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**For Action by: Chief Executives
Chief Operating Officers
Heads of information**

Action required by: Immediate

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24 April 2018

Dear colleagues

**Consolidated Rules for Managing Cardiac Referral To Treatment Waiting Times –
March 2018**

Please find attached the final version of the updated rules “CONSOLIDATED RULES FOR MANAGING CARDIAC REFERRAL TO TREATMENT TIMES - March 2018”. I also enclose the final version of the general RTT guidance completed in July 2017.

Yours sincerely

Lesley Law
Head of Planned Care

c.c. Chief Operating Officers, NHS Wales
Heads of Information, NHS Wales



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CONSOLIDATED RULES FOR MANAGING CARDIAC REFERRAL TO TREATMENT WAITING TIMES

March 2018

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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.

95% of patients on a cardiac RTT pathway will wait no longer than 26 weeks for treatment. No patient will wait longer than 36 weeks.

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 health boards are now offering reminder systems for your appointments, so ensuring the GP and hospital have your mobile number will support this.

Overview

Document summary

1. This document provides a complete reference source of the waiting times management rules relating to the 26 week cardiac referral to treatment (RTT) target.

Target development – 26 week RTT target

2. The achievement of the 26 week cardiac RTT target is the responsibility of NHS Wales.
3. The underlying principle of the target is that patients should receive excellent care without delay and should start their required treatment no later than 26 weeks from referral.
4. Within this waiting time period, both the patient and the NHS in Wales have their roles and responsibilities to achieve this target.
5. This document aims to set out clearly and succinctly the rules to ensure that each patient's cardiac RTT period begins and ends fairly and consistently. For the cardiac RTT pathway the clock continues to run across HBs and/or consultants for the management and recording of their pathway.
6. For cardiac RTT all the diagnostic tests required to support a cardiac pathway should be included within the waiting time clock, even if the test is not currently reportable. This guidance clearly highlights both the patient and NHS roles and responsibilities and the potential consequences if this mutual contract is not fully met.

Patient perspective

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.

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.

Guiding principles

7. This guidance is to ensure that the period patients wait for elective (planned) cardiac 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. Clinical need should dictate the appropriate waiting time for any cardiac pathway. The national cardiac RTT target should not distort clinical urgency.

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,

Patient perspective

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.

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.

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.

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. Health Boards (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. 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 or pathway start date (PSD).

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.

For some services such as cardiology 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.

Scope of the targets

26 week cardiac RTT target

16. The scope of the 26 week cardiac RTT target encompasses elective and specialist 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 cardiac RTT period begins on the receipt of a referral in secondary care and ends when treatment commences. Treatment will often continue beyond a first treatment and after a clock has stopped.
18. A self-referral or patient-initiated follow-up (see on symptoms SOS) will not begin an RTT period unless it follows a period of unavailability (see section on unavailability, page 28). If on this appointment a new decision to treat or change of management plan is made this will commence a new RTT clock start.
19. Some patients may be measured on more than one RTT period during the management of their condition in secondary or tertiary care. **However, the rule for cardiac RTT pathway is that the clock continues across HBs and consultants.**
20. 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 new cardiac RTT period is generated upon the clinical decision to end active monitoring.
 - A consultant to consultant referral for a non cardiac condition which means the cardiac pathway cannot continue, the cardiac pathway will stop and a new general RTT pathway clock will commence.

Patient perspective

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. Further details of clock start and stop points are available later in this document and a number of scenarios are contained in appendix A.
- 22 All waits for diagnostic and therapy services must form part of the cardiac RTT pathway.

To note: Guidance on community cardiology services will follow, upon completion of the evaluation of the service.

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

Included in the scope of the 26 week RTT target	
Included service area/ patient group	Notes
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

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 your referral has been accepted or you have not heard about your booking in the time line you have been told to expect, you can phone the hospital/area to ask for an update about the expected waiting times.

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

24. The table below highlights two services which are excluded from the scope of the 26 week cardiac RTT target. 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.
Transplant and clinical trials	Once a treatment option is agreed for entry onto a transplant list or clinical trial, the cardiac 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; and if you are ex military personnel etc.

Clinical responsibilities

The responsibilities of clinical staff in monitoring cardiac waiting times

25. 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.
26. 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.
27. Clinicians should ensure that their actions promote the principle of patients waiting the shortest possible time for treatment.
28. 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.
29. 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.
30. 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.
31. 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.

32. 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.
33. 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 or 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

34. The cardiac RTT period begins at the point a referral by a GP to a consultant in secondary care is accepted, and by any other healthcare professional where referral protocols exist. The clock will start on the date that the organisation receives the referral.
35. 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.
36. 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.
37. 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.
38. 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.

39. 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.
40. 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.
41. 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.
42. HBs need to work with primary care to ensure good quality information flows between the two areas to support effective patient care.
43. When the patient care transfers between organisations and or consultants, it is the responsibility of the transferring organisation to provide the correct pathway start date (PSD). The onward referral of patients should be standardised with the requirement that the PSD is provided by the referring consultant at the top of the referral.
44. The receiving organisation must ensure that the clinically communicated PSD is correctly used and captured in its patient admission system (PAS). This will ensure the ongoing wait is correctly continued across the pathway.

45. The PSD for patients under the category of active monitoring or surveillance is less straightforward. The most appropriate PSD for these patients has been agreed by the cardiac network to be the date when a decision to treat is made:
- i) either upon the receipt of a referral by consultant following an outpatient follow up appointment, where symptoms are considered to have deteriorated and intervention is required; or
 - ii) the date when the cardiac consultant is alerted of a deterioration following diagnostic tests.

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*).
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*).
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.

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.

50. Each attempt to contact the patient under the booking processes must be recorded and made available for subsequent audit.

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 9-5pm). 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.

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.

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.

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 (CNA), 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

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.

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. A reset can be applied where it has not been possible to agree a suitable date within the booking period you were originally planning. The adjustment will be for the time between the booking period you planned to the booked date you finally agree with the patient.

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 or 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 page 28).
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 reset but they remain on their current stage of the pathway. This reset should be communicated to the patient when rebooking the appointment.
68. On the second CNA within the same RTT 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 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

(Example scenarios are available in Appendix A Page 40)

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 to the pathway clock for this change.
78. **All referrals within a cardiac RTT pathway to diagnostic tests, therapy services or anaesthetic assessment will continue the 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 writing. It would be expected that patients should retain their place on the waiting list to acknowledge their previous wait and be treated

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.

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 is referred from an NHS organisation to an independent sector organisation as part of their NHS pathway, the clock will continue.

Clock stop outcomes

81. A clock stop outcome is used to define decision points along the pathway where a current RTT period will end.
82. 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 the agreed periods.
83. Treatment is defined as a clinical intervention intended at the time of the intervention to manage the patient's condition. This includes all treatments on the cardiac pathway, including cardiac surgery, TAVI, coronary intervention, ablation, heart rhythm devices and pacing.
84. The following treatments are some examples of definitive treatment (note that this is not intended to be an exhaustive list of treatments).

Revascularisation	Angioplasty (Percutaneous Coronary Intervention) CABG (coronary artery bypass surgery)
Valve Surgery	Aortic valve surgery Mitral valve surgery Combined aortic and mitral valve surgery
Other cardiac surgery	Adult congenital cardiac surgery Tumours Other surgical procedures eg. removal of pericardium
Device and other procedural therapy	Pacemakers for heart block Implantable defibrillators for arrhythmias Biventricular pacemakers for heart failure DC cardioversion for atrial fibrillation Ablation
Medical endpoints	Definitive medical therapy is initiated following a comprehensive assessment by the cardiologist <i>A trial of medical therapy possibly as a prelude to reconsidering revascularisation would not be included</i>

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 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.

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. 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.

88. When a patient is transferred between different consultants for reasons of clinical necessity other than cardiac, that prevents the current cardiac pathway being completed, the cardiac clock will stop. However if this is simply a request for advice, the cardiac clock will not be stopped and the patient's waiting time must be managed within the 26 week cardiac RTT period.
89. The date on which it is explained to the patient that clinical responsibility for their care is being transferred to another consultant (**not on the cardiac pathway**) will be a cardiac clock stop date. The receipt of the referral by the second consultant (**not on a cardiac pathway**) will begin a new RTT period. The receiving organisation should take into account the time already waited by the patient in deciding treatment priority/timescales.
90. 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.
91. 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.
92. 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.
93. A referral for a therapy treatment where this is the intervention intended to manage the patient's condition (treatment), is considered the start of definitive treatment which will constitute a stop clock.
94. If a patient is admitted as an emergency and receives an intervention for the condition for which they have an open cardiac RTT period, and the intervention meets the treatment definition, the clock will stop. The clock stop date will be the date of the intervention.

95. If a patient DNAs their 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.
96. 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.
97. 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.
98. 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

99. Following a cardiac clock stop, a patient should only continue to be reviewed by the clinician where this is clinically required. When a patient continues to be reviewed and a new decision to treat is made, a new cardiac RTT period should commence. The clock start date will be the date the new decision to treat or further investigate is made **either** at an outpatient follow up appointment, where symptoms are considered to have deteriorated and intervention is required, **or** the date when the cardiac consultant is alerted to a deterioration following diagnostic tests.

100. 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 of this is when medication treatment is no longer considered effective and an intervention 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.
101. When during an emergency admission or attendance a patient not currently on a cardiac waiting list is deemed to require a cardiac elective procedure after discharge a new cardiac clock will commence on discharge from their emergency episode. The clock start date will be the date of discharge from the emergency stay.
102. 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

103. 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.
104. 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.
105. 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.
106. When a patient is unavailable due to social reasons, an adjustment to the RTT period may be applied (*maximum 8 weeks*).
107. When the period of unavailability is less than two weeks, no adjustment may be made.
108. 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.

109. 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.

Accountability

Recording and reporting

Reporting formats

110. 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.
111. 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

112. The HB with current clinical responsibility for the patient is accountable for the monitoring of that patient's pathway.
113. When the patient's cardiac 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 cardiac pathways when the clock continues along the pathway from referral to intervention and/or surgery.
114. 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 the cardiac RTT periods are measured accurately.
115. 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

116. When the patient's RTT period is managed entirely within a single HB, the accountability for performance against the targets lies with that HB.
117. 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.
118. When NHS activity is commissioned from an independent sector provider, the accountability lies with the HB commissioning the activity.
119. Where NHS activity is commissioned from an English provider, the accountability for performance against the targets lies with the HB commissioning the activity.
120. Where the patient pathway is commissioned by Welsh Health Specialised Services Committee (WHSSC), the accountability for performance against the targets lies with the health boards on whose behalf WHSSC is commissioning. The health board with clinical responsibility for the patient at the reporting census date is responsible for reporting performance against the open pathway waiting time. Each health board must ensure that processes are in place to ensure that communication protocols are utilised so that appropriate information is shared, and RTT periods are measured accurately.

Accountability for reporting

121. 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.

122. 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.
123. 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.
Cardiac RTT target	95% of patients on a cardiac RTT pathway will wait no longer than 26 weeks for treatment. No patients will wait longer than 36 weeks.
Cardiologist	A clinician who undertakes at least 80% of his/her professional life in cardiology.
Chronic heart disease (CHD)	CHD can include any patient with chest pain/discomfort; shortness of breath; faintness,

blackout or palpitations; multiple risk factors for CHD / screening e.g. prior to major surgery.

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 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 a mutually 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.

Definitive treatments

All treatments on the cardiac pathway, including cardiac surgery, TAVI, coronary intervention, ablation, heart rhythm devices and pacing.

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, stabilises their symptoms, or stabilises their health so 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.

Interventional cardiologist

A clinician whose sub-specialty interest is angioplasty.

Health Board (HB)

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.

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. To be used on referral of a cardiac pathway across organisations and/or consultants to ensure the pathway clock continues from the original clinically determined start date

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
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, orthotics and 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

Appendix A – Pathway start date scenarios

The following scenarios seek to highlight how these rules should be applied in different circumstances. Scenarios are grouped as follows:

- A) Referrals from general practice
- B) Referrals from consultant to consultant
- C) Cardiac disease as a chronic condition with acute episodes
- D) Emergency admissions
- E) Initial outpatient consultation carried out by a non-physician
- F) Patient managed by GP with a special interest (GPwSI) in cardiology
- G) Patients managed across more than one health board

A) Referrals from general practice

Scenario A/1

A 44-year-old lady with a four week history of chest pain, is referred by her GP to a cardiologist for suspected CHD. She is seen in the cardiology clinic, has an exercise test at the same clinic which confirms angina and is put on the angiography waiting list. She has an angiogram and a decision is made by the same cardiologist that she requires angioplasty. She is put on the waiting list and later admitted for angioplasty.

- GP referral to cardiologist
- Receipt of GP letter by HB. **Clock starts**
- Patient put on cardiology out patient waiting list
- Initial consultation with cardiologist in one-stop clinic and put on angiography waiting list
- Angiogram undertaken and placed on angioplasty waiting list
- Admitted and angioplasty undertaken. **Clock stops**

Scenario A/2

A 66 year old man who has previously had CABG is referred by his GP to the local cardiologist for investigation of palpitations. The cardiologist undertakes an exercise test and echocardiogram at the same appointment. These are satisfactory but a period of monitoring with a rhythm recorder is then requested. Once the results of this are received the patient has a follow up appointment and is started on drug treatment for an intermittent atrial arrhythmia. He is seen for review again and has side effects from drug treatment. He is referred to the tertiary

centre to see an electrophysiologist who advises an ablation. He is then admitted for this definitive treatment.

Here the patient has underlying CHD and this is a likely cause for the arrhythmia. Definitive treatment is after several steps as an outpatient, but these are clinically justified as the rhythm recording has to be done over a period and follow up to assess response to drug treatment is then necessary.

- GP referral to local cardiologist
- Receipt of GP letter by health board. **First clock starts**
- Exercise tests and echo
- Period of diagnostic monitoring
- Results received started on drug treatment. **First clock stops**
- Seen in outpatient follow-up, problems with drug treatment consultant decides to refer to a tertiary centre for assessment and possible treatment
- Referral received by tertiary centre. **New (second) clock starts**
- Admitted for definitive treatment. **Second clock stops**

Scenario A/3

A 65 year old man who has had previous CABG in 1998 has been admitted to the local hospital on at least 3 occasions with chest pain in the last 4 months. He is dissatisfied that he has not been referred for further investigations and requests a second opinion. He is referred by his GP to the tertiary centre. On the initial consultation he has a further exercise test and echocardiogram and is advised to have repeat angiography. This confirms the echo findings of severe heart failure (severe LV dysfunction) and occluded grafts. He is felt to be too high risk for further surgery and is continued on medical therapy. As he has severe heart failure and meets the criteria for resynchronisation therapy and is also at high risk of arrhythmias he is referred to the electrophysiologist for resynchronisation therapy and defibrillator, which is undertaken urgently.

- Pre-steps: previous admissions. Patient requests second opinion.
- GP referral to tertiary centre for second opinion
- Receipt of GP letter by tertiary centre. **Clock starts**
- Exercise test and echocardiogram and repeat angiography
- Medical therapy ongoing (which is to support the stabilisation of the patient and is not part of definitive treatment.)

- Referral to electrophysiologist
- Admitted for resynchronisation therapy and defibrillator implantation. **Clock stops**

Scenario A/4

Mr Evans is referred by his GP to a general physician with shortness of breath and a history of respiratory problems. The general physician suspects a cardiac condition, orders an echocardiogram and, on receiving the result, refers Mr Evans to a cardiologist. The cardiologist sees Mr Evans, diagnoses heart failure and treats medically.

- GP referral to general physician
- Receipt of GP letter: **Clock starts**
- General physician sees patient
- Diagnostic test ordered
- Result received
- Patient referred to cardiologist - the patient is picked up on cardiac RTT monitoring and retrospectively tracked to their original pathway start date.
- Medical treatment initiated by cardiologist: **Clock stops**

Scenario A/5

Mr Elwyn is referred by his GP to a general physician who has significant experience in cardiology and refers him directly to a cardiac surgeon for cardiac surgery without going through a cardiologist.

- GP referral to general physician
- Receipt of GP letter: **Clock starts**
- General physician sees patient
- Referred to cardiac surgeon
- Referral received by cardiac surgeon- the patient is picked up on cardiac RTT monitoring and retrospectively tracked to their original pathway start date.
- Cardiac surgeon requests opinion from a cardiologist who sees patient and agrees that cardiac surgery is needed
- Admitted for surgery: **Clock stops**

Scenario A/6

A 75 year old patient with suspected CHD is referred by his GP to the local hospital. The patient is getting predictable chest pain on exertion and feels very breathless. He is seen by a local non-cardiac physician in clinic and she arranges an exercise test and echocardiogram as she has heard a heart murmur. Following these the patient is seen in clinic and referred to the local tertiary centre for an angiogram. At an outpatient appointment the cardiologist puts the patient on his waiting list. Once the angiogram has been undertaken it is clear this patient requires aortic valve replacement and CABG. He is referred to the cardiac surgeon who arranges an outpatient appointment and then places him on his waiting list. He is then admitted and the patient has the definitive treatment.

- GP referral to general physician
- Receipt of GP letter by HB: **Clock starts**
- Patient put on general physician outpatient waiting list
- Initial consultation with general physician, referred for exercise testing and echocardiogram.
- Exercise test appointment
- Echocardiogram appointment
- Follow up appointment with general physician when decision made to refer for angiogram
- Receipt of letter by tertiary cardiologist- the patient is picked up on cardiac RTT monitoring and retrospectively tracked to their original pathway start date.
- Initial consultation with tertiary cardiologist
- Angiogram and referral to cardiac surgeon
- Initial consultation by surgeon
- Admitted for surgery: **Clock stops**

B) Consultant to Consultant Referral

Scenario B/1

Miss Williams has been under the care of a general physician for some years with multiple medical co-morbidities. On her most recent follow-up appointment her condition is seen to have worsened and the general physician requests a cardiology opinion.

- General physician sees patient as part of a regular clinic review
- Referral to cardiologist received in cardiology department: **Clock Starts**

- Medical treatment initiated by cardiologist: **Clock stops**

Scenario B/2

Mrs Jones has been referred for a general medicine outpatient appointment by her GP with neuralgia. During the appointment the general physician finds an incidental cardiac problem which requires a cardiology opinion and refers Mrs Jones to a cardiologist.

- GP referral to general physician
- Receipt of GP letter
- General physician sees patient and finds **incidental** cardiac condition
- Referral to cardiologist received in cardiology department: **Clock starts**
- Investigations undertaken
- Admitted for angioplasty: **Clock stops**

Scenario B/3

A general physician refers a patient with suspected CHD to his cardiology colleague in a tertiary centre. The cardiologist sees the patient and notes that a stress test had already been undertaken and was positive. The patient is put on the angiography list at the clinic. The patient is admitted and has the procedure and a decision is then made to undertake a perfusion scan. If the results are positive then the patient may need angioplasty. The perfusion scan is performed after several months and the patient reviewed in clinic and told that an angioplasty is necessary. Following the clinic the patient is put on the list and definitive treatment is subsequently carried out.

- GP refers to a general physician
- Receipt of GP letter by health board. **Clock starts**
- General physician referral to cardiologist
- Receipt of referral letter- the patient is picked up on the monitoring and retrospectively tracked to their original pathway start date.
- Initial consultation with cardiologist and put on list for angiogram
- Angiogram and decision made to investigate further.
- Perfusion scan: ***The perfusion scan is not start of definitive treatment – it is an investigation and informs whether definitive treatment is required. The clock will remain ticking.***
- Outpatient review and decision made to list for angioplasty

- Admitted for angioplasty. **Clock stops**

Scenario B/4

A GP refers a 64 year old man to the local cardiologist with suspected CHD. The patient has a number of medical problems, including anaemia and renal impairment. The cardiologist reviews him but the patient is not well enough for exercise testing and requires referral to a renal physician. The patient requires further investigation of his anaemia and renal problems and once resolved is referred back to the cardiologist who obtains a stress test at this second clinic appointment. Problems show up and he requires angiography which is carried out at the DGH lab. He needs CABG and the cardiologist writes to the local tertiary centre where the cardiac surgeon arranges an outpatient appointment and then places the patient on the CABG waiting list. Eventually the patient has definitive treatment.

- GP referral to local cardiologist
- Receipt of GP letter by HB. **Clock starts**
- Initial consultation with cardiologist and referral to renal physician: **The cardiac clock stops** for the original referral (Patient starts a **new pathway clock for a renal pathway**).
- Initial consultation with renal physician
- Visits to investigative departments e.g. radiology
- Follow up with renal physician and treatment. (**Renal pathway stop clock**)
- Review by renal team and referral back to cardiologist. New **cardiac clock starts** when referral received by cardiology department.
- Review by cardiologist
- Exercise test performed and put on angiogram list
- Angiogram at DGH and referral to cardiac surgeon at tertiary centre
- Receipt of letter by cardiac surgeon
- Initial consultation with surgeon and put on list for CABG
- Admitted and CABG undertaken. **Clock stops**

Where a patient transfers from the care of one organisation to another but within the same treatment pathway, it is important that the onward referral clarifies the pathway start date (PSD).

Scenario B/5

A 58 year old man with two previous heart attacks is referred to the tertiary centre with a history of angina and more recently blackouts leading to loss of consciousness. He is given an urgent clinic appointment with the cardiologist and has an exercise test, which shows he has severe

coronary disease. At the end of the exercise he develops a serious arrhythmia. The cardiologist admits him. He has coronary angiography the next day and is found to have severe coronary disease. He has CABG the same day by the cardiac surgeon. The electrophysiologist then sees him on the same admission to undertake a provocation test to see if he is still susceptible to the arrhythmia, which he is. The EP specialist implants a defibrillator on the same admission.

Although this pathway becomes an emergency pathway, it started as a planned pathway through the planned referral and a clock start has already commenced and as such it is right that a clock end is captured thus completing the RTT pathway from the initial referral.

- Referral to tertiary centre
- Receipt of letter by tertiary centre: **Clock starts**
- Urgent consultation with cardiologist
- Exercise test – develops arrhythmia
- Admitted to hospital for angiography
- Has angiography. Has CABG the same day: **Clock stops**
- Provocation test
- Defibrillator implant

Scenario B/6

Mrs Morgan has been on the waiting list for a knee replacement for 10 months and is about to receive her treatment. In a pre-operative assessment she is found to have a previously unidentified heart murmur and is referred by the orthopaedic surgeon to a cardiologist. The cardiologist carries out diagnostic tests and pronounces Mrs Morgan fit for orthopaedic surgery. No further treatment for the cardiac murmur is deemed necessary.

- GP referral for orthopaedic surgery
- Receipt of referral by secondary care: **Orthopaedic clock starts**
- Orthopaedic surgeon sees patient
- Orthopaedic surgery planned sent from pre-op assessment
- Patient seen in pre op found to have heart-murmur
- Patient referred to cardiologist with heart murmur pre-surgery: **Orthopaedic RTT clock stop, cardiac clock starts**
- Patient seen by cardiologist
- Diagnostics carried out

- Patient pronounced fit for surgery – Discharged from cardiology referred back to orthopaedics. **Cardiac RTT clock stops, new orthopaedic RTT clock commences**
- Seen in pre-op assessment listed for orthopaedic surgery
- Orthopaedic surgery carried out. **Orthopaedic RTT clock stopped**

C) Cardiac disease as a chronic condition with acute episodes

Scenario C/1

Mr Davies has stable angina and has had his care managed jointly by the GP and a cardiologist. At a GP review appointment it becomes clear that his condition has destabilised and the GP requests that he is seen urgently by the cardiologist whose care he has been under. At the cardiology consultation an angiogram is booked which is followed by revascularisation.

- GP referral to cardiologist with unstable angina
- GP referral letter received by HB: **Clock starts**
- Cardiologist sees patient
- Angiogram booked and carried out
- Result received
- Patient referred for angioplasty
- Patient admitted and angioplasty undertaken: **Clock stops**

D) Emergency admissions

People admitted as emergencies with a cardiac condition should receive treatment in accordance with their clinical priority.

Scenario D/1

Mr Ellis is on holiday in West Wales where he is admitted as an emergency to the nearest cardiac care unit. He needs to be followed up by the cardiology department in his local hospital in South East Wales.

- Admitted as an emergency to health board 1
- Discharged from health board 1 referred for further investigation in his local health board 2. **Clock starts** when referral received by health board 2
- Seen at outpatient clinic in health board 2
- Patient undergoes investigations

- Following results of tests listed for pacemaker
- Admitted for pacemaker implantation: **Clock stops**

Scenario D/2

Mr Brown is attending an outpatient appointment for a rheumatology condition. He collapses in clinic with acute chest pain and is admitted to the cardiac care ward. He is stabilised and discharged home - with a follow up appointment for cardiology outpatients.

- Patient admitted as an emergency to CCU
- Patient seen by cardiologist on the ward and discharged home with a follow up appointment in cardiology outpatients
- At follow-up appointment, the decision is taken that Mr Brown will probably need revascularisation. **Cardiac clock starts**
- Patient undergoes investigations
- Patient admitted for angioplasty **Clock stops**

E) Initial outpatient consultation carried out by a non-physician

Scenario E/1

Miss Pugh is referred by her GP for chest pain assessment in the cardiology department of the local hospital. As part of the cardiology service redesign Miss Pugh has her first appointment at a non-physician led clinic where staff are working to agreed protocols and with the required competences. Following assessment Miss Pugh is then seen by the cardiologist and treatment initiated.

- GP referral to cardiology department
- GP referral received by HB: **Clock starts**
- Patient seen at non-physician led clinic
- Diagnostic tests ordered
- Results received
- Patient seen by cardiologist
- Medical treatment initiated: **Clock stops**

F) Patient managed by GP with a special interest (GPwSI) in cardiology

Scenario F/1

Mr Roberts is referred by his GP to a GPwSI in cardiology who works across the HB. The GPwSI carries out appropriate diagnostic tests, advises Mr Roberts' GP on the management of Mr Roberts and returns him to the care of the GP.

There is no starting or stopping of the clock as this referral is outside the scope of the target.

G) Patients managed across more than one health board

Scenario G/1

Mrs Williams has been receiving treatment for CHD for a number of years at her local health board. During a regular review appointment it becomes clear that her condition has worsens and a tertiary referral is required to health board two.

- Consultant referral at health board one to cardiologist in health board 2.
- Referral received by health board two. Health board two initiates a new pathway **start clock**

Scenario G/2

Mrs Kirkham referred by her GP with intermittent chest pain to a cardiologist at her local hospital. On reviewing Mrs Kirkham in her first appointment the cardiologist decides she requires some specific cardiac tests and may need potential treatment. The required tests are not provided at her local health board and therefore she is referred for diagnostics in another health board. The consultant refers Mrs Kirkham's case to a cardiologist at the tertiary site for them to review the results of the diagnostic test and decide if specialist treatment is required. On the review of the diagnostic tests the tertiary cardiologist decides that specialist treatment is required and the clinical care of Mrs Kirkham is transferred to the tertiary site. She is reviewed by the cardiologist at the tertiary site and a date for the treatment is agreed.

- GP referral to local cardiologist
- Receipt of GP letter by HB. **Clock starts**
- Initial consultation with cardiologist indicates specialist diagnostics are required to decide if specialist treatment is required.
- Referral for diagnostic tests sent to tertiary centre with an additional request for the tertiary cardiologist to review the results for possible consideration for specialist treatment.
- Diagnostics undertaken.
- Tertiary cardiologist reviews results and agrees specialist treatment is required. Clinical responsibility is taken over by the tertiary site who now takes responsibility to report Mrs

Kirkham's open pathway with her original pathway start date PSD which should be included in the referral request from the referring health board.

- **On confirmation of need for specialist treatment, the referring health board stops reporting Mrs Kirkham's pathway.**
- **The tertiary site is now responsible to continue to report the open RTT pathway with the correct PSD until treatment is commenced**
- Reviewed by tertiary cardiologist date agreed for treatment
- Admitted and treatment commenced – **Clock stops**

Scenario G/3

Mr Evans is seen in his local hospital for his six monthly follow up appointment with his cardiologist. During the appointment the cardiologist decides he requires some additional tests to ensure his current treatment plan is still effective. The diagnostic tests are not available at the local health board so a referral is made to another health board for the tests. Mr Evans has his tests at the other health board and is then followed up again by his cardiologist in his local hospital and his medication is changed.

- Consultant referral for diagnostic tests in health board 2
- Diagnostic referral received in HB 2 **diagnostic pathway clock starts** (8 week target)
- Patient receives diagnostic – **Diagnostic clock stops**

There is no requirement for a new RTT clock as the treatment pathway continues although slightly amended.

Scenario G/4

Mr Burgess is referred to his local health board for shortness of breath. On his first appointment with his local cardiologist it is decided that he requires special diagnostic tests (not available locally) to support his diagnostics. Mr Burgess has his tests and is reviewed again at his local hospital where it is decided that no treatment is required at this time but he will be actively monitored to ensure his condition remains stable.

- GP referral to local cardiologist
- Receipt of GP letter by HB. **Cardiac clock starts**
- Initial outpatient consultation with cardiologist indicates specialist diagnostics are required to support diagnostic and treatment pathway.
- Referral for diagnostic tests sent to tertiary centre (**Diagnostic pathway start date**)

- Diagnostic tests undertaken (***Diagnostic pathway closed date***)
- Reviewed with results of diagnostics tests in local hospital, active monitoring agreed
Cardiac clock stops

Scenario G/5

Mr Jones has been medically managed for his cardiology condition by his local cardiologist. Over time he starts to worsen and presents at his outpatient appointment with worsening symptoms.

The cardiologist requests a number of urgent tests which can not be undertaken locally and have to be undertaken at health board two. The diagnostic tests indicate that that interventional treatment is required. The patient is referred to health board 2 where the treatment is undertaken

- Consultant referral for diagnostic tests at health board 2 – Cardiac RTT and diagnostic clock start – health board 1
- Diagnostic tests undertaken – diagnostic clock stops
- Results received
- Decision to treat made – cardiac clock stop at health board 1. Within health board 2, the patient is picked up on cardiac RTT monitoring and retrospectively tracked to their original pathway start date
- Patient admitted for interventional surgery: **Cardiac clock stops.**

Where a patient transfers from the care of one organisation to another but within the same treatment pathway, it is important that the onward referral clarifies the pathway start date.

RULES FOR MANAGING REFERRAL TO TREATMENT WAITING TIMES

Version 7

July 2017

Version Control		Issued
Version 1.1		December 2009
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Version 6	Revised final version following feedback from Q1 phased implementation	July 2017
Version 7	Changes made due to CAN being resets not adjustments as the system could not support this	October 2017

Revisions from version 6

Page 18	(57)	CAN amended to read CNA
Page 18	(62)	explained the adjustment period allowed
Page 19	(67)	CNA resulting in a reset not adjustment as stated in version 6
Page 22	(80)	Clarity around consultant changes and clock stops (excluding cardiac)
Page 23	(92)	clarifying adjust is the time it takes for the excluded service to be provided from the referral
Page 24	(94)	Unavailability more than eight weeks

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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. (appendixC)
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

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.

notify the NHS, hospital and GP of any changes in circumstances while they are waiting to be seen at any stage.

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 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 non-obstetric 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 9-5pm). 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.

Inability to contact a patient

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.

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 CNA, 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. The adjustment will be for the period of difference from when you planned to book them to when you actually book the appointment. (Adjustment can only be applied at the booking stage)

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 or 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 reset but they will 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 affect on the patients RTT clock.
78. All referrals within an RTT period to diagnostic services, therapy assessments or anaesthetic assessment, will continue the clock. When 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 writing. It would be expected that patients should retain their place on the waiting list to acknowledge their previous wait and be treated

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.

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. A referral to another consultant **except for a cardiac pathway** will stop the current RTT clock and commence a new RTT clock. 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.

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.

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 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), 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 for the test 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 a mutually 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, orthotics and 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 designated USC-only referral methods e.g. fax lines.

Appendix A

Included diagnostic tests

- Barium enema
- Computerized tomography (CT)
- Echocardiogram
- Electromyography
- Endoscopy
 - Bronchoscopy
 - Colonoscopy
 - Sigmoidoscopy
 - Gastroscopy
 - Cystoscopy
- Exercise stress tests
- Fluoroscopy
- Magnetic resonance imaging (MRI)
- Nerve conduction studies
- Non-obstetric ultrasound
- Nuclear medicine
- Pathology
- Plain film x-rays
- Urodynamic pressures and flows
- Vascular investigations

Appendix B

Included therapy services

- Adult hearing aids (at point of fitting)
- Dietetics
- Occupational therapy
- Physiotherapy
- Podiatry
- Speech and language therapy

Appendix C

Policy documents

WHC (2004) 067 – Definitions to Support the Cancer Waiting Times SaFF Target

WHC (2005) 027 – Monthly data collection of cancer waiting times to start definitive treatment

WHC (2005) 090 – Implementation of a Guide to Good Practice

WHC (2006) 081 – Delivering a 26 Week Patient Pathway - An Implementation Framework

WHC (2007) 014 – Access 2009 - Referral to Treatment Time Measurement

WHC (2007) 051 – 2009 Access - Delivering a 26 Week Patient Pathway- Integrated Delivery and Implementation Plan

WHC (2007) 075 – 2009 Access Project – Supplementary Guidance for Implementing 26-Week Patient Pathways

Cancer waiting targets: A guide (Version 4) (Department of Health, 2005)

A Guide to Good Practice: Elective Services (NLIAH, 2005)

Cancer Waiting Times: a Guide for Urologists (NHS National Cancer Action Team, 2006)

Cancer Waiting Times SaFF 05/06 and 06/07 query log

Single Source Guidance on the SaFF 2006-07 Cancer Waiting Times Target (WAG letter to service, 2006)