Llywodraeth Cymru
Welsh Government

GIG CYMRU NHS WALES

Guidelines for the management of Referral to treatment waiting times

April 2025

Accessibility

Please be mindful of accessibility requirements whilst enacting this guidance. The Equality Act 2010 requires service providers to make reasonable adjustments to remove disadvantages faced by disabled people and those defined as vulnerable throughout this guidance. In addition, the Accessible Communication and Information Standards require that NHS bodies in Wales provide information to patients and/or their carers in a format that is accessible to those with additional communication and information needs.

Contents

Section 1: Overview..... **4**
Document summary..... 4
Developing the RTT targets..... 4
Additional resources..... 5

Section 2: Underpinning and operational guiding principles..... **6**
Do only what is needed and do no harm..... 6
Care for those with the greatest need first..... 7
Public and Professionals are equal partners through co-production..... 7
Reducing inappropriate variation..... 8
Services delivered at a regional centre/provision or external provider..... 8

Section 3: Supporting patients to pro-actively prepare for treatment..... 10

Section 4: Communication with patients..... 12
Managing patient expectation..... 13

Section 5: Scope of the targets..... **15**
The RTT targets..... 15

Section 6: Clinical responsibilities..... **18**
The responsibilities of clinical staff in monitoring and managing waiting times..... 18

Section 7: Referrals..... 21

Section 8: Booking processes and reasonable offer..... 24
Booking processes..... 24
Direct booking..... 25
Partial booking (two stage process) 26
Inability to contact a patient..... 27
Reasonable offer..... 27
Refusal of a reasonable offer..... 28
Could not attend (CNA)..... 29
Did not attend (DNA)..... 30

Section 9: Attendance outcomes..... **32**
Clocks continue outcomes..... 32
Clock stop outcomes..... 33
New clocks start outcomes..... 36
Managing patients on multiple pathways..... 37

Section 10: Adjustments..... **39**
Patient unavailability..... 39

Section 11: Service delivery..... **41**
Planned Care..... 41

Emergency care…… 42

Section 12: Accountability: Recording and reporting…… **43**
Reporting formats…… 43
Accountability for monitoring open pathways…… 43
Accountability for performance…… 44
Accountability for reporting…… 45

Glossary…… **46**

Appendices…… **66**
Appendix A - Policy documents
Appendix B – Treatment Function Title Codes

Version control…… **71**

IMPORTANT NOTE

The April 2025 Guidelines have been developed to take into account the new and evolving planned care landscape. It is acknowledged that system improvements will need to continue to be undertaken to enable health boards to fully implement these guidelines. This will include:

- Identification of vulnerable individuals.
- Identification of patient communication preferences and needs, including sensory needs.
- Recording and reporting of regional and commissioned provision of services.
- Management of pre-optimisation periods within the patient pathway.

Further work is ongoing to develop data standards and supporting system processes to reflect:

- The new ways of delivering planned care in the future.
- Embedding of patient reported outcome measures and assessments into the pathway to facilitate patient clinical stratification and clinical risk management.

Section 1: Overview

Document summary

1. This document provides a complete reference source of the waiting times management guidelines in line with the referral to treatment (RTT) targets and the direct access diagnostic and therapies targets. Guidelines on the management of cardiology/cardiac pathways are also provided in this document.

Developing the RTT targets

2. In December 2009, the national referral to treatment target in Wales became live stating that 95% of patient pathways would wait 26 weeks or less until commencement of treatment with 100% of people waiting 36 weeks or less.

3. The guiding principles of the target were set in policy through a range of Welsh Health Circulars (*Appendix A*).

4. The national targets were suspended during the covid pandemic in 2022 due to clinical need and infection control management and the impact this had on the capacity to deliver safe planned care.

5. The planned care recovery plan Our programme for transforming and modernising planned care in Wales and reducing the waiting lists was published in April 2022. The document sets a number of key access milestones for the NHS in Wales to deliver as part of the national commitment to recover planned care services to pre-covid levels. The recovery milestones currently supersede the national RTT targets as the national performance measures, however the 26-week target remains the fundamental RTT policy direction for Wales.

6. The achievement of RTT targets is the responsibility of health boards (HBs).

7. The underlying principle of waiting list management and the targets is that patients should receive excellent care without delay. Clinical urgency, assessed by the

receiving consultant, prioritises resources in line with assessed clinical need. Routine pathways are managed on a treat-in-turn basis where the longest waiters are seen first.

8. Within the waiting-time period, both the patient and the NHS have their roles and responsibilities to achieve this target.

9. This document aims to set out clearly and succinctly the guidelines to ensure that each patient's RTT clock 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.

Additional resources

10. The *Additional resources to support implementation of the RTT Guidelines* document has been developed to support staff to accurately and consistently apply the RTT Guidelines.

11. *How your health board manages waiting lists: What this means for those waiting for hospital appointments and treatment* and *being referred for specialist care* are public-facing documents that have been developed for local adaptation to provide information to those accessing planned care and their carers/family.

Section 2: Underpinning and operational guiding principles

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

12. There are several key principles which underpin the waiting times guidelines 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

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

14. HBs should ensure an efficient RTT pathway, as clinically appropriate, by implementing the new ways of delivering services e.g. maximising the multi-disciplinary team's capacity including non-consultant-led clinics, 'one-stop' clinics, 'straight-to-test,' 'straight-to-list', and Welsh regional centres/provision.

15. Where clinically appropriate to do so, health professionals should provide patients with the choice and convenience of face-to-face or virtual appointments. Synchronous virtual appointments via telephone or video should be maximised where clinically practicable. HBs may also undertake asynchronous reviews followed by written updates to the patient and referrer.

16. Where clinically appropriate to do so, alternative prudent ways of delivering care should be implemented that contribute to efficiency and productivity by maximising clinical capacity within the multi-disciplinary team. This would include see-on-symptom (SOS), patient-initiated follow-up (PIFU) and group clinics (face-to-face and virtual).

Care for those with the greatest health need first

17. Targets should not distort clinical priorities. RTT targets are maximum acceptable waits, and urgent patients should be treated as their clinical need dictates. (*The covid risk stratification of waiting list is no longer appropriate and RTT pathways should be either urgent or routine)*

Public and Professionals are equal partners through co-production

18. The concept of the NHS/patient 'compactum' 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 preferences within that time through shared decision-making and regular communication. Patients will be expected to pro-actively prepare and 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, not being listed for surgery or removal from the waiting list.

19. 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) The Accessible Communication and Information Standards require that NHS bodies in Wales provide information to patients and/or their carers in a format that is accessible to those with additional communication and information needs. 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 and ensure their contact details are kept up to date while they are waiting to be seen at any stage. Additional resources to inform patients of their rights, role and responsibilities when accessing planned care can be found in the following documents:

    - *How your health board manages waiting lists: What this means for those waiting for hospital appointments and treatment*
    - *Being referred for specialist care.*

20. 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 guidelines 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.

21. The guidelines 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 guidelines, 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 guidelines where these are directly in the patient's best interest. This national guidance needs to be supported by local access policies for each HB.

22. This national guidance should be supported by new patient referral models including e-referral platforms and the national community pathways platform.

Services delivered in a regional centre/provision and external providers

23. Regional centres (including regional provision offers within a health board) focus on the delivery of high-volume low complexity (HVLC) procedures and play an important part of plans to modernise and transform planned care delivery, increase surgical capacity, and offer more patients quicker access to treatment. Regional centres/provision exclusively deliver planned procedures, and all resources and capacity are ring-fenced for this purpose. Health boards may also, on occasion, commission external providers to deliver services on their behalf. Evidence shows that the main barrier to accessing treatment out of the health board area is transport. Health boards are expected to have a current ***Patient Transport Policy*** supported by clear information communicated both digitally and non-digitally to enable patients to access care in line with their needs. Patients' need to travel may be minimised through the provision of initial, pre-assessment and follow-ups at the local hospital with patients only being required to travel for treatment.

24. A clinician may refer a patient to a regional centre/provision or external provider in line with the patient's assessed clinical needs. Patients with more complex needs may need to remain on the waiting list for treatment at their local health board. In both cases, the pathway clock will continue.

25. When a clinician assesses that the regional centre/provision or external provider can meet the clinical needs of the patient, this becomes a 'reasonable offer' for treatment. However, a patient with wider, more complex medical or social barriers such as mobility or sensory impairments which NEPT (non-emergency patient transport) are unable to meet (either due to availability or the patient's level of needs). A good example of a legitimate barrier are those patients that fall into the vulnerable groups categories. In such cases, the patient should continue to wait to be treated locally, and the pathway clock will continue.

26. If a patient, who is deemed by the clinician as suitable for treatment at a regional centre/provision or external provider, provides no evidence of any other clinical or legitimate reason, declines to be treated at the offered site, there should be an additional conversation with the patient. The aim of the additional conversation is to discuss the potential medical or social barriers to them not taking up this offer in this location. If the barrier is judged NOT to be a **legitimate reason** this is considered to be **declining a reasonable offer**. If the clinician feels the patient needs to remain on the waiting list, their clock will be reset and start again at the appropriate stage of their pathway, and they will remain waiting at their local site. If the clinician feels they do not need to remain on the pathway, the RTT clock is stopped, and they are discharged back to the care of the GP.

27. If a patient has been referred to a regional centre/provision or external provider and the receiving clinician assesses the patient as not being suitable for treatment at that location due to their level of clinical need, the patient will be transferred back to the local health board for treatment. The pathway clock will continue.

Section 3: Supporting patients to proactively prepare for treatment

28. All HBs should provide the appropriate support to all those waiting for treatment. In line with the 3Ps Policy: *Promote, Prevent and Prepare for Planned Care* published in August 2023 (see *Appendix A)* all HBs should have a single point of contact where all those on a secondary care pathway can access information and support including Making Every Contact Count (MECC) conversations where tailored information and support can be identified to empower those waiting to better self-manage their health and pro-actively prepare for treatment. This includes the provision of, and signposting to, appropriate accessible Waiting Well information and services in line with their assessed health and wellbeing needs. All support provided should be underpinned by the principles defined in the 3Ps Waiting Well Patient's (or Person's) Charter.

29. All patients should be offered Waiting Well support in line with their individual needs to facilitate shared decision-making and pro-actively prepare for treatment. For those waiting on identified pathways, this will be supported by the EQ-5-DL and the refreshed "About You 2" assessment. The assessment should be repeated at six-monthly intervals thereafter during the waiting/preparation for treatment period. Patients' inability to pro-actively optimise their health may result in a longer waiting time, not being listed for surgery or removal from the waiting list.

30. If deterioration is identified on review of the EQ-5-DL and the "About You 2" assessment in line with the identified Waiting Well standard operating procedure, the clinician may reprioritise the patient.

31. All patients requiring surgical treatment and added to a waiting list should complete the digital assessment tool, with support if required, in line with the Planned Care Anaesthetics Clinical Implementation Network protocol. If, on review of the assessment, the clinician feels that the patient is not fit to undergo surgical treatment at that time, the patient should not be listed for surgery.

32. If the clinician feels the patient is not fit to be listed for surgery at that time, the patient should instead be offered support to optimise their health in preparation for treatment. The need for optimisation/pre-optimisation greater than 6 weeks (medical adjustment) will stop the clock, and the patient placed on active monitoring. The assessment of fitness for surgery needs to be sensitive to the potential additional issues related to “vulnerable groups”.

33. When the patient is considered ‘fit for treatment’ the clock should restart at the appropriate stage in the pathway, acknowledging the previous wait.

34. If pre-optimisation is required to be fit-for-surgery and the patient refuses, the consequences of their decision should be explained, and an alternative treatment plan offered in line with the patient’s clinical needs. If an alternative treatment plan is deemed appropriate by the clinician, the clock will stop when the alternative treatment commences, e.g., conservative treatment and/or condition management. If the clinician decides the patient should be discharged back to the care of the GP, the clock will stop.

Section 4: Communication with patients

NOTE: *There is a requirement within the Accessible Communication and Information Standards to ensure that correspondence sent to patients and/or their carers/parents is accessible for those with additional communication and information needs*

35. Information given to the public must provide up to date information on the expected timescales for their wait (based on local data), 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.

36. When confirming a referral with the patient, e.g. in the referral confirmation letter, the HB should inform patients how their appointments will be booked and to clearly define their role in agreeing and attending any booked appointments at locations appropriate for their clinical needs, including links to the HB website landing pages providing this information.

37. HBs should ensure that they have clear and accessible information on their website explaining to patients the guidelines relating to attending booked appointments, how to cancel and rearrange appointments, and the impact it will have on their waiting time if they do not attend an agreed appointment. Non-digital resources should also be made available. (See *How your health board manages waiting lists: What this means for those waiting for hospital appointments and treatment).*

38. HBs should ensure that they have meaningful communication with the patient on an RTT pathway a minimum of six-monthly if there has been no pathway activity/contact directly with the patient in line with the 3Ps Waiting Well Policy: Promote, Prevent, and prepare for Planned Care (see *Supporting patients to pro-actively prepare for treatment* and *Appendix A*).

39. HBs should ensure that if deterioration in a patient's clinical condition is identified, a clinical review will be undertaken for the purpose of reprioritising the patient as clinically indicated in line with agreed clinical escalation protocols. Changes in the patient's condition may be identified reviewing the EQ-5-DL and the "About You 2" assessment (for an agreed set of clinical conditions) which will be undertaken every 6 months until treatment starts. Patients may also express concerns regarding their worsening condition to other HB staff who can refer them to the HB Waiting Well single point of contact for assessment and possible escalation as necessary in line with clinically agreed standard operation procedures (SOPs).

40. All clinicians, in both primary and secondary care, should clearly communicate to patients their role and responsibilities in, and the benefits of, pro-actively preparing for their treatment/procedure to maximise their clinical outcomes. It should be made clear that preparing for treatment can reduce the risk of their procedure being postponed if they are unfit to undergo their treatment, not being listed for surgery or removal from the waiting list.

41. Patients should be provided with clear, accurate and transparent communications at the beginning of, and as required throughout their care journey. Communications with patients should be in a format appropriate to their needs and preferences, e.g. large print, digital, non-digital or relevant translations. It is important that patients are asked to confirm their communication needs and preferences at the beginning of their care journey and their preferred format when receiving communication from the Health Board. Where practicable this should be captured and made available to all services to ensure patient preference/patient needs are met. Refer to All Wales Standards for Accessible Communication and Information for People with Sensory Loss (see Appendix A).

GOOD PRACTICE: Hywel Dda University Health Board

Meeting the Communication and Information Needs of People with a Sensory Loss when Accessing our Healthcare Services. - Bevan Commission.

Managing patient expectation

42. HBs should inform patients on confirmation of their referral that they may be offered appointments outside the HB area and the reasons for doing this. This may include Welsh regional centres/provision or alternative providers where patients will receive specialist care sooner. HBs should inform patients who have barriers with travelling may be eligible for help and support to enable them to attend their appointments 'out-of-area'.

43. HBs should ensure that patients are aware that they may be offered a virtual appointment in accordance with their clinical need such as a telephone appointment or video appointment.

44. HBs should ensure that activity and outcomes relating to Waiting Well support services should be recorded and reported in line with published Data Standards This may include, but is not limited to pre-optimisation or prehabilitation, signposting to community resources, signposting to information.

Section 5: Scope of the targets

RTT targets

45. The scope of the RTT targets encompass 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.

46. The RTT targets do not replace the following waiting times targets:

- Cancer target (62 days) (see specific cancer document WHC 2021/001 (gov.wales) and Suspected cancer pathway: guidelines (WHC/2024/07) | GOV.WALES
- *New data set for Audiology pathways being finalised for reporting from April 2025.*
- Diagnostic tests (8-week waiting time operational target)
- Therapy services (14-week waiting time operational target)

47. Each of the above targets should be managed according to their own specific guidelines, where these exist. It is acknowledged that at the time of the publication of these guidelines, the planned care recovery targets are the delivery measures for performance monitoring. This national guidance is independent of all identified targets as its primary purpose is to ensure fair, equitable and transparent management of waiting times.

48. The RTT clock **starts**:

- on the receipt of a referral in secondary or tertiary care, or
- if a new treatment requirement is identified following a previously closed RTT pathway.

The RTT clock **ends** when:

- events for closure without treatment are met (Paragraph 52), or
- when definitive treatment commences.

Treatment will often continue beyond a first treatment and after a clock has stopped.

49. A referral received from a screening service will begin a new RTT clock.

50. A self-referral or patient-initiated follow-up will not begin an RTT clock unless it follows a period of unavailability, (see Section 10). If a new decision to treat or change of management plan is subsequently initiated, a new RTT clock will start.

51. Some patients may be on more than one RTT clock 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 need for a second hip or knee procedure after the original decision of bi-lateral replacement or cataract surgery). Good practice indicates that unless clinically agreed each procedure would be two separate reported pathways. The timeframe for the second procedure should be advised by the clinician on closure of the initial pathway. This advice will trigger a new RTT pathway. The new RTT clock should start on the date the advice was provided by the clinician that the patient is ready to start a new pathway.

52. Events other than treatment which can stop an RTT clock may include:

- A decision made that treatment is no longer clinically indicated for the patient.
- Commencement of active monitoring (including watch and wait and pre-optimisation)
- A consultant-to-consultant referral for a different condition within or outside the original health board (other than from cardiology to cardiac intervention/surgery). This **does not include** consultant-to-consultant referrals for the same condition, i.e. referral to a regional centre/provision or external provider commissioned to deliver services on behalf of the health board, or cardiology physician to cardiac surgeon internally.
- When a patient indicates that they no longer wish to receive treatment.

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

53. All waits for required diagnostic and therapy services are included in the RTT reporting of an RTT pathway. This includes diagnostic and therapy

procedures/services which are currently non-reportable and are not subject to the current 8 week and or 14 week reporting standards.

54. Patients with a recurrence of cancer, which is not covered by the 62-day targets, will be covered by the RTT targets but their clinical priority should determine their appropriate clinical wait.

55. For orthodontics, the first outpatient appointment will usually be considered the start of definitive treatment with the expectation that a treatment plan is agreed. Any subsequent treatment will be outside the RTT targets.

56. The table below provides some specific patient groups which are included within the scope of the RTT targets.

Included service area/patient group	**Notes**
Patients with recurrence of cancer	Any recurrence not covered by the 62- day cancer target.
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 RTT targets particularly challenging. The detailed reasons why these patients exceeded the target time should be recorded in the breach analysis.
Private patients	A patient cannot be both a private and an NHS patient for the treatment of one condition during a single visit to an NHS organisation. Any patient seen privately is entitled to subsequently change his or her status and seek treatment as an NHS patient. Any patient changing their status after having been provided with private services should not receive an unfair advantage over other patients (jump the queue). Patients referred for an NHS service following a private consultation or private treatment should join any NHS waiting list at the same stage as if the prior consultation or treatment were an NHS pathway. Their priority on the waiting list should be determined by the same criteria applied to other referrals. The entry on to the appropriate stage commences a new RTT clock start.

Section 6: Clinical responsibilities

The responsibilities of clinical staff in monitoring and managing waiting times

57. 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 the appropriate actions when those waiting times are not meeting the expected level of quality of care.

58. Clinical staff must be aware of national requirements and organisational policies in respect of waiting times. Local clinical practice should also reflect the national published guidance from the Planned Care Clinical Programme (Clinical Implementation Networks). 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.

59. Clinicians should ensure that their actions promote the principle of patients waiting the shortest possible time for treatment. Where clinically appropriate, this may include alternative pathways that maximise the capacity within the MDT, regional centres/provision and new ways of delivering services such as ‘straight to test’, ‘straight to list’ and one-stop clinics.

60. 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. Depending on their level of need, all patients should be supported to ‘wait well’ and prepare for treatment in line with the 3Ps Policy. This would include signposting to the HB Waiting Well SPOC, HB Waiting Well landing pages and/or referral to pre-optimisation and pre-habilitation services. This may further develop in line with the developments of pre-operative screening and assessment needs.

61. 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 as specified in the HB's Community Health Referral Pathways. Patient-centred referral is also supported on e-referral systems including 'request for treatment', 'request for investigation' or 'request for advice'. Additional information can also be accessed via synchronous and asynchronous advice and guidance.

62. 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. Additional information can also be accessed via synchronous and asynchronous advice and guidance. Referrers must ensure that the patient is aware of and agrees for a referral to be made.

63. Clinicians must cooperate with agreed local systems to enable the recording of the clinical outcome of all interactions with patients in line with published data standards. This would include both face-to-face and virtual contact. Virtual contact may be synchronous (by telephone or video call) or asynchronous (by letter or by electronic means). Contact may be on a 1:1 basis or within a group (group clinic or virtual group clinic).

64. 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.

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

66. Clinicians should ensure that all necessary information is provided to patients to enable them to engage in meaningful shared decision-making and be empowered and pro-active partners in their own care.

67. All decisions regarding whether patients who DNA/CNA or decline to be treated at a regional centre/provision or external provider remain on the waiting list will be made by the clinician in the originating health board.

Section 7: Referrals

68. The RTT clock will start when:

- a referral from a GP, GDP or any other healthcare professional where referral protocols exist is received by the secondary or tertiary hospital. This includes:
- a referral for 'straight-to-test'
- a referral for 'straight-to-treatment/list'
- a new treatment requirement is identified for the same condition following a previously closed RTT pathway.

The RTT clock starts at the time **it has been received** in the health board. This is to address any potential delays in the clinical triaging of received referrals so as not to disadvantage the patient. Acceptance of the referral into secondary care could trigger the *EQ-5-DL* and the *"About You 2"* assessment as part of preparation for treatment for **identified specialties.** Patients should be supported to understand their role in preparing for treatment to optimise their health and wellbeing and maximise the benefits from their treatment. Patient optimisation and prehabilitation also reduces the risk of treatments being postponed as the patient is unfit for treatment.

69. 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, this includes the national referral guidance processes agreed and supported through the Planned Care Programme and other national clinical networks. 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.

70. HBs should provide up-to-date information to referrers relating to the patient pathway that will be followed and the locations the service will be delivered from as indicated on the Community Health Pathways referral platform. This information should be communicated clearly to the patient. HBs should have systems and protocols in place to keep this information up-to-date and available to referrers.

71. HBs should indicate to the patient the likely waiting time to be seen for that specialty. Discussion should be supported by written information for patients on confirmation of referral and/or during consultation. HBs should signpost patients to where they can get additional information and support to 'wait well' and prepare for treatment including the Waiting Well SPOC and HB Waiting Well landing pages. HBs should have systems and protocols in place to keep this information up-to-date and available to patients and referrers.

72. 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. The referrer should be signposted to the local HB Community Health Pathways referral platform for further guidance.

73. 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**. Good practice of pool referrals in line with Community Pathways should reduce this risk.

74. When a referral is made to a clinician or specialty within the HB and the referral is forwarded to a Welsh Regional Centre/provision, **the clock does not stop**. It is the responsibility of the Regional Centre/provision accepting the referral to send confirmation to the patient and original referrer, e.g. the patient's GP.

75. If the referral is forwarded by the HB to the Welsh Regional Centre/provision, and the reviewing clinician deems the patient clinically inappropriate for treatment at the Welsh Regional Centre/provision, the referral should be returned to the HB. The

clock **does not stop**, and the patient should be seen within the same RTT clock period. It is the responsibility of the original health board to confirm with the patient that they will be treated at their local health board rather than the Regional Centre/provision.

76. The benefits of being treated at the Regional Centre/provision should be clearly communicated to the patient as well as the disadvantages of being treated locally, i.e. the patient may have to wait longer for their treatment. If a patient declines the offer to be treated at a Regional Centre/provision and they have a legitimate reason for refusing this offer, they may be treated locally, and their clock will continue. If they decline the offer but have no legitimate reason for doing so, they may be treated locally but their clock will be reset. (See *Additional resources to support implementation of the RTT Guidelines).*

77. When a referral does not comply with agreed referral guidelines as indicated within the Community Health Pathways the referral should not start until the referring clinician complies with the referral guidance. The HB should return the referral with advice on the next steps to take. HBs should work with primary care to turn such referrals around within 48hrs and 'return with advice' recorded within the e-referral platform.

78. 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 with a 48-hour turn-around target. It would be expected that the requested information is returned by the referring clinician within 48 hours. The RTT clock 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.

79. HBs need to work with primary care to ensure good quality information flows between the two areas to support effective patient care. This communication interface is supported by implementation of the Community Health Pathways and access to synchronous and asynchronous remote advice and guidance.

Section 8: Booking appointments and reasonable offer

Booking processes

80. All patient appointments should be booked using a patient-focused booking approach. The local booking processes used by HBs need to be clearly communicated to patients at referral to ensure patients are clear on their role and responsibilities in the process. In line with shared decision-making principles, all appointments should be made with the involvement of the patient. Their role and responsibilities in how the appointment will be mutually agreed and how to make changes should be clarified. This must be adhered to, even when the organisation does not hold complete contact details for the patient.

81. 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* on page 27).

82. Where available, patients should be provided with an opportunity to re-book their appointment on the HB patient-facing platform by selecting an available appointment slot. If the patient confirms the appointment on the platform, this will be considered as accepting a reasonable offer. Confirmation of the booking should be sent to the patient with information on how to access information if they make any changes to their booking and the consequences of doing this.

83. If the patient has indicated they do not wish to use a digital platform, the HB should ensure that they are provided with a non-digital alternative to prevent digital exclusion and inequity of access to care, e.g. letter inviting them to telephone the HB to book their appointment. The HB should ensure that information on digital and non-digital booking is provided on their website and included in the confirmation of referral letter. There is a requirement within the Accessible Communication and Information Standards to ensure that correspondence sent to patients and/or their

carers/parents is accessible for those with additional communication and information needs.

84. Where a fully automated model is utilised, and the HB sends the patient a letter/text/call/email to arrange a date, the HB should have a process in place to allow the patient to play an active role in changing the appointment if they cannot attend. Patients need to be clear about their role and responsibilities in agreeing dates in keeping with principles of co-production and shared decision-making. This process needs to be clearly explained to the patient 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* on pages 25-26).

85. The Armed Forces Covenant - Healthcare Priority / Special Consideration for Veterans / Ex-Armed Forces Personnel (WHC (2023) 022) (See *Appendix* A) states: 'All Armed Forces veterans are entitled to receive priority access to NHS care and treatment for any conditions (mental and physical) which are considered to be related to, or resulting, from their military service.' Where consultants or allied health professionals agree that the veteran's' condition is related to the patients' service, they are asked to prioritise veterans over other patients with the same level of clinical need. Veterans will not be given priority over other patients with more urgent clinical needs.

86. 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.

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

Direct booking

88. Direct booking can take place in two ways:

    i. An appointment can either be booked in a face-to-face or telephone interaction with the patient, or

    ii. Through a direct dialogue with the patient via letter/email and or text. In this case, any correspondence should be sent at least 10 working days prior to the appointment date. 10 working days is recognised as a *reasonable notice period*.

89. 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 to Friday 9am to 5pm). If contact with the patient has not been achieved, a letter must be sent to the patient, asking them to make an appointment or confirm attendance either by phone or on the patient-facing platform. 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.

90. Direct booking for clinics with less than 10 working days' notice should be done directly with the patient, either face-to-face or via telephone. If the patient **does not** accept the offer of a short notice appointment, this cannot be managed as a reasonable offer and the clock remains unaffected.

91. If a patient accepts a short-notice appointment this is then considered to be an agreed appointment, and the patient should be informed of the consequences if the appointment needs to be changed. If the patient does not attend the appointment, it should be managed as a CNA or DNA as appropriate.

Partial booking: 2-stage process

92. 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, including a choice of digital or non-digital methods. 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, or book their appointment via the patient-facing platform within the next 10 days (phone letter).

93. 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.

94. 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 is seen as good practice.

Inability to contact the patient

95. 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 patient and referrer notified.

Reasonable offer

96. 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.

97. Patients should be offered at least two possible dates and/or times, which must be more than two weeks in the future. In the case of offers of treatment at a regional provider/ outsourced contract the refusal to even be offered two appointments is

considered refusing a reasonable offer if they cannot provide a legitimate reason (as previous described under regional provision).

98. Patients should be offered appointments at any location providing the required service in line with patient's clinical needs. This includes a Welsh Regional Centre/provision or external provider. Travelling to locations other than the patient's local health board for treatment will be considered reasonable if this was explained to the patient when they were referred or in the receipt of referral acknowledgement.

99. An adjustment can be applied where it has not been possible to agree a suitable date within the booking period originally planned. The adjustment will be for the period of difference from when it was planned to pool them to when the appointment is actually booked. (Adjustment can only be applied at the booking stage).

100. HBs must consider postage times when sending letters offering a direct booking appointment to patients to avoid the patient receiving the letter on, or following, the day of the appointment. If a patient does not attend an appointment (and DNA recorded) and subsequently contacts the HB to state that they did not receive the appointment letter in time, the HB should amend the patient record, and the clock should continue with no adjustment. An alternative timely offer should be made to the patient at the earliest opportunity. To avoid this, HBs must ensure that letters offering a direct booking should be sent a minimum of 10 working days before the appointment date.

Refusal of a reasonable offer

101. A patient may 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 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). If the patient declares themselves as unavailable for the time period in which the offers are being made, the social unavailability guidelines will apply. (See Section 10). Additional consideration may be required for "Vulnerable groups" depending on their needs

102. If the patient is available during the offer period, but refuses a reasonable offer, the clock will be reset. It should be clearly explained to the patient that refusal of a reasonable offer to be treated at a regional/centre/provision may result in them waiting longer for their procedure. The new clock start will be the date that the patient refuses the offered appointments.

103. If a patient is clinically appropriate for treatment at a regional centre/provision or external provider and they are unable to provide a legitimate reason for not accepting, this is deemed to be refusing a reasonable offer. They may be treated locally but their **clock will be reset.**

Could not attend (CNA)

104. 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.

105. 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.

106. On the second CNA within the same pathway in the same HB, the patient should be treated as a DNA as they have broken the "compactum" 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.

107. 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.

108. When a patient as part of an already commenced pathway is referred for treatment at a Welsh Regional Centre/provision, for the purpose of practicality if the patients previous DNA/CNA episodes **cannot** be provided at the point of transfer, previous DNA/CNA episodes will not be considered when managing the patient pathway. However, any CNA/DNA incurred in the regional pathway will be managed under these guidelines.

Did not attend (DNA)

109. 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.

110. If the patient is a minor or is deemed 'vulnerable' in line with the definition and table below, consideration should be given to the appropriate application of this RTT Guidance. This should be further explored in the development of local policies and procedures i.e. 'was not brought' guidelines. For vulnerable patients, the pathway should remain open until any assessments are completed and its outcome determined. Once the outcome has been determined, the clinician responsible for the patient will decide if the patient is to be removed from the pathway for clinical reasons, or they remain on the pathway with their clock reset.

DEFINITION

In the context of the All-Wales Safeguarding Procedures, being 'vulnerable' is defined as in need of special care, support, or protection because of age, disability, risk of abuse or neglect.

However, for the purpose of this RTT, vulnerability relates to an individual's likelihood of experiencing disadvantage as a result of circumstances beyond their control. All children under the age of 18 should be considered/classed as "vulnerable" to risks and poor outcomes as a result of action or inaction by other people such as their carers/parents.

111. If a patient DNAs their appointment but later informs the hospital that their NHS transport did not arrive or was cancelled, this should be recorded as a hospital-initiated cancelation (HIC). As their non-attendance was due to reasons outside the patient's control, they should not be disadvantaged. It is the patient's responsibility to notify the hospital as soon as possible. A new appointment must be booked with no effect on the patient's RTT clock.

112. 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. To minimise the risk of clinical harm to the patient, they should be offered another appointment at the earliest opportunity, and a clock reset to their pathway made and explained.

113. 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. 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 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.

Section 9: Attendance outcomes

114. An outcome must be recorded within the information system for every patient interaction, whether the patient is present or not.

115. The outcome will fall into one of **four** categories:
    - clock continues,
    - clock reset,
    - clock stops, or
    - new clock starts.

116. 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 continues' outcomes

117. A 'clock continue' outcome is used to define decision points along the pathway where the current clock status will continue. Within an RTT clock period, the clock continues to tick until a clinical decision to stop is reached or first definitive treatment commences regardless of whether the treatment is to be delivered by the treating speciality or via a therapy service.

118. When there is no current RTT clock, the previous clock remains stopped. (A new clock may commence if the clinical need of a patient changes during any ongoing follow-up or trigger of the SOS, PIFU or supported self-management pathway).

119. If an appointment is cancelled by the organisation (HIC), the clock will continue, and a new appointment must be booked with no effect on the patient's RTT clock.

120. All referrals within an RTT clock period to diagnostic services, therapy assessments or anaesthetic assessment, will continue the clock.

121. When a patient is referred for treatment at a Welsh Regional Centre/provision for the same condition, the clock will continue.

122. When a patient is referred from an NHS organisation to an independent sector organisation as part of their NHS pathway, the clock will continue. This includes transfer of care to a Welsh Regional Centre/provision.

123. For those deemed as vulnerable under the definition (see Paragraph 110) waiting times accrued at one health board should still be used and counted if their care transfers to another health board for the same condition. This is to ensure that those deemed as vulnerable are not disadvantaged and have their pathway reset. Referral protocols for vulnerable groups need to be developed by health boards to manage this along the lines of cardiac pathways.

124. For other patients who move to reside in a different HB area mid-pathway, there is no formal requirement for the receiving health board to acknowledge the previous wait, however, it is good practice that the receiving HB should take into account the period the patient has already waited and offer an appointment at the earliest opportunity.

125. For patients who move to reside in a different HB area mid-pathway and are considered as being 'vulnerable' under the definition in Paragraph 110, the receiving health board is required to acknowledge the previous wait so as not to disadvantage the patient.

'Clock stop'

126. A clock stop outcome is used to define decision points along the pathway where a current RTT clock will end.

127. Clock stop outcomes are used for events which constitute a treatment, a decision that no treatment is required, when a patient commences a period of pre-

optimisation, when the patient is unavailable for medical or social reasons longer than the agreed periods (see Section 10), when advice and guidance is returned to the referring clinician, or they are clinically removed for non-compliance with accepting or attending appointments.

128. Treatment is defined as a clinical intervention intended at the time of the intervention to manage the patient's condition.

129. When treatment is given in a non-admission setting (i.e. procedures undertaken in an outpatient clinic setting), the clock will stop on the date the treatment commences. This can include therapy services delivered as the definitive treatment.

130. 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.

131. 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.

132. When a patient is transferred between consultants for reasons of clinical necessity that prevents the current pathway being completed, the clock will stop, e.g., prioritising a cardiac condition over an orthopaedic elective procedure. When this is simply a request for advice, this must be managed within the RTT clock 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 clock (not for cardiac pathway), however the organisation should take into account the time already waited by the patient in deciding treatment priority/timescales.

133. 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.

134. 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. They are then discharged from the waiting list.

135. When a diagnostic procedure converts to a therapeutic intervention which meets the treatment definition, the clock will stop. This may include a diagnostic endoscopy resulting in polypectomy which is considered the start of treatment. The clock stop date will be the date of the intervention. This may include activity undertaken in a 'one-stop-clinic.'

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

137. 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 six weeks in one period, the clock will stop. The clock stop date will be the date the organisation is made aware of the event.

138. If, in the opinion of a suitably qualified healthcare professional, a patient has a medical condition which will not be resolved within 6 weeks, 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.

139. 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.

140. If, following referral a patient is assessed by a healthcare professional as not being fit-for-treatment, the clock will stop to enable the patient to actively prepare for treatment e.g. pre-optimisation, pre-habilitation. This will be for a period as agreed with the patient. When the patient is deemed fit-for-treatment by a healthcare professional, the clock will restart at the appropriate stage of the pathway and continue until treatment is commenced.

141. 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 is outside the RTT guidelines.

New clock start

142. 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 clock 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 clock 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 clock: an example being physiotherapy being offered to support ongoing pain relief.

143. 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 clock will begin. The clock start date will be the date of discharge from the emergency stay.

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

145. 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 into the pathway rather than creating a new referral via the GP providing the patient now commits to their availability. (Local discretion and communication with the patient are appropriate). The patient should return to the pathway at the clinically most appropriate place, and a new RTT clock 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.

146. There are specific services which start a new RTT clock as shown below.

Service	Clock Start
Screening services	A decision to refer from a screening service would begin a new RTT clock.
Community paediatrics	A decision to refer from community paediatrics would begin a new RTT clock.
Routine dialysis treatment	A decision to refer following a dialysis session would begin a new RTT clock.
Obstetrics	A decision to refer from obstetrics for a non-obstetric condition would begin a new RTT clock.

Further information on Treatment Function Title Codes can be found in Appendix B.

Managing patients on multiple pathways

147. If a patient is already on a waiting list and the consultant feels it necessary for the patient to be added to a second waiting list, the procedure pathway with the least clinical priority should stop on active monitoring, e.g. if a patient is on an arthroplasty pathway but has cardiac needs that need to be addressed in order that the patient is fit for procedure, the cardiology pathway should be prioritised. The orthopaedics clock should stop. Clear communication should be sent to the patient and referrer informing them of this decision and what it means to them. When the clinical decision

is made that the patient's orthopaedic pathway can resume, the clock will be restarted at the most appropriate stage of their pathway. (For further guidance please refer to *Additional resources to support implementation of the RTT Guidelines* document). The clinical needs of "vulnerable groups" who may be on more than one pathway may need additional review.

Section 10: Adjustments

Patient unavailability

148. When a patient is unavailable due to a short-term medical condition, such as a cold, tooth infection an adjustment to the RTT clock 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 6 weeks. The patient should remain on the active waiting list and an adjustment of up to 6 weeks may be applied. If it is felt by a qualified healthcare professional not to be a condition which should resolve in 6 weeks a clock stop should be applied.

149. 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 6 weeks in each stage of the pathway.

150. 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 clock will end. A second 6-week period cannot be applied within the same stage of the pathway.

151. When a patient is unavailable due to social reasons, an adjustment to the RTT clock may be applied. (maximum 6 weeks).

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

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

154. When the period of unavailability is more than six weeks the patient should be removed from the pathway and the patient and referrer notified. This includes periods of social and clinical availability (see below). The patient and/or referrer should notify the health board when the patient is available, and the clock restarted at the most appropriate stage of the pathway. If the period of unavailability (including for purposes of patient optimisation) exceeds 6 months, a new referral will be required.

> **Social unavailability:** when the patient informs the health board that they are unavailable for more than 6 weeks due to patient choice, e.g., an extended holiday/period of travel.
>
> **Clinical unavailability:** when the patient is unable to receive treatment due to a clinical reason/decision. This may include during a period of optimisation or treatment on another pathway which has been prioritised.

Section 11: Service delivery

Planned care

155. Planned care relates to elective admissions and review activity, both face-to-face and virtual, undertaken with and without admission, in areas such as in outpatient environments, and hospital wards. This includes Welsh Regional Centres/provision. Care is planned to occur in the future.

156. When a patient clinically requires bilateral or sequential procedures, the RTT clock for the first procedure will be managed routinely under the RTT guidelines. A new RTT clock will begin when the patient is deemed fit and ready for the second or subsequent procedure/s. This will be clinically determined. The clock will start on the date of the decision to admit or carry out the procedure in an outpatient environment. The clock will stop on the date of admission or the date when the procedure is undertaken in an outpatient environment for the second or subsequent procedure/s.

157. 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 clock will end once active monitoring is decided. A new RTT clock 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 is made that the patient is ready to receive the treatment and stop on the date of admission for the procedure.

158. When a planned intervention is part of a surveillance programme RTT will not apply. When the decision is taken to commence a surveillance programme, the current RTT clock will end. This may be as a result of an initial intervention or diagnostic test leading to the surveillance programme.

Emergency care

159. RTT guidelines apply to elective pathways only and therefore admissions arising directly from emergency attendances will not begin an RTT clock. However, a new elective or planned pathway initiated through an emergency event will begin a new RTT clock. This includes episodes of same-day emergency care (SDEC) or attendance at a 'hot clinic.'

160. 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 clock. A later decision to treat would begin a new RTT clock. The clock would start on the date the decision is made.

161. 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 clock would begin. The clock would start on the date of discharge from the emergency stay/attendance.

162. 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 clock. The clock would start on the date the referral is received by the second consultant.

163. If a patient with a current RTT clock is admitted as an emergency and is treated for the same condition for which they were originally referred during their emergency stay, the RTT clock will stop. The clock will stop on the date the treatment is carried out.

164. If a patient with a current RTT clock is admitted as an emergency but is not treated for the same condition for which they were originally referred 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 guidelines for patient unavailability should be applied.

Section 12: Accountability: Recording and reporting

Reporting formats

165. 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.

166. HBs must ensure that appropriate systems are in place to capture the information necessary to meet the requirements for reporting.

Accountability for monitoring and managing open pathways

167. The HB with current clinical responsibility for the patient is accountable for the monitoring of that patient's pathway (except cancer).

168. When the patient's RTT pathway involves more than one organisation or information system, HBs must ensure that communication protocols are utilised so that appropriate information is shared and RTT clocks are measured accurately. (Particularly for cancer, cardiac pathways, and vulnerable persons (see definition Paragraph 110) when the clock continues along the pathway from referral to intervention and/or surgery).

169. When NHS activity is commissioned from an independent sector provider (non-NHS), the HB commissioning the pathway is accountable for the monitoring and reporting of that patient's pathway. HBs must ensure that communication protocols are utilised so that appropriate information is shared, and RTT clocks are measured accurately.

170. When a HB refers a patient for treatment at a Welsh Regional Centre/provision, the current model is that the referring HB is accountable for the monitoring and reporting of that patient's pathway. In future, it is anticipated that Welsh regional

centres/provision will become a stand-alone provider and be responsible for holding, managing, and reporting their waiting list. HBs must ensure that robust standard operating procedures are implemented to ensure effective communication and information-sharing between the HB and the Welsh Regional Centre/provision. The aim being to maintain patient safety and fairness in terms of waiting times, access to care and accurate RTT reporting. (For further guidance please refer to the *Additional resources to support implementation of the RTT Guidelines* document).

171. When a referral is made to an English NHS provider as part of a managed long-term commissioning contract, the English NHS provider is accountable for the monitoring of that patient's pathway, but this should be monitored by NHS Wales health board as part of their commissioning arrangements. English NHS providers must ensure that communication protocols are utilised so that appropriate information is shared, and RTT clocks 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

172. When the patient's RTT clock is managed entirely within a single HB, the accountability for performance against the targets lies with that HB.

173. When the patient's RTT pathway involves more than one HB, the HB delivering the care is accountable for performance against the RTT targets.

174. When NHS activity is commissioned from an independent sector provider, or NHS England as part of spot commissioning the accountability lies with the HB commissioning the activity. This also applies to those patients who are referred for treatment at a Welsh Regional Centre/provision until the Welsh regional centres/provision are established as stand-alone providers.

175. Where the patient pathway is commissioned by NHS Wales Joint Commissioning Committee (WJCC) the accountability for performance against the targets lies with the provider health board. HBs and WJCC must jointly ensure that communication protocols are utilised so that appropriate information is shared, and RTT clocks are measured accurately.

Accountability for reporting

176. 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.

177. 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.

178. When NHS activity is commissioned from an independent sector provider, (including a Welsh regional centre/provision), the HB commissioning the pathway is responsible for reporting performance against the target. HBs must ensure that communication and information-sharing protocols are utilised so that appropriate information is shared, and RTT clocks are reported accurately.

179. When a referral is made to an English provider through a long-term contract, that provider is responsible for reporting performance against the target. HBs must ensure that requirements for reporting are contractually included in commissioning agreements. In the case of short-term “spot purchase” commissioning, the HB commissioning the activity is responsible for reporting wait.

Glossary of Terms

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 95% of pathways should wait no more than 26 weeks from referral to treatment, 100% should not wait more than 36 weeks.
3Ps Policy	Promote, prevent, and prepare for planned care ensures that support and information is easily accessible to those who are waiting for their appointments and interventions in secondary care services and their carers. It reflects the clear drive to 'change the narrative to move away from the passive term 'waiting list' to move towards a proactive preparation list that will provide holistic support for people to help them manage their conditions and support people to prepare for surgery. This includes improving communication with people before they access care and whilst they are waiting and providing advice on actions, they can take to keep them well and fit enough to benefit from their treatment. (See also 'Waiting Well'). A link to the 3Ps Policy is provided in *Appendix A.*

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.
Advice and guidance	Advice and Guidance (A&G) allows a clinician (often in primary care, but also secondary care) to seek advice from another (usually a specialist) enabling a patient's care to be managed in the most appropriate setting, strengthening shared decision-making, and avoiding unnecessary outpatient activity and/or admission. This can be done digitally via the e-referral service, or through agreed IT platforms or email addresses (see 'asynchronous advice and guidance') or 'in real time' via a digital communication platform (see 'synchronous advice and guidance').
AHP	Allied Health Professional.

Asynchronous advice and guidance	When a clinician seeks advice from a specialist via the e-referral service, or through agreed IT platforms or email addresses.
Asynchronous review	An office-based review (sometimes called a desk-top review) which is conducted by the clinician alone or by a wider group of clinicians (e.g. MDT, Peer to Peer) which agrees an outcome/next stage of the patient's pathway but does not require dialogue with the patient at that time. This may also include clinical validation. Used as an alternative to a face-to-face patient review/appointment where clinically appropriate. Patients are informed after the review to confirm the agreed next stage.
Cancer target	The Welsh Government waiting times target for cancer treatment: 62 days for an urgent suspected cancer (USC).
Cardiac RTT target	The Welsh Government waiting times target for cardiac patients that 95% of pathways should wait no more than 26 weeks from referral to treatment, 100% should not wait more than 36 weeks.
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 guidelines.
Clock reset	An administrative process to change the start of the recorded RTT clock/pathway to the date of the event causing the reset.
Clock start	An event which commences an RTT clock/pathway within the RTT guidelines.
Clock stop	An event which ends an RTT clock/pathway within the RTT guidelines.
Community Health (Referral) Pathways	A digital platform which provides primary care clinicians with access to information on local secondary care referral pathways and protocols at the point of care to ensure patients are seen by the right clinician, in the right place, at the right time.
Consultant	A healthcare professional contracted by a Health Board who has been appointed by an Advisory Appointment Committee. They 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, Specialist Nurses, and Specialist AHPs. For

	diagnostic departments, this includes a non-medical scientist of equivalent standing to a consultant.
Consultant to consultant referral	Any patient referral made within a secondary/tertiary care environment from one consultant to another (see 'Consultant').
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 or a period of watch and wait monitoring.
DHCW (Digital Health and Care Wales)	Delivers digital services which meet both the requirements of Welsh Government, NHS Health Boards and Trusts and the health and care needs of the people of Wales.
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, for example, a GP referring directly for a diagnostic test.
Direct booking methodology	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.
E-referral system	An electronic referral system that enables primary care clinicians to communicate with a triaging secondary care clinician. The outcome of this activity may be a referral being accepted for a first OP appointment, a diagnostic or where secondary care is not clinically indicated at that point in time, advice, and guidance. (See 'Advice and guidance,' 'Request for advice', 'Request for investigation', 'Request for treatment and 'WPRS').
EQ-5-DL and refreshed About You 2 assessment	Assessment tool to identify a patient's individual needs, how their condition is impacting on their wider needs and to

	facilitate discussion on ‘what matters to them.’
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 have been empowered to become ‘experts’ in self-managing their condition to improve their quality of life. (See ‘Patient Initiated Follow Up’).
First definitive treatment	Any initial treatment clinically determined that treats or starts the treatment of the patient’s condition.
Group clinic	An alternative to one-to-one appointments where a group of patients with similar health needs/condition are reviewed by a clinician and the next stage of their pathway agreed. (See ‘Video Group Clinic’).
Health Board (HB)	The statutory NHS body.
Hot clinic	Where a patient's needs are rapidly assessed and addressed in a secondary care environment within a multidisciplinary structure.
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.
LAC	Looked after child. Under the Children Act 1989, a child is legally defined as 'looked after' by a local authority if he or she: • gets accommodation from the local authority for a continuous period of more than 24 hours. • is subject to a care order (to put the child into the care of the local authority) • is subject to a placement order (to put the child up for adoption).
LD (Learning disability)	A learning disability is defined by the Department of Health and Social Care (DHSC) (2001) as a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning), which started before adulthood.

Legitimate reason	Clinical or social reasons identified by the clinician or patient why they should not/cannot accept an offer to be treated at a regional centre/provision or external provider which are considered to be valid and accepted. Examples of a legitimate reason could be due to the patient's complex medical or social needs or due to their vulnerability.
Multi-disciplinary team (MDT)	A group of health and care staff who are members of different professions (e.g. doctors, nurses, AHPs) that work together to deliver health services to individual patients.
Mutually agreed	Agreed by both the patient and the HB.
NEPT	Non-emergency patient transport provided by WAST subject to certain conditions and eligibility criteria. Non-Emergency Patient Transport Service (NEPTS) - Welsh Ambulance Services University NHS Trust.
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.
Office-based decision	Any decision which affects the clinical management of the patient and has been made when the patient is not present. This is categorised and recorded as virtual activity.

	It is also referred to as an asynchronous or desk-top review. (See 'asynchronous review').
One-stop clinic	A one-stop clinic aims to provide its patients with their initial consultation, a diagnosis and treatment plan, or commencement of treatment, within one visit to the clinic.
Optimisation (see also pre-habilitation and pre-optimisation)	A process by which patients are supported to prepare for treatment to ensure they are as fit as they can be in preparation for surgery and recovery.
Organisation	The secondary care service, local Health Board known as the Trust in NHS England.
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 initiated follow-up (PIFU)	A PIFU pathway should be used as an alternative to routine follow-up in cases where the next appointment does not need to be booked at that point in time as the

	condition is being managed well by the patient. Therefore, the patient and clinician agree that the Patient initiates the next Follow Up when required, based on their understanding of their condition and when support is needed to maintain their health and wellbeing. This approach is usually used with patients with long-term conditions. (See also 'SOS' and 'Supported self-management').
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.
POVA	Protection of vulnerable adults.
Pre-habilitation (see also optimisation and pre-optimisation)	A process by which patients are supported to prepare for treatment to ensure they are

	as fit as they can be in preparation for surgery and recovery.
Pre-optimisation (see also optimisation and prehabilitation)	A process by which patients are supported to prepare for treatment to ensure they are as fit as they can be in preparation for surgery and recovery.
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. (See Community Health Pathways).
Referral protocols	Agreements reached and documented locally to identify accepted sources for referrals to specific services.
Referral to treatment (RTT)	The period between a referral being made for a particular condition and treatment being commenced for that condition.
Regional centre/provision	Regional centres/provision are dedicated hospital sites which carry out planned

	operations as well as related outpatient appointments and in some cases diagnostics. They may involve collaboration with other health boards or provide regional provision internally across health board areas.
Remote monitoring	A term used to identify patients who are managing their condition on a Self-Management pathway via a third-party medical system such Patient Knows Best, My Medical Record, etc, in collaboration with their clinical team. (See 'Self-management pathway').
Request for investigation	A request for investigation can be made by a primary care clinician/GP to secondary care via thee-referral platform. This occurs when the patient requires diagnostics to inform their treatment plan. (See also 'Request for Advice' and 'Request for Treatment').
Request for treatment	A request for treatment can be made by a primary care clinician/GP to secondary care via thee-referral platform. (See also 'Request for Advice' and 'Request for Investigation').
RTT clock	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 guidelines, which is reported as the RTT waiting time.
RTT period	See 'RTT clock.'
Screening programme	A recognised national programme of screening for particular conditions e.g. Breast Cancer Screening Programme.
SDEC (Same Day Emergency Care)	SDEC is the provision of same day care for emergency patients who would otherwise be admitted to hospital. Under this care model, patients presenting at hospital with relevant conditions can be rapidly assessed, diagnosed, and treated without being admitted to a ward, and if clinically safe to do so, will go home the same day their care is provided.
Secondary care	NHS care delivered as a result of a referral from primary care.
Self-management pathway	A patient-centred alternative to routine follow-up where patients are empowered and supported to better self-manage their condition and seek advice/appointment from the service when they clinically need to do so. (See also PIFU, SOS, and Remote monitoring').
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 6 weeks.
Single point of contact (SPOC)	Single point of contact to support people preparing for treatment.
SOS (See on symptom)	A patient-centred approach that is used as an alternative to routine follow-up which results in patients being discharged when clinically safe to do so and then relies on the patient to self-refer if there are any issues with their condition within an agreed timeframe. See on symptom pathways should be utilised for short-term conditions.
Specialist Nurse	A nurse who has specialised in a particular area of practice. Specialist Nurses can work independently as well as part of the clinical team.
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.
Straight to list	When a patient has been diagnosed with a particular condition in primary care and is accepted by the triaging clinician to go to Stage 4 of the pathway (listed for treatment) without the need for OP appointments and further diagnostics which add little or no value to the patient pathway.
Straight to test	When a patient is referred for a diagnostic without the need for a first OP appointment usually as part of an agreed clinical pathway for a more effective process.
Suitably qualified healthcare clinician/practitioner	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 stopped due to the patient being unavailable or medically unfit due to a co-

	morbidity to proceed to the next stage of the pathway.
Synchronous advice and guidance	When a clinician seeks advice and guidance from a specialist regarding the clinical management of a patient 'in real time' via a digital communication platform or telephone call (see 'Advice and guidance and 'Asynchronous advice and guidance').
Synchronous virtual review/appointment	A two-way conversation (in real time) between the service provider and the patient to agree the next step in the patient's pathway (e.g. telephone, video call). There is patient contact with the clinician in real time. Used as an alternative to face-to-face reviews/appointments. (See also 'asynchronous review').
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 or through a routine pathway and confirmed by the specialist. This is not restricted to designated USC-only.
Video group clinic	An alternative to one-to-one appointments where a group of patients with similar health needs/condition are reviewed by a clinician via a virtual video platform and the next stage of their pathway agreed. (See 'Group clinic').
Virtual activity	Activity that takes place using digital platforms or office-based decisions. Appointments or reviews that take place without the need for direct face-to-face contact (in the same place). This may be 'in real time' via telephone or video (see 'synchronous reviews' and 'virtual appointments') or an office-based decision without direct contact with the patient (see 'asynchronous reviews' and 'office-based decisions').

Virtual appointment	When a patient is reviewed in real time by a clinician via a video or telephone consultation. (See also 'virtual activity').
Waiting Well	A model that supports patients waiting for secondary care treatment to take pro-active action and make healthy decisions/choices to optimise their health and well-being to ensure they are as fit as they can be to receive treatment. (See also '3Ps Policy' and 'Promote, Prevent and Prepare for Planned Care' in *Appendix A*).
Welsh regional centres (including regional provision) (RC)	A model where patients can be referred by their HB for treatment for a diagnosed condition. There are 3 regions in Wales: North, Southwest and Southeast.
WPRS (Welsh Patient Referral Service)	A system that enables electronic referrals to go directly from GPs to clinicians. The system is hosted and maintained by NHS Wales Informatics Service (NWIS). The WPRS is the primary method for managing electronic referrals from primary care to secondary care. Clinicians can carry out a number of electronic actions with each referral, including prioritising, returning to the GP (with an explanation and/or advice), and redirecting to other services or clinics.

Appendix A

Policy documents

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

All Wales Standards for Accessible Communication and Information for People with Sensory Loss

Our programme for transforming and modernising planned care and reducing waiting lists in Wales (April 2022)

Promote, prevent, and prepare for planned care (3Ps Policy) (August 2023)

The role of outpatients in transforming planned care in Wales 2023-26 (August 2023)

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

WHC (2023) 022: Armed Forces Covenant – Healthcare Priority / Special Consideration for Veterans / Ex-Armed Forces Personnel

Appendix B: Treatment Function Codes

Surgical specialties

CODE	TREATMENT FUNCTION TITLE	INCLUDED/EXCLUDED
100	General Surgery Service	
101	Urology Service	
102	Transplant Surgery Service	
103	Breast Surgery Service	
104	Colorectal Surgery Service	
105	Hepatobiliary and Pancreatic Surgery Service	
106	Upper Gastrointestinal Surgery Service	
107	Vascular Surgery Service	
108	Spinal Surgery Service	
109	Bariatric Surgery Service	
110	Trauma and Orthopaedic Service	
111	Orthopaedic Service	
113	Endocrine Surgery Service	
115	Trauma Surgery Service	
120	Ear Nose and Throat Service	
130	Ophthalmology Service	
140	Oral Surgery Service	
141	Restorative Dentistry Service	
143	Orthodontic Service	
144	Maxillofacial Surgery Service	
145	Oral and Maxillofacial Surgery Service	
150	Neurosurgical Service	
160	Plastic Surgery Service	
161	Burns Care Service	
170	Cardiothoracic Surgery Service	
172	Cardiac Surgery Service	
173	Thoracic Surgery Service	
174	Cardiothoracic Transplantation Service	

Paediatric specialties

CODE	TREATMENT FUNCTION TITLE	INCLUDED/EXCLUDED
142	Paediatric Dentistry Service	
171	Paediatric Surgery Service	
211	Paediatric Urology Service	
212	Paediatric Transplantation Surgery Service	
213	Paediatric Gastrointestinal Surgery Service	
214	Paediatric Trauma and Orthopaedic Service	
215	Paediatric Ear Nose and Throat Service	
216	Paediatric Ophthalmology Service	
217	Paediatric Oral and Maxillofacial Surgery Service	
218	Paediatric Neurosurgery Service	
219	Paediatric Plastic Surgery Service	
220	Paediatric Burns Care Service	
221	Paediatric Cardiac Surgery Service	

CODE	TREATMENT FUNCTION TITLE	INCLUDED/EXCLUDED
222	Paediatric Thoracic Surgery Service	
223	Paediatric Epilepsy Service	
230	Paediatric Clinical Pharmacology Service	
240	Paediatric Palliative Medicine Service	
241	Paediatric Pain Management Service	
242	Paediatric Intensive Care Service	
250	Paediatric Hepatology Service	
251	Paediatric Gastroenterology Service	
252	Paediatric Endocrinology Service	
253	Paediatric Clinical Haematology Service	
254	Paediatric Audio Vestibular Medicine Service	
255	Paediatric Clinical Immunology and Allergy Service	
256	Paediatric Infectious Diseases Service	
257	Paediatric Dermatology Service	
258	Paediatric Respiratory Medicine Service	
259	Paediatric Nephrology Service	
260	Paediatric Medical Oncology Service	
261	Paediatric Inherited Metabolic Medicine Service	
262	Paediatric Rheumatology Service	
263	Paediatric Diabetes Service	
264	Paediatric Cystic Fibrosis Service	
270	Paediatric Emergency Medicine Service	
280	Paediatric Interventional Radiology Service	
290	Community Paediatric Service	
291	Paediatric Neurodisability Service	
321	Paediatric Cardiology Service	
421	Paediatric Neurology Service	

Medical specialties

CODE	TREATMENT FUNCTION TITLE	INCLUDED/EXCLUDED
180	Emergency Medicine Service	
190	Anaesthetic Service	
191	Pain Management Service	
192	Intensive Care Medicine Service	
200	Aviation and Space Medicine Service	
300	General Internal Medicine Service	
301	Gastroenterology Service	
302	Endocrinology Service	
303	Clinical Haematology Service	
304	Clinical Physiology Service	
305	Clinical Pharmacology Service	
306	Hepatology Service	
307	Diabetes Service	
308	Blood and Marrow Transplantation Service	
309	Haemophilia Service	
310	Audio Vestibular Medicine Service	
311	Clinical Genetics Service	

CODE	TREATMENT FUNCTION TITLE	INCLUDED/EXCLUDED
313	Clinical Immunology and Allergy Service	
314	Rehabilitation Medicine Service	
315	Palliative Medicine Service	
316	Clinical Immunology Service	
317	Allergy Service	
318	Intermediate Care Service	
319	Respite Care Service	
320	Cardiology Service	
322	Clinical Microbiology Service	
323	Spinal Injuries Service	
324	Anticoagulant Service	
325	Sport and Exercise Medicine Service	
326	Acute Internal Medicine Service	
327	Cardiac Rehabilitation Service	
328	Stroke Medicine Service	
329	Transient Ischaemic Attack Service	
330	Dermatology Service	
331	Congenital Heart Disease Service	
333	Rare Disease Service	
335	Inherited Metabolic Medicine Service	
340	Respiratory Medicine Service	
341	Respiratory Physiology Service	
342	Pulmonary Rehabilitation Service	
343	Adult Cystic Fibrosis Service	
347	Sleep Medicine Service	
348	Post-COVID-19 Syndrome Service	
350	Infectious Diseases Service	
352	Tropical Medicine Service	
360	Genitourinary Medicine Service	
361	Renal Medicine Service	
370	Medical Oncology Service	
371	Nuclear Medicine Service	
400	Neurology Service	
401	Clinical Neurophysiology Service	
410	Rheumatology Service	
420	Paediatric Service	
422	Neonatal Critical Care Service	
424	Well Baby Service	
430	Elderly Medicine Service	
431	Orthogeriatric Medicine Service	
450	Dental Medicine Service	
451	Special Care Dentistry Service	
460	Medical Ophthalmology Service	
461	Ophthalmic and Vision Science Service	
501	Obstetrics Service	

CODE	TREATMENT FUNCTION TITLE	INCLUDED/EXCLUDED
502	Gynaecology Service	
503	Gynaecological Oncology Service	
504	Community Sexual and Reproductive Health	
505	Foetal Medicine Service	
834	Medical Virology Service	

Mental health services

CODE	TREATMENT FUNCTION TITLE	INCLUDED/EXCLUDED
656	Clinical Psychology Service	
700	Learning Disability Service	
710	Adult Mental Illness Service	
711	Child and Adolescent Psychiatry Service	
712	Forensic Psychiatry Service	
713	Medical Psychotherapy Service	
715	Old Age Psychiatry Service	
720	Eating Disorders Service	
721	Addiction Service	
722	Liaison Psychiatry Service	
723	Psychiatric Intensive Care Service	
724	Perinatal Mental Health Service	
725	Mental Health Recovery and Rehabilitation Service	
726	Mental Health Dual Diagnosis Service	
727	Dementia Assessment Service	
730	Neuropsychiatry Service	

Other services

CODE	TREATMENT FUNCTION TITLE	INCLUDED/EXCLUDED
560	Midwifery Service	
650	Physiotherapy Service	
651	Occupational Therapy Service	
652	Speech and Language Therapy Service	
653	Podiatry Service	
654	Dietetics Service	
655	Orthoptics Service	
657	Prosthetics Service	
658	Orthotics Service	
659	Dramatherapy Service	
660	Art Therapy Service	
661	Music Therapy Service	
662	Optometry Service	
663	Podiatric Surgery Service	

CODE	TREATMENT FUNCTION TITLE	INCLUDED/EXCLUDED
670	Urological Physiology Service	
673	Vascular Physiology Service	
675	Cardiac Physiology Service	
677	Gastrointestinal Physiology Service	
800	Clinical Oncology Service	
811	Interventional Radiology Service	
812	Diagnostic Imaging Service	
822	Chemical Pathology Service	
840	Audiology Service	
920	Diabetic Education Service	
998	Diagnostic	
999	Allied Health Professional (AHP) Services	