is shown in Appendix One.

NHS Boards may wish to consider introducing these eight principles to one stop and pre-assessment clinics and Diagnostic services. It may also be appropriate to apply these principles to booking daycase and inpatient admissions.

As well as adopting the eight principles, NHS Boards should also ensure that the following underpinning actions are put in place.

Underpinning Actions

Prior to making a referral, the GP/referrer should use a booking fact sheet to discuss the process of referral with the patient. This should include information about how the hospital will communicate with patients in arranging their appointment and the patient's responsibilities in confirmation and attendance. Information provided from the hospital during the booking process should also reinforce the patient's options in relation to the date which has been offered and how to engage with the service.

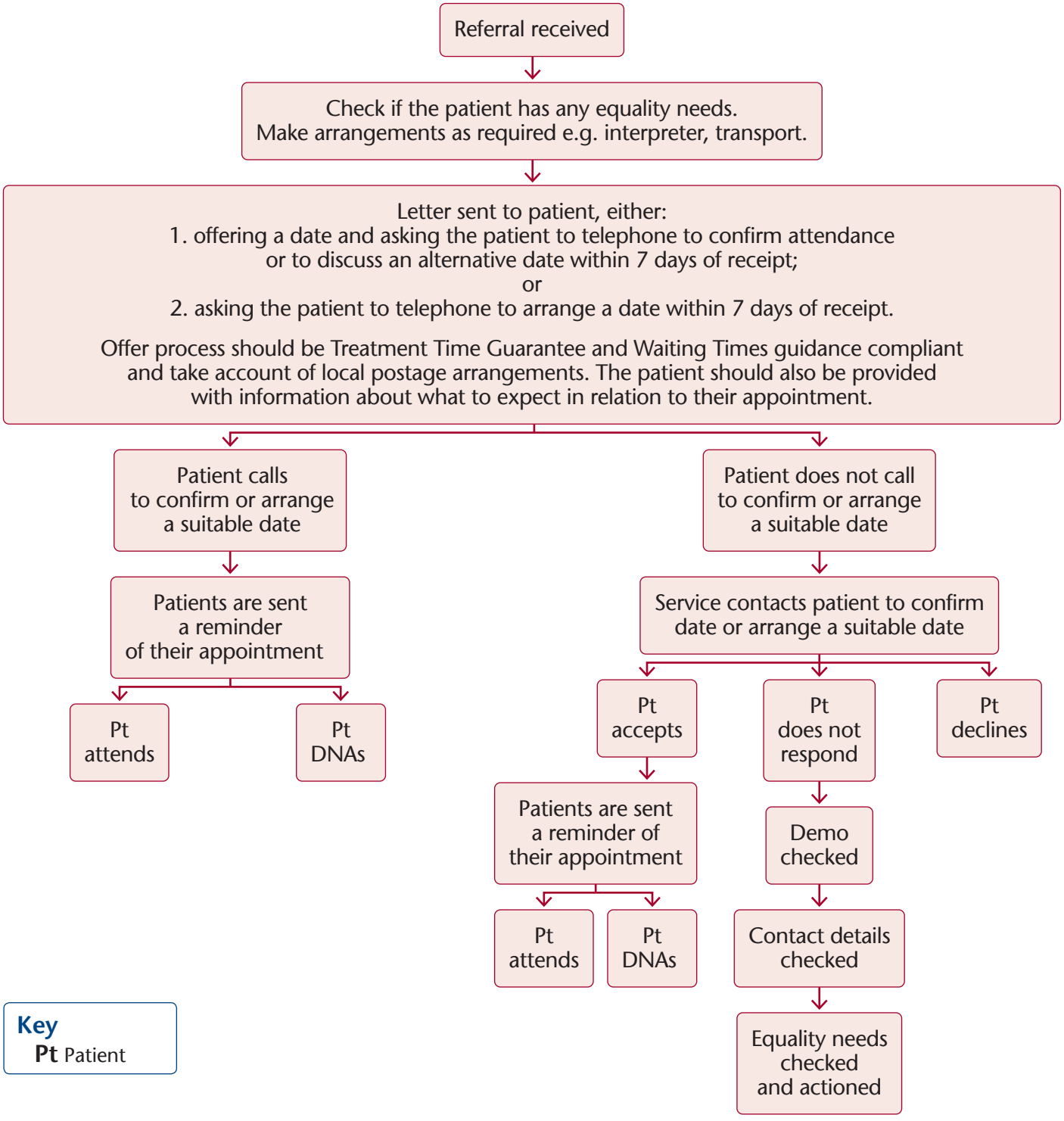
- Referral templates that enable the transfer of information about a patient's availability to attend and their equality needs should be in place. Equality needs are actions or provisions which impact on the likelihood of the individual attending an appointment and/or the consultation taking place. Examples of equality needs are the requirement to contact the patient by phone, providing information in a large font, booking an interpreter or arranging transport.
- Staff within an NHS Board should work to standard operating procedures/protocols to ensure equity in appointing patients, following Treatment Time Guarantee and Waiting Times guidance.
- As a matter of good practice the patient should receive a new appointment letter 14 days or at a minimum 7 days prior to the appointment, taking account of local postage arrangements. The letter should include details of how to confirm attendance or arrange and alternative date and time.
- Appointment letters should provide the patient with details of the impact on their waiting times should they need to change their appointment.
- A process should be established to promote booking in turn and to monitor booking processes.
- Patients who require a return outpatient appointment within six weeks of their first outpatient attendance should be provided with an appointment before they leave the outpatient clinic. For patients who require a return outpatient appointment

more than six weeks after their first outpatient attendance, a waiting list should be established. Patients should then be sent a letter asking them to contact the service to arrange a suitable return appointment. This process should begin six weeks prior to their recommended review date.

- A reminder/confirmation system should be in place to ensure patients are given a second notification of their appointment date and time.

All of the above should be made clear in NHS Boards Local Access Policy.

Appendix One: Recommended Booking Policy



Further Resources

Publications

Patient Pathway Management: Approaches to Booking and Access

The Planned Care Improvement Programme (May 2007)
www.scotland.gov.uk/Publications/2007/05/16153719/8

The Healthcare Quality Strategy for NHSScotland

The Scottish Government (May 2010)
www.scotland.gov.uk/Resource/Doc/311667/0098354.pdf

Online

NHSScotland Quality Improvement Hub

www.qihub.scot.nhs.uk

18 Weeks Referral to Treatment Standard website

www.18weeks.scot.nhs.uk

Scotland Performs—HEAT Targets

www.scotland.gov.uk/About/scotPerforms