

# RULES FOR MANAGING REFERRAL TO TREATMENT WAITING TIMES

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## DEFINITIONS

### Referral to treatment (RTT)

The period between a referral being made for a particular condition and treatment being commenced for that condition

### 26 week RTT target

Welsh Assembly Government waiting times target for December 2009 that no patient should wait more than 26 weeks from referral to treatment

### Diagnostic wait

The time waited from receipt of referral for a diagnostic investigation to the appointment for that investigation

### Inpatient/day case wait

The time waited from a decision to treat as an inpatient/day case to admission for the treatment

## Overview

### Document summary

1. This document provides a complete reference source of the waiting times management rules relating to: the 26 week referral to treatment (RTT) target; the direct access diagnostic and therapies targets; the cardiac RTT target; and the cancer targets.
2. If no rule is specified for the cardiac and cancer targets, the rule for the 26 week RTT target will apply.
3. For the purpose of this document, black font denotes rules which apply to the management of the 26 week RTT target and the component waiting times for outpatients, inpatients and day cases, diagnostics and therapies. **Red font** is used for rules which apply to the management of both the component waiting time targets for cardiology, cardiac physiology and cardiac surgery and the cardiac pathway RTT target. **Blue font** indicates rules which apply to the management of the cancer waiting times target.

### Target development – 26 week RTT target

4. In March 2005, the First Minister and Minister for Health and Social Services announced that, by December 2009, no patient in Wales will wait more than 26 weeks from GP referral to treatment, including waiting times for any diagnostic tests or therapies required<sup>1</sup>. *Designed for Life* (Welsh Assembly Government, 2005)<sup>2</sup> subsequently set out a vision of a service designed around patients, with a 10-year programme to transform the system and create a world-class health and social care service for the people of Wales.

## LINKS

<sup>1</sup> RTT e-learning programme: module 1 – Introduction to RTT

<sup>2</sup> [www.wales.nhs.uk/documents/designed-for-life-e.pdf](http://www.wales.nhs.uk/documents/designed-for-life-e.pdf)

**Local Health Board (LHB)**

The statutory NHS body

**RTT period**

The waiting time will be monitored using the concept of a clock, which will start and stop according to the events and transactions that occur along the course of the patient pathway. The measured period of time between a clock start and a clock stop, under RTT rules, which is reported as the RTT waiting time

**Cardiac RTT target**

Welsh Assembly Government waiting times target that no cardiac patient should wait more than 26 weeks from referral to treatment

**Cancer target**

Welsh Assembly Government target for cancer treatment: 62 days for an urgent suspected cancer (USC) and 31 days for a non-urgent suspected cancer (NUSC) referral

5. The guiding principles of the target were set in policy through a range of Welsh Health Circulars<sup>3</sup>.
6. The achievement of the 26 week RTT target is the responsibility of Local Health Boards (LHB).
7. The underlying principle of the target is that patients should receive excellent care without unnecessary delay. This document aims to set out clearly and succinctly the rules to ensure that each patient's RTT period begins and ends fairly and consistently.

**Target development – cardiac RTT target**

8. The cardiac RTT target was announced in 2005 and aims to achieve better clinical outcomes for patients with cardiac conditions, through early diagnosis and treatment.
9. Initial guidance for the target was set out in a Welsh Health Circular<sup>4</sup>. Ongoing guidance and rules have followed *A Guide to Good Practice: Elective Services* (NLI AH, 2005).

**Target development – cancer target**

10. The cancer targets were first developed as part of the Service and Financial Framework (SaFF) targets in 2004/05. Definitions and information requirements were developed by the SaFF Cancer Definitions Working Group, composed of representatives of the three Cancer Networks, Cancer Information Framework Project, Welsh Assembly Government (WAG) and the Cancer Services Coordinating Group.
11. The guiding principles of the target were first identified in a range of policy documents<sup>5</sup>.

**LINKS**

<sup>3</sup> and <sup>5</sup> See Appendix C, page 51

<sup>4</sup> WHC (2006) 078 – Total Cardiac Waiting Times, SaFF Target 5 (2006-07) – Consolidation Guidance

## Guiding principles

12. There are a number of key principles which underpin the waiting times rules. These guiding principles 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.
13. All patients should wait the shortest possible time for treatment.
14. The target should not distort clinical priorities. RTT targets are maximum acceptable waits and urgent patients should be treated as their clinical need dictates.
15. The concept of a NHS/patient 'contract' around the delivery of waiting times is implicit and reflected in the definitions below. Whilst this is not formalised, both parties have rights and responsibilities within the arrangement. LHBs will be required to deliver high quality care within the target time, and to allow for patient choices within that time<sup>6</sup>. Patients will be expected to make themselves available for treatment within reasonable timescales<sup>7</sup>. Their inability to do so may result in a longer waiting time. It is important that the rights and responsibilities of the patient are explained to them at the time of referral. This requires commitment from referrers and appropriate information resources for patients and healthcare staff.
16. Patients must be given adequate information on the expected timescales, 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.
17. Patients should be 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

### LINKS

<sup>6</sup> Read 'Clinical responsibilities', page 14

<sup>7</sup> Read 'Booking and reasonable offer', page 18

**Organisation**

The secondary care service, previously known as the Trust

**Patient pathway**

The process of a patient's care for a particular condition across the whole of the NHS, from primary care onwards

arranged under the rules relating to reasonable offer<sup>8</sup>, and therefore mutually agreed between the patient and the organisation.

18. 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<sup>9</sup>.
19. The rules have been written to be robust and clear. LHBs will be expected to maintain appropriate governance structures to ensure that where there is flexibility within the rules, the spirit of the targets is achieved<sup>10</sup>. All patient management methodologies should be transparent and guided by the principle of patients waiting the shortest time possible for treatment. There is provision for local variations to these rules where these are directly in the patient's best interest<sup>11</sup>.

**LINKS**

<sup>8</sup> Read 'Booking and reasonable offer', page 18

<sup>9</sup> Read rules in paragraphs 84, 104, 110, 140, 167 and 180

<sup>10</sup> Read rules in paragraphs 77, 91 and 140

<sup>11</sup> Read rules in paragraphs 105, 107, 108 and 111-113

**Direct access**

Patients who are referred directly rather than via a consultant-led clinic

**Consultant**

A person contracted by a Health Board who has been appointed by an Advisory Appointment Committee. He or she must be a member of a Royal College or faculty (see Glossary)

**Secondary care**

NHS care delivered as a result of a referral from primary care

**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

**Screening service**

A recognised national programme of screening for particular conditions, e.g. Breast Cancer Screening Programme

**Decision to treat**

A record of the event that a clinical decision to admit a patient to a particular Health Board has been made

## Scope of the targets

### 26 week RTT target

20. The scope of the 26 week RTT target encompasses elective treatment for all Welsh residents, whether treated in Wales or elsewhere. The target covers patients who are referred by a healthcare professional to a consultant in secondary or tertiary care, including consultants who work in the community.
21. The 26 week RTT target does not replace the following waiting times targets:
- Cancer target (31 and 62 days)
  - Cardiac RTT target
  - Fitting of adult hearing aids (direct access)
  - Diagnostic tests (non-RTT and direct access)
  - Therapy services (non-RTT and direct access)

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

22. The RTT period begins at the receipt of a referral in secondary or tertiary care and ends when treatment commences. Treatment will often continue beyond a first treatment and after a clock has stopped.
23. A referral received from a screening service will begin a new RTT period.
24. A self-referral or patient-initiated follow-up will not begin an RTT period unless it follows a period of unavailability<sup>12</sup>. If a new decision to treat or change of management plan is subsequently initiated, a new RTT period will begin.
25. Referral to a referral management centre (RMC) will not begin an RTT

### LINKS

<sup>12</sup> Read 'Patient unavailability', page 32

**Clock stop**

An event which ends an RTT period within the RTT rules

**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

**Consultant to consultant referral**

Any patient referral made within a secondary/tertiary care environment from one consultant to another

**Clock start**

An event which commences an RTT period within the RTT rules

**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

period. The RTT period will begin when the referral is passed on from the RMC and received in secondary or tertiary care.

26. Some patients may be measured on more than one RTT period during the management of their condition in secondary or tertiary care. This will include patients who have a planned sequence treatment<sup>13</sup>.
27. Events other than treatment which can end an RTT period may include:
  - A decision made not to treat a patient<sup>14</sup>
  - Commencement of active monitoring<sup>15</sup>
  - A consultant to consultant referral<sup>16</sup>

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

28. Only specified diagnostic and therapy services are included in the 26 week RTT target<sup>17</sup>. Appendices A and B detail the diagnostic tests and therapy services that are included. An adjustment may be made for time spent waiting for excluded diagnostics or therapies where this event precludes treatment commencing.
29. Patients with a recurrence of cancer, which is not covered by the 31 and 62 day targets, will be covered by the 26 week RTT target.
30. For orthodontics and restorative dentistry, the first outpatient appointment will be included in the RTT period. Any subsequent treatment will be outside the 26 week RTT target.
31. The table overleaf gives some specific services which are included within the scope of the 26 week RTT target. These are services for which clarification has been requested during the development of these rules. This list is not exhaustive.

**LINKS**

<sup>13</sup> Read rule in paragraph 184

<sup>14</sup> Read rule in paragraph 131

<sup>15</sup> Read rules in paragraphs 131 and 185

<sup>16</sup> Read rule in paragraph 132/RTT e-learning programme: module 2 – consultant to consultant referrals

<sup>17</sup> RTT e-learning programme: module 2 – referral to diagnostics/therapies

**Direct referral**

A referral made by a clinician in primary care directly to a diagnostic or therapy service

Included in the scope of the 26 week RTT target	
Included service area/ patient group	Notes
Recurrence of cancer	Any recurrence not covered by the 31 and 62 day cancer targets.
Fertility treatment	Treatment at level 1 and level 2 only <sup>18</sup> .
Clinical genetics	New conditions identified as a result of a genetic test.
Military personnel	Included to the extent that LHBs are responsible for their care. The target does not apply to MOD-commissioned care unless stated in agreements with LHB.
Prisoners	Prisoners should be treated within the same waiting time target as all other NHS patients. It is accepted that in some cases there will be circumstances unique to this population which may make achieving the 26 weeks RTT target particularly challenging. The detailed reasons why these patients exceeded the target time should be recorded in the breach analysis.

**26 week RTT target exclusions**

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

Excluded from the scope of the 26 week RTT target	
Excluded service area/ patient group	Notes
Emergency care episodes	Any emergency care episode. Further information on the management of referrals arising from an emergency care episode is available within this document.
Direct referrals to diagnostic and therapy services	Direct referrals from primary care to all diagnostic and therapy services are subject to component targets and are managed under the same rules as the 26 week RTT target.
Mental health services	All mental health services including Child and Adolescent Mental Health Services.

**Cardiologist**

A clinician who undertakes the majority of their clinical sessions in cardiology

Palliative care	Including hospice care.
Cochlea implants	Where the treatment intervention is the specific provision of cochlea implants.
Screening services	A decision to refer from a screening service would begin a new RTT period.
Community paediatrics	A decision to refer from community paediatrics would begin a new RTT period.
Routine dialysis treatment	A decision to refer following a dialysis session would begin a new RTT period.
Obstetrics	A decision to refer from obstetrics for a non-obstetric condition would begin a new RTT period.
Fertility treatment	Specialist level 3 fertility treatment is subject to policy approved maintenance of a maximum 18 month waiting time <sup>18</sup> .
Undergraduate dental education	Primary dental care carried out in a secondary or tertiary care setting solely for the purpose of supporting undergraduate dental education is excluded.

**Cardiac RTT target**

33. The scope of the cardiac RTT target encompasses all adult patients referred to a cardiologist at some stage in their pathway.
34. The target applies to all Welsh residents, whether treated in Wales or elsewhere.
35. The target includes waits for all diagnostic procedures and all referrals to other consultants by the cardiologist, where that referral is relevant to the diagnosis and treatment of the patients within the scope of the target.
36. Paediatric cardiology is excluded from the cardiac RTT target. This subspecialty is managed under the 26 week RTT target.

**LINKS**

<sup>18</sup><http://wales.gov.uk/topics/health/hcw/waywework/specialisedinfertility/fertilityservices/?lang=en>

**USC referral**

A referral where a suspicion of cancer is stated by the GP and confirmed by the specialist

**Specialist**

Used within the cancer target to denote a consultant who treats patients with cancer

**First definitive treatment**

Any initial treatment that treats the patient's cancer, stabilises their symptoms from cancer or stabilises their health so cancer treatment can commence

**Receipt of referral**

The referral is deemed to be received when it first arrives within the secondary or tertiary care service (see Glossary)

**NUSC referral**

Any patient diagnosed as having cancer and not referred by their GP as a USC or upgraded by the specialist on analysis of the GP referral

37. Heart transplantation is excluded from the cardiac RTT target. The clock stops on the date the patient is referred for consideration for transplant.

**Cancer target**

38. There are two targets within the cancer target: the 62 day and 31 day targets.
39. Newly diagnosed cancer patients that have been referred as urgent suspected cancer (USC), and confirmed as urgent by the specialist to start definitive treatment<sup>19</sup> within 62 days from receipt of referral at the LHB.
40. Newly diagnosed cancer patients not included as USC referrals (NUSC) to start definitive treatment within 31 days of a decision to treat.
41. All patients under 16 years of age at date of first definitive treatment should be grouped as children's cancer.
42. In the case where a patient is initially seen by the specialist privately, but is then referred for first definitive treatment under the NHS, the patient should be included under the 31 day target.
43. The targets only apply to patients with a newly diagnosed cancer. Some patients have metastases at presentation and so the treatment may be to the metastatic site rather than the primary site.
44. When a patient is diagnosed with a second new cancer, which is not a recurrence, then the cancer targets will apply to the treatment of this cancer.
45. When a patient is referred on suspicion of one cancer but is diagnosed with another cancer of greater clinical priority, within the same care

**LINKS**

<sup>19</sup> See Appendix D for further information on definitive treatment

ell, that care spell should be monitored under the 62 day target from urgent referral to treatment.

46. A patient who is diagnosed incidentally for cancer should be monitored under the 31 day target.
47. Treatment for recurrence of cancer is excluded from the cancer target, including a recurrence of the original primary cancer at a secondary site.
48. The table below shows a number of aspects of cancer care for which specific rules are identified. This list is not exhaustive. Further specific clarification is available, if required, through the cancer networks' websites<sup>20</sup>.

Cancer specific areas	
Cancer area	Notes
Kaposi's sarcoma	A new cancer care episode should be started for each Kaposi's sarcoma diagnosed.
In situ disease	All in situ disease is excluded with the exception of ductal carcinoma in situ (DCIS).

#### LINKS

<sup>20</sup> <http://howis.wales.nhs.uk/sewcn> (South East) <http://howis.wales.nhs.uk/nwcn> (North Wales) and <http://howis.wales.nhs.uk/swwcn> (South West)

**Referral guidelines**

Predetermined written criteria for referral that are formalised and agreed between the healthcare professionals making and receiving the referral

**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

**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

## Clinical responsibilities

### The responsibilities of clinical staff in monitoring waiting times

49. 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 LHBs to instigate action when those waiting times are not meeting the expected level of quality of care.
50. Clinical staff must be aware of national requirements and organisational policies in respect of waiting times.
51. Clinicians should ensure that their actions promote the principle of patients waiting the shortest possible time for treatment<sup>21</sup>.
52. Referrers must use the most efficient and patient-centred approach to referral that reduces the steps needed to reach treatment.
53. Clinicians must ensure that all decisions are made in a timely manner, and that any onward referrals are completed promptly, according to local guidelines, and include adequate information to allow the receiving clinician to initiate appropriate interventions with the minimum of delay.
54. Clinicians must ensure that they cooperate with agreed local systems to enable the recording of clinical outcome of all interactions with patients, whether face-to-face or by phone or letter<sup>22</sup>.
55. 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, whether those decisions are made in the presence of the patient or not<sup>23</sup>.
56. Clinicians must ensure that the clinical intention of any intervention is clear, whether this is an intended treatment<sup>24</sup> or an interim treatment.

**LINKS**

<sup>21</sup> Read 'Guiding principles', page 6

<sup>22</sup> Read rules in paragraphs 91, 114 and 195

<sup>23</sup> Read rules in paragraphs 18, 140, 164 and 178

<sup>24</sup> Read rules in paragraphs 128 and 173

**Referral protocols**  
Agreements reached and documented locally to identify accepted sources for referrals to specific services

## Referrals<sup>25</sup>

57. The RTT period begins at referral by a GP or GDP to a consultant in secondary or tertiary care, and by any other healthcare professional where referral protocols exist. The clock will start on the date that the organisation receives the referral<sup>26</sup>.
58. Referrers must use the most efficient and patient-centred approach to referral that reduces the steps needed to reach treatment. LHBs must ensure that patients are seen by the most appropriate individual once the referral has been received.
59. LHBs must ensure that clear decisions have been made on the procedures that will be offered, and that referrers are aware of these. If a referral is made for a procedure which is not offered by the LHB, it should be returned to the referrer.
60. When a referral is made to a clinician or specialty which does not treat this condition, it may be returned to the referrer with a full explanation<sup>27</sup>. The RTT period will end if the referral is returned. If an appointment is arranged, the RTT period will continue and any subsequent referral to the appropriate clinician will not stop the clock.
61. When the LHB directs a referral in error to a clinician who does not treat this condition, an onward referral to the appropriate clinician will not stop the clock. The patient must be seen by the new consultant within the same RTT period.
62. When a referral does not comply with agreed referral guidelines, it should be returned to the referrer for completion with guidance on what is required. The RTT period will continue whilst the information is obtained.

### LINKS

<sup>25</sup> RTT e-learning programme: module 2 – referrals

<sup>26</sup> Read about clock starts in paragraphs 65, 100, 153-157 and 183-190

<sup>27</sup> Read the guiding principle in paragraph 18 and rule in paragraph 140

**Clock continue**  
Any event which occurs along the patient pathway, but does not constitute a clock start or clock stop within the RTT rules

## Cardiac RTT target

63. Evidence-based guidelines and minimum data requirements for referrals have been developed across the cardiac networks. These are available on the cardiac networks' websites. LHBs must take responsibility for adapting and disseminating these guidelines and referral data sets, and ensuring that they are used by GPs in their area. LHBs must ensure that local referral management systems are in place and that they are adhered to.
64. When a referral is made under the cardiac guidelines to a clinician who does not treat the condition, the referral should be forwarded to the appropriate consultant and the clock will continue<sup>28</sup>.
65. The clock starts on the date that the first LHB receives the referral for a cardiac condition which leads, either at this point or subsequently, to a first appointment with a cardiologist. This is not the date when the referral is received in the cardiology or medical department, or the date when the patient is put on the outpatient list, if these are later than the date when the referral letter is received by the first LHB.

## Cancer target

66. Only referrals from GPs or GDPs can be designated as USC referrals.
67. A referral is designated as a USC when a suspicion of cancer is stated by the referrer and confirmed by the specialist initially receiving the referral.
68. A USC referral should be made via specified referral methods, such as USC safe haven fax lines. The USC cancer target will still apply to a USC referral received via another route.
69. A referral from a GP or GDP which has not been made as a USC may

### LINKS

<sup>28</sup> Read about other clock continue outcomes on page 25

be subsequently upgraded to USC status by the receiving consultant when he or she has viewed the referral information. The 62 day target will apply.

70. If a referral which has not been made as a USC is subsequently upgraded to a USC by the specialist, the 62 days commence from the date the hospital received the referral, not when the specialist reviewed the referral.
71. A USC referral may be downgraded by the consultant when he or she has viewed the referral information. The 26 week RTT target will apply. This decision should be communicated to the referring clinician.
72. When a USC referral is made to a clinician who does not treat the condition, it should be forwarded to the appropriate consultant. The 62 day clock will continue.

**Direct booking**

Booking methodology where an agreement of appointment is made through a direct communication between the organisation and patient

**Partial booking**

A system whereby appointments are agreed with the patient, following a written request from the Health Board for the patient to telephone to make an appointment

**Mutually agreed**

Agreed by both the patient and the Health Board

**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

**Out of hours contact**

Between 6pm and 9pm on weekdays and between 9am and 9pm at weekends

## Booking and reasonable offer

### Booking processes

73. All patient appointments should be booked using a patient-focussed booking approach, either through direct or partial booking. All appointments must be made with the direct involvement of the patient. This must be adhered to, even when the organisation does not hold complete contact details for the patient.
74. The booking clerk should be offering actual dates to the patient at the time of the communication. 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 two appointments.
75. Whenever possible, organisations should ensure that patients are treated in turn, allowing for considerations of clinical priority.
76. 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, partial booking may be used.
77. Each attempt to contact the patient under the booking processes must be recorded and available for subsequent audit.

### Direct booking

78. Direct booking can take place in two ways. An appointment can either be booked in a face-to-face interaction with the patient or through a direct dialogue with the patient.
79. Under the direct booking process, the LHB should make at least two attempts to contact the patient by telephone. These telephone calls must take place on different days, and at least one must be outside normal working hours. If contact with the patient has not been

achieved, a letter must be sent to the patient, asking them to phone and make an appointment.

### Partial booking

80. Under the partial booking process, an acknowledgement must be sent to the patient when the referral is received. A letter should then be sent to the patient four weeks before they are anticipated to be seen, asking them to phone and make an appointment (phone letter).
81. If the patient has not responded to the phone letter within two weeks, a reminder letter should be sent.

### Inability to contact a patient

82. When the organisation makes an attempt to contact the patient and they do not respond within three weeks, an adjustment to their waiting time may be made, beginning at the twenty-second day after the first contact was attempted. The maximum adjustment will be three weeks<sup>29</sup>.
83. If the patient has not responded to the booking process within six weeks from the date of the first attempted contact, they should be removed from the waiting list and the referrer notified<sup>30</sup>.

### Cardiac RTT target

84. When partial booking is used, the patient may be removed from the waiting list only after a reminder letter has been sent, and no contact has been received within two weeks.

#### LINKS

<sup>29</sup> Read 'Adjustments: Inability to contact a patient', page 34

<sup>30</sup> Read the guiding principle in paragraph 18 and rule in paragraph 140

**Suspension**

A period during which the cancer or cardiac clock is paused due to the patient being unavailable or medically unfit due to a co-morbidity to proceed to the next stage of the pathway

**Reasonable offer**

Any offer of an appointment mutually agreed between the patient and the Health Board

**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

**Cancer target**

85. When the organisation makes significant attempts to contact the patient and they do not respond within two weeks, the patient will be suspended<sup>31</sup> while the organisation makes further efforts to contact the patient. The suspension will begin two weeks after the first attempted contact and end when contact with the patient is achieved.

**Reasonable offer<sup>32</sup>**

86. A reasonable offer to a patient is defined as any date mutually agreed between the patient and the organisation. Any subsequent application of waiting times rules based on this offer (e.g. CNA, DNA<sup>33</sup>) may only be applied if the appointment date has been mutually agreed, and is therefore considered to be reasonable.
87. Organisations must ensure that all appointments are mutually agreeable, and that the patient has been offered a choice of dates within the agreed timeframes<sup>34</sup>.
88. Patients can be offered any number of dates and times, at least two of which must be more than two weeks in the future.
89. Patients should be offered appointments at the location providing the required service that is nearest to their home.
90. If an organisation intends to deliver a service in a pooled manner or across a number of locations, this must be agreed across the local health community and specified in the access policy. Patients must be fully informed of the possible locations at the earliest opportunity in their pathway. An offer at one of these locations will only be considered reasonable if this arrangement has been appropriately communicated to the patient.
91. All dates offered must be recorded and available for subsequent audit.

**LINKS**

<sup>31</sup> Read paragraphs 165-171 and 181, and Appendix E for suspension rules

<sup>32</sup> RTT e-learning programme: module 2 – reasonable offer

<sup>33</sup> Read paragraphs 101-113 for CNA and DNA rules

<sup>34</sup> Read rule in paragraph 73

**Pathway start date**

Used within the cardiac RTT target to denote the original clock start date caused by the receipt of a referral

**Adjusted pathway start date**

Used within the cardiac RTT target to denote the new clock start date caused by the application of an adjustment

If the required information is not recorded, it will be considered that no reasonable offer has occurred<sup>35</sup>.

**Cardiac RTT target**

92. Patients should be offered a minimum of three dates within a six week period from the date of the offer being made. One of these dates should be more than 14 days in the future.
93. LHBs may ask patients whether they are prepared to be seen by a consultant or at a location not specified in the LHB's access policy. In all cases, the patient may exercise their right of choice and choose to remain with the original clinician or location.
94. In a pooled environment, if the patient exercises their right to remain with an original consultant or clinic location, their consultant or clinic will not be changed. The waiting list date and adjusted pathway start date will be reset to the date of the decision. This should not affect their position on the waiting list, which should continue to be managed in order of their pathway start date.
95. When a patient exercises their right to remain with an original consultant or location, they must be advised at the time of choice that this decision may mean a longer wait than if they accept the change.
96. The appointment offered will normally be at a site specified in the LHB's access policy. If the appointment is offered at a site outside this policy, transport must be offered.

**Cancer target**

97. Any appointment date offered to a patient may be deemed reasonable. Organisations must give sufficient notice of any

**LINKS**

<sup>35</sup> Read rules in paragraphs 54 and 114

**Clock reset**

An administrative process to change the start of the recorded RTT period to the date of the event causing the reset

**Could not attend**

Any patient who contacts the organisation to notify that they will be unable to attend an agreed appointment is recorded as 'could not attend' (CNA)

**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; and 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

appointment date, taking account of the patient's clinical condition and personal circumstances.

**Refusal of a reasonable offer**

98. A patient may only be deemed to have refused a reasonable offer when the appropriate number of appointments has been offered and it has not proved possible to agree an appointment.
99. If the patient declares themselves as unavailable for the time period in which the offers are being made, the social unavailability rules will apply<sup>36</sup>.
100. If the patient is available during the offer period, but refuses a reasonable offer, the clock will be reset<sup>37</sup>. The new clock start will be the date that the patient refuses the offered appointments.

**Could not attend (CNA)<sup>38</sup>**

101. A CNA occurs when the patient gives 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 of the appointment.
102. A patient may have multiple CNAs within their RTT period, but only one CNA within each stage of the pathway.
103. On the first CNA within a stage of the pathway, the clock should be reset to the date on which the patient notifies the organisation of their inability to attend the appointment. A new appointment should be made as soon as the patient is available.
104. On the second CNA within the same stage of the pathway, the patient should be removed from the waiting list, and responsibility for ongoing

**LINKS**

<sup>36</sup> Read rules in paragraphs 161-164

<sup>37</sup> Read paragraphs 103, 105-108 and 112-114 for other clock reset rules

<sup>38</sup> RTT e-learning programme: module 2 – CNA

care returns to the referrer. Appropriate notification of removal must be given to the patient and the referrer<sup>39</sup>.

105. If the consultant responsible for the patient considers that they should not, for clinical reasons, be removed from the pathway following a second CNA, the clock will continue and no further adjustment or reset can be applied<sup>40</sup>.

### Cardiac RTT target

106. When a patient is unable to attend an agreed appointment, the adjusted PSD should be reset to the date on which the patient notifies the organisation of their inability to attend. A new appointment should be made as soon as the patient is available.
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, the adjusted PSD may be reset to the date the patient notifies the organisation of their inability to attend.

### Cancer target

108. If the consultant responsible for the patient considers that they should not, for clinical reasons, be removed from the pathway following a second or subsequent CNA, the waiting time may be reset to the date of notification.
109. If the patient is unable to attend an agreed appointment, an adjustment to the clock may be made for the number of days between the date of decision to treat and the date the admission was scheduled to take place.

#### LINKS

<sup>39</sup> Read the guiding principle in paragraph 18 and rule in paragraph 140

<sup>40</sup> Read other 'Clock continue outcomes', page 25

**Did not attend**

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)

**Did not attend (DNA)<sup>41</sup>**

110. 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<sup>42</sup>.
111. If the consultant responsible for the patient considers that they should not, for clinical reasons, be removed from the pathway following a DNA, the clock will continue and no adjustment or reset can be applied<sup>43</sup>. The organisation must actively seek to contact the patient to agree a new date for the appointment.

**Cardiac RTT target**

112. If the consultant responsible for the patient considers that they should not, for clinical reasons, be removed from the pathway following a DNA, the adjusted PSD will be reset to the date of non-attendance.

**Cancer target**

113. If the consultant responsible for the patient considers that they should not, for clinical reasons, be removed from the pathway following a DNA, the waiting time will be reset to the date of non-attendance.

**LINKS**

<sup>41</sup> RTT e-learning programme: module 2 – DNA

<sup>42</sup> Read the guiding principle in paragraph 18 and rule in paragraph 140

<sup>43</sup> Read other 'Clock continue outcomes', page 25

**Consultant office decision<sup>45</sup>**

Any decision which affects the clinical management of the patient and has been made when the patient is not present

## Attendance outcomes<sup>44</sup>

- 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 three categories: a clock continue, a clock stop, or a new clock start.

## Clock continue outcomes

- 116. A clock continue outcome is used to define decision points along the pathway where the current clock status will continue. Within an RTT period, the clock continues to tick. When there is no current RTT period, the previous clock remains stopped.
- 117. If an appointment is cancelled by the organisation, the clock will continue, and a new appointment must be booked.
- 118. All referrals within an RTT period to diagnostic services or for therapy assessments will continue the clock. Where the referral is to an excluded service an adjustment to the waiting time can be applied<sup>46</sup>.
- 119. A referral for an included therapy treatment will continue the clock.
- 120. A referral for an anaesthetic assessment will continue the clock.
- 121. When a patient is transferred between consultants for reasons other than clinical necessity, including pooled lists<sup>47</sup>, and when an offer of a shorter waiting time is made, the clock will continue, and the patient must be seen by the new consultant within the same RTT period. When a patient declines the offered change of consultant, no adjustment can be made.
- 122. When a patient's RTT period takes place across more than one organisation, and the consultant responsible for the care of the patient

**LINKS**

<sup>44</sup> RTT e-learning programme: module 2 – clinic outcomes

<sup>45</sup> RTT e-learning programme: module 2 – consultant office decisions

<sup>46</sup> Read paragraphs 173-175 for RTT excluded services rules

<sup>47</sup> Read rules in paragraphs 90 and 94

**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

**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

does not change, the clock will continue when the patient is transferred between the organisations.

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

**Cardiac RTT target**

124. When a patient's care takes place across more than one organisation, the cardiac RTT clock continues, whether the responsibility for care is transferred to a new consultant or not.

**Cancer target**

125. Where responsibility for a patient's care is transferred between consultants, the clock will continue.
126. Where a patient's care takes place across more than one organisation the cancer clock continues, whether the responsibility for care is transferred to a new consultant or not.

**Clock stop outcomes**

127. A clock stop outcome is used to define decision points along the pathway where a current RTT period will end.
128. Clock stop outcomes are used for events which constitute a treatment, a decision that no treatment is required or when the patient is unavailable for medical or social reasons<sup>48</sup>.
129. Treatment is defined as a clinical intervention intended at the time of the intervention to manage the patient's condition<sup>49</sup>.

**LINKS**

<sup>48</sup> Read 'Patient unavailability', page 32

<sup>49</sup> RTT e-learning programme: module 2 – start of treatment

130. When treatment is given in a non-admission setting, the clock will stop on the date the treatment commences.
131. 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.
132. 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 with the patient<sup>50</sup>.
133. When a patient is transferred between consultants for reasons of clinical necessity, the clock will stop. When this is simply a request for advice, this must be managed within the 26 week RTT period. The date on which it is explained to the patient that clinical responsibility for their care is being transferred to another consultant will be the clock stop date. The receipt of the referral by the second consultant will begin a new RTT period.
134. 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 with the patient.
135. 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.
136. When a diagnostic procedure converts to a therapeutic intervention which meets the treatment definition, the clock will stop. The clock stop date will be the date of the intervention.
137. A referral for an excluded therapy treatment, where this is the

#### LINKS

<sup>50</sup> Read the guiding principle in paragraph 18 and rule in paragraph 140

**Suitably qualified  
healthcare  
professional**

A healthcare professional approved by the consultant as competent to make a decision about the medical fitness of a patient to proceed to the next stage of the pathway

intervention intended to manage the patient's condition, will stop the clock<sup>51</sup>. The clock stop date will be the date the referral is made.

138. If a patient is admitted as an emergency<sup>52</sup> and receives an intervention for the condition for which they have an open RTT period, and the intervention meets the treatment definition, the clock will stop. The clock stop date will be the date of the intervention.
139. If a patient DNAs an appointment, has a second CNA in the same stage of the pathway, or is unavailable for more than eight weeks, the clock will stop<sup>53</sup>. The clock stop date will be the date the organisation is made aware of the event.
140. If, in the opinion of a suitably qualified healthcare professional, a patient has a medical condition which will not be resolved within 21 days, the patient should be returned to the referring clinician, or to another clinician who will treat the condition, and the clock will stop. The clock stop date will be the date the patient is determined to be medically unavailable for this period.
141. 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<sup>54</sup>.
142. If the patient being removed from the waiting list is under 18, consideration must be given to child protection implications. If the patient is younger than five years old, the health visitor should be informed of the removal.

**LINKS**

<sup>51</sup> Read 'RTT excluded services', page 34

<sup>52</sup> Read 'Emergency care', page 37

<sup>53</sup> Read 'Could not attend', page 22 and 'Did not attend', page 24

<sup>54</sup> Read the guiding principle in paragraph 18 and rule in paragraph 140

### Cardiac RTT target

143. A transfer of care between consultants for the treatment of a patient's cardiac condition will not stop the clock.
144. Where a patient is either socially or medically unavailable the rules on unavailability for the cardiac RTT target should be followed and the clock does not stop.

### Cancer target

145. The first definitive treatment is defined as any initial treatment that treats the patient's cancer, stabilises their symptoms from cancer or stabilises their health so cancer treatment can commence.
146. If the first definitive treatment is surgery, the clock will stop on the date that the first procedure took place, whether done on an inpatient or day case basis.
147. If the first definitive treatment is chemotherapy and/or anti-cancer treatment, including hormone/endocrine/immunotherapy, the clock will stop on the date that the first dose of the drug is administered to the patient.
148. If the first definitive treatment is radiotherapy, the clock will stop on the date that the first fraction of radiotherapy for this prescription is administered to the patient.
149. If the first definitive treatment is specialist palliative care, the clock will stop on the date of the first treatment/support meeting.
150. A purely diagnostic procedure, including biopsies, does not count as treatment unless the tumour is effectively removed by the procedure. If an excision biopsy is therapeutic in intent, that is the intention is to remove the tumour, then this will count as first treatment, irrespective of whether the margins were clear.

**Step change**

A substantial change to a current treatment plan, e.g. a change from oral to subcutaneous delivery of medication

**Incremental change in treatment**

A small change to a current treatment plan, e.g. adjustment of the dosage of a prescribed medication

**Emergency admission**

Patients admitted to hospital when admission is unpredictable and at short notice because of clinical need

151. First treatment refers to the first definitive treatment and may not necessarily be the first planned treatment decided upon by the multi-disciplinary team. If a patient is admitted as an emergency and undergoes immediate surgery, this could be classed as the first definitive treatment, with cancer confirmed on the histology as a result of this surgery. In this case, the date of first treatment would be earlier than the diagnosis. This will result in a negative waiting time which is always shown as zero.
152. A transfer of care between consultants for the treatment of a patient's cancer will not stop or reset the clock.
153. When a patient is either socially or medically unavailable, the rules on unavailability for the cancer target should be followed and the clock does not stop.

**New clock start outcomes**

154. Following a clock stop, a patient should continue to be reviewed by the clinician only where this is clinically required. When a patient continues to be reviewed and a new decision to treat is made, a new RTT period will start. The clock start date will be the date the new decision to treat is communicated to the patient.
155. When there is a step change in an ongoing treatment and the new treatment cannot be started at the point when the change is discussed with the patient, a new RTT period will begin. The clock start date will be the date the decision to change the treatment is communicated to the patient. An incremental change to ongoing treatment will not begin a new RTT period.
156. When a patient is placed on the waiting list during an emergency admission or attendance<sup>55</sup> for an elective procedure scheduled to take

**LINKS**

<sup>55</sup> Read 'Emergency care', page 37

**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

**Expert patient**

Patients experiencing a long-term health condition who become 'experts' in their own care to improve their quality of life

**SOS clinics**

Specialist direct access clinics that expert patients attend for urgent attention

place after discharge from the emergency stay, a new RTT period will begin. The clock start date will be the date of discharge from the emergency stay.

157. For clinical reasons, some patients will require a treatment at a later point in time<sup>56</sup>. A new RTT period will begin for these planned treatments on the date that it becomes clinically appropriate to undertake the procedure.
158. When a patient has been removed from the waiting list for reasons other than treatment, organisations should allow the patient to self-refer back into the pathway rather than creating a new referral via the GP<sup>57</sup>. The patient should return to the pathway at the clinically most appropriate place, and a new RTT period will begin. The clock start date will be the date the referral is received by the LHB. The maximum time allowed between the removal and a self-referral should be six months. After this time, a new referral should be created. The six-month maximum may be extended indefinitely in the case of 'expert patient' or SOS clinics.

**LINKS**

<sup>56</sup> Read 'Planned care', page 36

<sup>57</sup> Read rules in paragraphs 83, 84, 104, 110, 140, 167 and 180

**Short-term medical condition**

A medical condition precluding progression to the next stage of the pathway for less than 21 days

## Adjustments<sup>58</sup>

### Patient unavailability

159. When a patient is unavailable due to a short-term medical condition, an adjustment to the RTT period may be made. If, in the opinion of a suitably qualified healthcare professional, the patient has a condition which will be resolved within 21 days, the patient should remain on the active waiting list and an adjustment may be applied.
160. The adjustment should start from the date of the decision that the patient is medically unfit to the date that the patient is declared fit for the procedure. This period must not exceed 21 days in each stage of the pathway.
161. If a patient is reviewed after the expected recovery period and recovery has not been effective, or a further condition has developed, the patient should be returned to the referring clinician, or another clinician who will treat the condition, and the RTT period will end. A second 21 day period cannot be applied within the same stage of the pathway.
162. When a patient is unavailable due to social reasons, an adjustment to the RTT period may be applied.
163. When the period of unavailability is less than two weeks, no adjustment may be made.
164. When the period of unavailability is between two and eight weeks, an adjustment may be made for the full period of time that the patient is unavailable.
165. When the period of unavailability is more than eight weeks, the patient should be returned to the referrer and the RTT period will end.

### LINKS

<sup>58</sup> RTT e-learning programme: module 2 – adjustments to RTT period

### Cardiac RTT target

166. When a patient is unavailable due to either medical or social reasons, they should be suspended from the waiting list for the period of unavailability.
167. The period of suspension will begin on the date of the notification of unavailability, and end on the date the patient is available or fit to continue their pathway.
168. The maximum suspension period is six months for each type of suspension. If the patient cannot return to the pathway after a six month suspension, they should be removed from the waiting list and returned to the referrer.
169. When the patient is suspended for medical reasons, there must be robust mechanisms in place to deal with the reason for the suspension. A plan must be in place with the aim that when the suspension period ends, the patient will be fit.
170. If a new medical condition is found to have developed, the patient can be re-suspended for an additional six-month period.
171. In the case of pregnancy, the suspension period may exceed six months, providing the end date is recorded.
172. When the patient is suspended for social reasons, the total of six months may be made up of several individual periods of suspension. The total cumulative suspension across all stages of the pathway must not exceed six months.

### Cancer target

173. Patient unavailability will follow the same rules as the cardiac RTT target.

### RTT excluded services

174. If a patient is referred to a diagnostic or therapy service which is excluded from the scope of the 26 week RTT target, an adjustment may be applied<sup>59</sup>. An adjustment may only be applied if the input is essential before the intended treatment can take place.
175. When the referral is for an excluded diagnostic test, the adjustment will apply from the date of the referral to the date that the test is reported.
176. When the referral is for an excluded therapy assessment or interim treatment, the adjustment will apply from the date of the referral to the date that the assessment or intervention is carried out.

### Cardiac RTT target

177. All diagnostic and therapy services are included within the cardiac RTT target.

### Cancer target

178. All diagnostic and therapy services are included within the cancer target.
179. When a patient is referred for an MRI scan following a TRUS biopsy, an adjustment of 28 days may be applied to the waiting times for clinical reasons.

### Inability to contact a patient

180. When the organisation has made appropriate attempts to contact the patient to arrange an appointment and the patient does not respond within three weeks, an adjustment to their waiting time may be made,

#### LINKS

<sup>59</sup> Read Appendices A and B for the diagnostic tests and therapy services that are included

beginning at the twenty-second day after the first contact was attempted. The maximum adjustment will be three weeks<sup>60</sup>.

181. If the patient has not responded to the booking process within six weeks, they should be removed from the waiting list and returned to the referrer<sup>61</sup>.

### Cancer target

182. When the organisation makes an attempt to contact the patient and they do not respond within two weeks, the patient will be suspended while the organisation makes further efforts to contact the patient. The suspension will begin two weeks after the first attempted contact and end when contact with the patient is achieved.

#### LINKS

<sup>60</sup> Read 'Booking and reasonable offer', page 18

<sup>61</sup> Read guiding principle in paragraph 18 and rule in paragraph 140

**Planned care**

Elective admissions planned to occur in the future, where, for medical reasons, there must be a delay before a particular intervention can be carried out

**Surveillance procedures**

Procedures that are repeated at agreed intervals in order to monitor the patient's condition

## Planned care

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

## Emergency care

188. RTT rules apply to elective pathways only and, therefore, admissions arising directly from emergency attendances will not begin an RTT period. However, a new elective pathway initiated through an emergency event will begin a new RTT period.
189. If a patient is seen during an emergency attendance or admission by a consultant team and subsequent follow up is arranged under their care or at a specific emergency clinic, this will not begin a new RTT period. A later decision to treat would begin a new RTT period. The clock would start on the date the decision is made.
190. 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 basis, a new RTT period would begin. The clock would start on the date of discharge from the emergency stay.
191. If a patient is referred during an emergency attendance or admission to another consultant to be seen outside of the emergency event, the referral will begin a new RTT period. The clock would start on the date the referral is received by the second consultant.
192. If a patient with a current RTT period is admitted as an emergency and is treated for that condition during their emergency stay, the RTT period will end. The clock will stop on the date the treatment is carried out.
193. If a patient with a current RTT period is admitted as an emergency, but is not treated for that condition during their emergency stay, the clock will continue. In the event that the patient is deemed medically unfit to undergo the treatment for which they are waiting, the rules for patient unavailability should be applied.

## Accountability

### Recording and reporting

#### Reporting formats

194. All targets must be reported according to the requirements of the NHS Wales Data Dictionary<sup>62</sup>. Organisations must consult the data dictionary for details of required formats, fields, timescales and routes of reporting.
195. LHBs must ensure that appropriate systems are in place to capture the information necessary to meet the requirements for reporting.

#### Accountability for monitoring open pathways

196. The LHB with current clinical responsibility for the patient is accountable for the monitoring of that patient's pathway.
197. When the patient's RTT period involves more than one organisation or information system, LHBs must ensure that communication protocols are utilised so that appropriate information is shared, and RTT periods are measured accurately<sup>63</sup>.
198. When NHS activity is commissioned from an independent sector provider, the LHB commissioning the pathway is accountable for the monitoring of that patient's pathway. LHBs must ensure that communication protocols are utilised so that appropriate information is shared, and RTT periods are measured accurately.
199. When a referral is made to an English provider, the LHB commissioning the pathway is accountable for the monitoring of that patient's pathway. LHBs must ensure that communication protocols are utilised so that appropriate information is shared, and RTT periods

#### LINKS

<sup>62</sup> <http://datadict.hsw.wales.nhs.uk/>

<sup>63</sup> Read rules in paragraphs 122-125, 132, 142 and 151

are measured accurately.

### **Accountability for performance**

200. When the patient's RTT period is managed entirely within a single LHB, the accountability for performance against the targets lies with that LHB.
201. When the patient's RTT period involves more than one LHB, accountability for performance against the targets will be shared across all LHBs involved.
202. When NHS activity is commissioned from an independent sector provider, the accountability for performance against the targets lies with the LHB commissioning the activity.
203. Where NHS activity is commissioned from an English provider, the accountability for performance against the targets lies with the LHB commissioning the activity.
204. Where the patient pathway is commissioned by Health Commission Wales (HCW), the accountability for performance against the targets lies with HCW. LHBs and HCW must jointly ensure that communication protocols are utilised so that appropriate information is shared, and RTT periods are measured accurately.

### **Accountability for reporting**

205. The LHB with clinical responsibility for the patient at the reporting census date is responsible for reporting performance against the open pathway waiting time target.
206. The LHB with clinical responsibility for the patient at the time of treatment is responsible for reporting performance against the closed pathway waiting time targets.

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

### **Cancer target**

209. In a small number of cases there will be good clinical reasons for treatment time exceeding the target time. Potential examples of this include:

- When a patient is referred as a USC and there is diagnostic uncertainty as to whether they have cancer or not. These patients may require repeat diagnostic tests in order to reach a diagnosis.
- A patient who requires a particularly complex combination of scans and biopsies.
- A patient for whom there is genuine clinical uncertainty about the diagnosis and the clinician elects to observe the patient over (say) a three-month period.

These patients will exceed the 62 day wait and the detailed reasons why these patients exceeded the target time should be recorded in the breach analysis.

## Glossary

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

### **26 week referral to treatment target**

The Welsh Assembly Government waiting times target for December 2009, that no patient should wait more than 26 weeks from referral to treatment.

### **Active monitoring**

A clinical intervention where the decision is made to monitor a patient's condition closely in secondary care, resulting in active steps being taken to ensure that the patient is regularly assessed and that any change in condition can be responded to.

### **Adjustment**

A period of time for which the patient is either unavailable, for clinical or social reasons, or where the patient is referred to a service that is outside the scope of RTT.

### **Adjusted pathway start date (APSD)**

Used within the cardiac RTT target to denote the new clock start date caused by the application of an adjustment.

### **Admission**

The act of admitting a patient for a day case or inpatient procedure.

### **Cancer target**

The Welsh Assembly Government waiting times target for cancer treatment: 62 days for an urgent suspected cancer (USC) and 31 days for a non-urgent suspected cancer (NUSC) referral.

<b>Cardiac RTT target</b>	The Welsh Assembly Government waiting times target for cardiac patients that no patient should wait more than 26 weeks from referral to treatment.
<b>Cardiologist</b>	A clinician who undertakes the majority of their clinical sessions in cardiology.
<b>Clinic outcome</b>	A record of the event of a clinical decision made by a clinician. This decision will not necessarily be made within a clinic environment.
<b>Clock continue</b>	Any event which occurs along the patient pathway, but does not constitute a clock start or clock stop within the RTT rules.
<b>Clock reset</b>	An administrative process to change the start of the recorded RTT period to the date of the event causing the reset.
<b>Clock start</b>	An event which commences an RTT period within the RTT rules.
<b>Clock stop</b>	An event which ends an RTT period within the RTT rules.
<b>Consultant:</b>	A person contracted by a Health Board who has been appointed by an Advisory Appointment Committee. He or she must be a member of a Royal College or faculty. This includes GPs in cases where a GP is responsible for patient care and has an arrangement with a Local Health Board. For diagnostic departments, this includes a non-medical scientist of equivalent standing to a consultant.
<b>Consultant office decision</b>	Any decision which affects the clinical management of

the patient and has been made when the patient is not present.

**Consultant to consultant referral**

Any patient referral made within a secondary/tertiary care environment from one consultant to another.

**Could not attend (CNA)**

Any patient who contacts the organisation to notify that they will be unable to attend an agreed appointment is recorded as 'could not attend' (CNA).

**Decision to treat**

A record of the event that a clinical decision to admit a patient to a particular healthcare organisation has been made.

**Decision not to treat**

A clinical decision that, at the present time, no treatment is required for the condition for which the patient has been referred. This will normally result in the patient being discharged back to the referring doctor.

**Diagnostic wait**

The time waited from receipt of referral for a diagnostic investigation to the appointment for that investigation.

**Did not attend (DNA)**

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

**Direct access**

Patients who are referred directly rather than via a consultant-led clinic.

**Direct booking**

Booking methodology where an agreement of appointment is made through a direct communication between the organisation and patient.

<b>Direct referral</b>	A referral made by a clinician in primary care directly to a diagnostic or therapy service.
<b>Emergency admission</b>	Patients admitted to hospital when admission is unpredictable and at short notice because of clinical need.
<b>Expert patient</b>	Patients experiencing a long-term health condition who become 'experts' in their own care to improve their quality of life.
<b>First definitive treatment</b>	Any initial treatment that treats the patients cancer, stabilises their symptoms from cancer, or stabilises their health so cancer treatment can commence
<b>Incremental change in treatment</b>	A small change to a current treatment plan, e.g. adjustment of the dosage of a prescribed medication.
<b>Inpatient/day case wait</b>	The time waited from a decision to treat as an inpatient/day case to admission for the treatment.
<b>Intended treatment</b>	An intervention which, at that time, aims to manage the patient's condition.
<b>Interim treatment</b>	An intervention aiming to help the patient cope with their condition until the planned intended treatment can be delivered.
<b>Local Health Board (LHB)</b>	The statutory NHS body.
<b>Mutually agreed</b>	Agreed by both the patient and the LHB.
<b>Non-admission event</b>	Any event when the patient attends for an appointment but is not booked into a bed or trolley, e.g. an outpatient appointment.
<b>Non-USC referral (NUSC)</b>	Any patient diagnosed as having cancer who was not

referred by their GP as a USC or upgraded by the specialist on analysis of the GP referral.

**Organisation**

The secondary care service, previously known as the Trust.

**Out of hours contact**

Between 6pm and 9pm on weekdays and between 9am and 9pm at weekends.

**Partial booking**

A system whereby appointments are agreed with the patient, following a written request from the LHB for the patient to telephone to make an appointment.

**Pathway start date (PSD)**

Used within the cardiac RTT target to denote the original clock start date caused by the receipt of a referral.

**Patient pathway**

The process of a patient's care for a particular condition across the whole of the NHS, from primary care onwards.

**Planned care**

Elective admissions planned to occur in the future, where, for medical reasons, there must be delay before a particular intervention can be carried out.

**Pooled environment**

A service design where all parties have been informed, at the time of referral or first outpatient visit, that a group of clinicians are working together to provide the service, and where patients may be seen by any of the clinicians in the pool, at any given stage of treatment.

**Reasonable offer**

Any offer of an appointment mutually agreed between the patient and the LHB.

**Receipt of referral by the LHB**

The referral is deemed to be received when it first

arrives within the secondary or tertiary care service, irrespective of the department or individual receiving it. This will include electronic and paper referrals.

**Referral guidelines**

Predetermined written criteria for referral that are formalised and agreed between the healthcare professionals making and receiving the referral.

**Referral protocols**

Agreements reached and documented locally to identify accepted sources for referrals to specific services.

**Referral to treatment**

The period between a referral being made for a particular condition and treatment being commenced for that condition.

**RTT period**

The waiting time will be monitored using the concept of a clock, which will start and stop according to the events and transactions that occur along the course of the patient pathway. The measured period of time between a clock start and a clock stop, under RTT rules, which is reported as the RTT waiting time.

**Screening programme**

A recognised national programme of screening for particular conditions e.g. Breast Cancer Screening Programme.

**Secondary care**

NHS care delivered as a result of a referral from primary care.

**Self-referral**

The process whereby a patient initiates an appointment with a secondary care service, without referral from either a primary or secondary care clinician.

<b>Short-term medical condition</b>	A medical condition precluding progression to the next stage of the pathway for less than 21 days.
<b>SOS clinics</b>	Specialist direct access clinics that expert patients attend for urgent attention.
<b>Specialist</b>	Used within the cancer target to denote a consultant who treats patients with cancer.
<b>Stage of the pathway</b>	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.
<b>Step change in treatment</b>	A substantial change to a current treatment plan, e.g. a change from oral to subcutaneous delivery of medication.
<b>Suitably qualified healthcare professional</b>	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.
<b>Surveillance procedures</b>	Procedures that are repeated at agreed intervals in order to monitor the patient's condition.
<b>Suspension</b>	A period during which the cancer or cardiac clock is paused due to the patient being unavailable or medically unfit due to a co-morbidity to proceed to the next stage of the pathway.

**Tertiary care**

Specialised NHS care in services designated to provide the service in a specialist centre, and delivered as a result of a referral from within secondary care.

**Therapy services**

NHS services providing treatment by Health Professions Council registered professions i.e. arts therapies, dietetics, occupational therapy, orthoptics, 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.

**USC referral**

A referral where a suspicion of cancer is stated by the GP and confirmed by the specialist. This is not restricted to designated USC-only referral methods e.g. fax lines.

## Appendix A

### Included diagnostic tests

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

## Appendix B

### Included therapy services

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

## Appendix C

### Policy documents

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

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

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

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

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

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

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

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

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

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

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

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

## Appendix D

### Identifying definitive treatment

#### When is the start of definitive treatment?

The first definitive treatment should be agreed with the clinician responsible for the patient's management plan. This will be a clinical judgement.

First definitive treatment date: the treatment date may be any of the following:

“First treatment” refers to the first definitive treatment and may not necessarily be the first planned treatment decided upon by the MDT. If a patient is admitted as an emergency and undergoes immediate surgery, this could be classed as the first definitive treatment, with cancer confirmed on the histology as a result of this surgery. In this case the Date of First Treatment would be earlier than the diagnosis. This will result in a negative waiting time which is always shown as zero.

If the first definitive treatment is surgery:

- Record the date on which the first procedure took place, whether done on an inpatient or day case basis.

If the first definitive treatment is chemotherapy and/or anti-cancer treatment (including hormone/endocrine/immunotherapy):

- Record the date on which the first dose of the drug is administered to the patient.

If the first definitive treatment is radiotherapy:

- Record the date on which the first fraction of radiotherapy for this prescription is administered to the patient.

If the first treatment/support is specialist palliative care:

- Record the date of the first treatment/support from specialist palliative care.

If the first treatment is active monitoring:

- Record the date of the consultation on which this plan of care was agreed with the patient.

#### Examples of first definitive treatment

It may be useful to consider the various types of primary “treatment package” that different patients may receive:

- Many patients will receive a single treatment modality aimed at removing or eradicating the cancer completely or at reducing tumour bulk (e.g. surgery, radiotherapy or chemotherapy). In these cases the definition of “first definitive treatment” and the start date are usually straightforward.
- A second group of patients will receive a combination of treatments as their primary “treatment package” (e.g. surgery followed by radiotherapy followed by chemotherapy). In these cases

the “first definitive treatment” is the first of these modalities to be delivered, and the date is the start date of this first treatment.

- A third group of patients require an intervention which does not itself affect the cancer to be undertaken prior to the delivery of the anticancer treatment(s) – to enable these treatments to be given safely. Such interventions might include formation of a colostomy for an obstructed bowel or insertion of an oesophageal stent. As these interventions form part of the planned “treatment package” for the patient it has been agreed that the start date of the enabling intervention should be taken as the date of first definitive treatment.
- A fourth group of patients undergo a clearly defined palliative intervention (e.g. a colostomy or a stent) but do not then receive any specific anticancer therapy. For these patients the start date of this intervention should be recorded as the date of first treatment.
- A fifth group of patients do not receive any anticancer treatments but are referred specifically to a specialist palliative care (SPC) team. For these patients the date of the first assessment by a member of the SPC team is to be taken as the date of the first “treatment”.
- A sixth group will receive both anticancer treatment (e.g. radiotherapy) and a specialist palliative care assessment. In this instance the date of the anticancer treatment is to be taken as date of first treatment.
- Finally, some patients do not receive any specific anticancer treatment/intervention and are not referred to a SPC team. Where the patient is receiving symptomatic support and is being monitored these patients should be classified as undergoing “Active Monitoring”. It is recognised that this is somewhat unsatisfactory as this group encompasses patients with early cancer (e.g. localised prostate cancer where serial monitoring of PSA is undertaken) and those with advanced cancers for which no immediate specific interventions are considered to be warranted. These patients may, of course, require general palliative care including symptom control – given under the care of GPs and/or oncologists.

The first definitive treatment is normally the first intervention which is intended to remove or shrink the tumour. Where there is no definitive anti cancer treatment almost all patients will be offered a palliative intervention (e.g. stenting) or palliative care (e.g. symptom control), which should be recorded for these purposes

## Appendix E

### Suspension for social reasons

A patient may be suspended from the waiting list when, due to either medical or social reasons, the patient is unable to move on to the next stage of the pathway.

The clock stops when:

- When a patient has other commitments they wish to pursue prior to treatment or investigation (e.g. holiday)
- When a patient requests a period of time to think (e.g. to decide on treatment options)
- When a patient requests a second opinion before making a decision on treatment (the clock does not stop if the clinician requires a second opinion)

Suspensions must be clearly recorded in the patient notes. The position of any patient suspended must be reviewed regularly.

The clock does not stop:

- When a patient chooses a treatment with a longer waiting time (e.g. radiotherapy rather than surgery)
- A patient should not be suspended once an admission date has been agreed, unless the date is later than normal due to the need to resolve other medical problems prior to treatment

### Examples of social suspensions

A patient with cancer is seen by the oncologist and is suitable for a clinical trial. The patient is given the details and told he/she needs to make a choice about whether or not they wish to take part in the trial. This two-step process is good practice in terms of informed consent. Whilst taking the time to make the decision, the patient will be classed as suspended for patient reasons as he/she is technically unavailable for treatment. The clock starts again as soon as the patient has told the oncologist of their decision.

Note: Allowing patients time to consider treatment options is part of good clinical practice and is not confined to clinical trials.

A young patient is advised that potentially curative treatment involves significant risk of serious side effects (which may include peri-operative death). The patient wishes to be referred for a second opinion to see if they might avoid these outcomes but yet still achieve cure. The patient is suspended for patient reasons as they have made themselves unavailable for treatment whilst seeking a second opinion.

A patient is discussing their care-plan with a clinician and states (before any offer of an admission date is made) that they would like to take the holiday they have booked prior to treatment starting. As no offer of a TCI date had been made by the trust this can be classified as a suspension for patient

reasons. The period which the patient has made themselves unavailable should be adjusted out of the calculated waiting time.

### **Suspension for medical reasons**

The clock stops when:

- When a patient is unavailable for admission for a period of time due to another medical condition that needs to be resolved
- When a patient is unavailable for a diagnostic or staging test or treatment due to another medical condition that needs to be resolved (e.g. reduce weight)

Suspensions must be clearly recorded in the patient notes. The position of any patient suspended must be reviewed regularly.

The clock does not stop:

- When the trust is unable to offer treatment within the required timescales
- For a patient who requires repeat biopsies or scans because of uncertainty the first time round
- In patients for whom there is genuine clinical uncertainty about the diagnosis and the clinician elects to observe the patient over (say) a three month period
- A patient should not be suspended once an admission date has been agreed, unless the date is later than normal due to the need to resolve other medical problems prior to treatment

### Examples of suspension for medical reasons

Some cancer patients will have co-morbidities, which will require investigation and/or treatment prior to administering cancer treatment. For example a cancer patient with angina may be referred for a cardiology opinion prior to treatment. In this case the clock will only stop if the cardiology opinion is that the patient is medically unfit for cancer treatment. If the opinion is that the patient is fit for cancer treatment then the clock does not stop. Hence the clock does not stop whilst an opinion on the co-morbidity is being sought. A similar example would be where a patient with mouth cancer requires dental extraction prior to commencement of radiotherapy treatment – the clock would stop while the patient was not fit for treatment following the extraction, but not whilst they were waiting for the extraction.

Patients with severe frailty/cachexia related to the cancer. A patient who requires intensive nutritional support (e.g. through intravenous feeding or through nasogastric feeding) before they are fit for surgery. The clock stops for the period the patient is medically unfit for surgery, with the start date of this period of suspension being defined as the date when a medical opinion as to their being unfit for treatment was received.

A patient with cancer also has COPD. He/she is technically suitable for surgical resection but considered in need of a medical opinion (in this case usually a respiratory physician). The respiratory physician confirms the patient is medically unfit for the surgery at that time (clock stops at this point)

(see above) and wishes to institute a changed therapeutic regime to optimise their respiratory function before surgery. The patient is suspended until medically fit for the surgery.

In prostate cancer following a transrectal ultrasound-guided biopsy there may be swelling of the prostate gland. This makes interpretation of MRI scans unreliable. Many clinicians would advocate that there should be a planned interval of up to 4 weeks between biopsy and MRI, as the gland swelling means the patient is medically unfit for the scan and so a medical suspension is appropriate.