Elective Care Access Policy - HH(1)/CO/723/16

Previous document(s) being replaced

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Document Summary

This policy provides an overview of the key principles governing 18 weeks and other access targets. This document provides supporting detail on actual process and procedures to be followed for administrative and clinical staff.

Ownership

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Equality Impact Assessment

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<th>James Montgomery</th>
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Authorisation

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Signature

[Signature]

Date Authorised

| 30 September 2016 |

Dissemination

| Target Audience | All Trust Staff |

Dissemination and Implementation Plan

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<td>Publicise detail of new document via the intranet and Midweek Message</td>
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<td>1.</td>
<td>Review of BNHFT &amp; WEHCT policies to produce harmonised policy</td>
<td>Winchester staff please note: 2.1: routine appointments should take place within 6-8 weeks of referral, rather than 6-13 weeks 6.1: patients should be contacted within 5 working days of referrals being accepted, rather than 10 days 13.3: the procedure for clinically-initiated delays has changed</td>
<td>James Shield (Integration Team) with John Haynes &amp; Charlie Malcolmson</td>
<td>November 2011</td>
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<td>2.</td>
<td>Timetabled review</td>
<td></td>
<td>Z Ludick</td>
<td>October 2015</td>
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<td>3.</td>
<td>Update following National refresh document</td>
<td>This refresh of the national guidance emphasises that those patients who choose to wait longer should have their wishes accommodated without being penalised.</td>
<td>J. Uzzell</td>
<td>February 2016</td>
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<td>Update following advice from Monitor review</td>
<td>Clarity to when clock starts/stops and continues. Additional info re Management of Planned Patients and Armed Forces Covenant.</td>
<td>M Griffith</td>
<td>August 2016</td>
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1. **Introduction**

This document sets out HHFT local access policy. It describes how the Trust is managing the 18-weeks ‘universal pledge’ and National Cancer waiting time targets. The NHS Improvement Plan (2004) set out the commitment: “by 2008 no one will wait longer than 18 weeks from GP referral to hospital treatment (RTT)”. This applies to all Trust **consultant-led elective activity**, regardless of the location where the activity takes place. (Including Audiology activity)

The RTT pathways and compliance with the 18 week incomplete target is reported to our commissioners and to the Department of Health on a monthly basis.

In June 2015, Simon Stevens and the Secretary of State for Health accepted a recommendation from Sir Bruce Keogh that the incomplete pathway operational standard should become the sole measure of patients’ constitutional right to start treatment within 18 weeks.

**Incomplete/Still waiting Target:**

Includes all Patients who are still awaiting treatment.

Measure for compliance: 92% of patients who have yet to be treated should not be waiting more than 18 weeks.

Many patients will choose to be seen at the earliest opportunity. However, patients are entitled to wait longer for their treatment if they wish. Patients must be allowed to plan their treatment around their personal circumstances. Delays as a result of patient choice are taken account of in the tolerance of 8% set for achievement of the incomplete pathway waiting time operational standard.

As a result of the removal of the completed admitted pathway operational standard, there is no longer any provision to report pauses or suspensions in RTT waiting time clocks.

The access policy informs patients, relatives and staff of their rights and what to expect from the Trust. It is linked to the NHS Constitution (2013) and therefore to certain legal rights. It allows the Trust and commissioners to set out their local approach to managing and sustaining shorter waiting times, as set out in the NHS Constitution.

The Trust relies on GPs and other referrers to ensure patients understand their responsibilities in relation to their pathway and related timescales when being referred. This will help ensure that patients are referred under the appropriate clinical guidelines and are aware of the speed at which their pathway may be progressed and are in the best position to accept timely appointments throughout.

This policy provides an overview of the key principles governing 18 weeks and other access targets and incorporates the Trust’s Outpatients Guidance in the main body of the document.
2. **Purpose**

Everyone has the right (by law since 2010) to access certain services commissioned by the NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible. The waiting times are described in the *Handbook to the NHS Constitution (2013)*.

The main purpose of this policy is to describe the application of the rules for managing the 18-weeks “universal pledge”, and provides the necessary detail on actual process and procedures to be followed for administrative and clinical staff.

3. **Scope**

The policy reflects the requirements of the local population and ensures patients are treated in a way that is consistent with the NHS Constitution, and reflect the referral to treatment rules for inpatients and outpatients.

The policy demonstrates an understanding of the awareness of cancer patients described in a specific HHFT protocol “*Clock adjustments for Suspected and Diagnosed Cancer patients*”.

The policy ensures that patients are treated in clinical priority order, and patients with the same clinical priority should be treated in date order with the longest waiting patients treated first. The policy addresses a number of questions to allow care to be provided in an equitable and fair manner, allowing staff the opportunity to understand the rules and their application, avoiding errors and mistakes.

The Trust does however recognise the need to maximise resources (e.g. theatre lists, beds, Outpatient clinic capacity) and taking this into account may mean some patients are treated out of date order.

The following questions are addressed in the policy at a high level:

- What starts a clock?
- What stops a clock?
- What is a breach? How should the escalation process be managed?
- What are the criteria for adding patients to inpatient lists?
- What to do with “medically unfit” patients?
- What is a minimum data set and when is it used?
- What happens when a patient DNAs; next steps?
- What happens when a patient cancels any appointment?
- What happens when the Trust cancels any appointment?
- How active monitoring is applied and managed?
- Reference to Trust annual and study leave policy
- How does the Trust manage planned patients?
- How does the Trust manage diagnostic patients?
The detailed operational day to day management of these processes is explained in the “Referral to Treatment (RTT): A guide to managing 18 weeks” document.

This policy and procedure will be applied fairly and consistently to all employees who are authorised to work remotely, regardless of their protected characteristics as defined by the Equality Act 2010 namely, age, disability, gender reassignment, race, religion or belief, gender, sexual orientation, marriage or civil partnership, pregnancy and maternity; length of service, whether full or part-time or employed under a permanent or a fixed-term contract.

Where an employee has difficulty in communicating, whether verbally or in writing, arrangements will be put in place as necessary to ensure that the processes to be followed are understood and that the employee is not disadvantaged during the application of this policy.
In line with the Equality Act 2010, the Trust will make reasonable adjustments to the processes to be followed where not doing so would disadvantage an employee with a disability during the application of this policy.

4. **Explanation of Terms**

**Communication**- any and all written, electronic or fax documents.

**RTT** – Referral to Treatment – national reporting requirement for the time monitored between receiving referral for patient and the date they get their first treatment.

**2 Week Rule** – National reporting / performance requirement to monitor patients referred by their GP on a 2 week rule. Meaning they need to have received their 1st attendance within 2 weeks of being referred.

**Active Monitoring** – term used within Cancer and 18 week RTT performance reporting where the “treatment” for the patient is to wait and monitor their condition instead of surgery for example.

5. **Duties**

**Post Holders**

**Chief Executive**
The Chief Executive has ultimate accountability for ensuring robust systems are in place to ensure all patient pathways are booked and managed according to the policy.

**Divisional Operational Directors**
The Divisional Operational Directors are accountable for the delivery of this policy and adherence to relevant Key Performance Indicators.
In addition, the Divisional Operational Directors, via Operational Service Managers (OSMs), are responsible for ensuring compliance with this policy and the Chief Operating Officer has overall responsibility.

Clinical staff
Consultants, nurses and relevant allied health care professionals have a duty to follow the rules, managing elective care according to the rules and in line with the “universal pledge”. As such, a working knowledge is required and it is expected that staff will access relevant training sessions as and when required to acquire a working knowledge.

Operational services managers
Operational service managers are responsible for ensuring their teams are adequately trained in the management of the RTT rules. The management of capacity in line with demand is also their responsibility, as well as the RTT compliance on a monthly basis.

All staff
All staff are required to abide by the concept that the management of patients and their referral pathway will be equitable, transparent and communication with patients will be clear and concise to allow informed choices and decisions to be made. In addition, they must be free to escalate any concerns about patient pathways to the appropriate level to ensure that all specialties and departments are open in the approach that they take towards managing patient access to services.

Speciality Coordinators
Speciality coordinators are responsible for managing the patient pathway for all patients in line with this policy

18 week Validator
18 week Validators are responsible for reviewing patient pathways for accuracy and compliance with the RTT rules and policy

Booking Clerk
Booking clerks are responsible for the booking of patients for clinics or surgery in line with RTT rules and policy.

6.  Fit and Ready
As a general principle, the Trust expects that, before a referral is made for treatment on an 18-week pathway, the patient is ready, willing and able to attend for appointments and undergo any treatment that may be required within 18 weeks, after the initial referral. This will include being both clinically fit for assessment and possible treatment of their condition. The provider and commissioners will work together to ensure that patients understand this before starting and that they are ready and able to attend first outpatient appointments within Trust standards. Including 2 weeks for cancer fast track referrals first appointment.
7. **Referral Registration**
   Referrals will be received in one of the following areas:

   **E-Referral**
   The referral letter will be accessed directly by the appropriate member of staff and passed to the consultant to be accepted, rejected, or re-directed. Outpatient booking teams will look for double registrations on PAS and facilitate correction as required. Secretaries and/or specialty administrators will administrate any changes to the referral, for example redirecting it to another specialty or clinician, and will be responsible for maintaining the services on E Referral. This includes ensuring that services are accurately published and any worklists and slot issues are resolved.

   **Outpatients Administration and Booking Teams**
   The referral letter should be date stamped, GP/dental practice validated and the appropriateness of the referral established within specialty specific referral guidelines. The referral will be added to a waiting list if required.

   **Direct Referral to Clinician from Clinician**
   On receipt of the referral letter it will be date stamped by the receiving administrator and sent directly to the appropriate Outpatient Booking team to be registered on PAS before going to the clinician. A registered referral will be recorded on PAS. Reference: [Inter Consultant & AHP Referral Policy](#)

7.1 **Registration Process**
Referrals received are to be recorded onto the Trust PAS within 1 working day of receipt. Where systems are in place, referrals will then be scanned and kept electronically.

   Referrals are to be prioritised by the Consultant or other relevant clinician (maybe a referral to a nurse or allied health professional) and returned to Outpatient Booking teams in an electronic or paper format within 48 hours. On return of the referral from the clinician to the Outpatient Booking teams, booking procedures will be initiated and the appropriate appointment made on PAS (see booking of appointments).
7.2 Cancer Referrals/Two Week Rules
GPs are encouraged to refer patients with suspected cancer under the two week wait system by use of standard criteria-specific proforma. CCGs aim to expand services via E-Referral. All TWRs must be faxed through to designated safe havens. On receipt, the TWR referral is registered onto the Trust’s PAS. Where consultant approval has been given, the booking teams will contact the patients with details of the next available urgent appointment. The standard DNA cancellation standards apply.

7.3 Inter-Provider Transfers
To support patients and their care through the NHS, it is key that waiting lists for treatment are consistent across England. Therefore it is important that the correct start date is captured for patients who transfer from interface services to secondary care providers and from provider to provider. Inter-Provider Transfer (IPT) forms, containing the mandatory IPT data set, are required to be sent with the corresponding referral letter when transferring patients between providers. Any patients who are still awaiting treatment and move location within the UK, should be able to join the waiting list at the new provider at the same point they had reached with the original provider. This is key for patients who are in the Armed Forces and registered with a Defence Medical Service (DMS) Practice as Armed Forces personnel and their families move home more frequently than the general population and these moves are required as part of their military commitment. Processes should be in place to ensure that patients transferring between providers have the correct RTT start date.

7.4 Booking Outpatient Appointments
When arranging first appointments (both routine and urgent), every effort is made to contact all patients, regardless of specialty or referral source. Patients are informed that their referral has been received and will then contact the Trust to discuss available appointment dates. Following negotiation of an outpatient appointment, the Outpatient Booking teams will send a confirmation letter to the patient with the following details:

- Outline responsibilities of the hospital and the patient
- Confirming the appointment date, time and location
- Contact details at the hospital.

When the Outpatient Booking team is consistently unable to book first appointments within the specialty’s target wait this will be escalated to the appropriate OSM as a capacity issue. The Outpatient Booking team will not overbook slots without a request from the consultant secretary, or OSM.

Fixed booking may occur for specialty-specific reasons, such as capacity or clinical reasons.
Most patients will choose to be seen at the earliest opportunity. However, patients are entitled to wait longer for their treatment if they wish. Patients must be allowed to plan their treatment around their personal circumstances. Delays as a result of patient choice are taken account of in the RTT tolerance of 8% set for achievement of the incomplete pathway waiting time operational standard.

7.5 Generic Referrals
When a patient is registered as a generic referral and a booking made, it is the responsibility of the Booking office to amend the referral to the named consultant the patient has been appointed to.

7.6 Electronic Referrals
Ideally all GP referrals are received in the Trust in an electronic form rather than paper form. To adhere to Information Governance standards all external referrals have to be e-mailed to and from an NHS.net account.

7.7 Non-Responders
If patient does not contact the hospital (Non-Responder) within two weeks of receiving a letter or phone call, the patient is discharged and removed from the waiting list and GP advised. If subsequently the patient requires an appointment they will have to be re-referred or, if contact is made within one month of discharge, the patient will be put on as self-referral.

8. Cancer Referrals
All patients referred with suspected cancer will be seen by a clinician within 14 days from the date the letter/fax/communication is received in the Trust. Both an 18-week and a cancer clock must start for such referrals although the maximum cancer waiting time will take priority.

9. Outpatient Booking Team – Demographic Details
When patient contact is made the Outpatient Booking teams need to collect or confirm demographic details:
- Patient’s name
- Patient’s address
- Next of kin
- Telephone number (ideally mobile for texting purposes)
- GP and Practice
- Ethnic Origin
- Residency status

Patient Reminders
Where the service is available within HHFT and the patient has provided a mobile number the patient is routinely texted using SMS net:
Please don’t forget your appointment at xxx hospital on xxx at xxx time. To cancel or re book please contact the number on your appointment letter.

It is essential that Patients are asked if they give consent for the use of email or text messaging as means of communication with patients and that this is recorded on the relevant system and in the patient notes.

**Patient Communication**
A range of inserts and leaflets are available to be included in appointment confirmation communication or during outpatient appointments, following their approval and publication by the Trust. These can also be accessed on the Trust website.

### 10. Management of Outpatient Clinics

Clinic templates should match as closely as possible the numbers and types of patients who can be seen within each clinic. Any changes to clinic templates must be authorised by the Service Manager for that service and detailed on a specific pro forma attached.

Templates should reflect the priority mix of referrals. They identify the number of slots available for new (urgent and routine) and follow-up appointments, instructions on overbooking and specify the time each clinic is scheduled to start and finish.

Where changes are required to the template, adequate notice (minimum of 6 weeks) should be provided to ensure that changes may be made by the required date. Any permanent reduction in slots per outpatient clinic requires a minimum of 13 weeks written/electronic notice before the changes will become effective. Operational service managers (OSMs) are responsible for quantifying the effect of clinic template changes on their capacity to treat patients and where necessary ensuring that capacity is put in place to treat patients by their waiting time target.

Any requests to set up new clinics must be authorised by the manager for that service. It is the responsibility of the manager to agree arrangements with support departments to ensure that adequate resources are provided to enable all aspects of the new clinic to run effectively.

Clinic template changes are administered by Application Support or by the Outpatient Department, who may require up to 30 days to process requests.

All new slots must be made available to E referral.

### 11. Management of follow-up appointments

Follow up appointments must only be arranged where it is deemed clinically necessary. In general, where patients require a follow up appointment, this should
be agreed prior to leaving clinic. Where this is not possible, an appointment should be sent to the patient as soon as possible following the original attendance.

Follow-up appointments should be booked in line with the instructions on the outpatient outcome forms or discharge summaries. Consultants may also request an Outpatient follow up appointment following test results. It is the clinical team’s responsibility to ensure all sections of these forms are completed.

12. Recording of RTT and other Clinic Outcomes

Clinic outcomes should be updated appropriately (‘cashed up’) within 1 working day of the clinic taking place. Each patient attending clinic should have an outcome form filled in by the clinician. All outcome information should then be entered on to PAS within 1 working day. If it takes longer than 1 day to return outcome forms to the outpatient department (for clinics taking place in other areas of the Trust), the forms may be completed at the outpatient department’s discretion or returned to the relevant specialty to be completed.

If a patient does not have the outcome form completed it is the responsibility of the outpatient nurse for that clinic to highlight this to the relevant clinician. However, it is the responsibility of the clinician to ensure that outcome forms are completed and that sufficient outpatient procedural, 18-week pathway and next step information is provided to the administrative teams.

Data quality reports provide information of clinics where there are still outstanding outcomes. It is the relevant teams’ responsibility to ensure there are no un-outcomed clinics on a weekly basis so that any unrecorded outcomes are completed.

13. Clock Starts

A waiting time clock starts when:

a. A GP, dentist or other healthcare professional refers a patient to the Trust for any elective, consultant-led service for the patient to be assessed and, if appropriate, treated before responsibility is transferred back. For paper referrals this is the date the Trust receives the referral.

b. For ERS (Choose & Book) (Electronic patient referral system) referrals the clock starts on the date the patient calls to make an appointment and gives their unique booking reference number.

c. If a referral is made to a referral management or assessment service with an onward referral to a consultant led service, an 18-week clock is started.

d. If, following completion of an 18-week referral-to-treatment period, a patient requires additional treatment for a substantially new or different condition then a new 18-week clock starts. This is a clinical decision made in consultation with the patient.
e. When a patient becomes fit and ready for the second of a bilateral procedure

f. Upon a decision to start a substantively new or different treatment that does not already form part of that patient’s agreed care plan.

g. When a decision to treat is made following a period of active monitoring

h. When a patient rebooks their appointment following first appointment DNA that stopped and nullified their earlier clock.

14. Clock Pauses
In line with RTT Rules Suite guidance published in October 2015, the Trust will not apply pauses to any part of the patient’s RTT pathway.

15. Clock Stops
The 18-week clock stops either when the patient receives the first definitive treatment intended to manage the condition for which they have been referred; or for one of the other defined non-treatment clock stops. For example, a patient’s 18-week clock will stop where a period of active monitoring is decided as the appropriate clinical response and a new 18-week clock starts if a subsequent decision to treat is made. Clock stops may occur following an out-patient consultation, receipt of results from a diagnostic test or following surgery, for example.

The following situations would not stop the clock:
Patient admitted for diagnostic test or procedure only
Patient admitted for pre-treatment prior to first definitive treatment
Patient admitted for pre-op assessment only
Patient admitted for first definitive treatment but intended procedure is not carried out during admission

A clock stops when it is clinically appropriate to return the patient to primary care for treatment, or a clinical decision is made to start active monitoring. If a patient declines treatment having been offered it, the clock is stopped. This excludes patients delaying treatment. If a patient fails to attend (DNA) their first appointment following the initial referral that started the clock, the RTT clock is nullified resulting in the clock stopping but the stop not being reported in the monthly RTT return or any other performance reports. Specific details with effect for cancer maintained within HHFT Protocol – Going Further on Cancer Waits – Clock Adjustments for Suspected and Diagnosed Cancer Patients.

Patient-initiated cancellations
If a patient cancels, rearranges or postpones their appointment, this has no effect on the RTT clock, which should continue to tick. Patients should not be discharged back to their GP simply because they have cancelled or rearranged appointments or choose to wait longer than local waiting time targets; referral
back to the GP should always be a clinical decision, based on the individual patient’s best clinical interest.

16. Specific Guidance for Armed Forces

16.1 Access to Health Services for Military Veterans
In line with the Armed Forces Covenant guidance from the Department of Health, all veterans and war pensioners should receive priority access to NHS care for any conditions which are related to their service subject to the clinical needs of all patients. Military veterans should not need first to have applied and become eligible for a war pension before receiving priority treatment. GPs should notify the Trust of the patient’s condition and its relation to military service when they refer the patient so that the Trust can ensure that it meets the current guidance for priority service over other patients with the same level of clinical need. In line with clinical policy patients with more urgent clinical needs will continue to receive clinical priority.

16.2 Access to Health Services – Armed Forces Covenant
As part of this principle and in line with the Armed Forces Covenant, the Trust will ensure that members of the Armed Forces Community (including those serving, reservists, their families and veterans) are supported, treated equally and receive the same standard of, and access to healthcare as any other UK citizen in the area they live. The Trust will ensure that for those with concerns about their mental health who may not present for some time after leaving Service, will be able to access services with health professionals who have an understanding of Armed Forces culture. Families of serving personnel moving around the country, any time taken on an NHS treatment waiting list will be taken to account in their new location.

For further information on what you can expect if in the Armed Forces Community see Section C.2 Scope of the Covenant, Healthcare7. The Armed Forces Covenant sets out the relationship between the nation, the Government and the Armed Forces Community. The Covenant aims to ensure that those who the Armed Forces, whether as Regular Personnel or as a Reservist, their families and those who have served in the past (veterans), should face no disadvantage compared to other citizens in the provision of public and commercial services. Special consideration is appropriate in some circumstances. The Armed Forces Covenant looks to address a wide range of issues impacting on the Armed Forces Community, including health, education, housing, care and family life. The Armed Forces Act 2011 created the requirement for an annual Armed Forces Covenant report to be made to Parliament. For further information on the Covenant and the Annual Report visit: https://www.gov.uk/government/publications/the-armed-forces-covenant
17. Patient Choice Referrals (Electronic Patient Referral System)

17.1 First patient contact appointments
The quality of the initial referral is a crucial determinant in identifying the priority for attendance at outpatients. All GP to consultant first outpatient appointments should be referred via E referral where available. This system is being run for GP referred first appointments for all consultant-led clinics, and gives patients the opportunity to book the time and date of their appointments. Referrers must ensure letters are received within a maximum of five days from the initial E-Referral referral to enable the Trust to confirm the correct booking slot and to ensure that the appropriate clinical information is available for the consultant to review.

Unless there is a need for the referral to be seen by a clinician with a sub-specialty interest, GPs should refer patients to the appropriate specialty rather than a named consultant. With any referral, patient choice needs to be a factor that is taken into account. For continuation of care, patients who are under a named consultant should, as far as reasonably possible, remain under that consultant for future care. It is the responsibility of the operational service managers (OSM) to ensure consultants are issued with a smart card to enable them to access the system as a named consultant.

Clinical priorities will determine the urgency of the appointment. Clinically non-urgent patients are managed on “next in turn” basis - PTL lists are used to target patients for admission. Trust PAS systems are is used for the management of all patient referrals and outpatient clinics. All suspected cancer referrals received as a “two week wait” referral will be seen within 14 days by an appropriate clinician with the shortest waiting list.

E-Referral patients can phone into the Appointment Centre with an UBRN number and password, or book online, which allows for a negotiated appointment to be generated for the patient. Consultants are expected to review their referrals to assess appropriateness, and have the ability to accept, reject, or divert the referral to a more appropriate service. This should be done within 48 hours. If a referral is diverted the date of the new referral must be the same as the original referral.

Referrers must ensure communication is received within the national timeframes from the initial E-Referral referral to enable the Trust to confirm the correct booking slot and ensure that the appropriate clinical information is available for the consultant to review.

17.2 Clock start
The Date Received (clock start) for E-Referral appointments is the date on which the first appointment is made, at which point the UBRN (unique booking reference number) is said to be converted. If the Trust has to change the patient’s appointment to another more appropriate service/clinic, the original Date Received remains as the clock start.
It is the responsibility of the consultant secretary to electronically forward the GP referral letters from E-Referral within 2 working days and send for acceptance/rejection/redirection by the clinicians. This is the preferred method, though some paper based systems might still be in use.

All referrals must be returned promptly to the Outpatient Booking team within 48 hours of receipt. Where possible a referral will be redirected to the most appropriate clinic, rather than rejected and returned to the GP. The referrals will then be scanned into Patient Centre and a hard copy filed into the patient’s notes where appropriate.

Unless specifically instructed by a clinician, all new routine and urgent slots will be released on E-Referral. If there is no appointment available visible on E-Referral, the Trust will receive the referral request from The Appointment Line (TAL). A TAL report will be received daily by the Trust.

If an appointment cannot be made using E-Referral, it will be booked manually into the PAS system. The Outpatient Booking team will inform the patient of the appointment date and cancel the UBRN.

Patients should not be discharged simply because they have cancelled or rearranged appointments, or choose to wait longer than local waiting time targets.

18. Other referrals, non-consultant clinics, investigation and follow-up appointments
All of these referrals will continue to be part of the 18-week patient pathway until initial treatment has commenced.

If a consultant transfers a patient’s care to another consultant within the same episode of care, then this appointment should be classed as follow-up.

If a consultant forwards on a referral to another consultant or clinician before seeing the patient, then the patient is booked as a new appointment for the accepting clinician.

A&E referrals to a different specialty will be classed as new referrals. The Trust aims to ensure that, where possible, patients requiring a further appointment in their pathway (outpatients, diagnostic or treatment) – should leave the hospital with an agreed date.

19. Reasonable Offers
The Trust’s local definition of what constitutes a reasonable offer for any non-fast track urgent outpatient diagnostic appointment and for treatment (e.g. surgery) is two reasonable offers with a minimum of three weeks’ notice (i.e. need to offer different days).
The Trust aims to contact a patient within **five working days** of the referral being accepted. First contact can be by letter, inviting the patient to contact the hospital to arrange a suitable appointment date and time or by phone to discuss appointment dates. Where this is not possible to contact the patient, then a letter will be sent to the patient, proposing an appointment date and asking them to contact the Trust if they would like to arrange an alternative date.

Where a patient does not make contact within 10 working days following receipt of a letter or telephone messages (at least two attempts must be made by the hospital), the patient will be returned to their GP and discharged from the system as a non-responder. If subsequently the patient requires an appointment they will have to be re-referred or, if contact is made within one month of discharge, the patient will be put on as self-referral. For some specialties, the list of non-responders is sent to them for review and any additional decision making.

**20. Did Not Attends (DNAs) – First Appointments**

If a patient fails to attend their first appointment and it was clearly agreed with the patient and/or communicated with reasonable notice, their 18-week clock will be nullified and excluded from RTT reporting. The patient will be referred back to the care of the GP unless the secondary care clinician informs that the patient has clinical or social reasons why another appointment should be offered, such as for cancer or vulnerable patients. The final decision will be made by the clinician managing the patient’s care. For patients who have been discharged back to their GP and re-referred, a new 18-week clock will start, and treated as a new referral.

If the exception above applies, a second offer letter will be sent to the patient and a copy will be sent to the GP advising them of the initial failure to attend. A new 18-week clock starts when the patient contacts the department to set another appointment.

If the patient contacts the Outpatient Booking team having been discharged for genuine circumstances, their appointment can be reinstated as self-referral if within an appropriate timeframe. This will start a new 18 week clock.

**21. Did Not Attends (DNAs) – Subsequent Appointments and/or Procedures**

A risk identified by the Trust with the reduction in waiting times is an increase in DNA rates, as some patients prioritise other commitments ahead of their NHS appointments. If this occurs, the Trust will seek to bring this to the attention of the patient’s GP or referring clinician.

The management of children and/or pregnant woman who miss appointments is covered in two additional Trust policies:

- *Missed Appointments*
- *Management of children who miss appointments and families who disengage with Health Services Policy*
Patients who fail to attend subsequent appointments will be discharged back to the care of their GP (which will stop their clock) providing:

- The appointment was clearly agreed and communicated; and
- Discharging the patient is not contrary to their best clinical interests.

The final decision will be made by the clinician managing the patient’s care.

For patients who have been discharged back to their GP and re-referred, a new 18-week clock will start, as this is a new referral.

Where a decision is made to offer another appointment, the consultant will indicate on the outcome form to offer the patient another appointment. A letter will be sent informing the patient they have not attended and providing a new appointment date (clock continues). If a patient DNAs for a second time they will then be discharged (clock will stop).

The Trust has specific guidelines for women who fail to attend for antenatal care. The intention is to create and embed a risk-aware culture which ensures that there is clear and consistent identification throughout the whole of the pregnancy for women who require a higher degree of care and observation in an appropriate facility. It provides a framework to ensure prompt identification of these women, comprehensive management plans and makes explicit the communication channels that should be in place between health care professionals in order to implement treatment and improve outcomes.

22. Did Not Attends (DNAs) – Pre-Operative Assessments

If a patient fails to attend a pre-operative assessment (POA) then the patient should be contacted, ideally by a clinician/POA nurse, to discuss the reason.

It is expected that one of two outcomes will occur:

a) Agree a further date for a pre-operative assessment: or
b) Discharge back to the care of the GP - this will stop the 18-week clock.

23. Patients who are unavailable for outpatient appointments

Occasionally patients are temporarily unavailable to attend outpatient appointments. Where patients give advance notice of being unable to attend and do not require a further appointment, the appointment and patient episode should be cancelled and the date they contact the hospital recorded on PAS, with the reason for the cancellation.

Where patients give advance notice of being unable to attend and ask for a further appointment, a new appointment should be made retaining the original “Date
Request”. The original referral request received date should never be altered or removed, even if the patient cancels or DNA.

Patients who cancel their outpatient appointment should be given an alternative date at the time of cancellation. For some services this could include a telephone consultation.

24. Patient & Hospital Initiated Delays & Cancellations
Where the patient or Trust cancels an appointment or date for treatment the 18-week clock will continue and the patient needs to be rebooked at the earliest opportunity. Cancellations, whether patient or hospital initiated, do not stop the 18-week clock. The operational tolerances for 18 weeks take account of patient-initiated delays such as these.

Patients should not be discharged simply because they have cancelled or rearranged appointments, or choose to wait longer than local waiting time targets.

Where the Trust cancels an appointment all attempts will be made to ensure the patient is given another appointment as soon as possible, within the 18-week pathway. Wherever possible, a patient who has previously been postponed will not be postponed for a second time.

Patients will not have their admission cancelled by the Trust for non-clinical reasons on the day of admission. On the rare occasion where this is unavoidable, patients will be offered to be readmitted within 28 days.

24.1 Cancellation or reduction of clinic slots
The only acceptable reason for any clinic slot to be cancelled is the absence of the clinician. This can result from planned annual/study leave, or audit sessions, and unplanned sickness absence. Clinic slots should not be cancelled for any other purpose unless there are exceptional circumstances.

A minimum of six weeks’ notice is required of planned annual or study leave, if this is resulting in a clinic being cancelled or reduced. Clinic slots that need to be cancelled with less than six weeks’ notice, with the exception of sickness, will require approval from the OSM.

Completed cancellation forms should be emailed to OPD Cancellation inbox with the relevant OSM’s signature or their approval via email. It is the responsibility of OPD cancellation to inform senior nurse colleagues of any cancelled clinics. The Outpatient Booking team is responsible for cancelling clinics and reducing clinic slots for planned/unplanned leave. Where cancellations are initiated by the hospital, patients should be booked as close to their original appointment date as possible.
25. Clinically Initiated Delays (or Patient Unfit for Treatment/Surgery)

Patients who are neither clinically ready nor fit for surgery should not be added to an elective waiting list until they are fit for surgery.

If a patient is not medically fit to proceed with treatment, i.e. surgery, the Trust will ascertain the likely nature and duration. If the reason is that they have a condition that itself requires active investigation and/or treatment and the original treatment cannot be carried out until this is complete, then they will either be discharged back to the care of their GP to ensure the clinical condition is monitored and re-referred as soon as they are fit to be re-assessed for treatment; or they will be actively monitored by their Trust clinician where this is an appropriate clinical response via out-patient reviews. Either action results in the patient’s 18-week clock being stopped. Re-referrals from the GP or a subsequent decision by the clinician to attempt treatment again, will initiate a new clock start and pathway.

If the reason is transitory (such as a cold or chest infection), and therefore likely to be short term, the patient will be assessed to ascertain the likely nature and duration of the illness to see if they are fit to continue with the original operation date offered. If a patient is not going to be fit, the original date should be cancelled and a new date offered once the patient is again fit to proceed with the treatment. The clock should continue to run during this time. If the patient’s illness becomes more complicated or long term the process above should be followed.

26. Diagnostic Tests

As well as 18-week clocks, diagnostic tests attract their own, separate nationally measured diagnostic wait times as well as separate agreed timescales for those on two week wait pathway. The 6-week rule indicates that the diagnostic wait time is re-set to zero if a patient does not attend, cancels an appointment, or refuses two reasonable offers of appointments, and it starts again from the date of the rearranged appointment.

These 6-week diagnostic rules operate independently of the 18-week rules and unless a patient is discharged for not attending a subsequent appointment, or is unfit to proceed with the treatment or test in line with the 18-week policy statements – the 18-week clock may continue to tick, even though a diagnostic clock for the 6-week stage of treatment targets can be reset.

27. Bilateral Procedures

Where a patient requires a bilateral procedure and the second procedure is not undertaken at the same time as the first, the original clock stops when the first procedure is performed. Another new clock starts when a patient is fit and ready to be offered dates for the second procedure.
28. Management of Planned Patients

Patients on planned waiting lists should be booked in for an appointment at the clinically appropriate time and they should not have to wait a further period after this time has elapsed. For example, a patient due to have a re-test in 6 months time should be booked in around 6 months. Planned waiting list should be reviewed regularly to ensure patients are seen and treated at the clinically appropriate time.

29. Procedures not Normally Funded or Purchased by Commissioners

There are a number of procedures not normally purchased / funded by CCGs or which require specific approval from GPs or the CCGs before the Trust can proceed with treatment. In these instances approval must be obtained by either the GP or the consultant (depending on which procedure and what the policy states) before the patient can be listed for treatment. (Clock continues)

Consultants identifying procedures that require approval but the patient does not meet the set criteria need to consider whether IFR approval can be sought. In these instances the consultant should complete the CCG IFR form and submit this to the CSU including (again clock continues):

- A clear description of the exceptional circumstances, based on overriding clinical need
- Copies of any relevant correspondence
- Other supporting documentation e.g. robust evidence of clinical and cost effectiveness, consultant and other specialist assessments, appropriate costs.

Details on the CCG’s policies on procedures not normally purchased are available from the South CSU website: [http://www.southcsu.nhs.uk/documents/ifr](http://www.southcsu.nhs.uk/documents/ifr) or the Trust’s contracting team and pertains to a range of non-urgent / non cancer referrals and contains details of appeals and approval processes.

30. Referrals of Patients in line with agreed Referral Criteria

The Trust, CCGs and local GPs have also developed referral criteria for certain pathway / patients referrals, to ensure that the most clinically appropriate treatment is provided in timescales agreed. Further guidance can be found in within local Clinical Departments and the contracting Department. Pathways can be audited and non-payment of related activity if found to be non-compliant. Staff need to ensure any accepted referrals comply with this policy to ensure appropriate payment for activity.

Where patients are referred to the Trust and within the Trust and do not meet the agreed pathway criteria, Trust consultants should discharge patients back to the referrer – indicating the reason for the return of the referral.

Regular meetings and monitoring of new referral criteria should be ongoing between clinical and managerial staff within both the CCG and the Trust.
31. Discharge and cancelling referrals

31.1 Discharge when treatment complete
When a patient is discharged from a clinic, the appropriate outpatient receptionist is responsible for recording the patient’s outpatient attendance on the Trust’s PAS and recording that discharge was the outcome of that appointment. This can only be completed if a clinician has recorded the discharge on an outcome form; if there is no record, the attendance will be recorded as ‘disposal unknown’.

31.2 Discharge for all other circumstances
For other discharge circumstances, i.e. no patient contact, treatment no longer required, advice and guidance given, the outpatient receptionist is responsible for closing the referral on PAS with the correct reason for discharge. A letter to the GP and patient must be produced and sent following every case of discharge.

31.3 Closing Referrals opened in Error
If a referral is opened in error, the user closing the referral must always enter ‘Clerical Error’ as Reason for Closure and should ensure that the corresponding RTT Pathway is removed.

32. Data Quality
On a daily basis the Data Quality supervisor (or ‘Validator’) for each specialty will be responsible for validating the data quality:

- Long waiting patients without dates
- Duplicate referrals
- E-Referral outpatients for booking list – the TAL report

Any new patients waiting longer than 3 weeks without a date will be escalated to the relevant Operational Service Manager.

33. Private Patients
Private patients are booked and managed through the Private Patients’ Team, with outpatient appointments predominantly booked at the Candover Clinic at Basingstoke and North Hampshire hospital.

Private patients may be seen by appointment in OPD, usually at the end or the beginning of a clinic session. The Private Patients Manager should be advised in advance that the patient is attending the clinic and the patient must be identified as a private patient on PAS. A private patient’s form must be completed by the treating clinician and signed by the patient.

The Private Patients Manager will contact the patient to check the details of payment for their consultation, obtain authorisation from their insurers, where
appropriate, and ask the patient to sign an undertaking to pay for any treatment received. A charge will be made for any procedure that takes place, consumables or diagnostic services used and for any drugs prescribed and dispensed. All requests for diagnostic testing and for drugs to be prescribed should clearly be marked as “Private”.

The 18-weeks rules do not apply to private patients

34. Stakeholders Engaged During Consultation

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Date of Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention and Control (Lead Infection Prevention &amp; Control Nurse)</td>
<td>16/08/2016</td>
</tr>
<tr>
<td>Health and Safety (Health and Safety Advisor)</td>
<td>16/08/2016</td>
</tr>
<tr>
<td>Safeguarding (Trust Safeguarding Lead)</td>
<td>16/08/2016</td>
</tr>
<tr>
<td>Information Governance (Information Governance Manager)</td>
<td>16/08/2016</td>
</tr>
<tr>
<td>Risk and Compliance Manager (Risk and Compliance)</td>
<td>16/08/2016</td>
</tr>
<tr>
<td>Divisional Directors (Operational)</td>
<td>16/08/2016</td>
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<tr>
<td>Divisional Directors</td>
<td>16/08/2016</td>
</tr>
<tr>
<td>Clinical Directors</td>
<td>16/08/2016</td>
</tr>
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</table>

35. Dissemination and Implementation

<table>
<thead>
<tr>
<th>Action(s)</th>
<th>Owner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Publicise detail of new document via Intranet and Midweek message</td>
<td>Author and Communication Team</td>
</tr>
<tr>
<td>Communication to all Senior Managers to advise publication of policy</td>
<td>HHFT Healthcare Library</td>
</tr>
<tr>
<td>The policy will be available on the intranet</td>
<td>HHFT Healthcare Library</td>
</tr>
</tbody>
</table>

36. Training

In the event of the Department of Health guidelines being amended or updated, this policy will be reviewed and updated and appropriate training will be provided.

Individuals in the Trust should receive training to ensure they are aware of their responsibilities, in line with the Trust training needs analysis and will be conducting in line with the Trust Learning and Development Policy. Training will vary depending on the individual job role and can include;

RTT Training provided by RTT Performance Team
E-referrals Training provided by Outpatients
PAS training provided by IT Training
Secretarial/admin training provided by RTT Performance team
37. Monitoring Compliance with the Document
Compliance with the policy will be monitored by the Business Intelligence Team through regular spot checks.

Failures to comply with the policy will be reported to the Head of Performance, the Executive Management Team (EMT) meeting and fed back to the appropriate Divisional Ops Director / Manager.

38. References


39. Associated Documentation
Management of Children who Miss Appointments and Families who disengage with Health Services policy- HH(1)/CLALL/567/13
Missed appointments – HH93)/CL(G)63513

40. Contributors

<table>
<thead>
<tr>
<th>Contributor Job Title</th>
<th>Contributor Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>RTT Performance Manager</td>
<td>Julia Uzzell</td>
</tr>
<tr>
<td>Head of Contracts</td>
<td>Melanie Griffith</td>
</tr>
<tr>
<td>RTT performance Lead</td>
<td>Emma O’Callaghan</td>
</tr>
</tbody>
</table>
Appendix A– Equality Analysis Form

To be completed by the Policy Author at the development stage of the policy and before consultation. Part 1 should be forwarded to an Equality Analysis Lead (list available on the Document Control Trust Intranet page) for sign off and any comments from them considered and addressed before seeking final approval of the policy.

<table>
<thead>
<tr>
<th>Document Title:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PART 1 – Policy Author to complete and forward on to an EA Lead for sign off</td>
</tr>
</tbody>
</table>

1. Could the application of this document have a detrimental equality impact on individuals with any of the following protected characteristics? (See Note 1)  
   |   | Yes/No/NA | Summarise the equality and diversity related elements within the policy |
|---|---|---|---|
| a | Age | no | |
| b | Disability | no | |
| c | Gender reassignment | no | |
| d | Race | no | |
| e | Religion or belief | no | |
| f | Sex | no | |
| g | Sexual orientation | no | |
| h | Marriage & civil partnership | no | |
| i | Pregnancy and maternity | no | |

2. If ‘Yes’ to question 1, do you consider the detrimental impact to be valid, justifiable and lawful? If so, please explain your reasoning.

3. Specify with which, if any, individuals and groups you have consulted in reaching your decision. Consultants, Operational managers, clinical services leads and contracting team

| PART 2 – Equality Analysis Lead to complete and forward back to the Policy Author |
| Provide a brief summary of the potential impact of the policy and whether sufficient consideration has been given to the Equality Duty. |

This policy has been written to provide a high level overview of how patients can access Trust services.

Sufficient consideration has been given to the equality duty and the access criteria included in the document do not detriment any individuals with the protected characteristics listed in Part 1. Elements of the policy, for example the ability for patients to self-refer and the requirement for the Trust to demonstrate that patients have been contacted, protect patients who may have one of the protected characteristics listed.
Document Title:

1. Is this document recommended for publication? Yes
   If ‘yes’ go to question 3 if ‘No’ complete number 2 below.

2. This document is not recommended for publication because:

   a Amendments are suggested as follows:

   b A more detailed equality analysis should be undertaken as follows:

   c Other (please specify)

3. Specify with which, if any, individuals and groups you have consulted in reaching your decision.

Name: James Montgomery     Job Title: Outpatients Manager     Date: 16/08/16

PART 3 – Policy Author to complete on receipt of part 2 and before forwarding for final policy approval

1. I have reviewed the Part 2 assessment and have made the necessary amendments to the policy.
   • If you have answered ‘no’, please explain why not

Name: John Haynes     Job Title: Associate Director of Performance and Contracting     Date: 16/08/16

**Note 1**
Under the terms of the Equality Act 2010’s public sector Equality Duty, the Trust has a legal responsibility to think about the following three aims of the Equality Duty as part of our decision making and policy development.

- **Eliminate unlawful discrimination**, harassment and victimisation;
- **Advance equality of opportunity** between people who share a protected characteristic and people who do not share it; and
- **Foster good relations** between people who share a protected characteristic and people who do not share it.
Appendix B– Services excluded from RTT

Services which are excluded from RTT/access policy

Obstetrics
Physiotherapy
Podiatry
Dietetics
Health promotion
Diagnostic Imaging
Diagnostic endoscopy
Diagnostic pathology
Diagnostic physiological measurement
Mental health
### Appendix C– List of abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCG</td>
<td>Clinical commissioning group</td>
</tr>
<tr>
<td>DNA</td>
<td>Did not attend</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HHFT</td>
<td>Hampshire Hospitals Foundation Trust</td>
</tr>
<tr>
<td>OPD</td>
<td>Out-patient department</td>
</tr>
<tr>
<td>OSM</td>
<td>Operational services manager</td>
</tr>
<tr>
<td>PAS</td>
<td>Patient administration system</td>
</tr>
<tr>
<td>PMS</td>
<td>Patient management system</td>
</tr>
<tr>
<td>POA</td>
<td>Pre-operative assessment</td>
</tr>
<tr>
<td>RTT</td>
<td>Referral to hospital treatment time</td>
</tr>
<tr>
<td>TAL</td>
<td>The appointment line</td>
</tr>
<tr>
<td>TWR</td>
<td>Two week rule</td>
</tr>
<tr>
<td>UBRN</td>
<td>Unique booking reference number</td>
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