NHSScotland Waiting Times Guidance

November 2023

Scottish Government
Riaghaltas na h-Alba

Contents

1. Introduction

This guidance will support Health Boards to effectively manage their Planned Care waiting lists. This will support delivering healthcare services that will be:

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 at equitable rates, and wasteful or harmful variation will be eradicated.

There have been a number of significant changes affecting Planned Care Waiting Times in recent years, including pandemic backlogs, staff shortages and some of the most difficult winter periods the NHS has ever faced.

We are committed to delivering sustained improvements and year-on-year reductions through service redesign and enhancing regional and national working.

This guidance aims to account for ongoing improvements and changes to the way services are being delivered. Additionally, the principles which are contained within this guidance should be applied to **all** patients who have been referred for an appointment, diagnostic test, or treatment.

The Patient Rights (Scotland) Act 2011 supports the Scottish Government's vision for a high-quality NHS that respects the rights of patients, their carers and all the people who deliver NHS services.

The Act preserves in law that, once a patient has been diagnosed as requiring inpatient or day case treatment, a Health Board must take all reasonably practicable steps to ensure that the patient's treatment starts **within 12 weeks of the treatment having been agreed.** This is the Treatment Time Guarantee.

The intention of the Treatment Time Guarantee is to ensure timely access to care at the point of treatment. The Treatment Time Guarantee applies to all planned inpatient and day case treatments (with a few exceptions which are set out in The Patient Rights (Treatment Time Guarantee) (Scotland) Regulations 2012 (legislation.gov.uk))

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. To deliver the 18 Weeks Referral-To-Treatment standard, which states the initial referral and treatment date should aim to be within 18 weeks, all stages of the patient's pathway need to be as short as possible. This is why there are waiting times standards for each stage of treatment. Consequently, the aim is for the majority of patients to be seen in less than 12 weeks for both outpatients and the Treatment Time Guarantee.

2. Purpose

Purpose of this document

This document is an update from the version published in 2012, to provide guidance for Health Boards to assist them in the delivery of the national waiting times standards. The guidance will continue to make sure that patients who are waiting for their appointments are managed fairly and consistently across NHSScotland.

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)(No 2) Directions (2022), and the NHS Scotland National Access Policy.

The following material is provided for the use of NHS Scotland staff and in particular those who are responsible for collecting and recording patient information on these standards:

- 18 Weeks Referral-To-Treatment for 90% of patients;
- 12 weeks for new outpatient appointments for 95% of patients;
- 6 weeks for the 8 key diagnostic tests and investigations; and
- The 12-Week Treatment Time Guarantee as set out in legislation.

The guiding principles that must be followed for **all** patients are outlined in this document to ensure everyone is managed fairly and consistently across all of Scotland, with clear roles and responsibilities for both Health Boards, patients and for their families / carers.

3. Roles and Responsibilities

Roles and Responsibilities:

The Scottish Government is the owner of this guidance. The management of guidance and approval of revisions is the responsibility of the Scottish Government. The Scottish Government is also responsible for reviewing the performance of Health Boards, ensuring standards within this guidance are being met, and that waiting lists are being managed effectively.

Health Boards are responsible for the management of the patient journey and are expected to work collaboratively to ensure patients are treated as soon as possible. Health Boards are also responsible for providing clear information to patients throughout their journey, including information around waiting well.

Patients (and their carers) are responsible for communicating any and all changes to contact details and availability to their Health Board of Residence. Patients are also responsible for communicating any additional needs they may have. Patients should also ensure they are following clinical advice from their clinicians, General Practitioners (GPs), and Health Boards, throughout their wait and after their treatment/appointment.

Public Health Scotland have responsibility for the collection, quality assurance, analysis and reporting of national data on waiting times collected through the national WTs warehouse. This includes maintaining and developing national data standards, definitions and recording guidance. PHS will continue to work with NHS Boards to ensure the data they submit nationally is of sufficient quality and completeness to ensure their WTs performance can be accurately reported through official statistical publications.

Any enquires regarding national recording and data collection should be directed to phs.waittimessubmissions@phs.scot.

4. Communications

4.1 Communication with Patients

It is important that patients are provided with clear, accurate and transparent communications at the beginning of their care journey. This should detail what they should expect and their responsibilities while they are waiting for their appointment / test / treatment. Health Boards must have consistent, effective processes for communicating with patients on a regular basis.

Communications with patients should be in a form appropriate to their needs, e.g. large print or relevant translations. It is important that patients are asked to confirm their needs at the beginning of their journey and their preferred format when receiving communication from the Health Board. It may be necessary to contact the referring clinician or patient / patient's carer to clarify communication requirements such as different formats, languages or if an interpreter is required.

Communication can be in any form that the patient has indicated in writing that they consent to receiving information, including telephone, electronically or post.

Health Boards should maximise virtual appointments where appropriate and accepted by the patient, and their carers. However, patients should not be disadvantaged if they require a face-to-face appointment.

Guidance

Health Boards are required to communicate with a patient when:

- Active Clinical Referral Triage (ACRT) vetting is complete to explain which of the three pathways they are on and what the outcome of this is for the patient. Pathways include: opt-in or advice-only, patient requires diagnostics/imaging, or confirmation an appointment is required (digitally or face to face). This communication should start at the point the referral is received.
- a patient is added to an inpatient / day case waiting list (in which case they should be sent details of the Treatment Time Guarantee (TTG)).
- offering a patient an appointment.
- a patient is returned to referrer (this communication should also be sent to the referring clinician, to allow for review by the referring clinician).
- the Health Board breaches or is likely to breach TTG at 12 weeks.
- the patient advises they have a period of unavailability.
- a patient is invited to use Patient-Focussed Booking (PFB).
- a patient is reminded of PFB if an appointment has not been made 14 calendar days after the initial PFB letter.
- a patient is being rescheduled, after they Could Not Attend (CNA) one or two appointments.
- a patient cancels and is unable to rebook.
- informing a patient of a new date and time, following the patient's cancellation.
- a patient is being removed following multiple cancellations and a clinical review.
- a patient Did Not Attend (DNA) an appointment.

Within the communications given to patients, Health Boards are required to provide the following details.

- The impact on the patient's waiting time if they refuse reasonable offers.
- What happens when a patient Did Not Attend (DNA), Could Not Attend (CNA) or is unavailable and the impact this could have on their waiting time.
- Instructions on how and when to contact the hospital, as well as the timeframe in which to do this.
- Explanation of a reasonable offer / a reasonable offers package.
- How to either accept or decline offers of appointments.
- Explanation that the appointment may be offered anywhere in Scotland if clinically appropriate for the patient.
- Information for a point of contact in the receiving service.
- Inform the patient to contact their referring clinician if their condition changes.
- Signpost patients to supporting materials around looking after their mental health, and 'waiting well' information.

Best Practice

Patients should be provided with clear and relevant information regarding their treatment/appointment, at the point of secondary care referral, as well as when they are added to waiting list. New outpatients should also receive an ACRT communication. In addition, patients should be provided with information about Waiting Well, to support their health and wellbeing whilst waiting ('waiting well' information can be found on the NHS Inform website).

It is also best practice for a Health Board to communicate with a patient:

- when the patient is added to an outpatient waiting list for an appointment.
- to provide information on how to be fit and ready for the appointment.
- to inform them that there is financial aid available for travel, accommodation, and any other relevant expenses, for the patient and their carer (if necessary). This aid will be provided by the Health Board of Initial Receipt of Referral (HBIRR) if the patient is being asked to attend an appointment out with their Health Board of residence.
- to provide clear directions and information on where to go when they attend their appointment.
- to outline what to do if the patient feels their condition worsens.
- to remind the patient about their appointment(s).

A visual of Patient Communication Pathway Health Boards are expected to follow can be found in Annex 1

4.2 Communication with Patients when the Treatment Time Guarantee (TTG) is Breached

Guidance

If the Health Board believes that they are unable to meet a patient's Treatment Time Guarantee before it breaches, then according to The Patient Rights (Treatment Time Guarantee)(Scotland)(No 2) Directions (2022), the Health Board must provide the patient who is eligible for TTG (or where appropriate the patient's carer) with the following.

- An apology if the Health Board is unable to meet the TTG.
- An explanation of the reason that the Health Board did not deliver the Treatment Time Guarantee.
- Details of an online platform where the patient can access further information about the waiting time for their agreed treatment in the responsible Health Board.
- A point of contact within the receiving service for information regarding the waiting time in the event the patient is unable to access the online platform.
- A point of contact for advice regarding management of their condition pending receipt of agreed treatment.
- Details of a place / person they can contact should their symptoms or condition worsen.

A national template, which Health Boards can use for this, can be found in Annex 2.

If 12 months pass since the Health Board has written to the patient, and the patient has not received an estimated treatment date, the Health Board must provide in writing:

- an apology that the patient is still waiting for treatment.
- an explanation of the reason that the Health Board did not deliver the Treatment Time Guarantee.
- an estimated treatment date if this is possible, or details of an online platform where the patient can access further information about the waiting time for their agreed treatment in the responsible Health Board.
- a point of contact for advice regarding the waiting time in the event the patient is unable to access the online platform.
- a point of contact for advice regarding management of their condition pending receipt of agreed treatment.
- details of a place / person they can contact should their symptoms or condition worsen.

This process should continue until an offer of appointment is accepted by the patient for the agreed treatment.

It is expected that Health Boards maintain regular contact with patients and all other forms of communication continue.

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 to 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

Additional Support Needs

Guidance

Health Boards have a duty to ensure that patients are provided with information they can easily understand, and that appropriate support is put in place as required. Additional needs must be 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 must 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 (see Annex 5) provides examples of information that should be collected to support patients who have additional needs. Other information may be required.

Patients with additional support needs may also require extended appointments.

6. Offers of Appointment

6.1 Reasonable Offers

A reasonable offers package is the offer of two or more different dates of appointment for each stage of the patient's pathway.

Guidance

An offer of appointment from a Health Board to a patient is reasonable:

- if at least 10 calendar days' notice is given.
- if the appointment is at any location across NHS Scotland deemed clinically appropriate for the patient's needs.
- if a date is provided (not location only).
- if the patient consents to the mode of contact used to communicate the offer (e.g. video, phone call).
- regardless of whether it is offered pre- or post-TTG date.
- at short notice if accepted by the patient.

A patient can be referred back to the referring clinician, following a clinical review, or have their clock reset after refusal of two reasonable offers. The clinical review should be completed within the receiving service.

Additionally, Health Boards **must** ensure patients are informed of the impact of declining offers, Did Not Attend and Could Not Attend.

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

Best Practice

A Health Board should:

- give at least 14 calendar days' notice.
- treat patients as locally as possible with capacity taken into account as well as what procedures are offered in which location.
- have a reminder system in place, this will ensure patients are given a second notification of their appointment date and time.
- ensure the patient is notified as soon as possible and is advised of the support they will receive for travel outwith their Health Board area.

6.2 Appointment Location

Guidance

An offer of appointment at any location in NHS Scotland is considered reasonable. Health Boards must use judgement based on what is clinically appropriate according to the patient's circumstances.

- The Health Board should include service locations in their published Local Access Policy, which for example could be:
  - any site within that Health Board area providing the required service.
  - any site outwith the Health Board area where treatment is routinely provided, for example, another Health Board, the Golden Jubilee University National Hospital, or a National Treatment Centre.
  - the limited use of alternative providers, within or out with the Health Board area, including the independent sector.
- Patients are to be advised as early as possible if they need to travel for their appointment or treatment.
- The Health Board of initial receipt of referral is responsible for the cost of any transport and accommodation arrangements reasonably incurred by the patient and their carer (if necessary) if they must travel outwith their local Health Board for an appointment.
- Under regulation 4A of the Patient Rights (Treatment Time Guarantee) (Scotland) Regulations 2012, a patient may request to be seen in a specific location within the area of the responsible Health Board, where the original offer was for treatment outside of that area.
- The responsible Health Board **may** agree this, having considered the patient's health and wellbeing, **if** it is deemed reasonable and clinically appropriate to offer the patient an alternative appointment in a specific location for the agreed treatment to be carried out.
- A request to be seen in their local Health Board should **only** be allocated by the Health Board to ensure continuity of care, patient safety or for other clinical or exceptional reasons.
- If a patient chooses to wait to be seen in their local Health Board, the period between the date of the original offer and the date of the alternative offer does not count towards the calculation of waiting time.

Best Practice

Patients should be seen and treated in their local Health Board wherever possible. It may not always be possible for Health Boards to provide access locally for all patients and for all services if they are constrained by geography or specialist services for example.

6.3 Named Consultant

Guidance

- Patients will be 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 to a clinical team as part of the consultant-led service.
- Under regulation 4A of the Patient Rights (Treatment Time Guarantee) (Scotland) Regulations 2012, a patient may request to be seen by a specific named consultant. The responsible Health Board **may** agree this, taking into account the patient's health and wellbeing, **if** it is deemed reasonable and clinically appropriate to offer the patient an alternative consultant for the agreed treatment to be carried out.
- A named consultant should **only** be allocated by the Health Board to ensure continuity of care, patient safety or for other clinical or exceptional reasons.
- If a patient chooses to wait for a specific consultant, the period between the date of the original offer and the date of the alternative offer, does not count towards the calculation of waiting time.

6.4 Patient Refuses a Reasonable Offer

Guidance

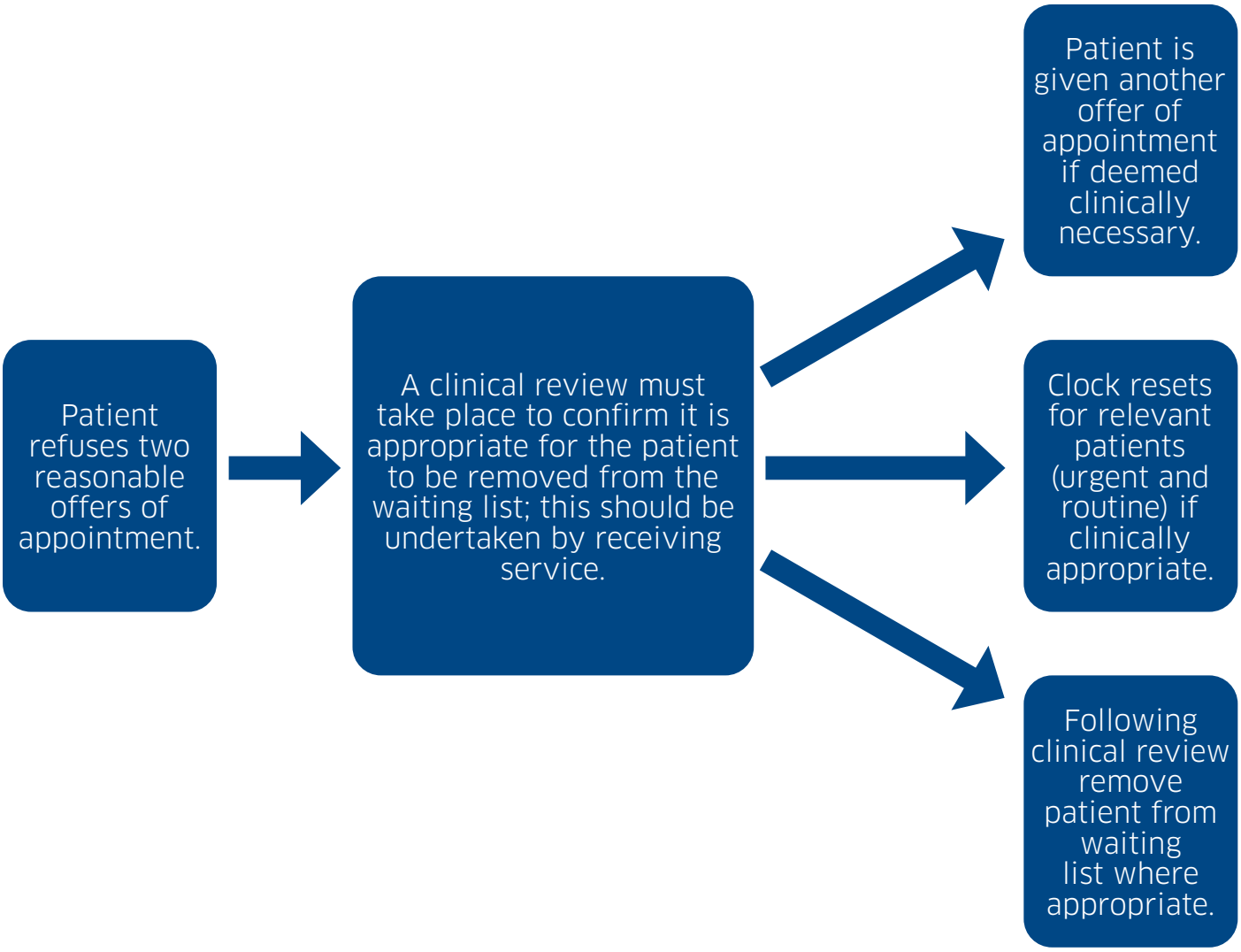
When a patient does not accept two reasonable offers of appointment, it is considered a patient refusal. In this instance, a clinical review should be completed for **all** patients, regardless if they are urgent or routine.

The clinical review is to determine if the patient should be removed from the list and referred back to the referrer or if they should be offered another appointment. If the patient is to be referred back to their referring clinician, the Health Board must record why this was appropriate. Health Boards **must** inform patients (or where appropriate the patient's carer), and the patient's General Practitioner (GP) or referring clinician (where possible), when the patient has been removed from the waiting list.

If following a clinical review, it is not reasonable to refer the patient back to their referring clinician, a further appointment should be offered (and the clock may be reset to zero). The clock must be reset to zero from the date the patient advised they were not accepting their second offer of appointment.

Figure 1:

This applies to all new outpatients, inpatient and day-case patients. This does not change how patients are tracked through Urgent Suspicion of Cancer pathways; this should continue to follow the cancer waiting times data and definitions manual.



7. Waiting List Validation and Removal

7.1 Waiting List Validation

Guidance

To support the management of patient waiting lists, Health Boards **must** complete the three stage waiting list validation on a regular and continual basis, which should not exceed six-month gaps.

The process that should be followed is below:

Stage 1 – Administration and Clerical Validation

- There should be a routine clean of the list to quality-check data. This includes removing patients that no longer require treatment.

Stage 2 – Patient Validation

- Communicate with the patient to confirm they wish to remain on the waiting list. This will also identify patients who require to be escalated for review by a clinical team.
- If a Patient-Focussed Booking process is available for the Health Board or service, implementation of this should be considered.
- Health Boards should check the patient has not been seen via another route, for example at Accident & Emergency or at a private appointment.

Stage 3 – Clinical Validation

- This will require review of the patient record and identification of appropriate actions including attendance at virtual clinics, patient management plans or treatment options for the patient.

In addition to local three-stage validation, the National Elective Coordination Unit (NECU) supports NHS Scotland Health Boards through a number of work streams, including national waiting list validation. This process is centrally coordinated by NECU and employs a digital validation platform, with capability to support high-volume administrative and patient validation. This process ensures that information held on waiting lists is accurate and supports Health Boards to identify those patients who have indicated that they still require to be seen are scheduled for their appointment or operation, and where appropriate remove patients who no longer require their appointment or operation. Further details of the work NECU do can be found here: National Waiting List Validation - How it works | The nation (nhscfsd.co.uk).

7.2 Waiting List Removal

Guidance

Following waiting list validation, if the outcome is to remove a patient from a waiting list, this should be confirmed to both the patient and referrer. It should include the reason for removal, the impact on their waiting time and who the patient should contact if they still wish an appointment / treatment.

Examples of reasons for removal from the waiting list include, but are not limited to:

- if the patient requests removal.
- the appointment is no longer needed for clinical reasons.
- the patient is unavailable for an extended period of time i.e. over the 24-week maximum unavailability permitted, as seen in paragraph 4 of the Directions.
- if the patient has been seen elsewhere (for example, privately).

8. Active Clinical Referral Triage (ACRT)

Active Clinical Referral Triage (ACRT)

Guidance

Active Clinical Referral Triage (ACRT) is the process whereby, following a new outpatient referral into secondary care, a senior clinician reviews a patient's record and carries out enhanced vetting to place the patient on the most appropriate pathway. In broad terms, outcomes include being removed from the list, either with or without the option to 'opt in' at a later date, or remaining on the list and waiting for an appointment. All Active Clinical Referral Triage (ACRT) outcomes should be recorded to allow for PHS data collection which will allow the impact of this process to be measured.

ACRT applies at each stage of the patient journey. Vetting outcomes should be assigned:

- at the initial referral stage.
- if an opt-in referral is received.
- following diagnostic test results.
- if the patient transfers to another specialty or service.

9. Booking Methods

Booking Methods

Across NHSScotland a number of booking methods are used for scheduling appointments and admission dates. Health Boards must ensure that their chosen approach to booking appointments is effective, to allow for efficiency across their organisation, in order to deliver safe and reliable services for patients.

Guidance

Each Health Board is responsible for ensuring that the method(s) selected for scheduling appointments locally, meets the waiting time standards or Treatment Time Guarantee. Booking methods also need to consider the criteria for a reasonable offer of appointment and the guidance under 'Communication with Patients' and 'Additional Support Needs'.

9.1 Patient-Focussed Booking

Guidance

Patient-Focussed Booking (PFB) is a scheduling process whereby a communication is sent to a patient inviting them to get in contact to make arrangements for their appointment.

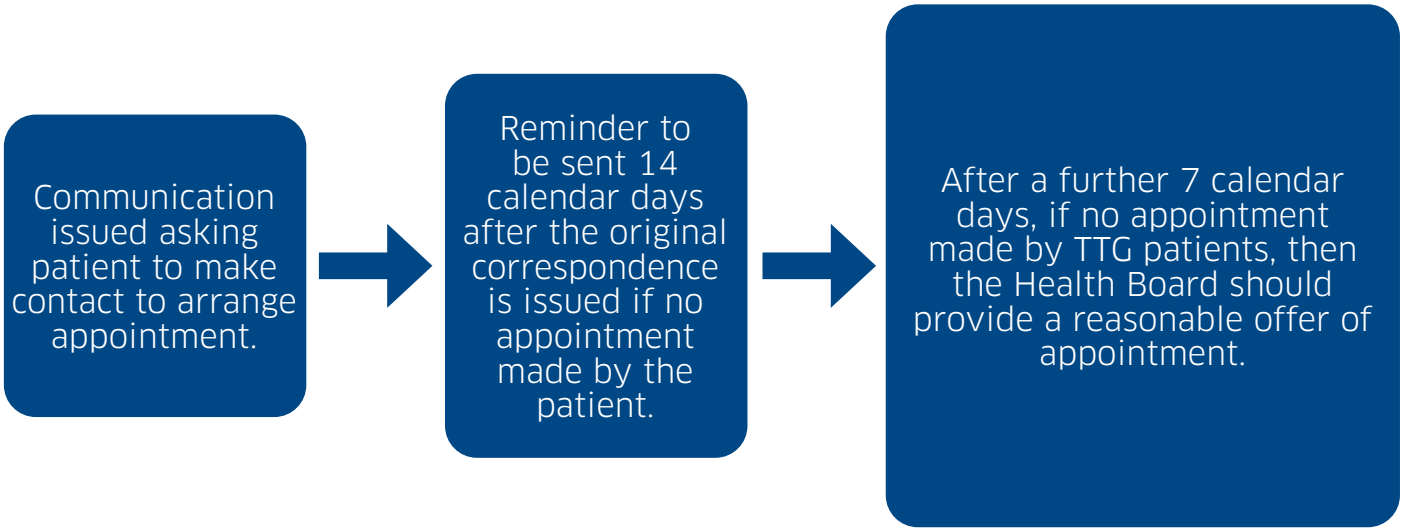
The process of Patient-Focussed Booking is shown below.

- An initial communication inviting the patient to get into contact is sent by the Health Board.
- A reminder must be sent after 14 calendar days, if the patient has not made contact.
- At this point PFB Unavailability will start for new outpatients.
- If there is no appointment made after a further 7 calendar days from the reminder was issued (totalling 21 calendar days), TTG patients **must** be provided a reasonable offer of appointment. At which point the guidance for both reasonable offers and patient refusals should be followed.

Best Practice

In certain circumstances, for example postal strikes or festive periods, it may be appropriate for the Health Board to extend the timescales for a patient response.

Figure 2:



9.2 Implied Acceptance

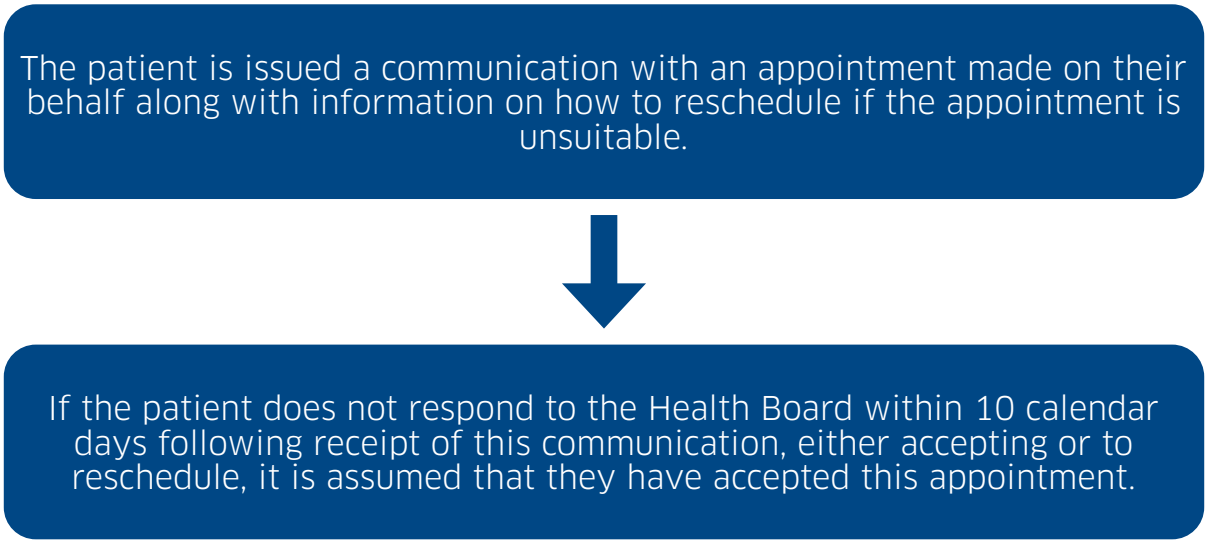
Implied Acceptance is a scheduling process whereby an appointment is made on behalf of a patient and issued to them. This is a reasonable offer, and should follow the criteria set out for Reasonable Offers.

Guidance

If no response has been received by the Health Board within 10 calendar days of the appointment being issued, it is then assumed that the patient has accepted the appointment.

The process for implied acceptance is shown below:

Figure 3:



Guidance

This offer of appointment would be classed as one reasonable offer:

- if the patient does not attend, it should be classed as a Did Not Attend (DNA)
- if the patient gets in contact and cancels within 10 days, it would be classed as a refusal.
- if the patient gets in contact and cancels after 10 days, it would be classed as a Could Not Attend (CNA).
- if the patient cancels three or more agreed appointments, the CNA process should be followed by Health Boards.

10. Non-Attendance

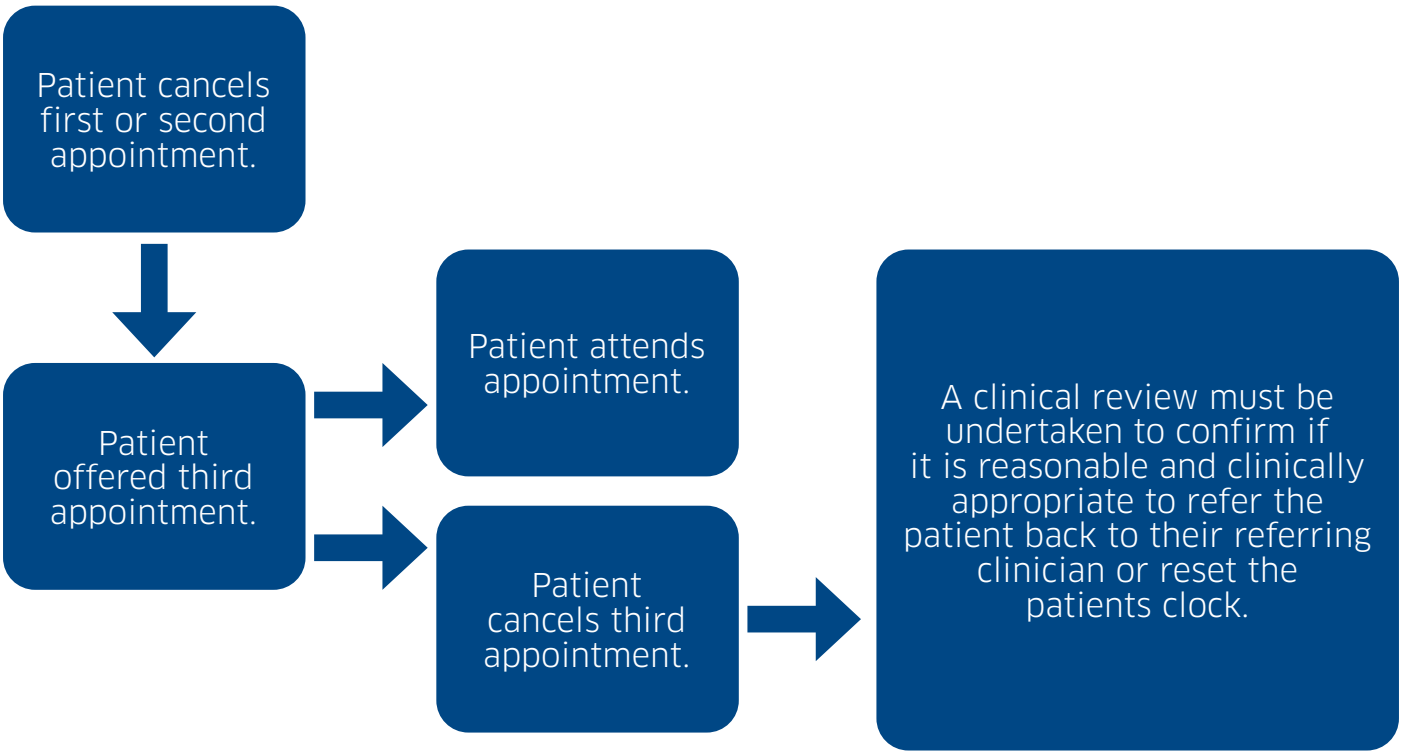
10.1 Could Not Attend

Guidance

If the patient has accepted a reasonable offer of appointment but gives the hospital notice that they will not attend that appointment, it is classed as a Could Not Attend (CNA). A patient may advise the Health Board they cannot attend an agreed appointment **any** time prior to attending their appointment. Systems should be in place to record this information.

After **the first or second** cancellation, a patient must be given another reasonable offer of appointment. At both the first and second cancellation, the Health Board may reset the patient's clock if clinically appropriate. If the patient cancels **three or more** agreed appointments, a clinical review must be undertaken to confirm if it is reasonable and clinically appropriate to refer the patient back to their referring clinician. In cases where referring back to the referrer is not appropriate, the Health Board may reset the patient's clock to zero (regardless of whether any waiting time standard has been breached), and offer the patient another appointment. This review is be undertaken by the receiving service. The date of the decision to refer the patient back to their referring clinician must be recorded on the patient administration system (PAS).

Figure 4:



If the patient is to be referred back to their referring clinician, the Health Board must record why this was appropriate. 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.

If following a clinical review, it is not reasonable to refer the patient back to their referring clinician, a further appointment should be offered. The clock should be reset to zero from the date the patient advised they were cancelling their third agreed appointment.

If the patient informs the Health Board that they have an illness, which they feel may prevent them from attending the appointment on the agreed date, clinical advice may need to be sought as to the clinically appropriate course of action.

- In some cases, Health Board staff may be able to confirm whether the patient's illness is likely to prevent their attendance, without the need for clinical input.
- If the clinician has advised that the patient's 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 illness will not prevent the agreed appointment or treatment from proceeding on the agreed date, the appointment should go ahead as planned.

Health Boards need to inform patients of the consequences of cancelling an agreed appointment.

10.2 Did Not Attend

Guidance

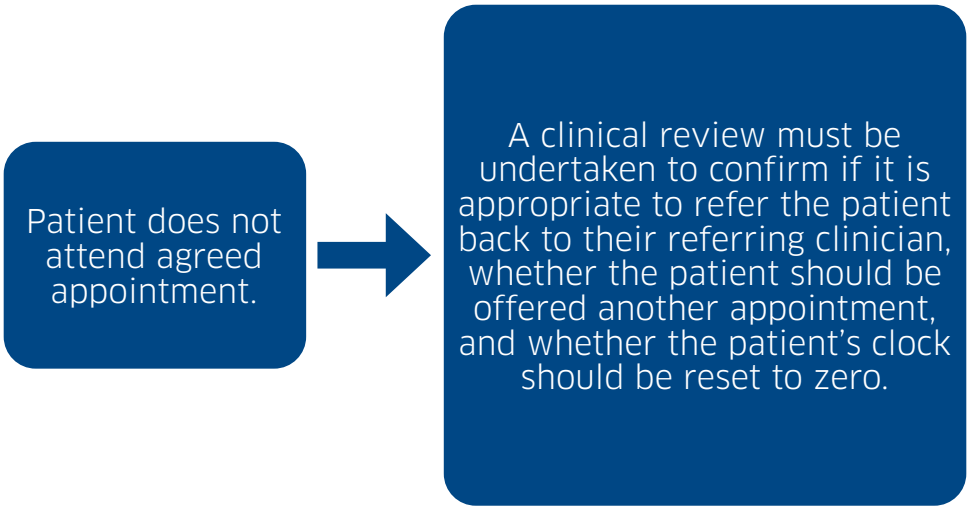
If the patient does not attend (DNA) an agreed appointment and has not given the Health Board any notice of this, a clinical review must be undertaken to confirm if it is reasonable and clinically appropriate to either refer the patient back to their referring clinician, reset the patient's clock to zero (from the date of the missed appointment), and offer the patient another appointment. This review should be undertaken by the receiving service. The date of the patient's non-attendance must be recorded on the patient administration system (PAS).

If the patient is to be referred back to their referring clinician, the Health Board must record why this was reasonable and clinically appropriate. 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.

If following a clinical review, it is not reasonable to refer the patient back to their referring clinician, a further appointment should be offered. The clock should be reset to zero from the date the patient did not attend their agreed appointment.

Health Boards should inform patients of the consequences of not attending an agreed appointment as soon as possible after treatment is agreed.

Figure 5:



10.3 Could Not Wait

Guidance

It is important that patients are advised prior to attending their appointment of the expected duration of their appointment. If the appointment is planned to consist of more than one consultation the patient **must** be made aware of this in advance.

If the patient is not willing to wait for their consultation/all consultations within the appointment, this should be recorded as a CNA. If this is the patient's first or second CNA, the patient should be made another reasonable offer of appointment, however if the patient has on three or more occasions cancelled an agreed appointment the CNA guidance should be followed.

All patients must be advised of any delay to their appointment. There may be occasions where the patient has registered their arrival for an appointment but cannot wait to be seen. The effect on the patient's clock will depend on the reason for the delay as seen below.

- If there is a delay, caused by the service, which is much longer than the patient could reasonably be expected to wait, then this should be recorded as 'Cancelled by Service'. The patient must be given another reasonable offer of appointment as soon as possible. For instance, a reasonable wait could be anything **up to 30 minutes**.
- If there is a delay in the appointment of less than 30 minutes and the patient is not willing to wait, then the outcome should be recorded as CNA. If this is the patient's first or second CNA, the patient should be made another reasonable offer of appointment; however if they have cancelled three or more agreed appointments previously, the CNA guidance should be followed.

Local judgement and flexibility will be necessary in these scenarios, and this should be detailed in the Health Boards Local Access Policy.

10.4 Cancelled By Service

Guidance

Patients must not be disadvantaged as a result of cancellations resulting from operational circumstances. Should this occur, there should be no change to the patient's waiting time clock and the patient should be made a further reasonable offer as soon as possible. Where possible, this should be within the waiting time standards and Treatment Time Guarantee; however, this prioritisation to the start of treatment must not be to the detriment of another patient with a greater clinical need for treatment.

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

11. Unavailability

Unavailability

Guidance

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

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

- **Medical -** A registered **medical** or **healthcare practitioner** has advised that the patient has another medical condition which prevents the agreed treatment from proceeding; or
- **Patient-Advised - the patient** has advised the Health Board that they are unavailable. The application of Patient-Advised Unavailability can only be made at the request of the patient (or, where appropriate, the patient's carer).

Where the patient is unavailable for an appointment / treatment, this period of time is deducted from the patient's waiting time.

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.

If the patient is unavailable for a known period, then the next available appointment should be offered following the end of that 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.

11.1 Patient-Advised Unavailability

Guidance

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

The timeline for patient-advised unavailability is as follows.

- Patients can have a maximum of 12 weeks **per reason** if required; however, patients are encouraged to be available for their treatment as soon as possible and should advise of the minimum period of unavailability.
- A review should be conducted at the end of each period of unavailability, and if required another period of up to 12 weeks can be applied. Again, patients are encouraged to be available as soon as possible for treatment, therefore the minimum amount of unavailability should be applied.
- Following the second period of Patient-Advised Unavailability, a clinical review must be completed to advise whether the patient can now be referred for an appointment or returned to referring clinician. The clinical review should be complete within the receiving service.
- If the patient is to be referred back to their referring clinician, the Health Board must record why this was appropriate. 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.

Health Boards are **not** to estimate a period of Patient-Advised Unavailability – the patient should be clearly asked when the period of unavailability starts and ends.

Good communication with the patient is essential to ensure the appropriate information is provided to the service.

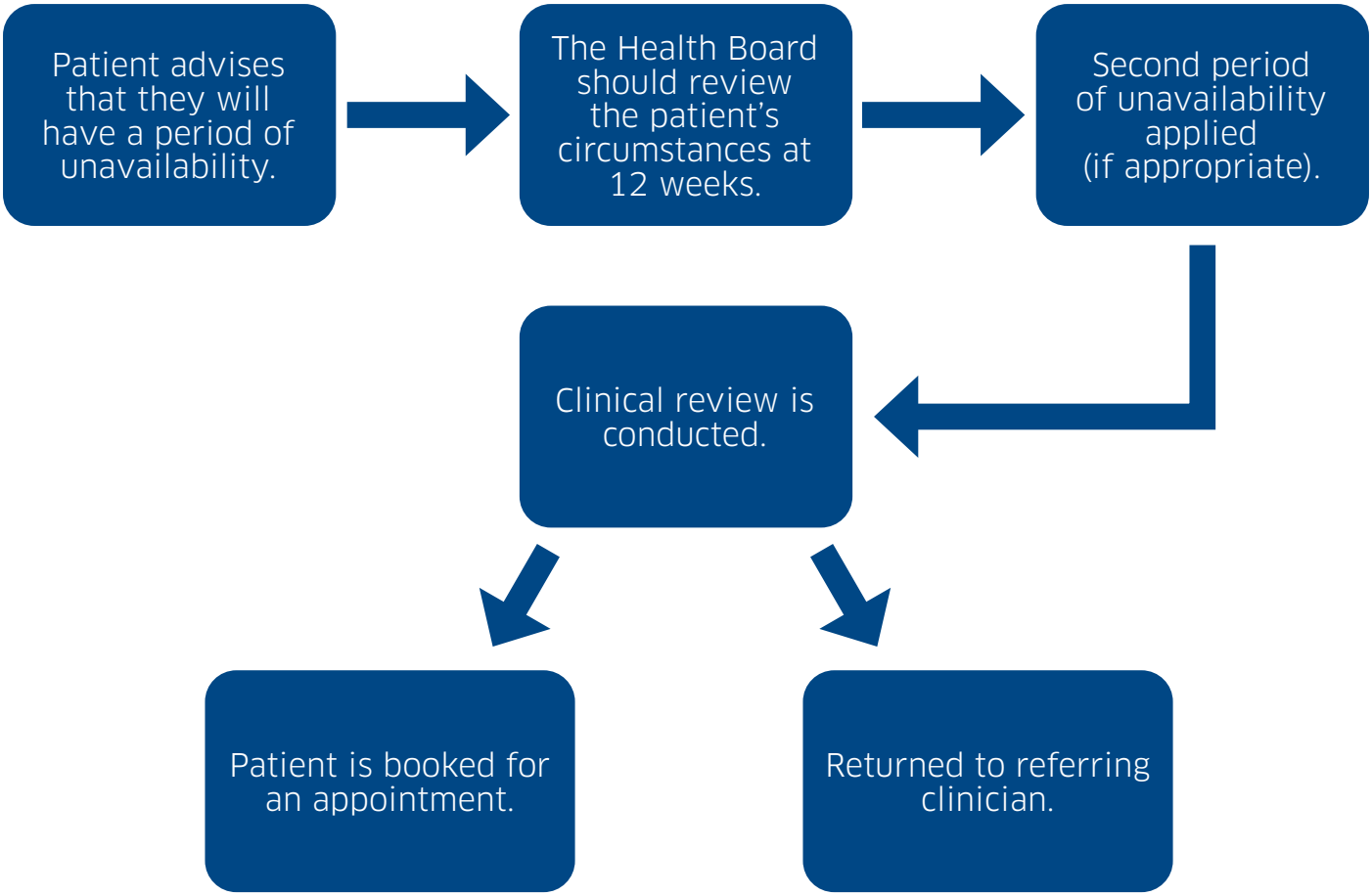
The start date of the period of unavailability is the date when the patient has advised the period of unavailability will start.

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

Examples of Patient-Advised Unavailability could include:

- Travel
- Personal Emergencies
- Care Responsibilities
- Jury Duty
- Work Commitments

Figure 6:


Patient advises that they will have a period of unavailability.
The Health Board should review the patient's circumstances at 12 weeks.
Second period of unavailability applied (if appropriate).
Clinical review is conducted.
Patient is booked for an appointment.
Returned to referring clinician.

11.2 Medical Unavailability

Guidance

This is when 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.

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 progressing.

The start 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 is the date the registered medical practitioner/clinician decides the patient is now fit and ready to undergo their treatment.

Allied Health Professional (AHP) Musculoskeletal (MSK) unavailability is when a registered **medical** or **healthcare practitioner** indicates that the patient needs a period of time before AHP MSK rehabilitation/intervention is undertaken. In this circumstance the whole period of the wait should be coded as a period of unavailability. For example, if the clinician / clinical protocol deems that a patient needs 6 weeks to recover after surgery then the unavailability will be 6 weeks.

However, to ensure these AHP MSK patients do not wait a further 4 weeks (the waiting time target), Health Boards should continue to ensure they manage their waiting lists appropriately. Health Boards should ensure the patients are offered an appointment at the appropriate time and without delay between the period of unavailability and the clinician's recommended time to start their rehabilitation / intervention.

AHP MSK Unavailability will be applied to a patients clock only.

Medical and AHP MSK unavailability relate to the patient and are **not** to be used to describe unavailability of the clinical service.

11.3 Patient-Focussed Booking Unavailability

Guidance - New Outpatients

Patient-Focussed Booking (PFB) Unavailability should begin to be applied 14 calendar days after the issue of the initial communication to the patient, inviting them to make an appointment.

Upon issue of the reminder communication one day of unavailability should be added every day until the patient makes an appointment. This should be up to a **maximum** of 7 calendar days of PFB unavailability.

When the maximum unavailability has been reached, a clinical review must be undertaken to confirm if it is reasonable and clinically appropriate to refer the patient back to their referring clinician. In cases where referring back to the referrer is not appropriate, the Health Board may reset the patient's clock to zero (regardless of whether any waiting time standard has been breached), and offer the patient another appointment.

12. Waiting Time Calculation

12.1 New Outpatients

Guidance

The Health Board that agrees the new outpatient appointment is responsible for ensuring that the patient is seen within the waiting times standard of 12 weeks.

The following must be captured on the appropriate systems.

- **Clock start** is the date when the referral is received.
- **Any clock adjustments.** Examples of adjustments can be found in Annex 3.
- **Clock stop** is the date of the new outpatient appointment, or the date a patient is removed from the outpatient waiting list.

For patients with a Long-Term Condition with an exacerbation or recurring symptoms, a new waiting time clock must be started for new referrals for the same condition. This does not apply to patients who are on Patient-Initiated Review (PIR).

For patients waiting for sequential bilateral treatment the waiting time for the second outpatient appointment is measured as a separate, second pathway with a new waiting time clock. The waiting time clock for the second outpatient appointment should not start until the clinician and patient agree to the treatment. The sequential treatment must not be managed as a Planned Repeat.

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

For patients transferred to a planned service via an urgent care service e.g. Accident & Emergency, Rapid Access Service, or a Minor Injuries Unit, a formal referral will not always be sent. The waiting time clock will start on the date of attendance at an urgent care service where the purpose of the appointment is for treatment, not a follow-up to treatment already started within an urgent care service.

For patients who self-refer or opt in via an Active Clinical Referral Triage (ACRT) **pathway,** a new waiting time clock starts on the date that the patient contacts the service.

For patients changing their permanent residence to another Health Board area, whose waiting time clock has already started and who request to be treated within that other Heath Board area (i.e. the Health Board of their new residence), their previous waiting time clock should be taken into account.

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

Guidance

The Health Board that agrees the treatment with a patient is required by law to take all reasonable steps to ensure that patients access their treatment within 12 weeks. Exceptions to the Treatment Time Guarantee can be found in Annex 4.

- **Clock start** is the date when the patient agrees treatment with their clinician.
- **Any clock adjustments.** Examples of adjustments can be found in Annex 3.
- **Clock stop** is the date that the patient starts to receive the agreed treatment, or the date the patient is removed from the waiting list.

Most patients will agree treatment at their outpatient appointment. This is when the patient's waiting time clock for their inpatient / day case treatment should start.

However, before the treatment can be agreed, some patients may be required to undergo a diagnostic test. The patient will be contacted about the test result, normally by phone or at a return outpatient appointment. In such cases, the treatment would be agreed at that time, which would be the start date of the Treatment Time Guarantee.

Should the patient indicate that they would like to have time to consider whether to proceed with the treatment, in this circumstance the patient's waiting time clock **will not** start until the patient agrees to proceed with the treatment.

Normally, the patient will be admitted to hospital on the day of treatment, and the patient's waiting time clock should stop on this day.

In some circumstances, the patient may be admitted for treatment the day before their surgery. Where this occurs in order to start the initial stages of treatment, for example, to administer medication or to clinically prepare the patient, this date should be recorded as the start of treatment.

For Referral to a One-Stop Service for patients seen on an inpatient or day case basis, the date the patient agrees treatment and the date of the treatment will be the same. The patient will have a zero-wait recorded against the Treatment Time Guarantee. For any patients for whom treatment cannot be undertaken on the day, the waiting time clock will continue.

For patients with a Long-Term Condition with an exacerbation or recurring symptoms, a new waiting time clock must be started for new referrals for the same condition. This does not apply to patients who are on Patient-Initiated Review (PIR).

For patients waiting for sequential bilateral treatment the waiting time for the second appointment is measured as a separate, second pathway with a new waiting time clock. The waiting time clock for the second appointment should not start until the clinician and patient agree to the treatment. The sequential treatment must not be managed as a Planned Repeat.

For patients transferred to a planned service via an urgent care service e.g. Accident & Emergency, Rapid Access Service or a Minor Injuries Unit, a formal referral will not always be sent. The waiting time clock will start on the date of attendance at an urgent care service where the purpose of the appointment is for treatment, not a follow-up to treatment already started within an urgent care service.

For patients changing their permanent residence to another Health Board area, whose waiting time clock has already started and who request to be treated within that other Heath Board area (i.e. the Health Board of their new residence), their previous waiting time should be taken into account.

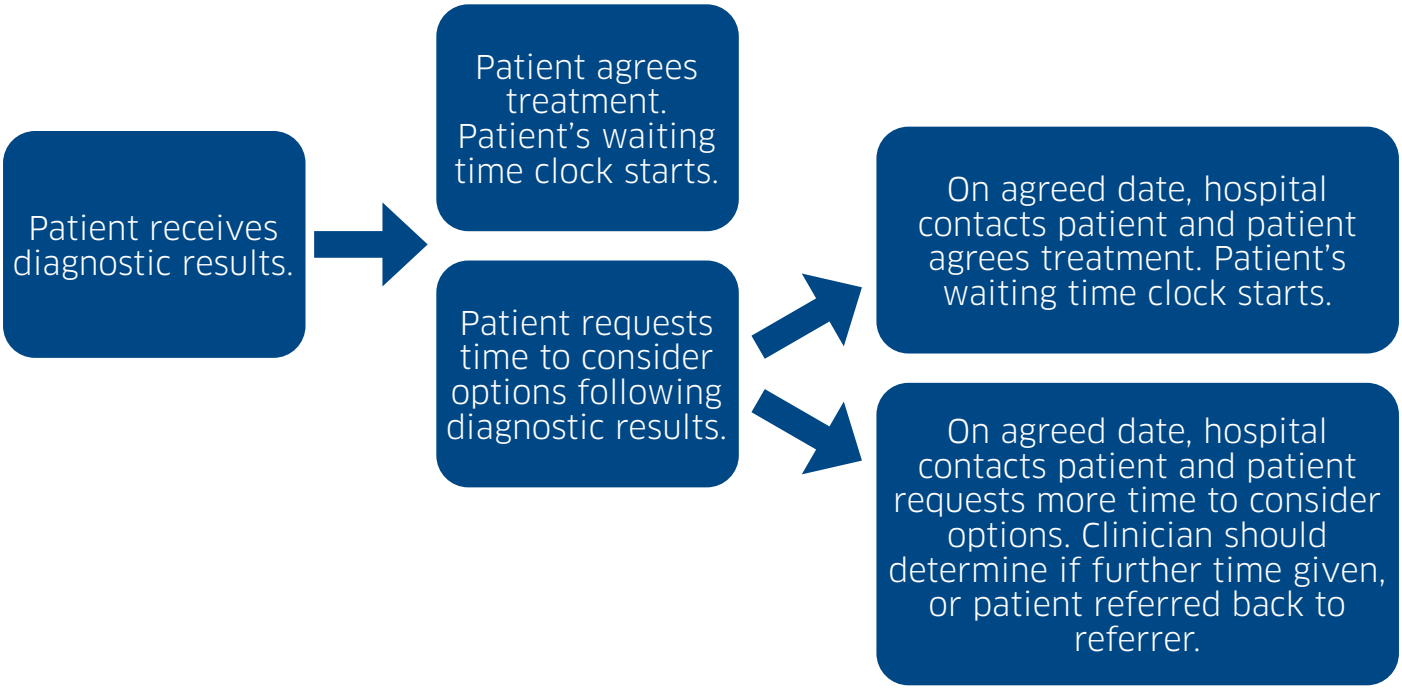
Best Practice

If the patient does not agree the treatment and has not been added to the waiting list, Health Boards should try to ascertain from the patient how long they wish to consider their options for treatment. They should also agree a date with the patient when the hospital will contact them to discuss the treatment further.

The waiting time clock starts on the date the patient is contacted if on this date the patient agrees treatment.

Should the patient wish for more time to consider the treatment, a discussion should 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 referring clinician.

Figure 7:



Guidance

Once the patient has agreed treatment and their waiting time clock has started, there will be a pre-operative assessment. The pre-operative assessment appointment is intended to ensure that the patient is fit for treatment which has already been agreed. This does **not** constitute agreeing to treatment so **must not** be taken as the start date of the patient's waiting time clock.

12.3 18 Weeks Referral-To-Treatment

Guidance

The 18 Weeks Referral-To-Treatment (RTT) standard applies to the entire patient journey from the initial referral to the start of treatment. Achieving the standard depends on waiting times for diagnostic tests, new outpatient appointments, inpatient and day case 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. This applies to:

- patients on a cancer pathway; and
- all patients added to a waiting list for planned treatment.

The following must be captured on the appropriate systems.

- **Clock start** is the date when the referral is received.
- **Any clock adjustments.** Examples of adjustments can be found in Annex 3.
- **Clock stop** is the date that treatment commences, appointments are concluded, or if the patient is removed from the waiting list.

For patients with a Long-Term Condition with an exacerbation or recurring symptoms, a new waiting time clock must be started for new referrals for the same condition. This does not apply to patients who are on Patient-Initiated Review (PIR).

For patients waiting for sequential bilateral treatment the waiting time for the second outpatient appointment is measured as a separate, second pathway with a new waiting time clock. The waiting time clock for the second outpatient appointment should not start until the clinician and patient agree to the treatment. The sequential treatment must not be managed as a Planned Repeat.

For consultant-to-consultant referrals a new waiting time clock will be started on receipt of the referral by the new consultant-led service if the referral is for a new condition or speciality. If the consultant-to-consultant referral relates to the same condition that the patient was initially referred for, then the existing clock will continue, and a new clock should not be started.

For patients transferred to a planned service via an urgent care service e.g. Accident & Emergency, Rapid Access Service or a Minor Injuries Unit, a formal referral will not always be sent. The waiting time clock will start on the date of attendance at an urgent care service where the purpose of the appointment is for treatment, not a follow-up to treatment already started within an urgent care service.

For outpatients that self-refer or opt in via an Active Clinical Referral Triage (ACRT) **pathway**, a new waiting time clock starts on the date that the patient contacts the service.

For patients changing their permanent residence to another Health Board area, whose waiting time clock has already started and who request to be treated within that other Heath Board area (i.e. the Health Board of their new residence), their previous waiting time clock should be taken into account.

12.4 Eight Key Diagnostic Tests and Investigations

Guidance

Diagnostic tests and investigations are used to identify a patient's condition, disease, or injury to enable a medical diagnosis to be made.

The Health Board that receives a request for a test or procedure is responsible for ensuring that investigation is undertaken, and the verified report is received by or made available to the requester within the **6-week** waiting times standard.

- **Clock start** is the date the responsible Health Board of initial referral area receives the request for the test or procedure.
- **Any clock adjustments.** Examples can be found in Annex 3.
- **Clock stop** is the date the verified report has been received by or made available to the requester, or the date the patient is removed from the waiting list.

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

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

For patients who require more than one diagnostic test, each procedure should be recorded as a separate new referral.

Health Boards are required to have a robust process in place to ensure results are communicated to patients in a timely manner.

13. Reporting Responsibilities

13.1 Reporting Responsibilities regarding Patient Records

Guidance

Where national reporting on waiting times relies on the submission of electronic patient records to the National Waiting Times datamart, it is the responsibility of the **Health Board of Treatment (HBT)** to ensure records are submitted for all patients they treat, irrespective of whether the patient resides in the Board. This is to ensure there is a consistent approach to reporting patients, including those who are referred across Health Board areas.

The following waiting time standards are included in this type of national reporting.

- New outpatient appointments.
- Inpatient / day case treatment under the TTG.
- New outpatient appointments at an Allied Health Professional (AHP) led Musculoskeletal (MSK) service

As a patient's waiting time clock is fully adjustable throughout their journey, the **Health Board of receipt of referral (HBR)** is required to collect the following data and provide this to HBT on transfer.

- Start date (e.g. Date of Referral Received for outpatients or Decision to Treat for inpatients / day cases).
- Clock adjustment dates and reasons.
- Any additional relevant information.

The HBT should provide the quality assured data in a timely manner. This includes:

- existing waits from data transfers; and
- all relevant information received from the Health Board of Referral.

In relation to submission of data to the National Waiting Times datamart, the above information will be supplemented by additional guidance from Public Health Scotland for both HBR and HBT.

13.2 Reporting Responsibilities ONLY regarding Eight Key Diagnostic Tests and Investigations

The Health Board of Initial Receipt of Referral is responsible for providing an aggregated return of the results of all eight of the key tests to Public Health Scotland.

14. Clinic Outcome

Clinic Outcome

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

Guidance

A clinic outcome must be recorded for every patient, this includes when a patient 'Did Not Attend' an appointment.

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

The nationally defined set of clinic outcome codes (see Annex 6) are to be used.

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

15.1 Armed Forces Relocation within the UK

Guidance

When a member of the UK armed forces or a member of their family moves into a new location in the UK, their previous waiting time should be taken into account. The expectation is that treatment in their new location will be met within the waiting time standards and Treatment Time Guarantee, according to their clinical need.

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

15.2 Paying Due Regard to the Armed Forces Covenant

Guidance

No veteran (including those who have served as reservists) or their family should be disadvantaged, as a result of their membership of the Armed Forces, when accessing NHS services.

It is for Health Boards and clinicians to determine how they ensure that they uphold their responsibilities under the Armed Forces Covenant duty. Further detailed guidance for veterans can be found at Armed_Forces_Covenant_Duty_Statutory_Guidance.pdf (publishing.service.gov.uk).

16. Glossary

Glossary

Appointment

An arrangement for a patient to be seen by or be in contact with one or more care professionals following an Appointment Referral.

Clinical Review

A clinical review **must** take place by the receiving service within the Health Board, prior to any patient being removed from a waiting list. Examples of a clinical review can be, but are not limited to, the following.

- The review of a patient's record by a clinician following a removal recommendation.
- A clinician recommending that a patient should be removed during a clinic.
- Agreed Removal Standard Operating Procedures (SOPs) in place for specific, routine procedures that have been pre-agreed and approved by a clinician.
- Agreed Removal Standard Operating Procedures (SOPs) to allow administration staff to remove patients during waiting list validation which have been pre-agreed and approved by a clinician.

Communication

The exchanging of information by speaking, writing, or using some other method, including but not limited to, online methods such as email or via online websites.

Health Board of Initial Receipt of Referral

The Health Board that receives the initial referral for the patient. In some cases, a patient may be transferred more than once in their treatment journey.

Health Board of Residence

The Health Board in the area of which a patient permanently resides.

Health Board of Treatment

The Health Board that treats the patient.

Health Care Provider

A Health Care Provider is an organisation acting as a direct provider of health care services.

Local Access Policy

Describes how the Health Board will manage access to its services and ensure fair treatment for all patients. Additionally, it outlines the responsibility of referrers, patients and receiving Health Boards, as well as the management of waiting times and communication with patients.

National Access Policy

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

One-Stop Service

A clinic where a patient will see a doctor or nurse, who may send them for a test and then discuss the results and next steps with them during their appointment.

Planned Repeat

When a patient is added to an inpatient / day case waiting list consisting of patients whose care is planned over a series of admissions for procedures or treatment.

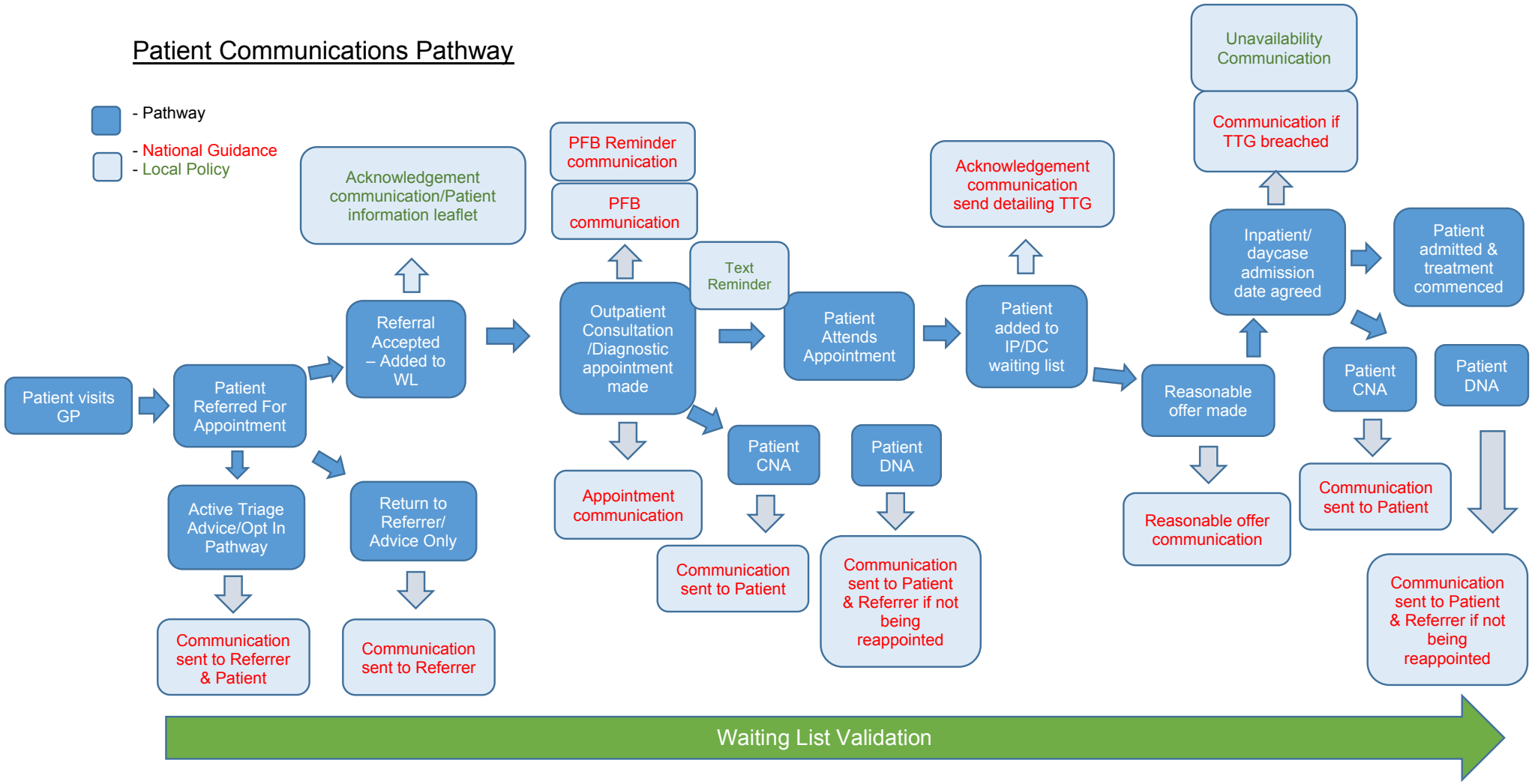
Principles

All guidelines (including best practice) noted in this guidance document that are not related to a measured target or guarantee.

17. Annexes

Annex 1 – Patient Communications Pathway

The visual below shows the package of patient communications Boards are expected to follow.



Annex 2 – Treatment Time Guarantee Patient Communication Template

Dear [addressee]

Planned Care - Addition to [speciality] [inpatient/day case] waiting list

I am writing to confirm that, as agreed with your consultant, you have been added to the waiting list for:

Procedure	[x]
Speciality	[y]
Health Board	[z]

In line with the Patient Rights (Scotland) Act 2011, you qualify for the Treatment Time Guarantee.

As we are focussed on treating people who are waiting too long for treatment, work is underway across NHS Scotland to increase activity, as we work towards achieving the 12-week Treatment Time Guarantee.

The work includes the commitment to maximising theatre productivity, optimising Golden Jubilee University National Hospital and National Treatment Centre capacity, and regional working. This will help ensure patients are seen as quickly as possible.

We have seen significant challenges for our NHS, including severe pressures over winter periods, staffing capacities, and the impact of rising inflation costs. This has affected almost all aspects of NHS care, including the number of planned care appointments, and procedures the health service was able to provide. Consequently, this has led to some waiting times that are longer than we would like them to be.

You can check the waiting time for [procedure], in [NHS Board] which comes under [National specialty], at [add website URL]. This information is collated by Public Health Scotland. It will provide you with an indication of the waiting time patients experienced over the last quarter, who completed their treatment. Your waiting time will depend on how urgent your need for treatment is. If your treatment is urgent, you may be treated sooner.

We will do everything possible to try and see you as soon as possible. You will be contacted as soon as an available date of treatment is identified.

If you are unable to access this information online, please contact:

Name of contact	[Team/contact point within receiving service]
Details	[Telephone/email address]

This is your first point of contact, and they will be able to provide you with this information.

While [NHS Board] will try to offer you an appointment in your local area, to ensure you are seen as quickly as possible, you may be offered an appointment outwith [NHS Board]; for example, this could be at the Golden Jubilee University National Hospital, another Health Hoard area, or a National Treatment Centre.

You will be informed as soon as possible if this applies to you. If this is the case, we will be able to assist with travel or accommodation costs.

It is important for you to be aware that you will be offered up to two appointments. However, if you cannot take up either offer of appointment your clinical team may decide to refer you back to your referring clinician. This may mean you are no longer on the waiting list for treatment, or reset your waiting time back to zero, which means you will be put back to the back of the waiting list.

For further information on waiting times for elective treatment, you may find it useful to visit NHS inform at Waiting times - Elective care | NHS inform. However, if you feel your condition has changed significantly for the worse, or you require further consultation, please contact [name of team/contact information within receiving service for patient].

Keeping Well

Looking after your physical and mental wellbeing in advance of planned treatment will give you the best chance of having a good recovery and a good outcome. This means that the treatment is more likely to go well, that you're likely to recover more quickly and you're more likely to get home sooner afterwards.

It is therefore important that you try to keep yourself as fit and healthy as possible while you wait for your treatment. This includes being as physically active as you can be and trying to maintain a good diet. If you smoke, then think about trying to stop. It's also important to look after your mental health. Information about support for stopping smoking and your mental health can be found below.

There is information available on NHS Inform to help you manage long-term pain and organisations that can provide further advice and resources to support you: NHS Inform - Chronic Pain

There is support available to help you keep as fit and healthy as possible. Visit Waiting Well - NHS Inform to find out more.

Information and support for your mental health

Samaritans – phone line 116 123 or email jo@samaritans.org

Breathing Space – phone line 0800 838587

Financial support and advice

Get help with debt and money - mygov.scot

Do you have any questions?

If you have any questions about your [appointment / treatment/procedure], please contact [telephone number] or visit [website] for more information.

It is also important that your contact details are correct. If your address or telephone number has changed recently, or you know of any dates when you will not be available to come in for treatment, please contact the [specialty] Office on [telephone number].

I appreciate any delay is disappointing but want to assure you that everything possible is being done to reduce waiting times across NHS [Board].

Thank you for your understanding during these challenging times.

Annex 3 – Clock Adjustment Examples

A patient's clock may be adjusted for reasons such as:

- Periods of unavailability whether they be medical, or patient advised
- If a patient refuses two or more reasonable offers of appointment
- If a patient cancels three or more appointments
- If a patient does not attend an agreed appointment
- During a suspension of the Treatment Time Guarantee

Annex 4 - Exceptions to the Treatment Time Guarantee

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

The Patient Rights (Treatment Time Guarantee) (Scotland) Regulations 2012 (legislation.gov.uk) outline any exceptions to the Treatment Time Guarantee. These are:

- assisted reproduction;
- obstetrics services; and
- organ, tissue, or cell transplantation, whether from living or deceased donor.

Mental Health services are not under the standards contained in this guidance, unless this requires planned admission to hospital for inpatient or day case treatment.

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

Annex 5 – Examples of Additional Needs Table

Additional Needs	Possible Requirements
Literacy issues	Requires information verbally Requires written information in large font Requires words and pictures version
Learning disability	Requires easy to read version Requires words and pictures version Using Makaton sign language Requires a carer or advocate present
English as a second language	Requires interpreter Requires information verbally Requires information translated
Speech impairment	Requires a written response Requires 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 staff to attend
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
Hearing impairment	Requires to bring a hearing dog Requires written information Uses text phone Uses email
Mobility issues	Requires ambulance/taxi/car 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 appointment Requires access to a Faith Room

Additional Needs	Possible Requirements
Socio-economic	Lack of bus/train services Money to travel to appointments Family constraints (e.g. caring responsibilities) Getting time off work Early discharge implications
Other	Requires appropriate chaperone

Annex 6 – 18 Weeks RTT Outpatient Clinic Outcome Recording

One Outcome Code must be selected for every patient seen at the Outpatient Clinic (new 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 their care 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

Annex 7 – Exclusions from 18 Weeks Referral-To-Treatment Standard

Referrals to the following services or some specific procedures are currently excluded from the 18 Weeks Referral-To-Treatment Standard, 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.
- Direct access referrals to Diagnostic Services where the referral is not part of a 'Straight to Test' referral pathway as there is no transfer of clinical responsibility to the consultant-led team.
- Exceptional Aesthetic Procedures which have been specifically excluded in the CMO(2019)05 - Exceptional Referral Protocol (previously known as the Adult Exceptional Aesthetic Referral Protocol) – refresh April 2019 (scot.nhs.uk).
- Genitourinary Medicine (GUM).
- Homoeopathy.
- Obstetrics.
- Organ and tissue transplants.

Mental Health services are not under the standards contained in this guidance, unless this requires planned admission to hospital for inpatient or day case treatment.

This publication is available at **www.gov.scot**

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