

System Elective Care Access Policy

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**Integrated
Care System**



The Shrewsbury and
Telford Hospital
NHS Trust

Telford

The Robert Jones and Agnes Hunt
Orthopaedic Hospital

NHS Foundation Trust



**Shropshire, Telford
Shropshire Community Health NHS Trust**
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Version Control

Version No.	Date	Brief Description
0.1	10/2/22	First draft
0.2	1/3/22	Second draft including: <ul style="list-style-type: none"> • first round of provider feedback • decision to include Welsh rules
0.3	07/4/22	Third draft including: <ul style="list-style-type: none"> • second round of provider steering group feedback • updated VBC Policy content • updated Consultant to Consultant Policy content
0.4	28/4/22	Fourth draft including: <ul style="list-style-type: none"> • updates to Cancer standards • Further IST feedback • includes the B1522 - Re-statement of existing consultant-led Referral to Treatment (RTT) waiting time rules guidance issued by NHSEI 4/4/22
0.5	20/5/22	Fifth draft including: <ul style="list-style-type: none"> • Updated contents page • Addition of Welsh rules as Appendix A
0.6	21/6/22	Sixth draft including: <ul style="list-style-type: none"> • Feedback and any suggested amendments from the June 2022 STW Planned Care Board • Updated to new ICS Corporate Font/Branding
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1.1	8/1/23	Annual review and update
1.2	2/2/24	Amendments following stakeholder review Updated national Cancer standards Reference to PIDMAS Checked for latest Welsh RTT Rules
2.0	12/6/24	Approved annual update via Strategic Commissioning Committee
2.1	2/7/24	Inclusion of local adjustments to national targets Reference to continued work surrounding health inequalities

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Introduction

Summary

NHS Shropshire, Telford and Wrekin (NHS STW) and its main NHS provider partners are united in its commitment to ensuring patients receive treatment in accordance with national standards and objectives. This whole-system Access Policy outlines the expectations and requirements in terms of managing patients treated in the county along all non-emergency pathways, referred to as 'elective care pathways'. It describes the high level generic elective care Access requirements, standards and rules that all of the major providers are required to adhere to, but should be read in conjunction with the individual relevant provider organisations Standard Operating Procedures (SOP's) that describes how these rules are operationalised within that organisation.

The policy itself is written to reflect English patient rules, however due to the juxtaposition of the county with neighbouring Wales there is an additional element to this Policy for Welsh Patients enclosed as **Appendix A**.

Important Points

NHS Shropshire, Telford and Wrekin and its provider partners involved in the delivery of elective care are committed to delivering high quality and timely elective care to patients. This policy:

- Sets out the rules and principles for Shropshire, Telford and Wrekin under which elective access to outpatient appointments, diagnostics and elective inpatient or day case treatment is managed;
- Gives staff clear direction on the application of the '[NHS Constitution](#)' in relation to elective waiting times;
- Demonstrates how elective access rules should be applied consistently, fairly and equitably.

The NHS Shropshire, Telford and Wrekin Elective Access Policy was developed collaboratively between the:

- NHS Shropshire, Telford and Wrekin;
- Shrewsbury and Telford Hospital NHS Trust;
- Robert Jones and Agnus Hunt Orthopaedic Hospital NHS Foundation Trust;
- Shropshire Community Health NHS Trust;
- NHS National Elective Intensive Support Team.

It will be reviewed and ratified on an annual basis, or earlier if there are changes to national elective access rules or locally agreed principles.

The Access Policy should be read in full by all applicable staff once they have successfully completed the relevant elective care training. It should not be used in isolation as a training tool.

The Shropshire, Telford and Wrekin Elective Access Policy is underpinned by and linked to a comprehensive suite of detailed Standard Operating Procedures (SOP's) owned by each provider organisation that should be referenced in conjunction with this overarching policy. All clinical and non-clinical staff must ensure they comply with both the principles stated within this policy and the specific instructions within the provider SOP's.

NHS Shropshire, Telford and Wrekin is committed to promoting and providing services which meet the needs of individuals and does not discriminate against any employee, patient or visitor.

Scope

This policy applies to the principles and procedures for the management of the different groups of patients encompassing elective pathways. These are categorised as follows:

- Patients on a Referral to Treatment (RTT) pathway awaiting treatment;
- Patients not on an RTT pathway but still under review by Clinicians;
- Patients on a cancer pathway;
- Patients who have been referred for a diagnostic investigation either by their GP or by a Clinician;
- Outlines English patient rules & standards (but also includes as Addendum A, Welsh RTT rules in place at the time of publishing this Policy version).

Purpose

The purpose of this policy is to ensure all patients requiring access to outpatient appointments, diagnostics and elective inpatient or day case treatment are managed equitably and consistently in line with national waiting time standards and the ['NHS Constitution'](#).

This policy describes the way in which the NHS Shropshire, Telford and Wrekin Integrated Care System (ICS) will collectively manage access and administration for patients who are waiting for or undergoing treatment on an admitted, non-admitted, Cancer or diagnostic pathway.

As set out in both Everyone Counts and the NHS Constitution, patients have the right to start Consultant led treatment within maximum waiting times. The policies and procedures comprising this policy adhere to national best practice and provide a framework to ensure that patients are treated transparently, fairly and reasonably.

Structure

The policy is structured into 4 sections as outlined below:

- 1) General Principles.
- 2) Pathway Specific Principles, Referral to Treatment and Diagnostic Pathways
- 3) Cancer Pathways.
- 4) Reference Information

1. General Principles

Foundation Principles

NHS Shropshire, Telford and Wrekin and its provider Trust partners will:

1. give priority to clinically urgent patients and treat everyone else in turn;
2. work to meet and better the maximum waiting times set by its Commissioners for all groups of patients;
3. at all times negotiate appointment and admission dates and times with patients;
4. work to ensure fair and equal access to services for all patients.

Roles and Responsibilities

Integrated Care System

Integrated Care Systems are large-scale partnerships that bring together multiple providers and commissioners of NHS services across a geographical area with local authorities and other local partners to collectively plan health and care services to meet the needs of their population.

The Shropshire, Telford and Wrekin Integrated Care System (ICS) is collectively responsible for the production, review and revision of this policy on at least an annual basis. Each of the three provider organisations will have a designated lead in this respect, usually the Patient Access Manager.

NHS Shropshire, Telford and Wrekin

NHS Shropshire, Telford and Wrekin is responsible for ensuring that provider Trust's, GPs and all other primary care staff adhere to the principles set out in this policy.

Primary Care Practitioners & GP's

Primary Care Practitioners and GP's, and other referrers play a pivotal role in ensuring patients are fully informed during their consultation of the likely waiting times for a new outpatient consultation, and of the need to be contactable and available when referred. GPs should ensure good quality referrals are submitted to the appropriate provider first time. In some cases an Advice and Guidance request will be made to Providers to enable the GP to manage the patient's condition within Primary Care. If when reviewed by a consultant it is deemed more appropriate for a patient to be seen then the Advice and Guidance request will be converted into an outpatient appointment. Where a Referral Interface Service (RAS & TRAQs) exists this ensures the adequate checks are made to ensure good quality, fully completed and accurate referrals are processed and the requirement adhered to.

Provider Organisations

The Provider organisations play another vital role in taking overall responsibility for the implementation of this Access Policy and having in place Board level accountability for the delivery of elective access standards.

Due to differences in organisational structure, the various functions and areas of responsibility for each role within the organisation are detailed within their respective Standard Operating Procedure (SOP).

Patients

The '[NHS Constitution](#)' recommends the following actions patients can take to help in the management of their condition:

- Patients can make a significant contribution to their own, and their families, good health and wellbeing, and should take personal responsibility for it.
- Patients should be registered with a GP practice as this is the main point of access to NHS care as commissioned by NHS bodies.
- Patients should provide accurate information about their health, condition, and status.
- Patients should keep appointments or cancel within a reasonable timeframe.

Staff Competency and Compliance

Competency

- As a key part of their induction programme, all new starters within the Provider Trust organisations will undergo mandatory contextual elective care training applicable to their role.
- All existing staff will undergo mandatory contextual elective care training on at least an annual basis.
- All staff will carry out competency tests that are clearly documented to provide evidence that they have the required level of knowledge and ability.
- This policy, along with the supporting suite of SOP's, will form the basis of contextual training programmes.

Compliance

- Functional teams, specialties and staff will be performance managed against key performance indicators (KPIs) applicable to their role. Role specific KPIs are based on the principles in this policy and specific aspects of the supporting suite of Standard Process Descriptions.
- In the event of non-compliance, a resolution should initially be sought by the team, specialty, or individual's line manager. The matter should then be dealt with via the Trust's disciplinary or capability procedures.

General Elective Access Principles

The NHS has set maximum waiting time standards for elective access to healthcare. In England, waiting time standards for elective care, including cancer, come under two headings:

- The individual patient rights (as set out in the '[NHS Constitution](#)').
- The standards by which individual providers and commissioners are held accountable by NHS England.

These are described in the table below. (Please note that the below includes any local adjustment).

English Operational Standard	Threshold
Referral to Treatment	
Percentage of service users on incomplete RTT pathways active waiters waiting less than 18 weeks from referral	92% at Specialty Level
Cancer	
Percentage of service users waiting no longer than 28 days for diagnosis and outcome of Cancer to be diagnosed or excluded.	70% By March 2025, 80% ambition by March 2026
Percentage of service users waiting no more than 31 days from decision to treatment for all cancers	Operating standard 96%
Percentage of service users waiting no more than 62 days from referral to treatment for cancer (until 25/26)	70% by March 2025
Cancelled operations	
All service users who have their operations cancelled on the day of admission (including day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the service user's treatment to be funded at the time and hospital of their choice	All patients
Diagnostic test waiting times	
Percentage of service users waiting less than 6 weeks from referral for a diagnostic test	95%

Individual Patient Rights

The '[NHS Constitution](#)' clearly sets out a series of pledges and rights stating what patients, the public and staff can expect from the NHS. A patient has the right to the following:

- A choice of hospital and Consultant.
- To begin their treatment for routine conditions following a referral into a Consultant-led service, within a maximum waiting time of 18 weeks to treatment.
- To be seen by a cancer specialist and have an outcome or diagnosis with 28 days of being referred on the cancer pathway.

If this is not possible, the NHS has to take all reasonable steps to offer a range of alternatives.

The right to be seen within the maximum waiting times does not apply if:

- The patient chooses to wait longer.
- Delaying the start of the treatment is in the best clinical interests of the patient (note that in both of these scenarios the patients RTT clock continues to tick).
- It is clinically appropriate for the patient's condition to be actively monitored in secondary or community care without clinical intervention or diagnostic procedures at that stage.

All patients are to be treated fairly and equitably regardless of race, sex, religion, or sexual orientation.

Further detail on patient choice and rights is outlined in the Shropshire Telford and Wrekin Choice Policy.

Patient Eligibility

NHS STW and its Provider Trust Partners have a statutory obligation to identify patients who are not eligible for NHS treatment without charge and to assess liability for charges in accordance with the National Health Service (Charges to Overseas Visitors) Regulations 2015 (as amended). The provider Partners Overseas Visitor Teams (OSV) will check every patient's eligibility for treatment. Therefore, at the first point of entry, patients will be asked questions that will help the providers assess 'ordinarily resident' statuses.

Some visitors from overseas, who are not ordinarily resident, may receive free healthcare, including those who:

- Have paid the immigration health surcharge.
- Have been granted or made an application for asylum or humanitarian protection.

Citizens of the European Union (EU) who hold a European Health Insurance Card (EHIC) are entitled to needs arising healthcare without charge whilst visiting the UK, and the country's Competent Authority will recover the full treatment costs from the country of origin. There are also several countries that have Reciprocal Healthcare agreements with the UK.

All staff have a responsibility to assist in the identification of patients who are overseas visitors and to refer them to the OSV team for clarification of status regarding entitlement to NHS treatment before their first appointment is booked or date to come in (TCI) agreed.

Immediately necessary or urgent treatment will not be cancelled or delayed should an eligibility assessment be required or based on the patient's ability to pay.

Patients Moving Between NHS and Private Care

Patients can choose to move between NHS and private status at any point during their treatment without prejudice. For example, where it has been agreed that a surgical procedure is necessary, the patient can be added directly to the elective waiting list if clinically appropriate. The RTT clock starts at the point the GP or original referrer's letter arrives in the Trust/service. The RTT pathways of patients who notify the relevant Provider Trust of their decision to seek private care will be closed with a clock stop applied on the date of this being disclosed by the patient.

In line with the 'Code of Conduct for Private Practice: Recommended Standards of Practice for NHS Consultant', patients who choose to be treated privately are entitled to NHS services on exactly the same basis of clinical need as any other patient.

Commissioner Approved Procedures

Since NHS STW operates within finite budgetary constraints the policy makes explicit the need for us all to prioritise resources and provide interventions with the greatest proven health gain. The intention is to ensure equity and fairness in respect of access to NHS funding.

NHS Shropshire, Telford and Wrekin (NHS STW) purchases the majority of healthcare services on behalf of the local population. NHS STW is required by law to operate within finite budgetary constraints. This means that NHS STW has to prioritise resources and provide interventions with the greatest proven health gain for the population they serve. As a consequence, some referrals, or interventions that patients may wish to receive, and which a clinician may wish to offer, cannot be funded. The intention is to ensure equity and fairness in respect of access to NHS funding and to ensure compliance with the NHS England Evidence Based Interventions Statutory Guidance.

The Value Based Commissioning and Evidence Based Interventions Policy (VBC/EBI Policy) provides details on restrictions and criteria associated with activity that is not routinely funded by NHS STW and the specified criteria required for the funding of certain referrals or interventions.

Commissioners, Primary Care Practitioners & GP's and both NHS and Non-NHS Service Providers treating patients of NHS Shropshire, Telford and Wrekin are expected to implement and adhere to this policy.

The EBI element of the Policy refers to a range of clinically recommended restrictions around certain interventions and procedures where the risk may outweigh the potential benefit, and these are known as Evidence Based Interventions (EBI).

VBC/EBI guidance is reviewed and refreshed nationally to reflect treatments and procedures where the evidence about their effectiveness or appropriateness may change. It is set out in the VBC Policy and is primarily directed at clinicians and other NHS staff who make decisions about patient care. There are two parallel and complementary objectives to EBI. First, to reduce the number of inappropriate interventions carried out by clinicians in the healthcare system, and second, to improve the quality of care that patients receive. By reducing interventions which the evidence shows are less effective, it will free up valuable resources such as time, so that more effective interventions can be carried out. At a time when demand is exceeding available capacity and the COVID-19 pandemic is further stretching the system's finite resources, effective use of clinical time must be a priority. This is

especially the case with surgical interventions which always carry the risk of complications or adverse reactions. Care should always focus on improving quality and standards. We will only achieve this if we innovate, maximise value and avoid waste.

The VBC/EBI list of recommendations is developed by an independent Expert Advisory Committee (the EAC), established in May 2019, to provide clinical leadership to the EBI programme. The Committee identified an initial long list of interventions from clinical evidence including NICE guidance, Choosing Wisely recommendations, academic studies and NHS STW's policies on Procedures of Limited Clinical Effectiveness (now known as Value Based Commissioning) collated through NHS Clinical Commissioners. At the same time, suggestions were taken from specialist clinicians, academics, commissioners, reflections from the EBI demonstrator community of 13 Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs). The EAC considered each test, treatment, and procedure before drafting guidance in collaboration with stakeholders including clinicians, commissioners and patients.

It took particular note of

- advice from Medical Royal Colleges,
- specialist societies,
- clinicians,
- clinical commissioners,
- professional leaders and
- charities²
- opinions from patients by liaising with patient advocates and patient representative groups, including the Strategic Co-Production Group at NHS England and NHS Improvement,
- the Academy of Medical Royal Colleges' Patient and Lay Committee and
- the Patients Association to test the proposals and understand patients' priorities.

Very occasionally, a clinician may think that their patient's clinical situation is so different to other patients with the same condition that it is appropriate that they should have different treatments to others. In such circumstances, clinicians, on behalf of their patient, may make an Individual Funding Request (IFR) to NHS STW for a treatment, which is not routinely commissioned by NHS STW. IFRs may be made in respect of NHS STW directly commissioned services and indeed any services, which are not commissioned. This route should only be used in exceptional circumstances and not as an alternative route to submitting a treatment for scrutiny through the Service Development process where there is likely to be a cohort (however small) of similar patients. For further details on what may be considered exceptional please see IFR policy which can be found on the NHS STW website.

Individual Funding Request (IFR) applications must be made by the specialist who will be providing the patient's treatment and full details of how the patient meets the clinical exceptionality criteria, as given in the IFR policy, should be provided on the application form. All supporting evidence of how the patient meets the exceptionality criteria or is unique within an identified cohort of patients should be submitted with the application form.

If a patient does not meet the clinical exceptionality criteria, as given within the IFR policy then funding should not be sought via the Individual Funding Request (IFR) route.

In considering individual cases NHS STW applies following definition of exceptionality:

- Where care is not routinely funded by the respective commissioner, evidence must be provided to show that the patient is significantly different to the population of patients with similar clinical needs who would also not be offered the treatment.
- This should include evidence that the patient is likely to gain significantly more benefit from the treatment than would be expected for other patients not currently offered it.

Exceptional clinical circumstances are defined as referring to a patient who has clinical circumstances which, taken as a whole, are outside the range of clinical circumstances presented by a patient within the normal population of patients with the same medical condition and at the same stage of progression as the patient. In making a case, therefore, the clinician must specify how this patient is clinically different from others currently excluded from treatment - either in reference to the clinical picture, the expected benefit, or both.

If patients choose to privately fund an intervention that is not normally funded by NHS STW, they will retain their entitlement to other elements of NHS care. For example, if they privately fund a cancer drug or cancer intervention not normally funded by NHS STW they will retain their entitlement to all the other elements of cancer care that other residents of Shropshire and Telford and Wrekin receive free of charge. However, when patients are privately funding an intervention, they are responsible for all the costs associated with that intervention, including Consultant costs and diagnostics. They are therefore unable to receive a mixture of privately funded and NHS STW funded care within the same appointment or intervention – in line with national guidance, they cannot ‘top-up’ an NHS STW funded appointment or intervention by paying for an additional intervention to be provided or monitored during the same consultation. The relevant policies can be found on the websites of the respective provider Trust’s, and the NHS STW website in the ‘commissioning’ section.

This policy will be kept under regular review, to ensure that it reflects developments in the evidence base regarding clinical and cost effectiveness. All efforts will be made to work with our main service providers to jointly review and update the policy.

VBC/EBI Policy Process

NHS Shropshire, Telford and Wrekin purchases the majority of healthcare services on behalf of the local population, and is required by law to operate within finite budgetary constraints. This means that NHS STW must prioritise resources and provide interventions with the greatest proven health gain for the population they serve. Consequently, some referrals or interventions that patients may wish to receive, and which a clinician may wish to offer, cannot be funded. The intention is to ensure equity and fairness in respect of access to NHS funding and to ensure compliance with the NHS England Evidence Based Interventions Statutory Guidance.

The Value Based Commissioning restrictions and criteria outlined within this policy provides details of activity that is not routinely funded by NHS STW and the specified criteria required for the funding of certain referrals or interventions.

Commissioners, General Practitioners, NHS and Non-NHS Service Providers treating patients of Shropshire, Telford and Wrekin are expected to implement and adhere to this policy and the referral, management and audit processes and pathways set out in the Policy.

Very occasionally, a clinician may think that their patient's clinical situation is so different to other patients with the same condition that it is appropriate that they should have different treatments to others. In such circumstances, clinicians with the most appropriate clinical knowledge, on behalf of their patient, may make an Individual Funding Request (IFR) to NHS STW for a treatment, which is not routinely commissioned. IFRs may be made in respect of NHS STW directly commissioned services and indeed any services, which are not commissioned. This route should only be used in exceptional circumstances and not as an alternative route to submitting a treatment for scrutiny through the Service Development process where there is likely to be a cohort (however small) of similar patients. For further details on what may be considered exceptional please see IFR policy which can be found on the ICS website:

<https://www.shropshiretelfordandwrekinICS.nhs.uk/wp-content/uploads/20211110-Individual-Funding-Request-Policy-2021.pdf>

Individual Funding Request (IFR) applications must be made by the clinician who will be providing the patient's treatment and full details of how the patient meets the clinical exceptionality criteria, as given in the IFR policy, should be provided on the application form. All supporting evidence of how the patient meets the exceptionality criteria or is exceptional within an identified cohort of patients should be submitted with the application form.

If a patient does not meet the clinical exceptionality criteria, as given within the IFR policy then funding should not be sought via the Individual Funding Request (IFR) route.

Evidence Based Interventions (EBI)

The VBC Policy also includes clinically recommended restrictions around certain interventions and procedures where the risk may outweigh the potential benefit, and these are known as Evidence Based Interventions (EBI).

EBI guidance is reviewed and refreshed nationally to reflect treatments and procedures where the evidence about their effectiveness or appropriateness may change. It is set out in this document and is primarily directed at clinicians and other NHS staff who make decisions about patient care. There are two parallel and complementary objectives to EBI. First, to reduce the number of inappropriate interventions carried out by clinicians in the healthcare system, and second, to improve the quality of care that patients receive. By reducing interventions which the evidence shows are less effective, it will free up valuable resources such as time, so that more effective interventions can be carried out. At a time when demand is exceeding available capacity, effective use of clinical time must be a priority. This is especially the case with surgical interventions which always carry the risk of complications or adverse reactions. Care should always focus on improving quality and standards. We will only achieve this if we innovate, maximise value and avoid waste.

The EBI list of recommendations is developed by an independent Expert Advisory Committee (the EAC), established in May 2019, to provide clinical leadership to the EBI programme. The Committee identified an initial long list of interventions from clinical evidence including NICE guidance, Choosing Wisely recommendations, academic studies and policies on Procedures of Limited Clinical Effectiveness (now known as Value Based Commissioning) collated through NHS Clinical Commissioners. At the same time, suggestions were taken from specialist clinicians, academics, commissioners, reflections from the EBI demonstrator community of 13 Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs). The EAC considered each

test, treatment and procedure before drafting guidance in collaboration with stakeholders including clinicians, commissioners and patients. It took note of advice from:

- Medical Royal Colleges,
- specialist societies,
- clinicians,
- clinical commissioners,
- professional leaders and
- charities²
- opinions from patients by liaising with patient advocates and patient representative groups, including the Strategic Co-Production Group at NHS England and NHS Improvement,
- the Academy of Medical Royal Colleges' Patient and Lay Committee and
- The Patients Association to test the proposals and understand patients' priority.

Referrals

NHS Shropshire Telford and Wrekin processes referrals and offers choice where applicable through the use of a referral interface service. For patients registered with Shropshire GP Medical practices this will be undertaken through the RAS (Shropshire Referral Assessment Service) arm of the service, and for those registered with Telford GP Medical practices the TRAQS (Telford Referral Assessment & Quality Service) arm of the service.

RAS also perform a referral interface service for other specific areas along the Welsh Border to ensure that those patients are offered a choice of being seen under English RRT rules.

Please note that where this Policy refers to children or adults, unless specifically stated otherwise, an adult is considered to be aged 16 or over.

Due to the variances in contracting and payment mechanisms in place for NHS Acute providers and Independent Sector (IS) providers it has been necessary to apply different approval processes for the same intervention across this policy, with the following annotation in the policy to ensure clarity:

A – NHS Acute providers, aligned payment and incentive mechanism with fixed payment and a variable element which is activity based.

IS – Independent sector providers, predominantly contracted on an activity payment basis.

Independent sector providers will be expected to request, record and present on request a prior approval authorisation code (PACC) for all VBC identified activity. Should a provider be unable to provide a PACC, the cost of the procedure will be challenged via contractual mechanisms.

The Service Providers will also work with NHS STW on a quarterly basis to undertake a retrospective audit against the cases where VBC/EBI activity has been undertaken without an approval code, in order to:

- determine the validity and clinical rationale of providing those procedures, or
- identify those cases where procedures have been undertaken without a code that cannot be clinically justified.

The results of this quarterly audit shall be used to work with the Service Providers in ensuring compliance with the Policy and its contents, and thereby ensuring existing resource is utilised

effectively and efficiently on services that are commissioned. This audit and its outputs also provide ongoing feedback of learnings to clinicians and ensure patient safety.

Military Veterans

In line with the '[Armed Forces Covenant](#)' published in 2015, all veterans and war pensioners should receive priority access to NHS care for any conditions related to their service, subject to the clinical needs of all patients. Military veterans should not need to have first applied and become eligible for a war pension before receiving priority treatment.

GPs will notify the relevant Provider Trust of the patient's condition and its relation to military service when they refer the patient, so that the provider can ensure 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 priority. The provider Trust's will ensure that patients who are Military Veterans are highlighted in their PAS system.

Prisoners, Vulnerable Patients

All elective standards and rules are applicable to prisoners. Delays to treatment incurred as a result of difficulties in prison staff being able to escort patients to appointments, or for treatment, do not affect the recorded waiting time for the patient.

The Provider Trust Partners will work with staff in the prison services to minimise delays through clear and regular communication channels and by offering a choice of appointment or admission date in line with reasonableness criteria. Where a significant delay is likely the patient will be referred to the Consultant to review to ensure that no harm will occur. The Consultant may at this point return the patients care to the GP if it is appropriate to do so and is in the best interests of the patient. See individual provider SOP for any restrictions or restriction criteria.

Vulnerable Patients

It is essential that patients, who are vulnerable, for whatever reason, have their needs identified at the point of referral.

This group of patients includes but is not limited to:

- Patients with learning difficulties, psychiatric problems, or dementia.
- Patients with physical disabilities or mobility problems.
- Children (under 18) for whom there is a safeguarding concern.
- Patients where English is not their first language.

Health Inequalities

NHS Shropshire, Telford and Wrekin are committed to developing a systematic approach to reducing health inequalities and addressing unwarranted variation in access, experience and outcomes and are continuing to work with system partners to ensure that the recovery of elective services is undertaken inclusively in line with NHSE Operational Planning Guidance.

The restoration of our NHS services will be data-driven guided by local insight and our approach will be informed by NHS performance reports that are delineated by ethnicity and deprivation, as evidence suggests these are the areas where health inequalities have widened during the pandemic.

When assessing and reviewing access to healthcare services we will implement the [Core20PLUS5](#) framework which defines key population groups and clinical focus areas for accelerated improvement in healthcare inequalities.

Service Standards

Key business provider Trust processes that support access to care will have clearly defined service standards, monitored by the provider partners and NHS STW. Compliance with each service standard will support effective and efficient service provision, and the achievement of referral to treatment standards. Key standards for implementation include the following:

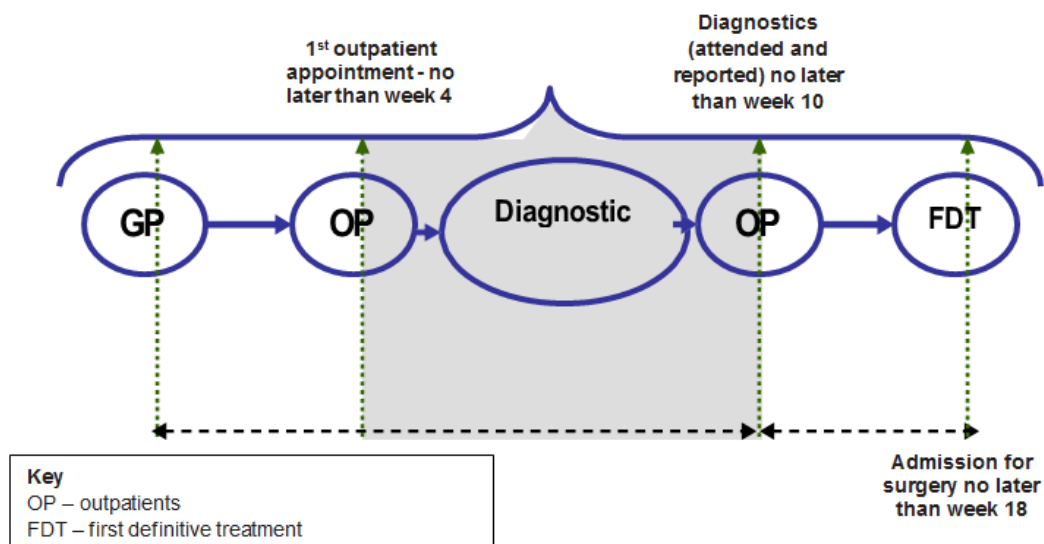
- Referral receipt and registration (within 24 hours/1 working day);
- Referral vetting and triage (within 48 hours of registration);
- Addition of urgent outpatient referrals to waiting list (within 48 hours);
- Addition of routine outpatient referrals to waiting list (within 5 days of registration).

Pathway Milestones

To achieve treatment within 18 weeks of receipt of referral, pathways should be designed with key milestones and sufficient capacity agreed with Clinicians and commissioners.

For example, you could break down surgical pathways into the milestones shown overleaf in Figure 1.

Figure 1: Key Milestones on a Surgical Pathway



The agreement and measurement of performance against pathway specific milestones is an important aspect of successful RTT sustainability. Pathway specific milestones should be agreed for each specialty (in line with robust demand and capacity analysis) in terms of the point of the pathway by which the following should occur:

- First outpatient appointment.
- Treatment decision.
- Treatment.

As a minimum, the following indicative differentiation should be applied to all routine patients under the care of surgical and medical specialties where an admission is rarely necessary for treatment.

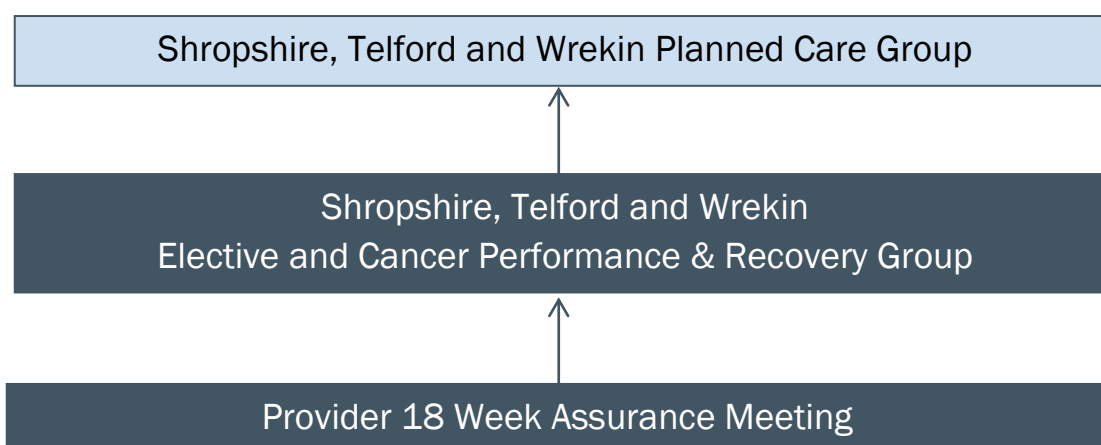
Pathway Milestone	Surgical Specialties	Medical Specialties
First Outpatient Appointment	No later than week 4	No later than week 8
Treatment Decision	No later than week 10	No later than week 14
Treatment	No later than week 18	No later than week 18

Monitoring

Operational teams will regularly, and continuously, monitor levels of capacity for each pathway milestone (for both outpatient and inpatient activity) to ensure any shortfalls are addressed in advance. This will avoid poor patient experience, resource intensive administrative workarounds and, ultimately, breaches of the RTT standard.

Regular and robust demand and capacity analysis is a critical success factor in understanding individual services, forward planning, and the delivery of elective care standards. Demand and capacity analysis should be undertaken on at least an annual basis, aligned to the annual planning process, by all specialties.

Elective Care Governance Structure



Reasonableness

'Reasonableness' is a term applicable to all stages of the elective pathway. Reasonableness refers to specific criteria which should be adhered to when offering routine appointments and admission dates to patients to demonstrate that they have been given sufficient notice and a choice of dates. A reasonable offer is defined as a choice of two dates with at least three weeks' notice.

Chronological Booking

Patients will be selected for booking appointments or admission dates according to clinical priority. Patients of the same clinical priority will be appointed in RTT chronological order, i.e., the patients who have been waiting longest will be seen first. Patients will be selected using only the patient tracking list (PTL) used by the relevant Provider NHS Trust.

Communication

All communications with patients and anyone else involved in the patients care pathway (e.g., general practitioner (GP) or a person acting on the patient's behalf), whether verbal or written, must be informative, clear and concise. Copies of all correspondence with the patient must be kept in the patient's Medical Records or stored electronically for auditing purposes.

GPs or the relevant referrer must be kept informed of the patient's progress in writing. When clinical responsibility is being transferred back to the GP/referrer, e.g., when treatment is complete, this must be made clear in any communication.

Communication with patients

All communications with patients, whether verbal or written, must be informative, clear, and concise and MUST be recorded on the PAS system.

The Provider organisation will use their PAS system to identify patients with specific communication needs and will, where possible and when notified, may make reasonable adjustments i.e., larger font letters/voicemail and/or text reminders of appointments/utilising communication addresses for carers as requested.

National Referral to Treatment and Diagnostic Standards

Referral To Treatment	
Incomplete	92% of patients on an incomplete pathway (i.e., still waiting for treatment) to be waiting no more than 18 weeks
Diagnostics	
Applicable to diagnostics tests	99% of patients to undergo the relevant diagnostic investigation within 5 weeks and 6 days (or 41 days) from the date of decision to refer to appointment date.

In addition to the elective care standards above, there are separate cancer standards which must be adhered to. The cancer standards are listed in ['section 3. Cancer Pathways'](#).

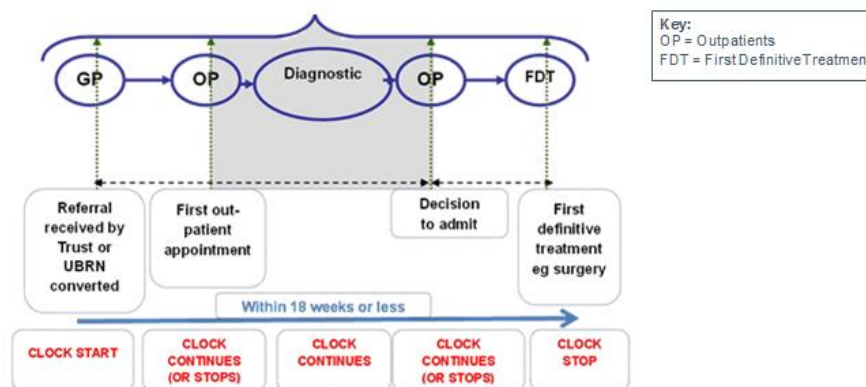
While the aim is to treat all elective patients within 18 weeks, the national elective access standards are set at less than 100% to allow for the following scenarios:

- **Clinical exceptions:** when it is in the patients best clinical interest to wait more than 18 weeks for their treatment.
- **Choice:** when patients choose to extend their pathway beyond 18 weeks by declining reasonable offers of appointments, rescheduling previously agreed appointment dates/admission offers, or specifying a future date for appointment/admission.
- **Co-operation:** when patients do not attend previously agreed appointment dates or admission offers (Missed Appointments) and this prevents the provider from treating them within 18 weeks.

Overview of National Referral to Treatment Rules

Figure 2 below provides a visual representation of the chronology and key steps of a typical RTT pathway.

Figure 2: The chronology and key steps of a typical RTT pathway



Clock Starts

The RTT clock start will occur when any healthcare professional (or service permitted by an appropriate commissioner to make such referrals) refers to a consultant led service. The RTT clock start date is the date when the provider receives the referral. For referrals received through NHS e-Referral, the RTT clock starts the day the patient converts their unique booking reference. Clock starts occur when:

- A referral is received into a consultant-led service, regardless of setting, with the intention that the patient will be assessed and, if appropriate, treated before clinical responsibility is transferred back to the referrer.
- A referral is received into an interface or referral management assessment centre which may result in an onward referral to a consultant-led service before clinical responsibility is transferred back to the referrer.
- A patient self refers into a consultant led service for pre-agreed services agreed by providers and commissioners.

English Patient Exclusions

A referral to most Consultant-led services starts an RTT clock, but the following services and types of patients are excluded from RTT:

- Obstetrics and midwifery.
- Planned patients.
- Referrals to a non-Consultant led service.
- Genitourinary medicine (GUM) services.
- Emergency pathway non-elective follow-up clinic activity.
- Referrals for patients from non-English commissioners

New Clock Starts for the Same Condition

Following active monitoring

Some clinical pathways require patients to undergo regular monitoring or review diagnostics as part of an agreed programme of care. These events would not in themselves indicate a decision to treat or a new clock start. If a decision is made to treat after a period of active monitoring/watchful waiting, a new RTT clock would start on the date of decision to treat (DTT).

Following a decision to start a substantively new treatment plan

If a decision is made to start a substantively new or different treatment that does not already form part of a patient's agreed care plan, this will start a new RTT pathway clock and the patient shall receive their first definitive treatment within a maximum of 18 weeks from that date. This is normally completed through the Clinic Outcome Form (COF).

For second side of a bilateral procedure

A new RTT clock should be started when a patient becomes fit and ready for the second side of a consultant led bilateral procedure.

For a rebooked new outpatient appointment following Missed Appointment

See '[First appointment Missed Appointments following initial referral](#)'.

Planned Patients

All patients added to the planned list will be given a due date for when their planned procedure/test should take place. Where a patient requiring a planned procedure goes beyond their due date, they will be transferred to an active pathway and a new RTT clock started. Once a patient has been transferred onto an active pathway the patient must be assigned an appropriate Priority code.

Based on work by the Royal Colleges, patients who do not wish to delay treatment, will be prioritised based on clinical review as follows:

- P1A: Procedure to be performed within 24 hours
- P1B: Procedure to be performed within 72 hours
- P2: Procedure to be performed < 1 month from review
- P3: Procedure to be performed < 3 months from review
- P4: Procedure to be performed > 3 months from review

The detailed process for management of planned patients is described in the relevant Provider Trust's SOP that should be referenced in conjunction with this policy.

Clock Stops for First Definitive Treatment

An RTT clock stops when:

- First definitive treatment starts, which could be:
 - > Treatment provided by an interface service.
 - > Treatment provided by a consultant led service.
 - > Therapy or healthcare science intervention provided in secondary care or at an interface service, if this is what the Consultant led or interface service decides is the best way to manage the patient's disease, condition or injury and avoid further interventions.
- A clinical decision is made and has been communicated to the patient, and subsequently their GP and/or other referring practitioner without undue delay, to add a patient to a transplant list.

Clock Stops for Non-Treatment

A waiting time clock stops when it is communicated to the patient, and subsequently their GP and/or other referring practitioner without undue delay that:

- It is clinically appropriate to return the patient to primary care for any non-Consultant led treatment in primary care.

- A clinical decision is made not to treat.
- A patient did not attend their first appointment which results in the patient being discharged.
- A decision is made to start the patient on a period of active monitoring.
- A patient declines treatment having been offered it.

Active Monitoring

Active monitoring is where a decision is made that the patient does not require any form of treatment currently but should be monitored in secondary care. When a decision to begin a period of active monitoring is made and communicated with the patient, the RTT clock stops. Active monitoring may apply at any point in the patient's pathway, but only exceptionally after a decision to treat has been made.

It is not appropriate to stop a clock for a period of active monitoring if some form of diagnostic or clinical intervention is required in a couple of days' time, but it is appropriate if a longer period of active monitoring is required before further action is needed. Stopping a patient's clock for a period of active monitoring requires careful consideration case by case and needs to be consistent with the patient's perception of their wait.

If a patient is unlikely to be fit for treatment within the foreseeable future, determined by the consultant and agreed with the patient, i.e., longer than 3 months, the options are:

- discharging to primary care for optimisation
- discharging with a decision not to treat
- Placed on active monitoring (per consultant)
- Patient initiated follow up (PIFU) active monitoring (per patient)

In all four scenarios this would stop the RTT clock.

Other circumstances in which a patient may be placed into a period of hospital-initiated active monitoring which would stop their waiting clock include:

- when a patient wishes to delay treatment at their current provider and declines 2 offers for reasonable treatment dates – the hospital may decide to commence a period of active monitoring, following a clinical conversation and agreement with the patient.
- when a patient declines 2 reasonable offers for earlier treatment dates at an alternative provider – the hospital may decide to commence a period of active monitoring, following a clinical conversation and agreement with the patient.

Example 1: Long-term conditions

Following diagnosis agreed with the patient that a hip replacement is required. However, BMI of patient remains significantly too high and needs to lose weight before surgery can take place. Place on active monitoring for condition of hip and discharge to primary care to manage weight loss. This is because it is unclear how long the weight loss program will take.

Example 2: Long-term conditions

Patient undergoes preoperative assessment, and a previously undiagnosed heart condition is identified. Patient placed on active monitoring for condition requiring surgery. Patient referred to cardiology for management.

Best Practice

Given the impact of the pandemic on longer waits, it is more likely that patients will be placed on active monitoring due to the deteriorating pathology of most conditions and because of the length of wait other conditions may have developed.

Patient Initiated Delays

Non-attendance of appointments/admissions (Missed Appointment – MA)

Other than at first attendance, Missed Appointments have no impact on reported waiting times. Every effort should be made to minimise MA's and it is important that a Clinician reviews every MA on an individual patient basis.

Children not brought to appointments – Was Not Brought (WNB)

Children who are not brought to their appointments are subject to the same RTT rules as adult patients. However, each Provider Partner has safeguarding guidance (Refer to SOP)

First appointment Missed Appointments following initial referral

The RTT clock is stopped and nullified in all cases (as long as the provider can demonstrate the appointment was booked in line with the 'reasonableness' criteria as detailed on page 23). If the Clinician indicates another first appointment should be offered, a new RTT clock will be started on the day the new appointment is agreed with the patient. For example, if the patient misses their appointment on 4th July and a conversation with the patient happens on 4th July to agree another appointment for 18th July, the new clock starts on 4th July.

Subsequent (follow-up) appointment/diagnostic/admission MA's

The RTT clock continues if the Clinician indicates that a further appointment/admission should be offered. If patients wait more than 18 weeks as a result of such delays, the 8% tolerance is in place to account for this. The RTT clock stops if the Clinician indicates that it is in the patient's best clinical interests to be discharged back to their GP/referrer.

Cancelling, declining, or delaying appointment and admission offers

Patients can choose to postpone or amend their appointment or treatment if they wish, regardless of the resulting waiting time. Such cancellations or delays have no impact on reported RTT waiting times. However, Clinicians will be informed of patient-initiated delays to ensure that no harm is likely to result from the patient waiting longer for treatment (Clinicians may indicate in advance, for each specialty or pathway, how long it is clinically safe for patients to delay their treatment before their case should be reviewed). Where necessary, Clinicians will review every patient's case individually to determine whether:

- The requested delay is clinically acceptable (clock continues).
- The patient should be contacted to review their options – this may result in agreement to the delay (clock continues) or to begin a period of active monitoring (clock stops).
- The patients best clinical interest would be served by discharging them to the care of their GP (clock stops).
- The requested delay is clinically acceptable, but the Clinician believes the delay will have a consequential impact (where the treatment may fundamentally change during the period of delay) on the patients treatment plan (active monitoring – clock stops).

The general principle of acting in the patients best clinical interest at all times is paramount. It is generally not in a patient's best interest to be left on a waiting list for an extended period, and so where long delays are requested by patients (i.e. of many months) a clinical review should be carried out, and preferably the treating Clinician should speak with the patient to discuss and agree the best course of action. Patients should not be discharged to their GP, or otherwise removed from the waiting list, unless it is for clinical reasons.

Children whose parents or careers - Cancelling, declining, or delaying appointment and admission offers

Children whose appointments are cancelled, declined or delayed are subject to the same RTT rules as adult patients. However, each Provider Partner has safeguarding guidance (Refer to SOP)

Patients Who Are Unfit for Surgery

If the patient is identified as unfit for the procedure, the nature and duration of the clinical issue should be ascertained.

Short term illnesses

If the clinical issue is short term and has no impact on the original clinical decision to undertake the procedure (e.g., cough, cold), the RTT clock continues.

Long term illnesses

If the clinical issue is more serious and the patient requires optimisation and/or treatment for it, Clinicians should indicate to administration staff:

- If it is clinically appropriate for the patient to be removed from the waiting list (this will be a clock stop event via the application of active monitoring).
- If the patient should be optimised/treated within secondary care (active monitoring, clock stop) or if they should be discharged back to the care of their GP (clock stop).

Specific Covid Position (February 2024):

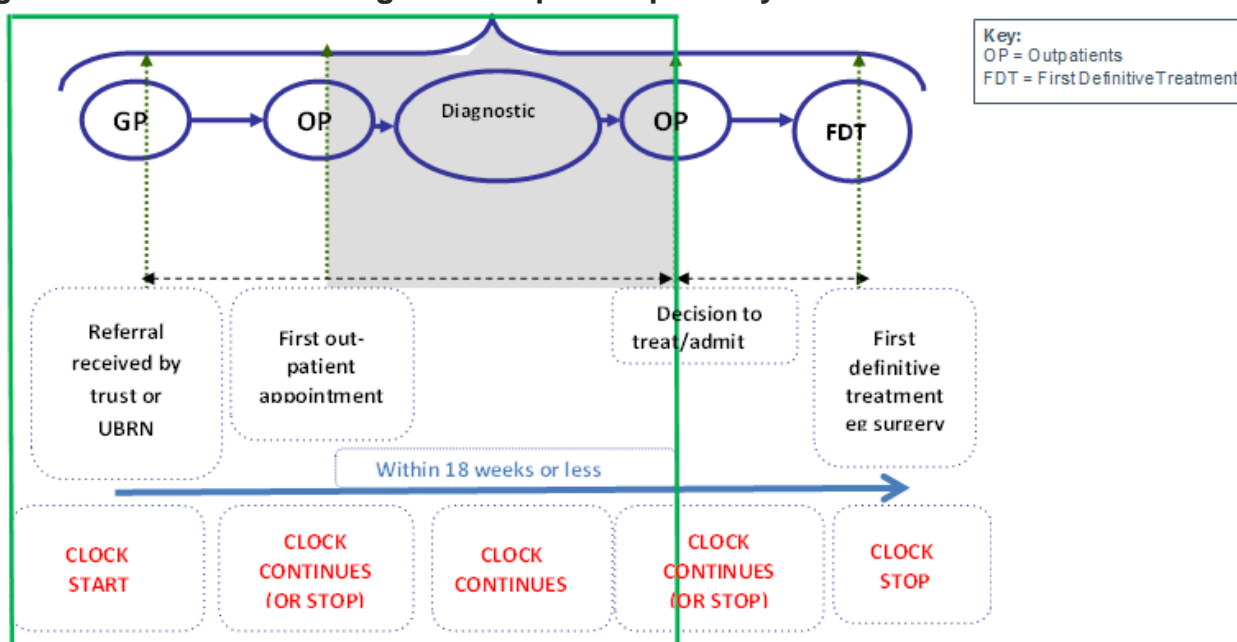
Current Royal College guidance is that patients who test positive for Covid should have their treatment/procedure delayed for seven weeks. However, clinical prioritisation can overrule this guidance if the consultant feels it is in the best interest for the patient.

2. Pathway Specific Principles, Referral to Treatment and Diagnostic Pathways

Non-Admitted Pathways

The non-admitted stages of the patient pathway (see Figure 3) comprise both outpatients and the diagnostic stages, as highlighted by the section with the green border around it in the diagram below. It starts from the clock start date (i.e., the date the referral is received) and ends when either a clock stop happens in outpatients (this could be the first, second or a further appointment) or when a decision to admit is made and the patient transfers to the admitted pathway.

Figure 3: Non-Admitted stages of the patient pathway



Receipt of Referral Letters

The NHS e-Referral Service (e-RS) must be used for referrals from English GPs and Referral Interface or Management Centres (RMCs).

Where clinically appropriate, referrals will be made to a service rather than a named Clinician. Services have agreed clinical criteria to support triage and vetting, and patients will then be allocated to the most appropriate Clinician, taking into account waiting times. Referring to services is in the best interests of patients as pooling referrals promotes equity of waiting times and allows greater flexibility in booking appointments. Paper based referrals will still be accepted from other Health Organisations and from Welsh GPs.

Pre-requisites prior to referral

In line with national RTT rules, before patients are referred, the GPs and other referrers should ensure that patients are ready, willing, and able to attend for any necessary outpatient appointments

and/or treatment, and that they fully understand, where possible, the implications of any surgery or other treatment which may be necessary.

Methods of Referral

NHS e-Referrals (e-RS)

All NHS e-Referrals must be reviewed and accepted or rejected by clinical teams within one working day for urgent referrals, or five working days for routine referrals.

Where there is a delay in reviewing e-Referrals this will be escalated to the relevant clinical management team and actions agreed to address it.

If an NHS e-Referral is received for a service not provided by the provider, it will be rejected back to the referring GP or Referral Interface Team advising that the patient needs to be referred elsewhere. This will stop the patients RTT clock.

All referrals are electronic apart from any paper-based inter-provider or consultant to consultant referrals.

Any paper referrals received from English GPs will be added to the PAS system and immediately cancelled (for audit purposes). The referral will be returned to the GP via a secure NHS.net account and the GP will be asked to refer in via the e-Referral service with the exception of 2 Week Wait Referrals who will be booked an appointment. NHS Shropshire Telford and Wrekin as the commissioners will be informed.

Secondary Care

It is the responsibility of the Clinical management teams, in conjunction with Clinicians, to ensure that the Directory of Services (DoS) is up to date in terms of the service specific criteria, and that the clinics are mapped to the relevant services. This gives the best chance of the patient being booked into the correct clinic at the first visit and reduces the rejection rate. Service Management teams should review and update their DoS on at least an annual basis in parallel with revision dates to the Access Policy. The Patient Access Team will initiate and co-ordinate reviews.

Paper-based Inter Provider/ Consultant to Consultant referrals

All paper based Inter Provider and Consultant to Consultant referral letters should be date stamped upon receipt into the provider and sent directly to the Central Booking or Appointments Office. Where referrals are received directly into the Central Booking or Appointments office, they will be date stamped on receipt and recorded on the PAS then forwarded to the relevant Clinician to triage.

Referral criteria/minimum data sets

- 1) The referrer is responsible for ensuring that the referral letter contains the essential minimum data set. This includes the patients NHS number, full patient demographics, and a preferred day, evening or mobile telephone number that the patient would like to be contacted on, as well as sufficient clinical data to enable the appropriate appointment to be made. The letter should also state the patient's current drug regime, clinical question to be answered and significant past medical history. An incomplete referral will be returned to the originating referrer. Referrals that are deemed to be misdirected to the wrong Consultant specialist will be returned to the referrer with a letter.

- 2) Referrals should be addressed to a speciality rather than a named Consultant and referrals will be allocated to the Consultant with the shortest waiting time. Named referrals will be allocated to the relevant Consultant but if they do not have sufficient capacity to accept the referral then a decision will be made, in conjunction with the Consultant and the speciality operational/service manager, to allocate the referral to an appropriate alternative Consultant. Exceptions to this would be where denying access to a sub speciality opinion would compromise clinical care.

Referral Types

Below are details of referral types, other than GP, which are out of the scope of elective care.

Emergency Clinics – All Specialties	GP referral is not required
Fracture Clinics	GP referral is not required
Obstetrics	The e-RS system does not currently support GPs to make referrals to same-day outpatient appointments
Maternity	The e-RS system does not currently support GPs to make referrals to same-day outpatient appointments
Screening Services	Non-Consultant led service
Pathology services	Non-Consultant led service
Referrals made by Clinicians other than GPs (such as other primary care professionals or hospital Consultants).	Not included within e-RS
TIA Clinics	The e-RS system does not currently support GPs to make referrals to same-day outpatient appointments
Rapid Access Clinics	The e-RS system does not currently support GPs to make referrals to same-day outpatient appointments

Internal Consultant to Consultant referrals

NHS STW requires clinicians in secondary care to seek prior approval of any onward referral for an outpatient appointment to other secondary care clinicians in line with the guidelines set out below. The policy ensures that the GP has a continuing oversight of the care given to their patients and that patients are seen and treated in the most appropriate setting.

The process should be managed by all parties to ensure that undue delays are not put into the system which would be detrimental to patient care.

These guidelines apply in the following referrals:

- Consultant to consultant referrals within a specialty where this is for a different condition that the patient was initially referred for
- Consultant to consultant referrals between specialties where this is for a different condition to that the patient was initially referred for
- Consultant to consultant referrals to another hospital trust where this is a specialist tertiary Centre.

The term “consultant” applies to any clinician (both referrer and receiver) within a secondary care provider including junior doctors, nurses, midwives, AHPs and other health professionals

Where a patient has been referred to one service within a provider by the GP, or has presented as an emergency, the contract allows the provider clinician to make an onward outpatient referral to any other service, without the need for referral back to the GP, where:

- Either the onward referral is directly related to the condition for which the original referral was made, or which caused the emergency presentation (unless there is a specific local NHS STW policy in place requiring a specific approach for a particular care pathway);
- or the patient has an immediate need for investigation or treatment (suspected cancer, for instance). By contrast, the contract does not permit a hospital clinician to refer onwards where a patient's condition is non-urgent and where the condition for which the referral would be made is not directly related to the condition which caused.

Consultant to consultant referrals require authorisation by an appropriate lead consultant. Patient's expectations should be managed during this process and therefore when the referral is sent back to the GP or Community Service; it should be made clear to the patient that the GP will be best placed to make a decision re: onward referral. In coming to a decision, the consultant should be making clear to the patient whether they are being directed back to the GP for onward referral or the consultant is onward referring directly.

The vast majority of referrals should be made from Primary to Secondary Care ("GP to Consultant") for the following reasons:

- To offer patient choice for each different episode of care. Patients should be offered the opportunity for 'Choice' in relation to referral for and opinion or management of a condition.
- To provide care closer to home wherever possible by ensuring management of patients within primary care where appropriate.
- To contribute to the management of secondary care capacity by ensuring only those genuinely needing secondary care receive it, and in a timelier way as part of 18 weeks pathway.

For these reasons, when a consultant decides that the opinion of another Consultant/service should be sought, in the majority of cases he/she will write back to the referring GP detailing this opinion so that the patient and their GP can agree on further management. There are however circumstances in which a "Consultant to Consultant" referral is clinically appropriate. This policy describes these. No matter how well defined these circumstances are, there will always be occasional exceptions where Consultants and Commissioners will have to take a view based on individual patients and clinical circumstances. These decisions will be recorded by the provider and submitted to the commissioners via the contract route for a joint decision.

Service Condition 8.5, NHS Standard Contract 2021/22, states with regards to Consultant-to-Consultant referrals:

"Except as permitted under an applicable Prior Approval Scheme (i.e., Values Based Commissioning Policy), the Provider shall not carry out, nor refer to another provider to carry out, any non-immediate or routine treatment or care that is unrelated to a Service User's original Referral or presentation without the agreement of the Service User's GP."

Circumstances in which Consultant to Consultant referrals ARE appropriate:

- The patient has an immediate need for investigation or treatment - confirmed or suspected cancer for instance;
- Urgent problems for which delay would be detrimental to the patients' health, and where the expectation here is that the patient would be seen within two weeks of the referral;

- The referral is part of a jointly clinically agreed pathway, in line with NICE Guidance and local improvement work as appropriate;
- Patients who remain under the original team referred to (e.g., neurology) but require simultaneous input directly associated with their current condition/treatment from another team (e.g. respiratory). Equally, when a patient needs onward referral, but the expertise/input of the initial team is still required e.g., if a patient with HIV has a hernia, the HIV team will still need to be available to the surgical team;
- Pre-operative assessments, including in other specialties such as cardiology;
- Pregnant patients who need review by other specialists as a result of their pregnancy and where a rapid opinion is required to ensure continuation of a healthy pregnancy;
- Patients referred following an emergency department attendance with a trauma related injury or an urgent condition. Or direct referral pathways agreed from Emergency Department. A tertiary referral to another Trust because the originating hospital does not provide the clinical service required;
- Referrals made under safeguarding (adult and child) guidance/legislation;
- Non-cancer tertiary / specialist Centre as agreed locally;
- Within a multi-disciplinary team, this should not be recorded as a new outpatient appointment but as a follow up appointment If it is about the same condition/referral as currently being treated;
- Referrals within a specialty for the same condition. Cross referral within the same department with subspecialty interests for the same condition can be made exceptionally, i.e. a cardiologist requesting a diagnostic. However, our expectation is that these would be exceptional and that all referrals will be previewed by a consultant at the time of booking to ensure that patients are not inconvenienced by being booked in with the wrong sub specialist;
- Consultant referrals to the memory clinic where a high index of clinical suspicion of a diagnosis of dementia is suspected;
- Within the Paediatric service generally where there is a need for the involvement of a tertiary centre (e.g., a neurologist, surgeon etc.) or another local specialist (e.g. ophthalmologist, ENT surgeon, community paediatrician, etc.). Also, within neonates follow up from an inpatient stay may include referral to other specialities within the Trust and Tertiary Centres (e.g. respiratory, cardiology, surgery).

Circumstances in which Consultant to Consultant referrals are NOT appropriate:

- The contract does not permit a hospital clinician to refer onwards where a patient's condition is non-urgent and where the condition for which the referral would be made is not directly related to the condition which caused the original GP referral or attendance at Emergency Department;
- In this situation, the contract requires the hospital clinician to refer back to the patient's GP. If the GP agrees, the onward referral can then be made (either by the provider clinician or by the GP) but the GP may instead choose to manage the patient's condition him/herself or to refer into a different service;
- Where a patient is transferred to the care of a Locum within the same specialty and same condition, if a first attendance has already taken place all subsequent appointments will be follow up attendances (this is consistent with RTT guidelines and will be perceived by the patient as a follow up).

Referral requiring redirection to another organisation (tertiary referrals)

NHS STW considers it is acceptable to make referrals into other organisation or to accept referrals from other organisations in the following circumstances:

- Suspected or diagnosed cancer;
- Urgent problems for which delay would be detrimental to the patient's health (the "two week rule" as applied to GP referrals);
- Where the destination is recognised as specialist and only accepts referrals from consultants;
- Where the referral is for a very specialist opinion or treatment where the destination of the referral is "the provider of choice";
- Where onward referral is expected and planned as an essential part of the same pathway of care;
- Referral to established multi-speciality combined clinics;
- Referrals relating to chronic multi-system diseases where specialist management or intervention is required, with close collaboration (i.e., sharing of complex clinical information);
- Referrals that facilitate discharge from or prevent an acute admission.

Outpatient Coding

Good quality outpatient data requires service providers to have effective administrative procedures in place to record accurate patient information. This is supported by timely and accurate recording of patient contacts. Understanding which patients and pathways have high levels of Consultant-to-Consultant referrals will help target interventions.

Compliance Monitoring

Any outpatient attendance and subsequent treatment resulting from a consultant-to-consultant referral made outside this policy will be subject to discussions at the monthly contract management meetings held between NHS STW and the Trust.

If there is evidence of an increase in consultant-to-consultant referrals then NHS STW may wish to audit a representative sample of consultant to consultant (C2C) referrals to establish whether such referrals are being made in accordance with the currently agreed policy and whether any change in clinical practice is necessary. Audit will be conducted jointly between the Trust and NHS STW. Audits will need to be undertaken in line with provider audit policies detailed within contracts.

The Trust will nominate two or more clinicians to work with the GPs. One GP and one Trust clinician will constitute an audit panel to review the audit sample. There will be 2 Audits carried out in a year, one in Q1, and one in Q3. The terms of reference and methodology is to be jointly agreed between both parties. It is envisaged that the audit panel will need to meet on three or more occasions to conduct the audit and the clinicians will need to agree between themselves suitable dates for audit sessions.

In order to make best use of the clinicians' time, it is proposed that the audit sample should initially be reviewed by a manager nominated by NHS STW and a manager nominated by the Trust. The managers will identify and record any C2C referrals that are clearly compliant with the C2C policy and other applicable commissioning policies. (Examples may include urgent cancer referrals, A&E consultant referrals to Fracture Clinic, or management of the condition for which the patient was initially referred). The auditors will be given access to the sample records either by the Trust providing appropriate access to their systems or by extracting the original patient notes. Information from the sample will be recorded on a data collection form.

NHS STW will provide the Trust with a list of records (volume to be agreed) from SLAM reports in order to achieve a confidence level of 95% with a confidence interval of 5% for the level of compliance with the C2C policy. The Trust will be required to make these records available to the auditors. The audit lead will prepare a report highlighting the auditors' conclusions and any recommendations for amendments to the policy and/ or the Trusts' management arrangements for C2C referrals. Where there is any difference of opinion between the auditors that cannot be resolved by discussion, this will be recorded in the audit findings. Outcomes of any audits will first be presented to the Contract Meeting with the provider.

Reference – for further detail and to be read in conjunction with this Policy, see the:

- NHS STW Consultant to Consultant Policy, and
- NHS STW Value Based Commissioning and Evidence Based Interventions Policy.

Inter Provider Transfers (IPTs)

Incoming IPTs

All IPT referrals will be received electronically via the provider's secure generic NHS.net email account into the Central Booking or Appointments Office. The provider expects an accompanying MDS (Minimum Data set) pro-forma with the IPT, detailing the patient's current RTT status (the receiving provider will inherit any RTT wait already incurred at the referring Trust if they have not yet been treated) and if the patient has been referred for a new treatment plan for the same condition (where a new RTT clock will start upon receipt at the provider organisation) the patient's pathway identifier (PPID) should also be provided. If the IPT is for a diagnostic test only, the referring Trust retains responsibility for the RTT pathway.

If any of the above information is missing, the referral should be recorded on PAS and the information actively chased by the Booking Office.

Outgoing IPTs

The provider Trust will ensure that outgoing IPTs are processed as quickly as possible to avoid any unnecessary delays in the patient's pathway.

An accompanying MDS (Minimum Data Set) pro forma will be sent with the IPT, detailing the patient's current RTT status (the receiving Trust will inherit any RTT wait already incurred if the patient has not yet been treated). If the patient has been referred for a new treatment plan for the same condition, a new RTT clock will start on receipt at the receiving Trust. The patient's patient pathway identifier (PID) will also be provided.

If the outgoing IPT is for a diagnostic test only, the provider Trust retains responsibility for the RTT pathway.

Referrals, and the accompanying MDS, will be emailed securely from the specialty NHS.net account to the generic central booking office NHS.net account. The central booking office will verify (and correct if necessary) the correct RTT status for the patient. If the patient has not yet been treated, the RTT clock will be nullified at the provider Trust. They will then forward to the receiving Trust within one working day of receipt into the generic email inbox.

Booking New Outpatient Appointments

e-Referral service

Patients who have been referred via e-RS should be able to choose, book and confirm their appointment before the provider receives and accepts the referral.

If there are insufficient slots available for the selected service at the time of attempting to book (or convert their Unique Booking Reference Number UBRN), the patient will appear on the appointment slot issue (ASI) work list. ASI's are managed and reported as standard practice by the provider Trust, the process of which should be detailed within their operational SOP.

If a patient's appointment has been incorrectly booked on the NHS e-Referral system into the wrong service at the provider by the referrer, the referral should be electronically re-directed in the e-Referral system to the correct service. A confirmation letter of the appointment change will be sent to the patient. The patients RTT clock will continue to tick from the original date when they converted their UBRN.

Paper based referrals

Appointments will be booked in order of clinical priority (urgent before routine) and then in chronological order of referral received date.

Patients will be selected for booking from the provider Trust's patient tracking list (PTL) only. A fixed appointment will be sent to the patient however, they will have the opportunity to change this.

Patients will be offered a choice of at least two dates with three weeks' notice within the agreed first appointment milestone for the specialty concerned. Appointment dates can be offered with less than three weeks' notice and, if the patient accepts, this can then be defined as 'reasonable'. Where there is insufficient capacity to offer an appointment within the required milestone, this should be escalated to the relevant service manager.

Any appointment offers declined by patients should be recorded on the PAS. This is important for two reasons: full and accurate record keeping is good practice, and the information can be used at a later date to understand the reasons for any delays in the patient's treatment, e.g. hospital or patient initiated.

Clinic Attendance and Outcomes (New and Follow-up Clinics)

Arrival of patients

Patient demographic details should be checked at every clinic attendance and amended as necessary on the Provider Trust's PAS system. The status of overseas visitors will be checked at this time. The OSV team must be notified where it is suspected that there is an overseas visitor.

Every patient, new and follow-up, whether attended or not, will have an attendance status and outcome recorded on the PAS at the end of the clinic. All clinics should have completed and recorded outcomes, or 'be cashed up' within two working days of the clinic taking place. Clinic outcomes (e.g., discharge, further appointment) and the patients updated RTT status will be recorded by Clinicians on the agreed clinic outcome form (COF) and forwarded to reception staff immediately.

When they attend the clinic, patients may be on an open pathway (i.e., waiting for treatment with an RTT clock running) or they may already have had a clock stop due to receiving treatment or a

decision not to treat being agreed. It is possible for patients to be assigned any one of the following RTT statuses at the end of their outpatient attendance, depending on the clinical decisions made or treatment given/started during the consultation:

Patients on an open pathway

- Clock stops for treatment.
- Clock stops for non-treatment.
- Clock continues if requiring diagnostics, therapies or being added to the admitted waiting list.

Patients already treated or with a decision not to treat (stopped clock)

- New clock start if a decision is made regarding a new treatment plan.
- New clock start if the patient is fit and ready for the second side of a bilateral procedure.
- Stopped RTT clock if the patient is to be reviewed following first definitive treatment.
- Stopped RTT clock if the patient is to continue under active monitoring.
- Accurate and timely recording of these RTT statuses at the end of the clinic are therefore critical to supporting the accurate reporting of RTT performance.

Booking Follow-up Appointments

Patients on an open pathway

Where possible, follow-up appointments for such patients should be avoided by discussing likely treatment plans at first outpatient appointment, and/or use of telephone/digital/written communication where a face-to-face consultation is not clinically required. Where unavoidable, such appointments must be booked to a timeframe that permits treatment by week 18 (unless the patient chooses a later date).

Follow-up appointments should be agreed with the patient prior to leaving the clinic where practically possible. This provides the best opportunity for patient choice to be accommodated within the required timescale for achievement of the RTT standard.

Patients Not on An Open Pathway

Patients who have already been treated or who are under active monitoring and require a follow-up appointment should be managed via the partial booking of follow-ups (PBFU) process. Before they leave the clinic, it will be clearly explained to the patient that:

- They will be added to the Follow-up Active Booking List;
- An appointment will then be agreed with the booking office.

Patient Initiated Follow-Up (PIFU)

Follow-up appointments have traditionally been offered at routine intervals depending on a person's condition. Some people might need to be seen sooner than their scheduled next appointment but do not know to get in touch with their clinical team, and even if they do, they may not be seen for several weeks. Others may be invited to attend appointments at a time when their condition is stable, potentially causing them unnecessary inconvenience and anxiety.

When a patient or carer, within a certain timeframe, can initiate follow-up appointments themselves when needed, PIFU gives patients or their carers greater control and involvement over their follow-up care. By allowing them to be the ones who initiate follow-up appointments, patients can be seen

quickly when they need to be, such as when their symptoms or circumstances change, and otherwise avoid the inconvenience of potentially unnecessary appointments that may be of low clinical value.

This is a key part of the focus on empowering patients and delivering personalised care in the NHS. PIFU can be used where clinically appropriate, in a wide variety of specialties, for people of any age, with short and long-term conditions, and for single and multiple conditions. This is not a new concept, and PIFU commonly goes by a number of other names, including open access follow-up, patient led follow-up, patient triggered follow-up, patient-initiated appointments, supported self-managed follow-up, self-managed follow up, see on symptom, open appointments, open self-referral appointments or patient activated care. In the context of cancer, this is often part of personalised stratified follow-up. Within the above definition, PIFU must meet three minimum quality standards:

1. All patients and/or carers should have PIFU explained to them and the opportunity to ask questions and raise concerns. If they do not understand how or when to trigger an appointment, PIFU should not be used (see information on shared decision-making);
2. A standard operating procedure (SOP) that includes patient safety nets should be in place.
3. All patients placed on PIFU pathway should be logged and tracked on the organisation's IT system, and the service able to report on key metrics including the number of patients who are on a PIFU pathway.

PIFU can be used for patients of any age, provided the patient and their clinician agree it is right for them. In some cases, it may be appropriate for the patient to share the responsibility for initiating appointments with a carer or guardian. PIFU can be used alongside routine timed appointments if the patient requires appointments at regular intervals but would still benefit from being able to book an appointment between these if they experience a change in symptoms. Individual services should develop their own guidance, criteria and protocols on when to use PIFU and be clear that it should not be used as a substitute for the appropriate timely discharge of patients.

Booking Patient Initiated Follow Up (PIFU)

Patients who have been placed on a PIFU pathway who activate a need for an appointment within their defined timescale will be booked in accordance with agreed timeframes.

Patients who have been placed on a PIFU pathway and do not attend an appointment should be investigated to establish that there are no health inequalities, and the patient should be contacted to understand why they have not attended. Providers should assess the impact of digital exclusion for all services offered via remote digital means and make reasonable adjustments including the offer of face-to-face appointments especially for Core20PLUS population groups. The Consultant may at this point return the patients care to the GP if it is appropriate to do so and is in the best interests of the patient.

Booking Stratified Follow Up

Patients who have been placed on a Stratified Follow Up pathway will have their tests undertaken when required and a clinical decision made on their appropriate treatment and will be informed by the responsible Clinician.

Advice & Guidance

Advice & Guidance allows one clinician to seek advice from another clinician, i.e., a GP seeking advice from a secondary care consultant. This provides the clinician seeking advice with direct access to timely support and information that enables them to better deal with that particular patient

and thereby preventing potentially unnecessary hospital appointments and providing the patient with a more timely course of action.

Virtual Consultations

A virtual consultation enables contact between a patient and GP, Consultant or other health professional without the need for visiting the premises in person, in some cases preventing unnecessary trips to hospital to have instead, and appointment that can be adequately conducted online or over the telephone.

Patients who do not attend – Missed Appointments (MA) – formerly DNA's

All patient MA's (new and follow-up) will be reviewed by the Clinician at the end of clinic in order for a clinical decision to be made regarding next steps

(see '[Clock Stops for Non-Treatment](#)' for the application of RTT rules regarding MA's). A COF must be completed for each patient that misses their appointment.

Patients on a PIFU pathway who miss their appointments should be investigated to establish that there are no health inequalities, and the patient should be contacted to understand why they have missed their appointment. Providers should assess the impact of digital exclusion for all services offered via remote digital means and make reasonable adjustments including the offer of face-to-face appointments especially for Core20PLUS population groups. The Consultant may at this point return the patients care to the GP if it is appropriate to do so and is in the best interests of the patient.

Follow-up Appointments

- Patients who require an appointment within six weeks should be fully booked as they leave their outpatient appointment where possible.
- Patients who require an outpatient follow-up appointment in more than six weeks' time will be sent a fixed appointment. However, they will have the opportunity to change this if unsuitable.
- Long term follow-up appointments will be agreed between consultant and the patients GP around the clinical needs of the patient.
- Any patients who require a further appointment outside of agreed clinical protocols will need to be flagged to the service management team and relevant Clinicians for further investigation with a view to establishing the appropriateness of the further follow-up appointment. However, if the speciality Clinician deems that this is not in the best clinical interests of the patient's care, they can be offered a further follow-up appointment outside of the six-month rule.

Personalised Outpatients

The Clinical Prioritisation programme is part of the outline NHS response to elective recovery and is designed to support the prioritisation of waiting lists as part of the recovery of elective activity. The priority now is to ensure that all patients on an outpatient (non-admitted) pathway have been reviewed and clinically prioritised' to support discussions with patients about their condition, to give greater clarity of the number of patients awaiting appointments at each priority level, to inform service capacity planning, and support the booking of patients.

Technical Validation

Technical validation is the first stage of any clinical prioritisation. Data quality issues & potential errors should be reviewed and corrected as far as possible prior to clinical review in order to provide as accurate and up to date as possible list for clinical review. Data quality issues may be identified

through the reports from a digital tool that targets those pathways which are more likely to be incorrect, as well as local data quality reports. Issues likely to affect the management of the patient's pathway should be prioritised.

For outpatient pathways, potential issues are likely to include:

- Duplicate entries where patients may have already been seen i.e., expedite letters are registered as new referrals;
- Pathway sequencing that appears incorrect through incorrect codes;
- Missing waiting list or pathway information;
- Patients on an outpatient waiting list without an active RTT clock, where one would be expected.

Technical validation should not delay the administrative and clinical prioritisation process, but checks should be completed to an adequate level to support the generation of a list of patients to be contacted by the trust.

Administrative Validation

Patients (or for paediatric patients a parent or appropriate guardian) should be contacted by letter, telephone, or email to confirm their current circumstances, needs and preferences relating to their treatment, so that up-to-date information is available to support the clinical prioritisation process.

The Trust should consider appropriate patients to contact and the appropriate means, taking into account those patients who may have an already booked/confirmed appointment in the near future, when the patient was added to an outpatient waiting list, and when the patient was last contacted. The means of contact is likely to depend on the volume of patients, urgency of booking, patient demographics, and staff availability.

Patients should be asked to indicate whether they still require treatment or whether they have been treated elsewhere or if their condition has otherwise resolved.

Clear information should be provided to the patient about next steps. Some patients may proceed to a shared decision-making discussion with an appropriate clinician, and information should be provided about this to enable patients to participate fully in that discussion. This will include:

- identifying where further information is needed to enable the clinical team to assign or update a prioritisation category;
- where patients are undecided about whether to proceed with treatment, or wish to discuss their condition and their treatment options;
- or where a patient may go on to be listed for a diagnostic or surgical procedure included in national guidance on evidence-based interventions.

If contacting by letter or e-mail patients should be given adequate time to respond (at least 2 weeks from receipt of letter) and given clear information about the need to respond and next steps if they do not. Further attempts must be made to contact any patients who do not respond to the letter, or who cannot be contacted by telephone. Some of these attempts should be made outside of normal working hours, as well as contacting the patient's GP or referrer.

Information provided by patients should be recorded on the Trust's PAS system to support clinical prioritisation and document any booking instructions.

Patients should not be removed from the outpatient waiting list without a clinical decision not to treat and to discharge back to the referrer. Patients not yet seen, and awaiting an appointment, would not be expected to be removed unless for exceptional reasons

Administrative validation should be completed to an adequate level to enable identification of those patients on an outpatient waiting list with a clear decision to proceed to an appointment, and those patients where further information, or a shared decision-making discussion is required. A list of those patients requiring further review should be generated to support the clinical validation process.

Clinical Validation

Information provided by the patient on their current condition, fitness, and availability to proceed should be collated to enable a specialty level review of the outpatient waiting list.

Where a patient has indicated that they wish to proceed with an outpatient appointment, and there are otherwise no indications requiring a shared decision making discussion between the patient and an appropriate clinician, a clinical priority category may be assigned and recorded based on the locally agreed process appropriate for the patient's condition, a confirmation letter should be sent to the patient and their GP at this point to confirm the patients notes have been reviewed and the patient prioritised. A separate clinical discussion with the patient will not usually be required. The specialty team may also be able to identify those patients potentially suitable for an appointment in the Independent Sector based on this information.

The list of patients to be reviewed should be ordered in a way to enable patients with the most urgent conditions to be reviewed first based on the information available (such as urgency indicated at referral, medical condition, sub-specialty, and the length of time that the patient has been waiting for an appointment).

Appropriate information should be available to support the process, including information provided by the patient during the administrative validation process on their current condition, fitness, and availability.

The discussion with the patient should include the following elements:

- The clinician's assessment of the patient's priority (2ww, urgent or routine);
- The patient's current condition, symptoms, and any other clinical conditions or factors that may affect their potential treatment; whether the patient is potentially suitable for an appointment in the Independent Sector or an alternative setting other than in secondary care (where this is the case, we recommend that this information is captured on the local PAS/IT system to allow easy identification of these patients).

All Provider NHS Trust's must ensure that all contacts with patients are recorded whether by letter to the patient and GP or in the PAS system.

Appointment Changes and Cancellations

Appointment changes initiated by the patient

- If the patient gives any prior notice that they cannot attend their appointment (even if this is on the day of clinic), this should be recorded as a cancellation and not Missed Appointment.
- If the patient requires a further appointment, this will be booked with the patient at the time of the cancellation.
- If the patient is on an open RTT pathway, the clock continues to tick. If there are insufficient appointment slots within the agreed pathway milestones, the issue must be escalated to the relevant clinical management team. Contact with patient must be made within two working days to agree an alternative date.

- If the patient has never been seen and advises they do not wish to progress their pathway, they will be removed from the relevant waiting list and a clock stop and nullification applied. The patient will be informed that their Consultant and GP will be informed of this.
- After two instances of the same pathway events occurring, a clinical review of the case should be triggered. This will determine the appropriate next steps which could include a return the referring clinician providing the following guidance is adhered to:
 - provider can demonstrate that the appointment was clearly communicated to the patient;
 - discharging the patient is not the contrary to their best clinical interests, which may only be determined by a clinician.
- If as a result of the patient cancelling, a delay is incurred which is equal to or greater than a clinically unsafe period of delay the patients' pathway should be reviewed by their consultant. Upon clinical review, the patients' Consultant should indicate one of the following:
 - Clinically safe for the patient to delay: continue progression of pathway. The RTT clock continues;
 - Clinically unsafe length of delay: Clinician to contact the patient with a view to persuading the patient not to delay. The RTT clock continues;
 - Clinically unsafe length of delay: in the patient's best clinical interests to return the patient to their GP. The RTT clock stops on the day this is communicated to the patient and their GP.

Example 1:

Patient is booked to attend a first outpatient appointment on a date more than 3 weeks ahead but does not attend. No prior notice has been given. A Missed Appointment would be recorded, and the clock nullified. The referral should be returned to the GP to explain the patient has been removed from the clinic waiting list. Any decision to return a patient to primary care should be subject to the caveats set out in RTT rules and best practice outlined below.

Example 2:

Patient is booked to attend a pre-assessment clinic appointment ahead of planned hip surgery. The patient contacts the hospital to cancel the appointment. Patient should be re-booked for another pre-assessment clinic and remain on the waiting list for surgery.

Best Practice

Consideration should be given to the impact of multiple hospital cancellations on the likelihood of missed appointment events. Providers should avoid multiple cancellations and rebooking wherever possible as this has a negative impact on patient experience and efficiency. Equally, patients who refuse multiple reasonable offers of appointment should be reviewed to assess whether discharge to GP is appropriate.

Patients who miss their first appointment on an RTT pathway may have their clock nullified (stopped and not reported) as long as the provider can demonstrate that the appointment was clearly communicated to the patient. Patients who cancel an appointment in advance are not considered a Missed Appointment and would not have clocks nullified.

An offer is reasonable where the offer for an outpatient appointment or an offer of admission is for a time and date 3 or more weeks from the time the offer was made.

•The above is a more explicit and consistent interpretation of the existing RTT rules associated with patient compliance.

Appointment changes initiated by the provider

- Provider initiated changes to appointments will be avoided as far as possible as they are poor practice and cause inconvenience to patients. In the event of a Provider initiated cancellation, the patients' RTT clock continues to tick from the original referred received date.
- The patient will be contacted to arrange an alternative appointment date and time. Both an apology and a reason for cancellation will be given. The Provider Trust will make every effort to ensure that they do not cancel patients' appointments.
- If the cancellation is within two weeks of the appointment date, the patient will be telephoned. If the cancellation is outside of the timeframe, the patient will be contacted by letter. Appointments will be made as close to the original appointment as possible. This is particularly important when patients need to re-attend for test results or to review medication.
- Patients will be contacted immediately if the need for the cancellation is identified and offered an alternative date(s) that will allow patients on open RTT pathways to be treated within 18 weeks. Equally, this will allow patients not on open pathways to be reviewed as near to the clinically agreed timeframe as possible.
- If a patient is cancelled or rescheduled twice by the Provider Trust, this will need to be escalated immediately to the appropriate service manager to take immediate action.
- Clinicians are actively encouraged to book annual leave and study leave as early as possible. Clinicians must provide 6 weeks' notice of a clinic has to be cancelled or reduced.

Clinic Management

Clinic templates

Detail on how clinics and booking processes are operationally managed will be described and set out in the each of the provider organisations' operational SOP.

These shall include where appropriate:

- Clinic templates and changes to clinic templates
- Consultants notice of leave or clinical cancellation
- Cancelling clinics and patient choice
- Reduced clinics
- Booking rules and processes
- Effective and efficient clinic capacity utilisation

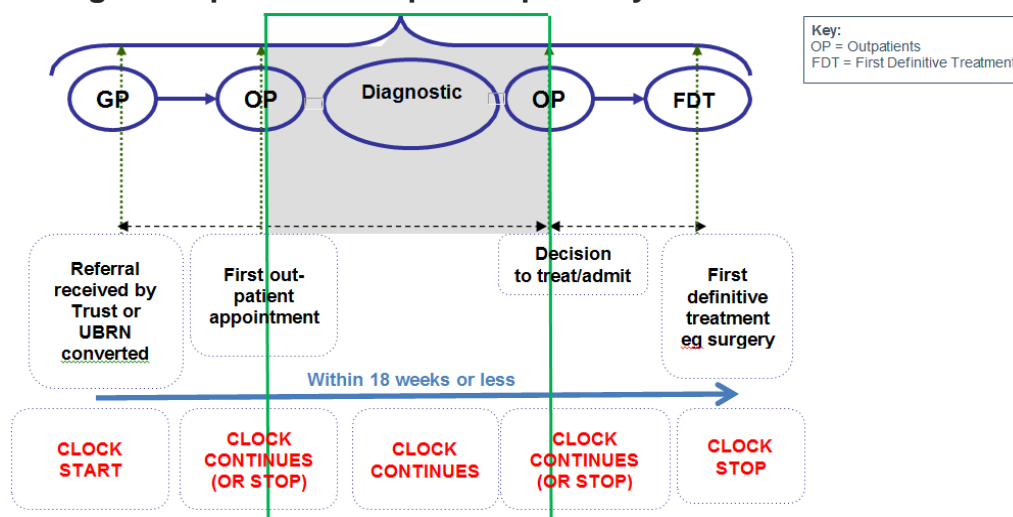
Diagnostics

The section within the green border on the Figure 4 diagram represents the diagnostic stage of the RTT pathway which forms part of the non-admitted pathways. It starts at the point of a decision to refer for a diagnostic test and ends on the results/report from the diagnostic procedure being available to the requester.

It is important to note, however, that patients can also be referred for some diagnostic investigations directly by their GP where they might not be on an 18-week RTT pathway. This will happen where the

GP has requested the test inform future patient management decisions, i.e., have not made a referral to a Consultant-led service at this time.

Figure 4: Diagnostic phase of the patient pathway



Patients with a Diagnostic and RTT Clock

The diagnostics section of an RTT pathway is a major pathway milestone. A large proportion of patients referred for a diagnostic test will also be on an open RTT pathway. In these circumstances, the patient will have both types of clock running concurrently:

- Their RTT clock which started at the point of receipt of the original referral.
- Their diagnostic clock which starts at the point of the decision to refer for diagnostic test (often at the first outpatient consultation).

Straight to Test Arrangements

For patients who are referred for a diagnostic test where one of the possible outcomes is review and if appropriate treatment within a consultant led service (without first being reviewed by their GP) an RTT clock will start on receipt of the referral. These are called straight-to-test referrals.

Patients with a Diagnostic Only Clock

Patients who are referred directly for a diagnostic test (but not Consultant-led treatment) by their GP, i.e., clinical responsibility remains with the GP, will have a diagnostic clock running only. These are called direct access referrals.

Patients may also have a diagnostic clock running only where they have had an RTT clock stop for treatment or non-treatment and their consultant refers them for a diagnostic test with the possibility that this may lead to a new RTT treatment plan.

National Diagnostic Clock Rules, Reasonable Offers, Cancelling or Not Attending

Patients referred for a diagnostic clock rules:

- **Diagnostic clock start:** the clock starts at the point of the decision to refer for a diagnostic test by either the GP or the Consultant.
- **Diagnostic clock stop:** the clock stops at the point at which the patient undergoes the test.
- **A reasonable offer:** for diagnostic tests a reasonable offer is a date and time of three or more weeks from the time that the offer was made at any of the Provider Trust sites. Should a patient accept an appointment less than three weeks into the future, this becomes a reasonable offer. All offered and declined appointments will be recorded on CRIS. Some diagnostic tests will be undertaken on an admitted basis.
- **Patients who decline two reasonable appointment offers:** if a patient declines two reasonable offers, the clock for the 6-week diagnostic standard can be re-set from the first appointment offered. The clock cannot be reset if there is no evidence that the appointments offered to and declined by the patient were reasonable.
- **Patients who do not attend – Missed Appointment (MA):** Standard Radiology MA protocol will apply (in line with Provider Trust policy on outpatient appointment MA's – see section 2), when a patient does not attend for the first time. A radiology Clinician will review the diagnostic request with a view to discharging the patient providing that:
 - The delay is not contrary to their best clinical interest.
 - The clinical interests of vulnerable patients (see the Safeguarding Children Policy or Safeguarding Vulnerable Adults Policy and Procedure for the relevant Provider) are protected.
 If the patient is to be discharged, the following process must be adhered to:
 - A copy of the request form, plus the CRIS generated Missed Appointment letter, will be sent to the referring Consultant/GP.
 - The request will be cancelled on CRIS.

Adjustments to the 6-week diagnostic standard as outlined above do not affect the patients 18 week RTT waiting time. It is therefore important that staff is aware of patients who are on both a diagnostic 6 week and 18-week RTT pathway and that their care is delivered in line with both national standards.

Booking Diagnostic Appointments

The appointment will be booked directly with the patient at the point that the decision to refer for a test was made wherever possible (e.g., the patient should be asked to contact the diagnostic department by phone or face to face to make the booking before leaving the hospital).

If a patient declines, cancels or does not attend a diagnostic appointment, the diagnostic clock start can be reset to the date the patient provides notification of this.

However:

- The Provider Trust must be able to demonstrate that the patient's original diagnostic appointment fulfilled the reasonableness criteria for the clock start to be reset.
- Resetting the diagnostic clock start has no effect on the patients RTT clock. This continues to tick from the original clock start date.

Diagnostic Cancellations, Declines and/or Missed Appointments for Patients on Open RTT Pathways

Where a patient has cancelled, declined and/or not attended their diagnostic appointment and a clinical decision is made to return them to the referring Consultant, the RTT clock should continue to

tick. Only the referring Consultant can make a clinical decision to stop the RTT clock, if this is deemed to be in the patient’s best clinical interests, by discharging the patient or agreeing a period of active monitoring.

Active Diagnostic Waiting List

All patients waiting for a diagnostic test should be captured on an active diagnostic waiting list, regardless of whether they have an RTT clock running, or have had a previous diagnostic test. The only exceptions are planned diagnostic patients.

Active Planned Diagnostic Waiting List

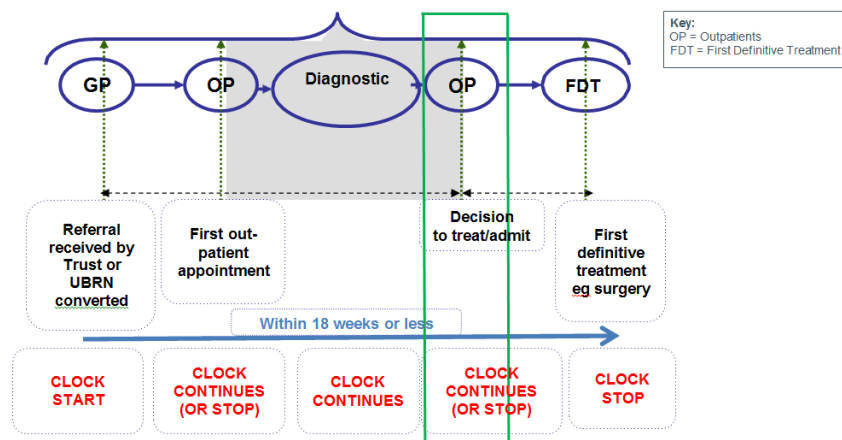
Patients who require a diagnostic test to be carried out at a specific point in time for clinical reasons are exempt from the diagnostic clock rules and will be held on a planned waiting list with a clinically determined due date identified. However, if the patients wait goes beyond the due date for the test, they will be transferred to an active waiting list and a new diagnostic clock and RTT clock will be started.

Therapeutic Procedures

Where the patient is solely waiting for a therapeutic procedure, for example in the radiology department, there is no six-week diagnostic standard. However, for many patients there is also a diagnostic element to their admission/appointment, and so these patients would still be required to have their procedure within six weeks.

Pre-Operative Assessment (POA)

Figure 5: Stages in Pre-Operative Assessment



All patients with a decision to admit (DTA) requiring a general anaesthetic will attend a pre-operative clinic on the same day, where possible, to assess their fitness for surgery. The vast majority of patients can be assessed by the Provider Trust’s dedicated pre-operative nurse specialists.

Patients should be made aware in advance that they may need to stay longer on the day of their appointment for attendance in POA.

For patients with complex health issues requiring a POA appointment with a Consultant, the Provider Trust will aim to agree this date with the patient before they leave the clinic. The Provider Trust will aim to agree an appointment no later than seven working days from the decision to admit.

Patients who miss their POA appointment will be contacted with a view to agreeing a further appointment. If they miss their subsequent appointment again, they will be returned to the responsible Consultant. The RTT clock continues to tick throughout this process.

If the patient is identified as unfit for the procedure, the nature and duration of the clinical issue should be ascertained. If the clinical issue is short term and has no impact on the original clinical decision to undertake the procedure (e.g., cough, cold, UTI), the RTT clock continues. However, if the clinical issue is more serious and the patient requires optimisation and/treatment, Clinicians should indicate to administration staff if it is clinically appropriate for the patient to be removed from the waiting list, and if so whether the patient should be:

- Optimised/treated within secondary care (active monitoring clock stop for existing pathway and potentially new clock start for optimisation treatment).
- Discharge to primary care for optimisation
- Discharged back to the care of their GP (clock stop – discharge).

When the patient becomes fit and ready to be treated for the original condition, a new RTT clock would start on the day this decision is made and communicated to the patient.

Example: short-term conditions

Patients presents with a medical condition that requires further pre-operative tests

This might be a patient with known heart disease has had recent episode/s of angina that requires a cardiac echo or other cardiac investigations prior to surgery. The patient should remain on the WL and be rebooked at an appropriate time

Example 1: Long-term conditions

Following diagnosis agreed with patient that hip replacement required. However, BMI of patient to high and needs to lose weight before surgery can take place. Place on active monitoring for condition of hip and discharge to primary care to manage weight loss. This is because it is unclear how long the weight loss program will take.

Example 2: Long-term conditions

Patient undergoes preoperative assessment, and a previously undiagnosed heart condition is identified. Patient placed on active monitoring for condition requiring surgery. Patient referred to cardiology for management

Best Practice

Specific Covid Position (April 2022):

Current Royal College guidance is that patients who test positive for Covid should have their treatment/procedure delayed for seven weeks. However, clinical prioritisation can overrule this guidance if the consultant feels it is in the best interest for the patient.

Acute Therapy Services

Acute therapy services consist of physiotherapy, dietetics, orthotics and surgical appliances. Referrals to these services can be:

- Directly from GPs where an RTT clock would NOT be applicable.

- During an open RTT pathway where the intervention is intended as **first definitive treatment** or **interim treatment**.

Depending on the particular pathway or patient, therapy interventions could constitute an RTT clock stop. Equally the clock could continue to tick. It is critical that staff in these services know if patients are on an open pathway and if the referral to them is intended as first definitive treatment.

Physiotherapy

For patients on an orthopaedic pathway referred for physiotherapy within Secondary Care as first definitive treatment the RTT clock stops when the patient begins physiotherapy. If the patient is referred into Primary Care for Physiotherapy this will stop the RTT clock.

For patients on an orthopaedic pathway referred for physiotherapy as interim treatment (as surgery will definitely be required), the RTT clock continues to tick when the patient undergoes physiotherapy.

Surgical Appliances

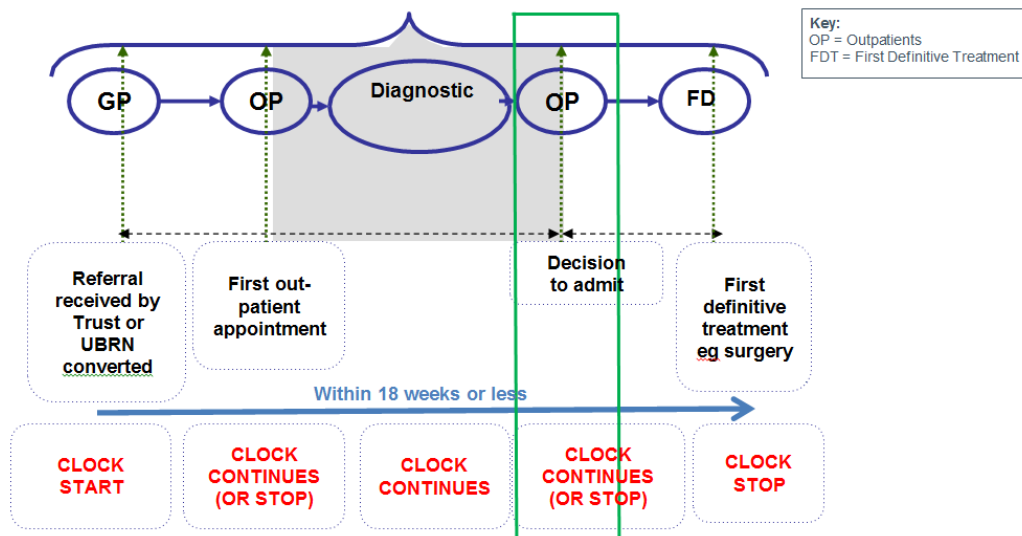
Patients on an orthopaedic pathway referred for a surgical appliance with no other form of treatment agreed. In this scenario, the fitting of the appliance constitutes first definitive treatment and therefore the RTT clock stops when this occurs. The process on how this is managed and provided will be described in the relevant provider Trust's Access Policy implementation SOP.

Dietetics

If patients are referred to the dietician and receive dietary advice with no other form of treatment, this would constitute an RTT clock stop. Equally, patients could receive dietary advice as an important step of a particular pathway (e.g., bariatric). In this pathway, the clock continues to tick.

Non-Activity Related RTT Decisions

Figure 6: Stages in the management of non-activity related RTT decisions



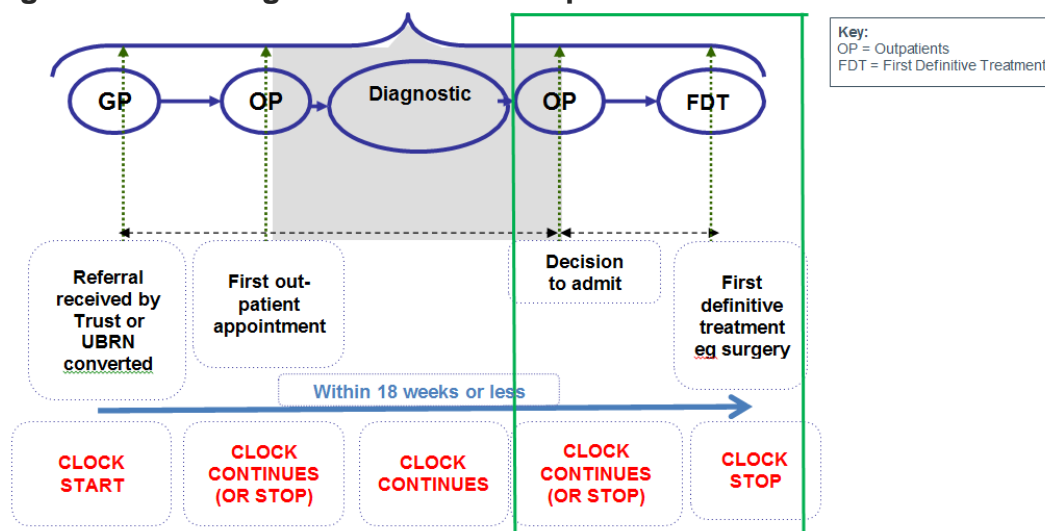
Where Clinicians review test results in the office setting and make a clinical decision not to treat, the RTT clock will be stopped on the day this is communicated in writing to the patient.

Administration staff should update PAS with the clock stop. The date recorded will be the day the decision not to treat is communicated in writing to the patient.

Admitted Pathways

The section within the green border on Figure 7 represents the admitted stage of the pathway. It starts at the point of a decision to admit and ends upon admission for first definitive treatment.

Figure 7: Stages in the management of admitted patients



Adding Patients to the Active Inpatient or Day Case Waiting List

Ideally patients will be fit, ready and available before being added to the admitted waiting list. However, they will be added to the admitted waiting list without delay following a decision to admit, regardless of whether they have undergone pre-operative assessment (see '[Pre-operative Assessment](#)') or whether they have declared a period of unavailability at the point of the decision to admit (see '[Patient Initiated Delays](#)').

The active inpatient or day case waiting lists/PTLs includes all patients who are awaiting elective admission. The only exceptions are planned patients, who are awaiting admission at a specific clinically defined time.

In terms of the patients RTT clock, adding a patient to the inpatient or day case waiting will either:

- Continue the RTT clock from the original referral received date.
- Start a new RTT clock if the surgical procedure is a substantively new treatment plan which did not form part of the original treatment package, providing that either another definitive treatment or a period of active monitoring has already occurred. The RTT clock will stop upon admission.

Completion of waiting list 'to come in' (TCI) forms

A waiting list TCI form will be completed at the time of the decision to admit, in full by the Clinician making the decision to admit for all patients added to the waiting list. The process for this will be described in the provider Trust's operational SOP linked to this policy.

Adding patients to the admitted waiting list

Patients must be added to the admitted waiting list within two working days of the decision to admit. When logging a patient on the waiting list module of the PAS, the Booking or Appointments team must ensure that:

- Patients are not already listed for the same condition.
- The entry is recorded correctly as either active or planned.
- Full treatment text and an accurate procedure code are noted.
- That the patient is not already scheduled for surgery for another procedure under a General Anaesthetic.
- Any communication with the patient should be recorded on the PAS.

The clinical prioritisation programme is designed to support the prioritisation of waiting lists as part of the recovery of elective activity. The priority is to ensure that all patients on an admitted patient care pathway have been reviewed and clinically prioritised to support discussions with patients about their planned care, to give greater clarity of the number of patients awaiting procedures at each priority level, to inform service capacity planning, and support the booking of patients.

Waiting lists should be validated in two or three stages:

1. Technical validation: To ensure the waiting list is accurate and up to date.
2. Patient discussion: Patients are contacted by a locally determined competent team to establish their wishes.
3. Clinical Validation: Via remote clinical consultation, for patients who wish to discuss their situation in more detail using shared decision making (SDM).

Example 1: Clinical Prioritisation determines patient should not delay treatment

Based on work by the Royal Colleges, patients who do not wish to delay treatment, will be prioritised based on clinical review as follows:

- P2: Procedure to be performed < 1 month from review
- P3: Procedure to be performed < 3 months from review
- P4: Procedure to be performed > 3 months from review

Example 2: Clinical Prioritisation determines patient would prefer to delay treatment and agreed clinically appropriate

Patients who have been offered two dates for treatment and have declined to accept for non-Covid reasons, but still wish to remain on the waiting list will be coded as P6. This is if the reason given to continue to wait is not COVID-19 related. P6 to be assigned to patients who wish to defer treatment for "social" reasons.

Best Practice

NHSE/I has published a suite of guidance setting out core principles to be applied in all patient communications. These include enabling shared decision making and using clear, accessible and easy to understand language. The guidance, along with an aide memoire and template patient letters, can be found online here:

<https://www.england.nhs.uk/coronavirus/publication/good-communication-with-patients/>

RTT Waiting List Rules

Providers Partners need to assure themselves, the system and regulators that they have taken all reasonable steps to maintain “clean” waiting lists and apply RTT rules appropriately.

Clean validated W/L	Comments
Missing codes including RTT status, Treatment Function Code, latest RTT outcome code (RTT pathways only)	Identify relevant cohorts from PTL & understand why data is missing/ incomplete. Use information from review to correct recording practice.
Use national DQ tool (LUNA) to support identification of and correction of patient records e.g. TCI in the past, outcome discharge but still on list etc.	List of indicators to be prioritised for maximum impact i.e. where likely to affect pathway management & reporting
Planned admissions – only patients meeting the criteria correctly are recorded as planned.	Check Planned list for specialties and procedure codes usually part of RTT but recorded as planned; check that planned patients have due date recorded
Rules assurance	Comments
Reporting of eRS Appointment Slot Issues / Referral Assessment Service patients included in local and national waiting list data sets. Clock starts must reflect date of first attempted UBRN conversion.	All referrals should be visible on internal PTL reports for pathway management and included in local and national reporting (if not registered on PAS within 24 hours, referral with wait time must be accounted for and actively managed through other means)
Patients with multiple DNAs and patient cancellations are clinically reviewed and actioned.	Assurance provided through process review
Active Monitoring (watchful wait) applied appropriately.	Metrics to be agreed

Patients Requiring More Than One Procedure

If more than one procedure will be performed at one time by the same surgeon, the patient should be added to the waiting list with extra procedures noted. If different surgeons will work together to perform more than one procedure, the patient will be added to the waiting list of the Consultant surgeon for the priority procedure with additional procedures noted. If a patient requires more than one procedure performed on separate occasions by different (or the same) surgeon(s):

- The patient will be added to the active waiting list for the primary (1st) procedure.
- When the first procedure is complete and the patient is fit, ready and able to undergo the second procedure, the patient will be added (as a new waiting list entry) to the waiting list, and a new RTT clock will start.

Patients Listed for More Than One Procedure

A patient referred for two separate conditions resulting in the requirement for two admissions for different procedures could be managed in the following ways.

On completion of the first procedure the clock is stopped for that particular pathway. If the patient is unfit as a result of the first surgery to undergo the second surgery and there is no prospect of the patient becoming fit then the patients clock can be stopped (decision not to treat) and patient should be discharged back to the care of their GP or alternatively the patient could be placed on a period of active monitoring by the Clinician until the patient becomes fit, ready and available to proceed with the second procedure.

Patients can be on a waiting list for more than one procedure at the same time within the rules with two separate RTT clocks; providing they are different procedures for different conditions. For instance, if someone is at 16 weeks for knee replacement and 4 weeks for hernia repair (with a likely

wait of 12+ more weeks) the patient should not be removed from the hernia repair waiting list just because they have had or about to have a knee replacement. If there is an issue with a patient being fit for a second procedure and the Trust is wanting to date them, then the patient may need to come off the list while they wait to be optimised (depending on how long that may take) but the Trust should look to prioritise that patient when they are fit and ready so as not to disadvantage them.

Where patients are under the care of two separate specialties for two separate conditions and both conditions require admission for treatment, the patient should remain on both lists. If at the time a TCI is offered for one of the procedures, the patient is not fit, ready and available due to the other procedure, a period of active monitoring should be initiated as per the medically unfit principles. Where a procedure is a minor procedure that does not require general anaesthetic, it may be appropriate to proceed. This should be confirmed with the consultant.

Bilateral Procedures

Patients will usually be put onto the admitted waiting list for one side at a time, unless where clinically indicated to perform bilateral surgery on the same admission.

The RTT clock will stop when the first definitive treatment begins (i.e., when the procedure is carried out). Once the patient is fit and ready to proceed with the second procedure, a new clock will start when the patient is listed on the provider PAS system.

If the decision to admit involves two procedures as part of the single pathway of treatment the clock stops when the first treatment begins. The subsequent procedure is undertaken based on clinical need as part of the same pathway, but the clock has already stopped. This is a process for planned patients who are managed according to clinical need.

Subsequent Treatments for the Same Condition

If following active monitoring a patient is added to waiting list a new clock will start on the day Decision to Admit is made and communicated with the patient. This also applies to a patient on a previous emergency pathway. Patients who are removed from the waiting list will need to be reviewed in outpatients first before being re-instated unless based on clinical judgement this is decided against by the Consultant. The new clock start date will be either the date of the GPs request or the date of the review in outpatients.

Patients Requiring Thinking Time

Patients may wish to spend time thinking about the recommended treatment options before confirming they would like to proceed. It would not be appropriate to stop their RTT clock where this thinking time amounts to only a few days or weeks. Patients should be asked to make contact within an agreed period with their decision.

It may be appropriate for the patient to be entered into active monitoring (and the RTT clock stopped) where they state they do not anticipate making a decision for a matter of months. This decision can only be made by a Clinician and on an individual patient basis with their best clinical interests in mind.

In this scenario, a follow-up appointment must be arranged around the time the patient would be in a position to make a decision. A new RTT clock should start from the date of the decision to admit if the patient decides to proceed with surgery.

Where a patient requires 'thinking time' of less than 2 weeks, their clock continues. If a patient requires more thinking time this should be with the support of the clinician, and it may be appropriate to initiate a period of active monitoring.

Scheduling Patients to Come in for Admission

Clinically urgent patients will be scheduled first, followed by routine patients. All patients will be identified from the Provider Trust's Waiting List/PTL, and subject to the clause above about clinical priorities, will be scheduled for admission in chronological order of RTT wait.

Patients will be offered a choice of at least two admission dates with three weeks' notice within the agreed milestone for the specialty concerned. Admission dates can be offered with less than three weeks' notice and if the patient accepts, this can then be defined as 'reasonable'.

If there is insufficient capacity to offer dates within the required milestone, this issue will be escalated to the relevant service manager. Any admission offers declined by patients will be recorded on the PAS. This is important for two reasons:

- Full and accurate record-keeping is good clinical practice.
- The information can also be used at a later date to understand the reasons for any delays in the patient's treatment, e.g., hospital or patient initiated.

The Inpatient Appointment Letter

A letter must be generated immediately following the agreement of an appointment date.

The letter must contain the following core details:

- Patients name.
- NHS Number & Hospital Number.
- Date letter sent to patient.
- Date and time of admission.
- Details of necessary pre-assessment before admission.
- Where to report on arrival.
- Named contact for queries relating to admission.
- Reference to instructions for admission and/or booklet.
- Specific information about the treatment.
- General information about the patients stay in hospital and discharge.
- General information about the hospital facilities (car park etc.).

Planned Waiting Lists

Patients will only be added to an admitted planned waiting list where clinically they need to undergo a procedure at a specific time. The due date for their planned procedure will be included in the planned waiting list entry. Patients on planned waiting lists will be scheduled for admission at the clinically appropriate time and they should not have to wait a further period after this time has elapsed.

When patients on planned lists are clinically ready for their care to begin and reach their due date for their planned procedure, they will either be admitted for the procedure or be transferred to an active

waiting list and a new RTT clock will start. For some patients (e.g., surveillance endoscopies) a diagnostic clock would also start.

Patients Declaring Periods of Unavailability While on the Waiting List

If patients contact the Provider Trust to communicate periods of unavailability for social reasons (e.g., holidays, exams), this period should be recorded on the PAS.

If the length of the period of unavailability is equal to or greater than a clinically unsafe period of delay (as indicated in advance by consultants and recorded in the specialty guidance), the patients pathway will be reviewed by their Consultant.

Upon clinical review, the patients Consultant will indicate one of the following:

- Clinically safe for the patient to delay: continue progression of pathway. The RTT clock continues.
- Clinically unsafe length of delay: Clinician to contact the patient with a view to persuading the patient not to delay. The RTT clock continues. In exceptional circumstances if a patient decides to delay their treatment it may be appropriate to place the patient under active monitoring (clock stop) if the Clinician believes the delay will have a consequential impact on the patient's treatment plan.
- Clinically unsafe length of delay: in the patient's best clinical interests to return the patient to their GP. The RTT clock stops on the day this is communicated to the patient and their GP. The patient could also be actively monitored within the Trust.

Patients Who Decline or Cancel Inpatient Admission Appointment Offers

If patients decline an appointment offer or contact the Provider Partner to cancel a previously agreed appointment date, this will be recorded on the PAS. The RTT clock continues to tick. If, as a result of the patient declining or cancelling, a delay is incurred which is equal to or greater than a clinically unsafe period of delay (as indicated in advance by consultants and recorded in the specialty guidance), the patients pathway will be reviewed by their Consultant. Upon clinical review, the patients Consultant will indicate one of the following:

- Clinically safe for the patient to delay: continue progression of pathway. The RTT clock continues.
- Clinically unsafe length of delay: Clinician to contact the patient with a view to persuading the patient not to delay. The RTT clock continues.
- Clinically unsafe length of delay: in the patient's best clinical interests to return the patient to their GP. The RTT clock stops on the day this is communicated to the patient and their GP.
- The requested delay is clinically acceptable, but the Clinician believes the delay will have a consequential impact (where the treatment may fundamentally change during the period of delay) on the patients treatment plan-active monitoring.

Patients Who Do Not Attend Admission

Patients who do not attend for admission will have their pathway reviewed by their consultant. If the patient's Consultant decides that they should be offered a further admission date, the RTT clock continues to tick. If the patients' Consultant decides that it is in their best clinical interests to be discharged back to their GP, the RTT clock will then be stopped.

On-The-Day Cancellations

Where a patient is cancelled on the day of admission or day of surgery for non-clinical reasons, they will be rebooked within 28 days of the original admission date and the patient must be given reasonable notice of the rearranged date. The patient may choose not to accept a date within 28 days.

Hospital Cancellations of Inpatient Admission Dates

There are various reasons why an operation may have to be cancelled which fall into three main categories:

- cancellation by the Provider Trust for clinical reasons;
- cancellation by the Provider Trust for non-clinical reasons; and
- cancellation by the patient.

These should be included on any subsequent electronic discharge letter or in the patient's notes. All reasons for cancellation will be added to the PAS by the Booking Office.

Cancellation by the Provider Trust for clinical reasons

If the operation is cancelled because the patient is unfit for surgery or the operation is no longer required the clock stops and the patient should be referred back to their GP. The exception to this is patients who develop colds, D&V prior to admission and would be expected to recover in 7-10 days, the clock continues for these patients.

Cancellation by the Provider Trust for non-clinical reasons

The Provider Trust will only cancel a patients' admission when it is not possible to carry out the procedure (e.g., bed capacity, unplanned leave, emergency cases). Everything must be done to try and avoid a hospital cancellation as it causes distress to the patient and an operational problem to the hospital. Should it be necessary to cancel elective admissions, priority will be given to clinically urgent cases and long waiters. The new date also has to be within the 18-week patient target. Every effort should be made to avoid cancelling a patient's admission: Theatre lists should not be cancelled except under exceptional circumstances. Only the following can authorise this cancellation:

- SCHAT - Director of Operations or delegated deputy
- SaTH – Chief Operating Officer or delegated deputy
- RJAH – Chief Operating Officer or delegated deputy

Admitting Patients

Where a patient's admission is a procedure or operation constituting first definitive treatment as part of an RTT pathway, the admission on the PAS will stop the patient's clock.

Emergency Admissions for an Elective Procedure

Where patients are admitted as an emergency for an elective procedure the patient will be removed from the waiting list and their RTT clock stopped.

Removals Other Than Treatment

Patients who state that they do not wish to receive treatment will have their waiting list entry removed and their clock stopped.

3. Cancer Pathways

Introduction and Scope

This section describes how the NHS STW and its Provider Trust partners manage waiting times for patients with suspected and confirmed cancer, to ensure that such patients are diagnosed and treated as rapidly as possible and within the national waiting times standards. This policy is consistent with the latest version of the Department of Health's '[Cancer Waiting Times Guide](#)' and includes national dataset requirements for both waiting times and clinical datasets.

Policies

As defined in the '[NHS Constitution](#)', patients have the right to expect to be seen and treated within national operational standards ensuring timely diagnosis and treatment, equity of care and patient choice.

If a patient is referred for consultant-led treatment, they have the right to choose which provider (and the team within that provider) they are referred to from all those who have a contract to provide the service.

Patients can ask to be referred to a different hospital if:

- They have to wait more than 18 weeks before starting treatment for a physical or mental health condition, if your treatment is not urgent
- They have to wait more than 28 days before being seen on a cancer pathway
- Patients do not have to move to another provider. There is no consequence to the patient if they choose not to change.

Best Practice

- Strengthening the offer of "informed" choice to patients at point of referral –working with primary care to ensure that patients are made aware of the providers available to them including the independent sector
- Embed proactive offer of choice of alternative providers for long-waiters through offering better advice and options, and proactively contacting long wait patients

Patients will, wherever possible, be offered dates for appointment or treatment in chronological order, based on the number of days remaining on their cancer pathway, unless there are clinical exceptions.

Wherever possible, patients will be given reasonable notice and choice of appointments and admission dates as defined within the policy.

Accurate data on the Provider Trust's performance against the national cancer waiting times is recorded in the cancer management system and reported to the National Cancer Waiting Times Database within nationally predetermined timescales.

Where patients are at risk of breaching any of the cancer standards it is expected that all staff will follow the published cancer escalation policy.

All staff (to whom this document applies)

- Have a duty to comply fully with this policy/procedure and are responsible for ensuring they attend all relevant training offered.
- Are responsible for bringing this policy to the attention of any person not complying with it.

- Will ensure any data created, edited, used, or recorded on the Provider Trust's IT systems in their area of responsibility is accurate and recorded in accordance with this policy and other Provider Trust policies relating to collection, storage and use of data to maintain the highest standards of data quality and maintain patient confidentiality.

Training/Competency Requirements

All staff involved in the cancer pathway will be expected to undertake initial cancer waiting times training within the first three months of appointment within their respective Provider Trust. All relevant staff will have annual refresher cancer waiting times training.

Cancer Waiting Time Standards

Table 1 outlines the key cancer waiting times standards that the Trust must comply with.

Table 1: Key cancer waiting time standards

Service standard	Operational standard
28 day Faster Diagnosis Standard (FDS) - Receipt of urgent referral for suspected cancer, receipt of urgent referral from a cancer screening programme (breast, bowel, cervical), and receipt of urgent referral of any patient with breast symptoms (where cancer not suspected), to the date the patient is informed of a diagnosis or ruling out of cancer	75%, rising to 80% in 2025/26
31 day standard - From Decision To Treat/Earliest Clinically Appropriate Date to Treatment of cancer - merges existing 31-day decision to treat/earliest clinically appropriate date to treatment into one standard for all treatments of cancers. This also brings some subsequent treatments not currently in scope of existing standards into scope of this new standard	96%
62 day standard - From receipt of an urgent GP (or other referrer) referral for urgent suspected cancer or breast symptomatic referral, or urgent screening referral or consultant upgrade to First Definitive Treatment of cancer. This merges the 62-day referral/consultant upgrade standards into one 62-day standard for patients from either an urgent suspected cancer referral, breast symptomatic referral, urgent screening referral or a consultant upgrade	85%

Clock Starts

28 Day

Receipt of urgent referral for suspected cancer, receipt of urgent referral from a cancer screening programme (breast, bowel, cervical), and receipt of urgent referral of any patient with breast symptoms (where cancer not suspected), to the date the patient is informed of a diagnosis or ruling out of cancer

31 day

A 31 day cancer clock will start:

- From Decision To Treat/Earliest Clinically Appropriate Date to Treatment of cancer

62 day

A 62 day cancer clock can start:

- From receipt of an urgent GP (or other referrer) referral for urgent suspected cancer or breast symptomatic referral, or urgent screening referral or consultant upgrade to First Definitive Treatment of cancer.

If a patient's treatment plan changes, the DTT can be changed, i.e., if a patient had originally agreed to have surgery but then changed their mind and opted for radiotherapy instead.

Clock Stops

62 day

A 62 day cancer clock will stop following:

- Delivery of first definitive treatment.
- Placing a patient with a confirmed cancer diagnosis onto active monitoring.

Removals from the 62 day pathway (not reported):

- Making a decision not to treat.
- A patient declining all diagnostic tests.
- Confirmation of a non-malignant diagnosis.

28 Day

A 28 day cancer clock will stop following:

- A patient being told they have cancer
- A patient being told they do not have cancer

31 day

A 31 day cancer clock will stop following:

- Delivery of first definitive treatment.
- Placing a patient with a confirmed cancer diagnosis onto active monitoring.
- Confirmation of a non-malignant diagnosis.

In some cases where a cancer clock stops the 18-week RTT clock will continue, e.g., confirmation of a non-malignant diagnosis. For a more detailed breakdown of the cancer rules please read the latest cancer waiting times guidance or the cancer operational policy.

GP/GDP Urgent /Suspected Cancer Referrals

All suspected cancer referrals should be referred by the GP/GDP on the relevant cancer pro forma provided and submitted via the e-referral system.

Day 0 is the date the referral was received.

The first appointment can be either an outpatient appointment (face to face or telephone appointment) with a relevant Healthcare Professional or investigation relevant to the referral, i.e. 'straight to test'.

Downgrading Cancer Referrals

The Provider cannot downgrade urgent/suspected referrals. If the Consultant believes the referral does not meet the criteria for a urgent/suspected referral a member of their clinical team must contact the GP to discuss. If it is decided and agreed the referral does not meet the urgent/suspect criteria, the GP can retract it and refer on a non-urgent/suspected cancer referral pro forma. It is, however, only the GP who can make this decision.

Two Referrals on the Same Day

If two referrals are received on the same day, both referrals are subject to day 28 faster diagnostic standard and, if two primary cancers are diagnosed, treatment for both cancers must start within 62 days of receipt of referral if clinically appropriate.

Screening Pathways

The clock start is the receipt of the referral (day 0) which for the individual screening programmes is as follows:

- Breast: receipt of referral for further assessment (i.e., not back to routine recall).
- Bowel: receipt of referral for an appointment to discuss suitability for colonoscopy with a specialist screening practitioner (SSP).
- Cervical: receipt of referral for an appointment at colposcopy clinic.

Consultant Upgrades

Hospital specialists have the right to ensure that patients who are not referred urgently as suspected cancer referrals or through the screening programmes, but who have symptoms or signs indicating a high suspicion of cancer, are managed on the 62 day pathway. This can be achieved by upgrading the patients onto a 62 day upgrade pathway.

The 62 day pathway starts (day 0) from the date the patient is upgraded. Upgrade must occur before the DTT date. Patients not upgraded at this point will be measured against the 31 day DTT to first definitive treatment.

An upgrade is intended for suspected new primaries only, not those who may be suspected of a recurrence.

Who can upgrade patients onto a 62 day pathway?

The specialist team receiving the referral or reviewing the patient or diagnostic result can delegate the responsibility to upgrade the patient. This could be:

- Specialist nurse/practitioner, either by triaging the referral form/letter or at nurse led initial clinic.
- Specialist registrar either by triaging the referral form/letter or at initial clinic.
- Radiologist/histologist/other Provider Trust Clinicians on reviewing patients and/or diagnostics.

Responsibilities

The Consultant or delegated member of the team upgrading the patient is responsible for informing the multi-disciplinary team (MDT) co-ordinator that an upgrade has occurred, in order for the patient to be tracked on the correct pathway.

Subsequent treatments

The policy should include details on subsequent treatments and the management of earliest clinically available date.

If a patient requires any further treatment following their first definitive treatment for cancer (including after a period of active monitoring) they will be monitored against a 31 day subsequent treatment clock. The clock will start following the patient agreeing a treatment plan with their Clinician. This will be the decision to treat (DTT) date.

In some circumstances it may be appropriate for the Clinician to set an ECAD (earliest clinically available date) which is when a patient needs to recover following their first definitive treatment. An

ECAD can be adjusted but only if the date has not passed. The 31 day clock start date should be the same as the ECAD date for these patients.

Reasonableness

For patients on a cancer pathway, an offer will be deemed to be reasonable if 48 hours' notice of an appointment/diagnostic test/admission is given.

Faecal Immunochemical Testing (FIT) Guidance

Specific guidance around the application of Cancer Waiting Times (CWT) guidance to FIT implementation. In line with existing cancer waiting times practice, Lower GI urgent suspected cancer referrals cannot be rejected by secondary care providers because a FIT result has not been included, or the FIT test result is negative on the referral form.

In these scenarios, providers can avoid patients inappropriately continuing on the Lower GI urgent suspected cancer pathway by contacting the referrer and asking them to agree to withdraw or downgrade the referral. Providers can also remove patients from the LGI FDS pathway through the first seen appointment, this is explained in further detail below. Local Lower GI urgent suspected cancer referral forms should be updated to include information on FIT, and education on the use of FIT in the lower GI pathway provided for primary care to support uptake.

The clock start remains when the urgent suspected cancer referral is received by secondary care. It is therefore recommended all GP practices follow the BSG/ACPGBI guidance² and provide FIT testing for all patients with colorectal symptoms (bar those with anal/rectal mass or anal ulceration) prior to the referral to support appropriate decision making and to make sure for those referred the result is available in time for clinical triage and therefore allows for prompt decision making.

A patient referred on an urgent cancer suspected pathway is required to have a first seen date. In line with the Best Practice Timed Pathway for colorectal cancer, this should be clinical triage appointment with the patient and can be performed virtually/by telephone. This process is normally led by a nurse with oversight from a consultant.

Pauses

There are four adjustments allowed on a cancer pathway, one in the urgent/suspected cancer pathway and three in the 62/31 day pathway:

- **Urgent/suspected cancer:** If a patient misses their initial (first) outpatient appointment or attendance at diagnostic appointment, e.g., endoscopy, the clock start date can be reset to the date the patient rebooks their appointment (the date the patient agrees the new appointment not the new appointment date). The process for how this happens will be described in the provider Trust's operational SOP.
- **62/31 day pathways:** An adjustment for treatment can be applied if a patient declines a 'reasonable' offer of admission for treatment (for both admitted and non-admitted pathways). For cancer patients under the 31-day or 62-day standard, the adjustment would be the time between the date of the declined appointment (the offered To Come In date) to the point when the patient could make themselves available for an alternative appointment.
- **62/31 day pathways:** An adjustment can be applied if it is deemed clinically essential to treat another medical condition before treatment for cancer can be given, after a decision to treat the cancer has been made. In such cases the adjustment would apply from the point at which it is confirmed that a patient needs treatment for the other medical condition, to the point at which after receiving treatment for this condition the patient is deemed clinically fit to commence their cancer treatment.

- 62/31 day pathways: Where a patient opts for egg harvesting prior to their cancer treatment, an adjustment can be applied from the point at which the decision is made until eggs are harvested. An adjustment cannot be applied for the period of time taken for the patient to wait to be seen by the egg harvesting service, only from the point at which the patient is seen by the service and agrees to egg harvesting to the point where harvesting takes place.

Any pause must be supported by clear documentation in the cancer management system and PAS or other relevant clinical system. The Trust will ensure that admission dates offered to the patient will be recorded.

Patient Cancellations

If the patient gives any prior notice that they cannot attend their appointment (even if this is on the day of clinic), this should be recorded as a cancellation and not a Missed Appointment. The Provider Trust will make every effort to reschedule patient appointments at the convenience of the patient. If a patient cancels an appointment the following guidance must be followed.

First appointment cancellations

Urgent/suspected referral patients who cancel their first appointment should be offered another appointment for as soon as possible to allow for the diagnosis/outcome to be achieved within 28 days from the referral being received.

Subsequent cancellations

Patients who cancel an appointment/investigation date should be offered an alternative date within seven days of the cancelled appointment (no waiting time adjustment will apply).

Multiple cancellations

All patients who are referred on a 62 day GP pathway, screening pathway or breast symptomatic referral who cancel two consecutive appointments (i.e. outpatient, diagnostic investigation) will be contacted by an appropriate member of staff to identify any factors that may be stopping the patient attending. Another appointment will be offered if the patient agrees.

Patients can be discharged after multiple appointment cancellations (two or more) if this has been agreed with the patient. However, where a patient has cancelled multiple appointments on a 62 day GP pathway, screening pathway or breast symptomatic referral (i.e. outpatient, diagnostic investigation), an appropriate member of staff will contact the patient to identify any factors that may be stopping the patient attending and another appointment will be offered if the patient agrees.

Patient Missed Appointments (MA's)

Patients will be recorded as an MA if they do not turn up to a clinic or diagnostic appointment, turn up late or turn up in a condition where the Provider cannot carry out whatever was planned for them: for example, if they have not taken a preparation they needed to take before the appointment. (This also includes patients who have not complied with appropriate instructions prior to an investigation.)

First appointment

All patients referred as urgent /suspected cancer including 28 day diagnosis, screening, upgrade and breast symptomatic who miss their first outpatient appointment should be offered an alternative date within 14 days of the missed appointment.

A waiting-time adjustment applies from receipt of referral to the date the patient makes contact to rearrange the appointment and all details must be recorded on the cancer management system.

If a patient misses their first appointment for a second time they will be discharged back to the referring GP.

Subsequent appointments

If a patient misses any subsequent appointment, they should be escalated to the Consultant in clinic for a decision on the next step which may include discharge back to the GP.

Patients who are not contactable

If the patient is not contactable at any time on their 62/31 day pathway, a record of the time and date of the call to them in the 'additional information' section on PAS should be made at the time of the call.

Two further attempts will be made to contact the patient by phone, one of which must be after 5.00pm.

Each of these calls must be recorded in real time on the PAS. These attempted contacts must be made over a maximum two-day period.

If contact cannot be made by such routes, the GP surgery must be contacted to ask for alternative contact routes.

If the patient remains not contactable:

- For first appointments: An appointment will be sent to the patient offering an appointment stating that the Provider Trust has attempted to offer a choice of appointment, and that the patient should contact the urgent/suspected cancer appointments team office to rearrange the appointment if it is inconvenient
- Appointments (other than first) on 62/31 day clinical pathway: Attempts to contact patient will be made as outlined above. If contact cannot be made, the Consultant should decide:
 - > to send a 'no choice' appointment by letter
 - > to discharge the patient back to the GP.

Patients who are unavailable

If a patient indicates they will be unavailable for 28 days or more on their pathway after their first appointment, the patient's healthcare records will be reviewed by the managing Clinician to ascertain if the delay is safe for the patient. If the Clinician has any concern over the delay they will contact the patient to discuss if they can make themselves available. Patients will not be discharged if they make themselves unavailable.

Diagnostics

Refusal of a diagnostic test

If a patient refuses a diagnostic test, the refusal will be escalated to the managing Clinician to discuss with the patient. If the patient refuses all diagnostic tests, they will be removed from the cancer pathway and discharged back to their GP.

Managing the Transfer of Private Patients

If a patient decides themselves to have any appointment in a private setting, they will remove themselves from the cancer pathway.

If a patient transfers from a private provider onto an NHS waiting list, they will need to be upgraded if they have not made a DTT and the Consultant wants them to be managed against the 62 day target. If a DTT has been made in a private setting the 31 day clock will start on the day the referral was received by the Trust.

Tertiary Referrals

Inter provider transfer (IPT) forms will be used for all outbound referrals for patients on a cancer pathway. Where possible, information will be transferred between Trusts electronically. Transfers will be completed via a named NHS contact. A minimum dataset and all relevant diagnostic test results and images will be provided when the patient is referred.

Entering Patients on the Tracking Pathway

Urgent / Suspected cancers: GP/GDP referrals

On receipt of an urgent/suspected cancer from a GP/general or dental practitioner, the urgent/suspected cancer appointments team will record the referral (including known adjustments, referring symptoms and first appointment) onto the cancer management system. The urgent/suspected cancer booking team are responsible for booking a patient's first appointment and making sure that any missed appointments/breach reasons are entered correctly prior to validation by the Cancer Performance Manager.

Suspected cancers: screening patients

The Cancer Pathway co-ordinator team will be responsible for entering patients referred via the screening programme onto the cancer management system database, except bowel screening where it's the responsibility of the bowel screening admin team to enter these referrals on the cancer management system.

Suspected cancers: Consultant upgrades

For upgrade before initial appointments the urgent/suspected cancer appointments team will be responsible for entering patient details onto the cancer management system database and allocating the patient an appointment within the guidelines.

For upgrades at any other point of the pathway the MDT co-ordinator will be responsible for updating the cancer management system and will begin tracking of the pathway.

Suspected/confirmed cancers (31 day patients)

Patients not referred via a urgent/suspected cancer screening/Consultant upgrade referral should not be entered onto the cancer management system until they have a confirmed cancer diagnosis. The only exception is patients with suspected cancer who are being discussed at an MDT meeting. Once a patient has been diagnosed with either a new cancer or recurrence, a record should be entered in the cancer management system, selecting the appropriate cancer status (by the Cancer Pathway co-ordinator) ~~within 24 hours of being notified.~~

Confirmed cancers

The Cancer Pathway co-ordinator is responsible for ensuring a patient with a newly diagnosed cancer has a record entered on the cancer management system, and keeping that record updated.

Monitoring and Auditing

It is the responsibility of the cancer information team to run a weekly programme of audits for data completeness and data anomalies.

Any data anomalies are highlighted to the relevant tumour site Cancer Pathway co-ordinator for investigations and correction. Response to the cancer information team must occur within 24 working hours of the anomaly being raised in order not to delay the audit programme and to ensure accurate performance available at all times.

4. Reference Information

Glossary Terms

Term	Definition
31 day pathway	The starting point for 31 day standard is the date a patient agrees a plan for their treatment or the date that an earliest clinically appropriate date (ECAD) is effected for subsequent treatments.
62 day pathway	Any patient referred by a GP with a suspected cancer on a 2WW referral pro-forma, referral from a screening service, a referral from any healthcare professional if for breast symptoms or where a routine referral has been upgraded by a hospital Clinician, must begin treatment within 62 days from receipt of referral.
Active monitoring	Where a clinical decision is made to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures.
Active waiting list	The list of elective patients who are fit, ready and able to be seen or treated at that point in time. Applicable to any stage of the RTT pathway where patients are waiting for hospital resource reasons.
Bilateral procedures	Where a procedure is required on both the right and left sides of the body.
Breach	A pathway which ends when a patient is seen/receives their first treatment outside the 14-day first seen, 62 day referral to treatment and/or 31 day decision to treat to treatment target times.
Chronological booking	Refers to the process of booking patients for appointments, diagnostic procedures and admission in date order of their clock start date.
Consultant led service	A service where a consultant retains overall responsibility for the care of the patient. Patients may be seen in nurse led clinics which come under the umbrella of consultant led services.
Day case	Patients who require admission to the hospital for treatment and will need the use of a bed but who are not intended to stay in hospital overnight.
Decision to admit	Where a clinical decision is made to admit the patient for either day case or inpatient treatment.
Direct access	Where GPs refer patients to hospital for diagnostic tests only. These patients will not be on an open RTT pathway.
Elective care	Any pre-scheduled care which doesn't come under the scope of emergency care.
First definitive treatment	An intervention intended to manage a patient's disease, condition or injury and avoid further intervention. What constitutes first definitive treatment is a matter of clinical judgement in consultation with the patient.

Term	Definition
Fixed appointments	Where an appointment or admission date is sent in the post to the patient without the opportunity to agree a date.
Full booking	Where an appointment or admission date is agreed either with the patient at the time of the decision or within 24 hours of the decision.
Incomplete pathways	Patients who are waiting for treatment on an open RTT pathway, either at the non-admitted or admitted stage.
Inpatients	Patients who require admission to the hospital for treatment and are intended to remain in hospital for at least one night
Nullified	Where the RTT clock is discounted from any reporting of RTT performance.
Oncology	The branch of science that deals with tumours and cancers.
Partial booking	Where an appointment or admission date is agreed with the patient near to the time it is due.
Patient-initiated delay	Where the patient cancels, declines offers or does not attend appointments or admission. This in itself does not the stop the RTT clock. A clinical review must always take place.
Planned waiting list	Patients who are to be admitted as part of a planned sequence of treatment or where they clinically have to wait for treatment or investigation at a specific time. Patients on planned lists should be booked in for an appointment at the clinically appropriate time. They are not counted as part of the active waiting list or are on an 18-week RTT pathway.
Reasonable offers	A choice of two appointment or admission dates with three weeks' notice.
Straight to test	Arrangements where patients can be referred straight for diagnostics as the first appointment as part of an RTT pathway.

Acronyms & Abbreviations

Term	Definition
ASIs	Appointment slot issues (list): a list of patients who have attempted to book their appointment through the national E-Referral Service but have been unable to due to lack of clinic slots.
Cancer Management System	A database system used to record all information related to patient cancer pathway by MDT co-ordinators, CNSs and Clinicians.
Cancer Pathway co-ordinator	Person responsible for tracking patients, liaising with clinical and clinical assessment unit staff to ensure progress on the cancer pathway, attending the weekly patient tracking list (PTL) meeting, updating the trust database for cancer pathway patients and assisting with pathway reviews and changes. Co-ordinates the MDT meeting and records the decision for progress along the cancer pathway.
Cancer PTL	Patient tracking list: a complex spread sheet used to ensure that cancer waiting times standards are met by identifying all patients on 62 day pathways and tracking their progress towards the 62 or 31 day standards.
CNS	Clinical nurse specialists: use their knowledge of cancer and treatment to co-ordinate the patients care plan and act as the patient's 'keyworker'.
COF	Clinic outcome form.
COSD	Cancer outcomes and services dataset: the key dataset designed to define and deliver consistency in data recording, data submission and analysis across cancer in the NHS, including diagnostics, staging, treatment and demographic information. Data is submitted to the cancer registry and used for national reporting.
MA	Missed appointment, did not attend: patients who give no prior notice of their non- attendance.
DTT	Decision to treat (date): the date on which the Clinician communicates the treatment options to the patient and the patient agrees to a treatment.
ECAD	Earliest clinically appropriate date that it is clinically appropriate for an activity to take place. ECAD is only applicable to subsequent treatments.
e-RS	(National) e-Referral Service.
GDP	General dental practitioner (GDP): typically leads a team of dental care professionals (DCPs) and treats a wide range of patients, from children to the elderly.
GP	General practitioner: a physician whose practice consists of providing on-going care covering a variety of medical problems in patients of all ages, often including referral to appropriate specialists.

Term	Definition
ICS	Integrated Care System; collaborative partnership working involving providers, commissioners, local authorities, the voluntary & care sector and other local partners as one system to plan health and care services that meet the needs of their local population.
IOG	Improving outcomes guidance : NICE guidance on the configuration of cancer services.
IPT	Inter-provider transfer.
MDT meeting	A multidisciplinary team meeting where individual patients care plans are discussed and agreed.
MDS	Minimum dataset: minimum information required to be able to process a referral into the cancer pathway or for referral out to other Trusts.
MDT	Multidisciplinary team: here describing a group of doctors and other health professionals with expertise in a specific cancer, who together discuss and manage an individual patient's care.
NCWTDB	National cancer waiting time's database: all cancer waiting times general standards are monitored through this.
NHS STW	NHS Shropshire, Telford and Wrekin: accountable for the commissioning of local services and acute care, allocation of NHS budget and produces a five-year system plan for local health services.
PAS	Patient administration system records the patients' demographics (e.g. name, home address, date of birth etc.) and details all patient contact with the hospital, both outpatient and inpatient.
PbR	Payment by Results (PbR) is a system of paying NHS healthcare providers a standard national price or tariff for each patient seen or treated.
PPID	Patient pathway identifier.
PTL	Patient tracking list. A tool used for monitoring, scheduling and reporting on patients on elective pathways (covering both RTT and cancer).
RACPC	Rapid access chest pain clinic.
RCA	Root cause analysis: defines steps on a patient's pathway and identifies breach reasons. In the context of this policy, this is not the same as the level of investigation involved in an RCA for, for example, a Serious Incident (SI).
RMC	Referral management centre.
RTT	Referral to treatment.
SMDT	Specialist multidisciplinary team meeting: where individual patients' care plans are discussed and agreed; takes place across multiple organisations and involves support from a centre specialising in treating a particular tumour type.

Term	Definition
TCI	To come in (date). The date of admission for an elective surgical procedure or operation.
TIA	Transient ischaemic attack: a mini stroke caused by a temporary disruption in the blood supply to part of the brain.
TSSG	Tumour site specific group.
UBRN	Unique booking reference number.

Links to Recommended Further Reading

Click on the title of the publication to view the document.

Title	Published by	Publication date
Referral to treatment Consultant led waiting times Rules Suite.	Department of Health	October 2015
Recording and reporting referral to treatment (RTT) waiting times for consultant led elective care.	NHS England	October 2015
Recording and reporting referral to treatment (RTT) waiting times for consultant led elective care: frequently asked questions.	NHS England	October 2015
The NHS Constitution.	Department of Health	July 2015
Diagnostics waiting times and activity Guidance on completing the 'diagnostic waiting times & activity' monthly data collection.	NHS England	March 2015
Diagnostics FAQs Frequently Asked Questions on completing the 'Diagnostic Waiting Times and Activity' monthly data collection.	NHS England	February 2015
Equality Act 2010.	Department of Health	June 2015
Overseas Visitor Guidance.	Department of Health	December 2018
Cancer waiting times.	Department of Health	October 2015
Delivering cancer waiting times good practice guide.	NHS Improvement	July 2016
Armed Forces Covenant.	Ministry of Defence	July 2015
Value Based Commissioning Policies.	NHS Shropshire, Telford and Wrekin	February 2022
NHS England Patient Choice Guidance	NHS England	December 2023

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The Shropshire Community Health NHS Trust

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<https://www.shropscommunityhealth.nhs.uk/>

Welsh Patient RTT Rules & Standards

Version Control		Issued
Version 1.1		December 2009
Version 2.1	Andrew Sallows / James Ross / Martyn Rees	September 2011
Version 3	Lesley Law, Martyn Rees, Andrew Jones, Phil Barry with feedback from Paul Rothwell and Sandra Mc Connell	Draft Feb 2017
Version 4	Feedback from all HBs except Powys	March 2017 for final comment
Version 5	Final version for phased implementation from April 2017	3 rd April 2017
Version 6	Revised final version following feedback from Q1 phased implementation	July 2017

Revisions from version 5

Page 8	(20)	Highlight link to section on availability
Page 9	(21)	Example of planned sequence treatment
Page 9	(23)	No adjustments for diagnostics for cardiac pathway
Page 9	patient	Complete sentence, "where they are sending your referral to"
Page 12	(33)	Inclusion of word national in relation to guidelines
Page 12	(34)	"should" changed to must
Page 15	(44)	comment related to NHS process
Page 16	(47)	link to reasonable offer indicated
Page 16	(48)	link to section on direct and partial booking
Page 19	(63)	Minimum of two offers (flexibility of offering more)
Page 19	(64)	Link to rules on availability
Page 19	(67)	"Adjustment" rather than "reset" (also explained how)
Page 21	(76)	Explains when a new clock may commence
Page 21	(77)	Inclusion of "No adjustment to the waiting"
Page 21	(78)	Cardiac rules need to include all diagnostics part of pathway
Page 23	(88)	Different for cardiac pathway
Page 23	(92)	Different for cardiac pathway
Page 30	(127)	Part of contract with NHS English providers

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Patient perspective

The aim of the NHS will be for you to wait the shortest time possible inline with your clinical need.

The target is to start treatment within 26 weeks of receipt of your referral for 95% of patients with a maximum of 36 weeks for all patients

You should be fully informed as part of the referral process, through discussion and if required a patient leaflet will be given: This should inform you of what is expected of you along the referral to treatment (RTT) pathway.

When you are referred you are giving your consent to be contacted to attend for a medical review and or medical test which will start your pathway in hospital services.

You need to ensure the GP and the hospital services have your updated and correct contact details.

To support you a number of HBs are now offering reminder systems for your appointments, so ensuring the GP and hospital have your mobile number will support this.

Your details are safe and all confidentiality procedures are followed with these systems. However if you do not wish to be contacted via your mobile please state this.

Overview

Document summary

1. This document provides a complete reference source of the waiting times management rules relating to the 26 week referral to treatment (RTT) target and the direct access diagnostic and therapies targets. For RTT it is noted that some complex cases may take longer than this and a maximum of 36 weeks has been set to reflect this.

Target development – 26 week RTT target

2. In March 2005, the First Minister and Minister for Health and Social Services announced that, by December 2009, no patient in Wales will wait more than 26 weeks from GP referral to treatment, including waiting times for any diagnostic tests or therapies required. *Designed for Life* (Welsh Government, 2005) subsequently set out a vision of a service designed around patients, with a 10-year programme to transform the system and create a world-class health and social care service for the people of Wales.
3. The guiding principles of the target were set in policy through a range of Welsh Health Circulars. (appendix C)
4. The achievement of the 26 week RTT target is the responsibility of health boards (HBs).
5. The underlying principle of the target is that patients should receive excellent care without delay. For other than complex clinical reasons and should start their required treatment no later than 26 weeks from referral, with a maximum of 36 weeks to allow for clinically complex cases.
6. Within this waiting time period, both the patient and the NHS have their roles and responsibilities to achieve this target.
7. This document aims to set out clearly and succinctly the rules to ensure that each patient's RTT period begins and ends fairly and consistently. It clearly highlights both the patient and NHS roles and responsibilities and the potential consequences if this mutual contract is not fully met.

Patient perspective

The clinician who reviews your referral request will make a decision on your clinical need based on the information in your referral.

After your referral is assessed the hospital will notify you that they have received your referral. In this letter/phone/text they will give you an indication on the length of time you will wait to be seen for your review/tests.

You will be actively involved in agreeing your appointments. Once you have agreed your appointment you need to make every effort to attend.

There may be times when for some reason it may not be possible to attend the agreed date or time. If so, you need to inform the hospital as soon as you know, to arrange a new date. Your waiting time will be reset to reflect the time lost due to the change, but you will remain on the waiting list.

It is important that you try to keep your agreed appointment dates. If you require more than one change along the pathway, your referral may be sent back to your referrer and your waiting time will be stopped.

Guiding principles

This guidance is to ensure that the period patients wait for elective (planned) care are measured and reported in a consistent and fair manner. The guiding principles of the referral to treatment target clearly reflect the Prudent Health principles:

8. There are a number of key principles which underpin the waiting times rules, and apply to all targets. These principles apply to all interactions with patients, and must be considered in the formation of all waiting times and access policies and procedures.

Do only what is needed and do no harm

9. All patients should wait the shortest possible time for treatment.

Care for those with the greatest health need first

10. The target should not distort clinical priorities. RTT targets are maximum acceptable waits, and urgent patients should be treated as their clinical need dictates.

Public and Professionals are equal partners through co-production

11. The concept of a NHS/patient 'compact' around the delivery of waiting times is implicit and reflected in the definitions below. Both parties have rights and responsibilities within the arrangement. HBs will be required to deliver high quality care within the target time, and to allow for patient choices within that time. Patients will be expected to make themselves available for treatment within reasonable timescales and at sites and times where the service is delivered, sometimes outside of the HB area. Their inability to do so may result in a longer waiting time.
12. It is important that the rights and responsibilities of the patient are explained to them at the time of referral, either directly, through written resources or being signposted to electronic resources (websites). This requires commitment from referrers and appropriate information resources for patients and healthcare staff. Patients have a duty to notify the NHS, hospital and GP of any changes in circumstances while they are waiting to be seen at any stage.

Patient perspective

If you do not turn up or do not notify the hospital until after the appointment, you may be referred back to your GP and your pathway will stopped.

While waiting you are encouraged to follow the advice of your GP at all times.

You should try to keep yourself well and comply with any medication that you have been prescribed.

You may find it useful to join a local support group or seek advice on what you may do while you wait. Your GP should have information on what is available within your local area.

13. Within the information given to the public, it must give them adequate information on the expected timescales, the anticipated process and their responsibilities to assist the NHS to provide efficient and effective treatment of their condition. Patients will be empowered through this information to question and monitor their own progress against the target.

14. Patients should be encouraged to become involved in all decisions relating to their care. This should include potential treatment options and administrative arrangements. All appointments within an RTT period must be arranged under the rules relating to reasonable offer, and therefore be mutually agreed between the patient and the organisation. When a patient is removed from a pathway for reasons other than treatment, both the patient and referrer must be fully informed of the reasons behind this decision and any requirements for reinstatement.

Reduce inappropriate variation through evidenced based approaches.

15. The rules have been written to be robust and clear. HBs will be expected to maintain appropriate governance structures to ensure that where there is flexibility within the rules, the spirit of the targets is achieved. All patient management methodologies should be transparent and guided by the principle that patients should wait the shortest time possible for treatment. There is provision for local variations to these rules where these are directly in the patient's best interest. This national guidance needs to be supported by local access policies for each HB.

Patient perspective

When your referral letter is received by a hospital site your waiting time begins. This is sometimes known as the start of your waiting time clock.

You should receive confirmation from the hospital informing you that your referral has been received and accepted. This should also provide you with current approximate waiting times for the speciality you have been referred into. These details are also sent to your GP practice. This should help you know how long you will wait for your initial appointment.

The communication letter, text, phone with the information leaflet and/or hospital website should provide you with information on what to do if you have any questions about your waiting time and/or referral.

Scope of the targets

26 week RTT target

16. The scope of the 26 week RTT target encompasses elective treatment for all Welsh residents, whether treated in Wales or elsewhere. The target covers patients who are referred by a healthcare professional to a consultant in secondary or tertiary care, including consultants who work in the community.

17. The 26 week RTT target does not replace the following waiting times targets:

- Cancer target (31 and 62 days)(see specific cancer document April 2017)
- Fitting of adult hearing aids (direct access) (14 week waiting time target)
- Diagnostic tests (non-RTT) (8 week waiting time operational target appendix A for list)
- Therapy services (non-RTT) (14 week waiting time operational target appendix B for list)

Each of the above targets should be managed according to their own specific rules, where these exist.

18. The RTT period begins on the receipt of a referral in secondary or tertiary care and ends when treatment commences. Treatment will often continue beyond a first treatment and after a clock has stopped.

19. A referral received from a screening service will begin a new RTT period.

20. A self-referral or patient-initiated follow-up will not begin an RTT period unless it follows a period of unavailability, (see section on availability page 26). If a new decision to treat or change of management plan is subsequently initiated, a new RTT period will begin.

Patient perspective

For some services such as orthopaedics specific services in the community have been set up. Your referral may first be seen by this service where an assessment /or treatment from another professional may be deemed appropriate for your care. Your GP should inform you where he is sending your referral to.

The waiting time target includes the time from the receipt of your referral into secondary care to the start of any required treatment for your clinical need.

In some cases starting treatment may only be one stage in a longer pathway.

Your secondary care treatment pathway will be based on your clinical need.

Along with your health professional (doctor, dentist, nurse or therapists) you should play an active role in discussion and decisions at each stage of your pathway.

You should ensure that you clearly understand the next stage of your pathway after each meeting/discussion so that you can monitor your own pathway.

21. Some patients may be measured on more than one RTT period during the management of their condition in secondary or tertiary care. This will include patients who have a planned sequence treatment. (e.g. such as a second hip or knee procedure after the original decision of bi-lateral replacement)

22. Events other than treatment which can end an RTT period may include:

- A decision made not to treat a patient
- Commencement of active monitoring (Watch and wait)
- A consultant to consultant referral (other than from cardiology to cardiac intervention/surgery)

Further details of clock start and stop points are available later in this document.

23. Only specified diagnostic and therapy services are included in the 26 week RTT target. Appendices A and B detail the diagnostic tests and therapy services that are included. An adjustment may be made for time spent waiting for excluded diagnostics or therapies where the requirement for such a test or service precludes treatment commencing. ***(No adjustments should be made for a cardiac pathway inline with the past cardiac pathway management rule)***

24. Patients with a recurrence of cancer, which is not covered by the 31 and 62 day targets, will be covered by the 26 week RTT target but their clinical priority should determine their appropriate clinical wait.

25. For orthodontics and restorative dentistry, the first outpatient appointment will be included in the RTT period. Any subsequent treatment will be outside the 26 week RTT target.

To note: Guidance on CMAT services is being issued by the planned care programme July 2017.

Patient perspective

Not all pathways and treatments are covered in the 26 week access target.

However the principle of waiting the shortest time possible regardless of your pathway remains the golden rule.

If you have not heard from the hospital that you referral has been excepted or you have not heard about your booking in the timeline you have been told to expect, you can phone the hospital/area to ask for an update about the expected waiting times.

26. The table below gives some specific services which are included within the scope of the 26 week RTT target. These are services for which clarification has been requested during the development of these rules. This list is not exhaustive.

Included in the scope of the 26 week RTT target	
Included service area/ patient group	Notes
Recurrence of cancer	Any recurrence not covered by the 31 and 62 day cancer targets.
Fertility treatment	Treatment at level 1 and level 2 only (covered under www.wales.nhs.uk/sites3/docpen.cfm?orgin=898&id=176655).
Clinical genetics	New conditions identified as a result of a genetic test.
Military personnel	Included to the extent that HBs are responsible for their care. The target does not apply to MOD-commissioned care unless stated in agreements with HB. Waiting times for military personnel are subject to the provision in the letter from Director of Operations to Directors of Planning – July 2011
Prisoners	Prisoners should be treated within the same waiting time target as all other NHS patients. It is accepted that in some cases there will be circumstances unique to this population which may make achieving the 26 weeks RTT target particularly challenging. The detailed reasons why these patients exceeded the target time should be recorded in the breach analysis.
Private Patients	<p>A patient cannot be both a private and a NHS patient for the treatment of one condition during a single visit to a NHS organisation.</p> <p>Any patient seen privately is entitled to subsequently change his or her status and seek treatment as a NHS patient.</p> <p>Any patient changing their status after having been provided with private services should not receive an unfair advantage over other patients. (Jump the queue)</p> <p>Patients referred for a NHS service following a private consultation or private treatment should join any NHS waiting list at the same point as if the prior consultation or treatment were a NHS service.</p> <p>Their priority on the waiting list should be determined by the same criteria applied to other referrals.</p> <p>The entry on to the appropriate stage commences a new 26 week clock start.</p> <p>If treatment has already commenced within the private sector, then a referral from private to NHS would not start a new RTT clock but be recorded as ongoing follow-up care. Only if there is a significant planned change in treatment would a new RTT clock commence.</p>

Patient perspective

Due to the specialist nature of some pathways they may not be included in the 26 week target.

You should be informed of the expected waiting times and as previously stated the golden rule is that your clinical priority will be the key driver and you should wait the shortest time possible.

26 week RTT target exclusions

27. The table below gives some specific services which are excluded from the scope of the 26 week RTT target. These are services for which clarification has been requested during the development of these rules. This list is not exhaustive.

Excluded from the scope of the 26 week RTT target	
Excluded service area/ patient group	Notes
Emergency care episodes	Any emergency care episode. Further information on the management of referrals arising from an emergency care episode is available within this document.
Mental health services	All mental health services including Child and Adolescent Mental Health Services.
Palliative care	Including hospice care.
Cochlea implants	Where the treatment intervention is the specific provision of cochlea implants.
Screening services	A decision to refer from a screening service would begin a new RTT period.
Community paediatrics	A decision to refer from community paediatrics would begin a new RTT period.
Routine dialysis treatment	A decision to refer following a dialysis session would begin a new RTT period.
Obstetrics	A decision to refer from obstetrics for a nonobstetric condition would begin a new RTT period.
Fertility treatment	Specialist level 3 fertility treatment is subject to policy approved maintenance of a maximum 18 month waiting time.
Undergraduate dental education	Primary dental care carried out in a secondary or tertiary care setting solely for the purpose of supporting undergraduate dental education is excluded.
Transplant and clinical trials	Once a treatment option is agreed for entry onto a Transplant list or clinical trial, the RTT clock will stop. The wait for these services are outside the RTT rules.

Patient perspective

The clinician referring your details for review will send it to the speciality area which they deem most appropriate for your need.

They should only specifically refer to a named

consultant/medical professional where:

1. they are the only clinician with the recognised skills to deal with your clinical needs **or**
2. you have recently been under the clinician for the same/similar condition.

It is the medical professional who receives and reviews your referral who will make a clinical judgement on your clinical priority to be seen. They will then inform the appointment booking services of this to agree when you will be booked for your appointment.

It is important that all your relevant details are correct and up to date such as:
contact information;
special communication needs; If you are ex military personnel, as for some conditions you may be prioritised.

Clinical responsibilities

The responsibilities of clinical staff in monitoring waiting times

28. Waiting times for patients are one of the indicators of quality of service.

Clinicians should make themselves aware of the current waiting times applying to their service, and work with HBs to instigate action when those waiting times are not meeting the expected level of quality of care.

29. Clinical staff must be aware of national requirements and organisational policies in respect of waiting times. As part of this awareness, they should be actively aware of their own current waiting times and use this to discuss options and potential waits for their patients along their pathway.

30. Clinicians should ensure that their actions promote the principle of patients waiting the shortest possible time for treatment.

31. Clinicians should also ensure that patients are fit to proceed with the most appropriate treatment. If they are not fit this should be discussed with the patient to understand their options.

32. Referrers must use prudent healthcare principles to ensure the most efficient and patient-centred approach to referral that reduces the steps needed to reach treatment.

33. Clinicians should make decisions in a timely manner, and that any onward referrals are completed promptly, according to local/national guidelines, and include adequate information to allow the receiving clinician to initiate appropriate interventions with the minimum of delay. Referrers must ensure that the patient is aware and is in agreement for a referral to be made.

34. Clinicians must cooperate with agreed local systems to enable the recording of the clinical outcome of all interactions with patients, whether face-to-face or by phone or letter.

35. Clinicians in secondary and tertiary care must ensure that all decisions relating to a patient's care or treatment are communicated to the patient

and their primary care clinician in a timely manner, whether those decisions are made in the presence of the patient or not.

36. Clinicians must ensure that the clinical intention of any intervention such as tests or treatment is clear to patients, and whether it is just a stage of the agreed pathway or considered start of definitive treatment and as such ends the pathway clock.

Patient perspective

You should discuss with your GP/ dentist/ optometrist (the professional referring you) the reason for the referral and the potential options.

On agreeing to be referred you are starting a pathway of care which will use valuable NHS resources. At any time while you are waiting and you feel that you no longer want to be referred, you must let your GP and hospital know so that your pathway can be stopped.

As part of the referral you may be asked for some additional information by either your GP or the hospital which may be required to ensure you are seen by the most appropriate person in the quickest time.

Referrals

37. The RTT period begins at referral by a GP or GDP to a consultant in secondary or tertiary care, and by any other healthcare professional where referral protocols exist. The clock will start on the date that the organisation receives the referral.
38. Referrers must use the most efficient and patient-centred approach to referral that reduces the steps needed to reach treatment, based on prudent healthcare principles. As part of the referral information, referrers should include verified up to date patient contact details including mobile phone numbers and email addresses where available. Referrers should seek the consent of the patient to be contacted by the HB by such means as text, email or telephone and indicate if consent is given for this, and this should be included within the referral information. HBs must ensure that patients are seen by the most appropriate individual once the referral has been received and accepted.
39. HBs should provide up to date information to referrers relating to the patient pathway that will be followed, the likely waiting time and the locations the service will be delivered from, in order that this can be communicated clearly to the patient. Discussion should also be supported by written information for patients either provided during consultation or by signposting where they can get additional information. HBs should have systems in place to keep this information up to date and available to referrers.
40. If a referral is made for a procedure which is not offered by the HB, it should be returned to the referrer with a full explanation and no clock will be started.
41. When a referral is made to a clinician or specialty which does not treat this condition, but is treated by the HB, the HB has the responsibility to direct the referral to the correct clinician / clinical team and the clock does not stop.
42. When the HB directs a referral in error to a clinician who does not treat this condition, an onward referral to the appropriate clinician will not stop

the clock. The patient must be seen by the new consultant within the same RTT period.

43. When a referral does not comply with agreed referral guidelines the referral should not start until the referrer confirms full compliance and appropriateness of the referral is confirmed. This may include specific questionnaires to support prioritisation. HBs should work with primary care to turn such referrals around within 48hrs.
44. If the referral has insufficient information to enable a clinical decision to be made, it should be returned to the referrer for completion with guidance on what is required. The RTT period will continue whilst the information is obtained as the delay is not related to a patient's breach of the shared contract, but due to NHS process.
45. HBs need to work with primary care to ensure good quality information flows between the two areas to support effective patient care.

Patient perspective

The role of the hospital is to offer you an appointment within the clinical timelines requested by your consultant and where possible within the national waiting times.

While effort will be made to make it as close to your home as possible, depending on the speciality and the waiting times, the quickest appointment may be at another site.

You will be offered an appointment that is the best fit for your requirements; however you will have an opportunity to change it if it is not suitable when offered.

Once you have agreed the appointment any subsequent changes required by yourself could result in a longer wait or even a return of your care to your GP, if you do not attend an appointment without warning.

How your appointment will be booked will be highlighted in the acceptance letter/phone call/text. Your full participation in the agreed process will be needed or your waiting time may be affected.

Booking and reasonable offer

Booking processes

46. All patient appointments should be booked using a patient-focused booking approach. The booking processes used by HBs needs to be clearly communicated to patients at referral to ensure patients are clear on their role in the local process. All appointments should be made with the involvement of the patient and their role to make any changes clear around how the appointment will be mutually agreed. This must be adhered to, even when the organisation does not hold complete contact details for the patient.
47. No organisation should be seeking periods of unavailability in order to meet targets. The focus of the booking interaction should be on achieving a mutually agreeable date, and not on simply offering just two appointments (*see more detail on reasonable offer page 18*).
48. Where a fully automated model is utilised and the HB sends the patient a letter/text/call offering a date the HB should have a process in place to allow the patient to play an active role in changing the appointment if it is not mutually agreeable. Patients need to be clear about their role in agreeing dates in keeping with principles of co-production. This process needs to be clearly explained to the patients when they are referred. Whenever possible, organisations should ensure that patients are treated in turn, allowing for considerations of clinical priority (*see section on direct and partial booking page 17*).
49. If a patient is to be seen within six weeks a direct booking system should be used. If the appointment is going to be more than six weeks in the future, confirmation of the acceptance of the referral is needed either by letter, text or phone.
50. Each attempt to contact the patient under the booking processes must be recorded and available for subsequent audit.

Patient perspective

Often the hospital may want to contact you by phone to a land line or a mobile. Please ensure that your details are the most up to date on your GP and hospital system.

If you have problems with being contacted by text and or phone, please let this be known to both your GP and hospital.

Direct booking

51. Direct booking can take place in two ways. An appointment can either be booked in a face-to-face interaction with the patient or through a direct dialogue with the patient, letter/email and or text.
52. Under the direct booking process, if the appointment is being made by telephone the HB should make at least two attempts to contact the patient. These telephone calls must take place on different days, and at least one must be outside normal working hours (Monday -Friday 95pm). If contact with the patient has not been achieved, a letter must be sent to the patient, asking them to phone and make an appointment or confirm attendance. If the patient has not responded to the reminder letter within two weeks from the date the letter was sent, and a minimum of four weeks after the first attempted contact, the patient should be removed from the waiting list and the patient and referrer notified.

Partial booking (two stage process)

53. Under the partial booking process, an acknowledgement must be sent to the patient when the referral is received and accepted. This should explain the booking process that will be used for their appointment. A letter should then be sent to the patient four weeks before it is anticipated they will be seen, asking them to phone and make an appointment within the next 10 days (phone letter).
54. If the patient has not responded to the phone letter within two weeks, a reminder letter or alternative contact (email text etc.) should be sent requesting contact within a further two weeks and informing the patient failure to do so will result in them being removed from the waiting list.
55. If the local booking process is to send a proposed appointment date in the second letter, (after the acknowledgement letter from referral), the patient should be clearly directed on their options and timeline (two weeks) to change this appointment. After this date, the appointment will be deemed as mutually agreed as long as the date was sent within three weeks of the date offered. An opportunity to actively confirm the date is required via, phone or text reminder process.

Patient perspective

There are a wide variety of appointments, across lots of specialties and the choice of dates and times for any one speciality may be limited.

Every effort will be made to agree a suitable date with you but flexibility may be required to agree a suitable date and time when the clinic you require is being held.

If you are unavailable to attend an appointment during the period aimed for, an adjustment will be made to your waiting time clock, and this will be explained to you at the time of your booking.

Inability to contact a patient

56. If the patient has not responded to the booking process within four weeks from the date of the first attempted contact, they should be removed from the waiting list and the referrer notified.

Reasonable offer

57. A reasonable offer to a patient is defined as any date mutually agreed between the patient and the organisation. Any subsequent application of waiting times rules based on this offer (e.g. Could Not Attend CAN, Did Not Attend - DNA) may only be applied if the appointment date has been mutually agreed, and is therefore considered to be reasonable.

58. Organisations must ensure that all appointments are mutually agreeable, and that the patient has been offered a choice of dates within the agreed timeframes, if required to get an agreed date.

59. Patients should be offered a number of possible dates and/or times, at least two of which must be more than two weeks in the future. (see rules for reasonableness on the amount of offers under para 63)

60. Patients should be offered appointments at any location, providing the required service preferably at a venue that is nearest to their home. Venues a distance from the patient's home will be considered reasonable if this was explained to the patient when they were referred or in the receipt of referral acknowledgement.

61. All dates offered must be recorded and available for subsequent audit. If the required information is not recorded, it will be considered that no reasonable offer has occurred.

62. An adjustment can be applied where it has not been possible to agree a suitable date within the booking period you were originally planning.

Patient perspective

Patients who have not kept an appointment at any stage along the pathway and have not notified the organisation in advance are identified as 'did not attend' (DNA)

Unless the clinician feels your care will be clinically affected your clock will stop and your care will be referred back to your GP.

If the clinician still wishes to see you, your waiting time will be reset to the date of your DNA'd appointment.

Refusal of a reasonable offer

63. A patient may only be deemed to have refused a reasonable offer when a minimum of two appointments appropriately spaced apart and on alternative dates have been offered and it has not proved possible to agree an appointment. Two appointments may not be possible for some appointments such as agreeing treatment locations, diagnostic test dates of for clinics that run only monthly. Local discretion on reasonable offer on these occasions is appropriate and should be explained to the patient and noted in their records. (*Offering more than two at one time may also be beneficial where it is reasonable to do so*)
64. If the patient declares themselves as unavailable for the time period in which the offers are being made, the social unavailability rules will apply. (see section 105 page 26)
65. If the patient is available during the offer period, but refuses a reasonable offer, the clock will be reset. The new clock start will be the date that the patient refuses the offered appointments.

Could not attend (CNA)

66. A CNA occurs when the patient gives prior notice of their inability to attend a mutually agreed appointment. A patient may give notice up to and including the day but prior to the actual time of the appointment.
67. If a patient CNAs within any stage of the pathway, a new mutually agreed appointment must be made as soon as the patient is available and their clock will be adjusted to reflect the time between the original appointment and the date of the rearranged agreed date, they remain on the pathway. This reset should be communicated to the patient when rebooking the appointment.
68. On the second CNA within the same pathway, the patient should be treated as a DNA as they have broken the "compact" to be reasonably available and as such they are at risk of being removed from the waiting list, and responsibility for ongoing care returns to the referrer.

Appropriate notification of removal must be given to the patient and the referrer.

69. If the consultant responsible for the patient considers that they should not, for clinical reasons, be removed from the pathway following a second CNA, they can remain on the pathway and their clock will be reset.

Did not attend (DNA)

70. If the patient does not attend (DNA) an agreed appointment without giving notice, the patient should be removed from the waiting list and responsibility for ongoing care returns to the referrer. Appropriate notification of removal must be given to the patient and the referrer.

71. If the consultant responsible for the patient considers that they should not, for clinical reasons, be removed from the pathway following a DNA, they remain on the pathway and their clock will be reset.

72. The DNA reset may be applied on a maximum of two occasions in any given RTT pathway. Confirmation of any reset must be communicated verbally and or by letter to the patient and the referrer on future contact. If the patient DNAs for a third time or more, and the consultant responsible feels the patient should remain on the waiting list, the pathway should be stopped and the clinician should write to the referrer and patient seeking clarification that they need to continue on the pathway. Only if this is confirmed by the referrer and the patient will they be reinstated on the waiting list and the clock will be reset to the date of confirmation from the referrer and patient that they wish for the patient to remain on the pathway. They should restart at the most appropriate stage of the pathway based on their clinical need and their past pathway.

Patient perspective

Any decision which affects the clinical management of your care and has been made when you were not present should be documented and shared with you and your GP.

As part of any interaction between you and your clinical team, you should be informed of the next expected step and any potential options.

Any appointment cancellation by the hospital will result in another appointment being made as quickly as possible. Your waiting time will not be adjusted for this change and the clock will continue to count. The hospital needs to make every effort to still meet the clinical and national targets for your needs.

Depending on your pathway and some of your choices the clock may be adjusted. If any of the changes along the pathway are due to the hospital no adjustments should be made.

Attendance outcomes

73. An outcome must be recorded within the information system for every patient interaction, whether the patient is present or not.
74. The outcome will fall into one of three categories: a clock continue, a clock stop, or a new clock start.
75. Health boards need to ensure 100% compliance with outcome coding after any patient interaction, either face to face or virtual, to reduce the need for validation of un-coded activity.

Clock continue outcomes

76. A clock continue outcome is used to define decision points along the pathway where the current clock status will continue. Within a RTT period, the clock continues to tick until a clinical decision to stop is reached. When there is no current RTT period, the previous clock remains stopped. *(A new clock may commence if the clinical need of a patient changes during any ongoing follow-up).*
77. If an appointment is cancelled by the organisation, the clock will continue, and a new appointment must be booked with no adjustment applied.
78. All referrals within an RTT period to diagnostic services, therapy assessments or anaesthetic assessment, will continue the clock. Where the referral is to an excluded diagnostic an adjustment to the waiting time can be applied. (see appendix A and B for tests and therapy services which are included as part of RTT pathway) ***This is not the case for a cardiac pathway all diagnostics should be included in the cardiac waiting time clock.***
79. Where the patient has been informed of service options and the consequences of remaining with a named consultant (and/or hospital site), the organisation can reset the clock to the date the patient informed the organisation about their decision. The patient should be informed of the consequences of their decision either verbally or in

Patient perspective

While a clock start is clear when your referral is received by the hospital, the clock stop can be for several reasons; however you should be actively involved in this process.

The main stop point is when the treatment required for your condition is started, if indeed you need treatment.

Depending on your clinical need the start of treatment can be just that, the start, for others it may be the end of that particular episode of care.

writing. It would be expected that patients should retain their place on the waiting list to acknowledge their previous wait and be treated appropriately when resources are available. Within recorded waiting times, this will be seen as treating out of turn but is reasonable and fair for patients' true waits. This reset may only be applied *once* in any individual patient pathway. The patient must be informed verbally or in writing of the consequences of their decision in terms of their new expected waiting times at the point they make their decision.

80. When a patient's RTT period takes place across more than one organisation, and the consultant responsible for the care of the patient does not change, the clock will continue when the patient is transferred between the organisations. HBs must ensure that communication protocols are utilised so that appropriate information is shared, and RTT periods are measured accurately.
81. When a patient is referred from an NHS organisation to an independent sector organisation as part of their NHS pathway, the clock will continue.

Clock stop outcomes

82. A clock stop outcome is used to define decision points along the pathway where a current RTT period will end.
83. Clock stop outcomes are used for events which constitute a treatment, a decision that no treatment is required or when the patient is unavailable for medical or social reasons longer than they agreed periods.
84. Treatment is defined as a clinical intervention intended at the time of the intervention to manage the patient's condition.
85. When treatment is given in a non-admission setting, the clock will stop on the date the treatment commences.
86. When treatment is to be delivered following an admission, the clock will stop on the date of admission. If the treatment is not carried out during the admission, the clock stop must be retracted and the clock will continue.

87. When a decision is made not to treat at the present time, the clock will stop. This may be either a clinical decision not to treat, including

Patient perspective

For some pathways possible involvement in a clinical trial could be offered by your clinician. This will be offered based on your clinical condition and in discussion with you. You need to consider and discuss this with your clinician.

During your pathway you may be sent for tests or therapy treatments, these may be seen as possible treatment options and seen as a clock stop again this should be explained to you.

Where you're chosen treatment is a procedure/operation it will be important that you are fit for it when required.

If while you are waiting you become ill with another condition which affects your fitness for treatment an adjustment can be made to your wait, while you get fit.

If this is for a more prolonged condition over three weeks you will be taken off the waiting list and both you and your GP will be informed by letter of the reasons and the guidelines specifying the requirements for a return to the pathway at a later date.

active monitoring, or a patient decision to refuse or defer treatment. The clock will stop on the date the decision is communicated to or by the patient.

88. When a patient is transferred between consultants for reasons of clinical necessity that prevents the current pathway being completed, the clock will stop. When this is simply a request for advice, this must be managed within the 26 week RTT period. The date on which it is explained to the patient that clinical responsibility for their care is being transferred to another consultant will be the clock stop date. The receipt of the referral by the second consultant will begin a new RTT period (*not for cardiac pathway*), however the organisation should take into account the time already waited by the patient in deciding treatment priority/timescales.

89. If a patient is enrolled on a clinical trial or added to a transplant list, the clock will stop on the date the decision is communicated to the patient.

90. If a patient elects to have the next stage(s) of their pathway delivered privately outside the NHS, the clock will stop when this intention is communicated to the organisation.

91. When a diagnostic procedure converts to a therapeutic intervention which meets the treatment definition, the clock will stop. The clock stop date will be the date of the intervention.

92. A referral for an excluded therapy treatment, where this is the intervention intended to manage the patient's condition (treatment), this is considered the start of definitive treatment which will constitute a stop clock. The clock stop date will be the date the referral is made. If the therapy referral however is only part of the pathway, it does not stop the clock but an adjustment for the wait can be made (*see section under RTT excluded services, this excludes cardiac pathways*)

93. If a patient is admitted as an emergency and receives an intervention for the condition for which they have an open RTT period, and the intervention meets the treatment definition, the clock will stop. The clock stop date will be the date of the intervention.

94. If a patient DNAs an appointment and is deemed clinically appropriate for removal, or has a second CNA during the pathway, or is unavailable for more than eight weeks in one period, the clock will stop. The clock stop date will be the date the organisation is made aware of the event.
95. If, in the opinion of a suitably qualified healthcare professional, a patient has a medical condition which will not be resolved within 21 days, the patient should be returned to the referring clinician, or to another clinician who will treat the condition, and the clock will stop. The clock stop date will be the date the patient is determined to be medically unavailable for this period.
96. If a patient is removed from the waiting list for reasons other than treatment, the patient and their referrer must be informed of the removal and the reasons for it. The information given must include the full reasons for removal and guidelines specifying the requirements for a return to the pathway. A full audit trail of this communication must be maintained.
97. If the patient being removed from the waiting list is under 18, consideration must be given to child protection implications and their risks from being removed need to be considered and documented. If the patient is younger than five years old, the health visitor should be informed of the removal.

New clock start outcomes

98. Following a clock stop, a patient should continue to be reviewed by the clinician only where this is clinically required. When a patient continues to be reviewed and a new decision to treat is made, a new RTT period will start. The clock start date will be the date the new decision to treat is made. When there is a step change in an ongoing treatment and the new treatment cannot be started at the point when the change is discussed with the patient, a new RTT period will begin: An example being when pain relief is no longer considered effective and an operation is now considered the best treatment, a new clock would be started when this decision is made and continue until the patient is admitted for the operation. A full audit trail of this should be

maintained. The clock start date will be the date the decision to change the treatment is communicated to the patient. An incremental change to ongoing treatment will not begin a new RTT period: an example being physiotherapy being offered to support ongoing pain relief.

99. When during an emergency admission or attendance a patient is placed on the waiting list for an elective procedure scheduled to take place after discharge from the emergency services (A&E or/and emergency admission), a new RTT period will begin. The clock start date will be the date of discharge from the emergency stay.

100. For clinical reasons, some patients will require a treatment at a later point in time. A new RTT period will begin for these planned treatments on the date that it becomes clinically appropriate to undertake the procedure.

101. When a patient has been removed from the waiting list for reasons other than treatment, mainly non availability while trying to book appointments, organisations should allow the patient to self-refer back into the pathway rather than creating a new referral via the GP as long as the patient now commits to their availability. (Local discretion and in communication with the patients is appropriate). The patient should return to the pathway at the clinically most appropriate place, and a new RTT period will begin. The clock start date will be the date the referral is received by the HB. The maximum time allowed between the removal and a self- referral should be six months. After this time, a new referral should be created. The six-month maximum may be extended indefinitely in the case of 'expert patient' or See On Symptoms SOS clinics where guidelines are in place and agreed jointly by the clinician and patient to facilitate appropriate use of SOS for each patient.

Adjustments

Patient unavailability

102. When a patient is unavailable due to a short-term medical condition, such as a cold an adjustment to the RTT period may be made. While this may be applied by receptionists, where required it should be supported by a suitably qualified healthcare professional, who agrees that a patient has a condition which will be resolved within 21 days. The patient should remain on the active waiting list and an adjustment of up to 21 days may be applied. If it is felt by a qualified medical professional not to be a condition which should resolve in 21 days a clock stop should be applied.

103. The adjustment should start from the date of the decision that the patient is medically unfit and continue to the date that the patient is declared fit for the procedure. This period must not exceed 21 days in each stage of the pathway.

104. If a patient is reviewed after the expected recovery period and recovery has not been effective, or a further condition has developed, the patient should be returned to the referring clinician, or another clinician who will treat the condition, and the RTT period will end. A second 21 day period cannot be applied within the same stage of the pathway.

105. When a patient is unavailable due to social reasons, an adjustment to the RTT period may be applied. (*maximum 8 weeks*)

106. When the period of unavailability is less than two weeks, no adjustment may be made.

107. When the period of unavailability is between two and eight weeks, an adjustment may be made for the full period of time that the patient is unavailable.

108. When the period of unavailability is more than eight weeks the patient should be returned to the referrer but this should be discussed and agreed by their consultant.

RTT excluded services

109. If a patient is referred to a diagnostic or therapy service which is excluded from the scope of the 26 week RTT target, an adjustment may be applied if it is a stage of their pathway. An adjustment may only be applied if the input is essential before the intended treatment can take place.

110. When the referral is for an excluded diagnostic test, the adjustment will apply from the date of the referral to the date that the test is undertaken.

111. When the referral is for an excluded therapy assessment or interim treatment, the adjustment will apply from the date of the referral to the date that the assessment or intervention is carried out.

Planned care

112. Planned care relates to elective admissions planned to occur in the future where, for medical reasons, there must be delay before a particular intervention can be carried out. This will include the second part of a bilateral procedure, sequential treatments, interventions where a delay is necessary due to developmental maturity, and surveillance procedures.
113. When a patient clinically requires bilateral or sequential procedures, the RTT period for the first procedure will be managed routinely under the RTT rules. A new RTT period will begin when the patient is deemed fit and ready for the second or subsequent procedure/s. The clock will start on the date of the decision to admit and stop on the date of admission for the second or subsequent procedure/s.
114. When a required intervention must be delayed until a certain level of developmental maturity is reached, the patient will be actively monitored until ready to undergo the procedure. At the time of this decision the current RTT period will end. A new RTT period will begin when the consultant decides that the patient is ready and fit for the procedure, and a decision to admit is made. The clock will start on the date of the decision to admit and stop on the date of admission for the procedure.
115. When a planned intervention is part of a surveillance programme no RTT period will apply. When the decision is taken to commence a surveillance programme, the current RTT period will end. This may be as a result of an initial intervention or diagnostic test leading to the surveillance programme.

Emergency care

116. RTT rules apply to elective pathways only and therefore admissions arising directly from emergency attendances will not begin an RTT period. However, a new elective or planned pathway initiated through an emergency event will begin a new RTT period.

117. If a patient is seen during an emergency attendance or admission by a consultant team and subsequent follow up is arranged under their care or at a specific emergency clinic, this will not begin a new RTT period. A later decision to treat would begin a new RTT period. The clock would start on the date the decision is made.
118. If a patient is seen during an emergency attendance or admission by a consultant team, and there is a decision to treat the patient on an elective or planned basis, a new RTT period would begin. The clock would start on the date of discharge from the emergency stay.
119. If a patient is referred during an emergency attendance or admission to another consultant to be seen outside of the emergency event, the referral will begin a new RTT period. The clock would start on the date the referral is received by the second consultant.
120. If a patient with a current RTT period is admitted as an emergency and is treated for that condition during their emergency stay, the RTT period will end. The clock will stop on the date the treatment is carried out.
121. If a patient with a current RTT period is admitted as an emergency, but is not treated for that condition during their emergency stay, the clock will continue. In the event that the patient is deemed medically unfit to undergo the treatment for which they are waiting, the rules for patient unavailability should be applied.

Accountability

Recording and reporting

Reporting formats

122. All targets must be reported according to the requirements of the NHS Wales Data Dictionary. Organisations must consult the data dictionary for details of required formats, fields, timescales and routes of reporting.
123. HBs must ensure that appropriate systems are in place to capture the information necessary to meet the requirements for reporting.

Accountability for monitoring open pathways

124. The HB with current clinical responsibility for the patient is accountable for the monitoring of that patient's pathway (except cancer).
125. When the patient's RTT period involves more than one organisation or information system, HBs must ensure that communication protocols are utilised so that appropriate information is shared and RTT periods are measured accurately. (Particularly for cancer and cardiac pathways when the clock continues along the pathway from referral to intervention and/or surgery)
126. When NHS activity is commissioned from an independent sector provider (non NHS), the HB commissioning the pathway is accountable for the monitoring of that patient's pathway. HBs must ensure that communication protocols are utilised so that appropriate information is shared, and RTT periods are measured accurately.
127. When a referral is made to an English NHS provider, the English NHS provider is accountable for the monitoring of that patient's pathway. English NHS providers must ensure that communication protocols are utilised so that appropriate information is shared, and RTT periods are measured accurately. The Welsh targets need to be communicated as part of any contracts with other NHS providers (England and Wales).

Accountability for performance

128. When the patient's RTT period is managed entirely within a single LHB, the accountability for performance against the targets lies with that HB.
129. When the patient's RTT period involves more than one HB, the HB of patient's residence is accountable for performance against the RTT targets.
130. When NHS activity is commissioned from an independent sector provider, the accountability lies with the HB commissioning the activity.

131. Where NHS activity is commissioned from an English provider, the accountability for performance against the targets lies with the HB commissioning the activity.

132. Where the patient pathway is commissioned by Welsh Health Specialised Services Committee (WHSSC), the accountability for performance against the targets lies with WHSSC. HBs and WHSSC must jointly ensure that communication protocols are utilised so that appropriate information is shared, and RTT periods are measured accurately.

Accountability for reporting

133. The HB with clinical responsibility for the patient at the reporting census date is responsible for reporting performance against the open pathway waiting time target.

134. The HB with clinical responsibility for the patient at the time of treatment is responsible for reporting performance against the closed pathway waiting time target.

135. When NHS activity is commissioned from an independent sector provider, the HB commissioning the pathway is responsible for reporting performance against the target. HBs must ensure that communication protocols are utilised so that appropriate information is shared, and RTT periods are reported accurately. When a referral is made to an English provider, that provider is responsible for reporting performance against the target. HBs must ensure that requirements for reporting are contractually included in commissioning agreements.

Glossary

This glossary offers definitions of terms used within this document. Where possible, the NHS Wales Data Dictionary definition is used, and the latest version of the data dictionary should be consulted for up-to-date definitions when required. These explanatory definitions should be considered only in relevance to this document.

26 week referral to treatment target	The Welsh Government waiting times target established December 2009, that no patient should wait more than 26 weeks from referral to treatment.
Active monitoring	A clinical intervention where the decision is made to monitor a patient's condition closely in secondary care, resulting in active steps being taken to ensure that the patient is regularly assessed and that any change in condition can be responded to.
Adjustment	A period of time for which the patient is either unavailable, for clinical or social reasons, or where the patient is referred to a service that is outside the scope of RTT.
Admission	The act of admitting a patient for a day case or inpatient procedure.
Cancer target	The Welsh Government waiting times target for cancer treatment: 62 days for an urgent suspected cancer (USC) and 31 days for a non-urgent suspected cancer (NUSC) referral.
Cardiac RTT target	The Welsh Government waiting times target for cardiac patients that no patient should wait more than 26 weeks from referral to treatment.
Cardiologist	A clinician who undertakes the majority of their clinical sessions in cardiology.
Clinic outcome	A record of the event of a clinical decision made by a clinician. This decision will not necessarily be made within a clinic environment.
Clock continue	Any events which occur along the patient pathway, but do not constitute a clock start or clock stop within the RTT rules.
Clock reset	An administrative process to change the start of the recorded RTT period to the date of the event causing the reset.
Clock start	An event which commences an RTT period within the RTT rules.
Clock stop	An event which ends an RTT period within the RTT rules.
Consultant:	A person contracted by a Health Board who has been appointed by an Advisory Appointment Committee. He or she must be a member of a Royal College or faculty. This includes GPs in cases where a GP is responsible for patient care and has an arrangement with a Local Health Board. For diagnostic departments, this includes a non-medical scientist of equivalent standing to a consultant.

Consultant office decision	Any decision which affects the clinical management of the patient and has been made when the patient is not present.
Consultant to consultant referral	Any patient referral made within a secondary/tertiary care environment from one consultant to another.
Could not attend (CNA)	Any patient who contacts the organisation to notify that they will be unable to attend an agreed appointment is recorded as 'could not attend' (CNA).
Decision to treat	A record of the event that a clinical decision to admit a patient to a particular healthcare organisation has been made.
Decision not to treat	A clinical decision that, at the present time, no treatment is required for the condition for which the patient has been referred. This will normally result in the patient being discharged back to the referring doctor.
Diagnostic wait	The time waited from receipt of referral for a diagnostic investigation to the appointment for that investigation.
Did not attend (DNA)	Patients who have not kept an appointment at any stage along the pathway and have not notified the organisation in advance are identified as 'did not attend' (DNA).
Direct access	Patients who are referred directly rather than via a consultant-led clinic.
Direct booking	Booking methodology where an agreement of appointment is made through a direct communication between the organisation and patient.
Direct referral	A referral made by a clinician in primary care directly to a diagnostic or therapy service.
Emergency admission	Patients admitted to hospital when admission is unpredictable and at short notice because of clinical need.
Expert patient	Patients experiencing a long-term health condition who become 'experts' in their own care to improve their quality of life.
First definitive treatment	Any initial treatment that treats the patients cancer, stabilises their symptoms from cancer, or stabilises their health so cancer treatment can commence
Incremental change in treatment	A small change to a current treatment plan, e.g. adjustment of the dosage of a prescribed medication.
Inpatient/day case wait	The time waited from a decision to treat as an inpatient/day case to admission for the treatment.
Intended treatment	An intervention which, at that time, aims to manage the patient's condition.
Interim treatment	An intervention aiming to help the patient cope with their condition until the planned intended treatment can be delivered.
Health Board (LHB)	The statutory NHS body.

Mutually agreed	Agreed by both the patient and the LHB.
Non-admission event	Any event when the patient attends for an appointment but is not booked into a bed or trolley, e.g. an outpatient appointment.
Non-USC referral (NUSC)	Any patient diagnosed as having cancer that was not referred by their GP as a USC or upgraded by the specialist on analysis of the GP referral.
Organisation	The secondary care service, previously known as the Trust.
Out of hours contact	Between 6pm and 9pm on weekdays and between 9am and 9pm at weekends.
Partial booking	A system whereby appointments are agreed with the patient, following a written request from the LHB for the patient to telephone to make an appointment.
Pathway start date (PSD)	Used within the cardiac RTT target to denote the original clock start date caused by the receipt of a referral.
Patient pathway	The process of a patient's care for a particular condition across the whole of the NHS, from primary care onwards.
Planned care	Elective admissions planned to occur in the future, where, for medical reasons, there must be delay before a particular intervention can be carried out.
Pooled environment	A service design where all parties have been informed, at the time of referral or first outpatient visit, that a group of clinicians are working together to provide the service, and where patients may be seen by any of the clinicians in the pool, at any given stage of treatment.
Reasonable offer	Any offer of an appointment mutually agreed between the patient and the HB.
Receipt of referral by the HB	The referral is deemed to be received when it first arrives within the secondary or tertiary care service, irrespective of the department or individual receiving it. This will include electronic and paper referrals.
Referral guidelines	Predetermined written criteria for referral that are formalised and agreed between the healthcare professionals making and receiving the referral.
Referral protocols	Agreements reached and documented locally to identify accepted sources for referrals to specific services.
Referral to treatment	The period between a referral being made for a particular condition and treatment being commenced for that condition.
RTT period	The waiting time will be monitored using the concept of a clock, which will start and stop according to the events and transactions that occur along the course of the patient pathway. The

	measured period of time between a clock start and a clock stop, under RTT rules, which is reported as the RTT waiting time.
Screening programme	A recognised national programme of screening for particular conditions e.g. Breast Cancer Screening Programme.
Secondary care	NHS care delivered as a result of a referral from primary care.
Self-referral	The process whereby a patient initiates an appointment with a secondary care service, without referral from either a primary or secondary care clinician.
Short-term medical condition	A medical condition precluding progression to the next stage of the pathway for less than 21 days.
SOS clinics	Specialist direct access clinics that expert patients attend for urgent attention.
Stage of the pathway	A section of the RTT period. There are four stages: referral to first outpatient appointment; waiting for a diagnostic test; waiting for a subsequent outpatient appointment; waiting from decision to treat to the start of treatment. Stages of the pathway are contiguous, do not have to occur in this order, and any individual stage may occur more than once in any given pathway.
Step change in treatment	A substantial change to a current treatment plan, e.g. a change from oral to subcutaneous delivery of medication.
Suitably qualified healthcare professional	A healthcare professional approved by the consultant as competent to make a decision about the medical fitness of a patient to proceed to the next stage of the pathway.
Surveillance procedures	Procedures that are repeated at agreed intervals in order to monitor the patient's condition.
Suspension	A period during which the cancer or cardiac clock is paused due to the patient being unavailable or medically unfit due to a co-morbidity to proceed to the next stage of the pathway.
Tertiary care	Specialised NHS care in services designated to provide the service in a specialist centre, and delivered as a result of a referral from within secondary care.
Therapy services	NHS services providing treatment by Health Professions Council registered professions i.e. arts therapies, dietetics, occupational therapy, orthotics, prosthetics, physiotherapy, podiatry, speech and language therapy.
Treat in turn	Management of the waiting list to ensure that patients are seen and treated in appropriate order,

	based on their clinical need and length of wait. HBS need to be able to explain and evidence any variance to treat in turn rates through their local policies as long as they reflect other WG strategic goals
USC referral	A referral where a suspicion of cancer is stated by the GP and confirmed by the specialist. This is not restricted to a designated USC-only referral methods e.g. fax lines.