RAMSAY HEALTH CARE

Ramsay Access Policy

Waiting List Policy and Management

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Waiting List Policy and Management of Patients Accessing NHS Treatment

Document	Ramsay Health Care Access Policy
Author	John Shepherd
Version	v10.1
Date	22/02/2023
Revision Date	February 2023

Version Control

Version Number	Reason for variation	Date
7.0	**Updated to reflect NHSE national guidance on model Access Policies; also updated some requirements in line with current approach adopted within Ramsay**	**02/11/2018**
7.2	**Amends to reflect changes in approach and emphasis**	**04/09/2019**
9.0	**General update; application of revised rules post Covid-19 and implementation of Clinical Prioritisation process; removal of references to historic PAS (Cosmic)**	**01/07/2022**
10.0	**Amendment to include new "C" clinical prioritisation codes and adoption of new RTT rules related to Active Monitoring**	**27/02/2023**
10.1	**Amendment to date typo on p2**	**09/05/2023**

Next Review Date:	**February 2024**

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1.0 Introduction

Ramsay Health Care UK ("Ramsay") is committed to providing high quality care to patients and delivering an exemplary standard of patient access as is required and expected of a modern and efficient NHS service provider. Ramsay will manage waiting times within national guidelines, offering quick and reliable access to services and to providing patient choice. Specifically, this policy:

- ensures that national guidance and best practice is followed to ensure that patients are treated promptly, efficiently, consistently and in order of clinical priority
- sets out the specific rules and principles under which Ramsay manages elective access to outpatient appointments, diagnostics and elective inpatient or day case treatment
- gives staff clear direction on the application of the NHS Constitution in relation to elective waiting times
- demonstrates how elective access rules should be applied consistently, fairly and equitably and managed according to clinical priority

The NHS Constitution states that all individuals have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible.

It is recognised that the Covid-19 pandemic has had a material impact on all healthcare providers and led to significant changes to the way in which providers manage patients who are waiting for diagnosis and treatment. Covid-19 has not changed the fundamental requirements and rights outlined in the NHS Constitution nor national rules and guidance for providers managing their patient waiting lists, but to ensure clinical appropriateness and to reduce variation this document has been updated accordingly.

This means:

1. Wherever possible, to start consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions
2. Patients will be reviewed regularly if the patient states that they are unwilling to agree a date for their attendance, admission or treatment due to Covid-19. In such cases their treatment will not be paused, nor will they be discharged back to their GP
3. Where the 18 Weeks' target is not met, the ISB must take all reasonable steps to offer a suitable alternative provider that would be able to see or treat the patient more quickly than the provider to which they were originally referred

This policy outlines the processes that must be followed when managing the booking of outpatient appointments, arranging inpatient admissions and day cases, and the management of appropriate schedules by the staff of Ramsay.

The policy reflects the key access targets:

- Current outpatient, inpatient and diagnostic waiting times
- The referral to treatment target (RTT)

This document has been written in conjunction with the guidelines for managing elective patients on an 18 Week Pathway and replaces any previous Patient Access Policies. It does NOT supersede national referral to treatment (RTT) guidance and rules in any way. Where there is any contradiction with national RTT rules, the national rules take precedence.

The Ramsay Access Policy is underpinned by a comprehensive suite of detailed standard operating procedures (SOPs) used by Ramsay hospitals to actively manage their waiting lists. All clinical and non-clinical staff must ensure they comply with both the principles within this policy and the specific instructions within SOPs.

This Access Policy will be reviewed and ratified at least annually or earlier if there are changes to national elective access rules or locally agreed principles.

2.0 Purpose

The purpose of this policy is to ensure all patients requiring access to outpatient appointments, diagnostics and elective inpatient or day-case treatment are managed equitably and consistently, in line with national waiting time standards and the NHS Constitution. It covers the management of patients at all sites where Ramsay operates, including outreach clinics.

The policy:

- is designed to ensure the management of elective patient access to services is transparent, fair, equitable and managed according to clinical priorities
- sets out the principles and rules for managing patients through their elective care pathways
- applies to all clinical and administrative staff and services relating to elective patient access at Ramsay

Every process in the management of patients who are waiting for treatment must be clear and transparent to the patients and to partner organisations and must be open to inspection, monitoring and audit.

Responsibility for achieving national RTT standards ultimately lies with each hospital's Senior Leadership Team. However, staff throughout the hospital share this responsibility. This includes NHS booking staff, team members within the business office and medical secretaries.

The NHS Constitution recommends the following actions patients can take to help in the management of their condition and in turn achievement of prompt treatment:

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

Ramsay will give priority to clinically urgent patients and treat everyone in turn. As per the Armed Forces' Covenant, war pensioners and service personnel injured in conflict will receive priority treatment if the condition is directly attributable to injuries sustained in conflict.

- Ramsay will follow all Guidance issued by NHS England and local commissioners relating to waiting times, including all associated targets, guidelines and rules[1]
- Ramsay will meet and seek to improve on the maximum waiting times set by NHS England and local commissioners for all groups of patients

[1] "Referral to treatment consultant-led waiting times Rules Suite", Department of Health, October 2015
"Recording and reporting referral to treatment (RTT) waiting times for consultant led elective care", NHS England, April 2021
"RTT Rules Application COVID-19 FAQs", Elective Care Improvement Support Team, NHS England, v1.1, January 2021
"Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care: Frequently Asked Questions", NHS England, October 2015
"Addendum to Elective care model access policy Covid-19", Elective Care Improvement Support Team, NHS England, v7, June 2021

- Ramsay will, whenever possible, discuss and agree appointment and admission dates and times with patients.
- Ramsay will work to ensure fair and equal access to services for all patients

In accordance with training needs analysis, staff involved in the implementation of this Policy, both clinical and clerical, will undertake training provided by Ramsay and regular annual updates. Policy adherence will be part of the staff appraisal process.

Ramsay will ensure that management information on all waiting lists and activity is recorded on Ramsay's Patient Administration System (PAS), known as "Maxims".

Ramsay will monitor the Referral to Treatment (RTT) pathway by using Patient Tracking Lists (PTL) measuring the patient's length of wait from referral to "definitive treatment" including new outpatient appointment, diagnostic test and elective admission.

It is the responsibility of all members of staff to understand the RTT principles and definitions.

3.0 General Elective Access Principles

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

- the individual patient rights (as defined in the NHS Constitution)
- the standards by which individual providers and commissioners are held accountable by NHS Improvement and NHS England

3.1 Individual Patient Rights

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

- choice of hospital and consultant
- to begin their treatment for routine conditions following a referral into a consultant-led service, within a maximum waiting time of 18 weeks to treatment

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

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

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

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

3.2 Clinical Stratification

The challenges caused by the Covid-19 pandemic has necessitated the need for clinical review of key cohorts of patients. The findings from these clinical reviews inform the decisions for individual pathways and grouped cohorts as part of Ramsay's elective governance arrangements.

These arrangements include a clinical validation exercise of a hospital's waiting list, to ensure all patients waiting for treatment wish to continue waiting. In addition, there is also a Clinical Prioritisation process which assigns a clinical priority to all patients on an admitted care pathway (i.e. awaiting day case or in patient admission).

The Prioritisation process followed by Ramsay follows national guidelines and is one based on clinical need and not length of time waited. The clinical Prioritisation of Ramsay's waiting lists is ongoing process, with patients reviewed regularly to check the priority has not changed.

In line with national guidance[2], patients will be assigned to one of the following groups with the relevant Prioritisation recorded in Maxims:

Emergency/Urgent	P1	C1
< 1 month	P2	C2
< 3 months	P3	C3
> 3 months; delay 3 months possible	P4	C4

Patients will primarily be assigned one of the main "P" Prioritisation codes, depending upon the clinicians' determination of their priority. If a patient chooses to defer their treatment by not accepting a date for treatment, they will be reassigned a "C" code aligned to their previous clinical priority. For example, P3 to C3.

Where patients repeatedly choose to defer their treatment, subject to clinician consent, they may be moved from the active waiting list to Active Monitoring. The point at which patient can be moved to Active Monitoring will be patient specific and based upon individual circumstances but rejecting a second offer may be sufficient. The switch to Active Monitoring will stop the patient's RTT clock. At this point patients will be offered further dates for surgery. When a patient accepts one of these dates, they will be moved back to the main active waiting list and a new RTT clock will be started. If the patient continues refuse reasonable offers of dates for surgery, then subject to clinician consent, patients may be discharged back to their GP.

3.3 Patient Eligibility

All providers of NHS care, including Ramsay, have an obligation to identify patients who are not eligible for free NHS treatment and specifically to assess liability for charges in accordance with Department of Health and Social Care guidance /rules.

Ramsay reserves the right to validate a patient's eligibility for treatment. Therefore, at the first point of referral, patients will be asked questions that will help assess the patient's 'ordinarily resident' status.

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

- have paid the immigration health surcharge
- have come to work or study in the UK
- have been granted or made an application for asylum

Citizens of the European Union (EU) who hold a European Health Insurance Card (EHIC) and have the right of residency in the UK are also entitled to free healthcare, although Ramsay may recover the cost of treatment from the country of origin.

[2] Based on the prioritisation tool produced by the Federation of Surgical Specialty Associations and endorsed by all surgical colleges: https://fssa.org.uk/_userfiles/pages/files/covid19/prioritisation_master_240720.pdf

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

3.4 Patients Moving Between NHS and Private Care

Patients have a right to move between NHS and private treatment at any point during their treatment pathway without prejudice. However, specific rules do apply when the patient is switching to NHS treatment having previously been treated as a private patient.

3.4.1 Private to NHS Transfers

Where it has been agreed, for example, that a surgical procedure is necessary, the patient can be added directly to the elective waiting list if clinically appropriate. However, the patient cannot be seen to have "queue jumped" the NHS waiting list through the benefit of having received part of their pathway privately. To that end, the patient's NHS RTT clock will start at the point the GP or original referrer's letter arrived in the hospital, meaning they will be joining the NHS waiting list at the point at which they would have been if their entire pathway had been on the NHS.

It is important to note that technically any patient transferring from being a private patient to the NHS does not need to have a separate NHS appointment or referral prior to being added to the waiting list. For example, if a patient has had their first appointment and diagnostic tests under a private service and then wishes to transfer to the NHS for treatment, they can be added to the NHS waiting list without having to have another first appointment/diagnostics. However, it is recognised that many ICBs do require patients to revert to their GP in the first instance for a new NHS referral.

A new referral must be created on the PAS to reflect the NHS to Private status.

3.4.2 Patients transferring from the NHS to Private

NHS patients already on NHS waiting lists opting to have a private procedure must be removed from the NHS waiting list. Such patients' RTT pathways should be closed with a clock stop applied on the date of this being disclosed by the patient.

A new referral must be created on the PAS to reflect the NHS to Private status.

Under NHS rules, patients are not permitted to "mix and match" NHS and Private care within the same pathway, e.g. the patient has an NHS referral and an initial outpatient attendance, diagnostics performed privately and then wishes to revert to the NHS for surgery. Such switching to jump waiting lists is not permitted. Similarly, NHS patients are not permitted to "top-up" their NHS care by paying for additional aspects privately (e.g. wanting to receive an upgraded lens during a cataract operation) or extending their hospital admission for additional days as a private patient). Patients are wholly private or wholly NHS, they cannot be both simultaneously.

3.5 Commissioner-Approved Procedures

Patients referred for specific treatments where there is limited evidence of clinical effectiveness, or which might be considered cosmetic, can only be accepted with the prior approval of the relevant

commissioner, whether that be the patient's ICB or in certain circumstances NHS England. These procedures of limited clinical value/effectiveness can also be known as 'low priority procedures'.

Each Ramsay hospital will have its own process for identifying patients whose treatment needs commissioner prior approval and the subsequent mechanism for applying for such approval, reflecting respective commissioners' own specific requirements. Evidence of compliance to commissioners' policies should be recorded within Maxims, as should evidence of prior approval being granted, including where appropriate the authorisation number provided by commissioners.

Ramsay hospitals should bear in mind both locally-determined commissioning policies, plus also national policies (known as 'Evidence Based Interventions'[3]). Similarly, there are also specific commissioning policies for Armed Forces' personnel as determined by NHS England.

The NHS Standard Contract between the Ramsay hospital and main commissioner will define the time commissioners have to respond to prior approval requests. In accordance with national guidance, a failure by the commissioner to respond within this timescale is deemed to mean automatic approval for the request and the patient can proceed to treatment.

3.6 Members of the Armed Forces

In line with the Armed Forces Covenant from the Ministry of Defence (MOD), members of the Armed Forces Community (see glossary) should enjoy the same standard of, and access to, healthcare as that received by any other UK citizen in the area they live.

For serving personnel, including mobilised Reservists, primary healthcare is provided by the Defence Medical Service (DMS) part of the MOD, whilst secondary care is provided by the local NHS or Independent Healthcare provider such as Ramsay. Arrangements are made for personnel injured on operations to be treated in conditions suited to their specific needs and are not likely to be treated in a Ramsay hospital. For family members, primary healthcare may be provided by the MOD, usually when accompanying Service personnel at their posting. Any such family members requiring referral to secondary care will be treated in the same way as Serving personnel and will be referred to us from a DMS GP (with a referrer code prefixed by A91).

If a member of the Armed Forces is on an NHS waiting list and is moved around the country due to a new posting, any waiting time accrued will be carried forward with them. As with the Serving personnel, family members should retain their relative position on any NHS waiting list, if moved around the UK due to the Service person being posted.

Veterans and war pensioners receive their healthcare from the NHS (rather than the MOD) and should receive priority treatment where their condition is related to the patient's military service, subject to the clinical needs of all other patients. GPs should notify the hospital of the patient's condition and its relation to military service when they refer the patient, so the hospital can ensure it meets the current guidance for priority service over other patients with the same level of clinical need.

[3] https://www.england.nhs.uk/evidence-based-interventions/

In line with clinical policy, patients with more urgent clinical needs will continue to receive clinical priority.

Links to further information:

Armed Forces Covenant:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/49469/the_armed_forces_covenant.pdf
NHS Choices, Armed Forces Healthcare:
http://www.nhs.uk/NHSEngland/Militaryhealthcare/Pages/Militaryhealthcare.aspx

3.7 Prisoners (Ministry of Justice Healthcare)

In the vast majority of cases Ramsay hospitals is not deemed to be an appropriate setting for the treatment of prisoners. As such any referrals received from prisons for a serving prisoner should be returned to the referring GP.

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

3.8 Cross Border Healthcare

Patients resident in the devolved administrations (Scotland and Wales) are entitled to receive emergency treatment at Ramsay when required, however prior approval for all Elective Treatments, including Outpatient appointments, must be obtained (from the relevant Health Board) before booking an appointment or receiving treatment. Northern Ireland patients receive treatment in the same manner as English residents).

Further details can be found in Ramsay's guidance on determining the Responsible Commissioner.

3.9 Service Standards

Key business processes that support access to care will have clearly defined service standards, monitored by the hospital. Compliance with each service standard will support effective and efficient service provision, and the achievement of referral to treatment standards.

Key standards for implementation include the following:

- referral receipt and registration (within 24 hours)
- referral vetting and triage (within 48 hours of registration)
- addition of urgent outpatient referrals to waiting list (within 48 hours of registration)
- addition of routine outpatient referrals to waiting list (within 5 days of registration)
- urgent patient contacted by the hospital after addition to waiting list (within 48 hours)
- routine patient contacted by the hospital after addition to waiting list (within 2 weeks)
- urgent diagnostic reporting (within 24 hours)
- routine diagnostic reporting (within 48 hours)

3.10 Pathway Milestones

To achieve treatment within 18 weeks of receipt of referral, pathways are subdivided into components or subsections, each of which should be completed in a timely manner. Failure to achieve the required target in one subsection of the pathway is likely to have a knock-on effect on the remaining elements, putting at risk compliance to the overall 18 Week pathway.

It is important to recognise that not all specialties (or conditions/ proposed treatments) will follow the same pathway, with subsections taking longer for some specialties than they do for others. Nonetheless, the 18 Week timetable should still be achieved for all patients in all specialties.

In headline terms, a typical surgical pathway can be disaggregated into the milestones shown in Figure 1 below.

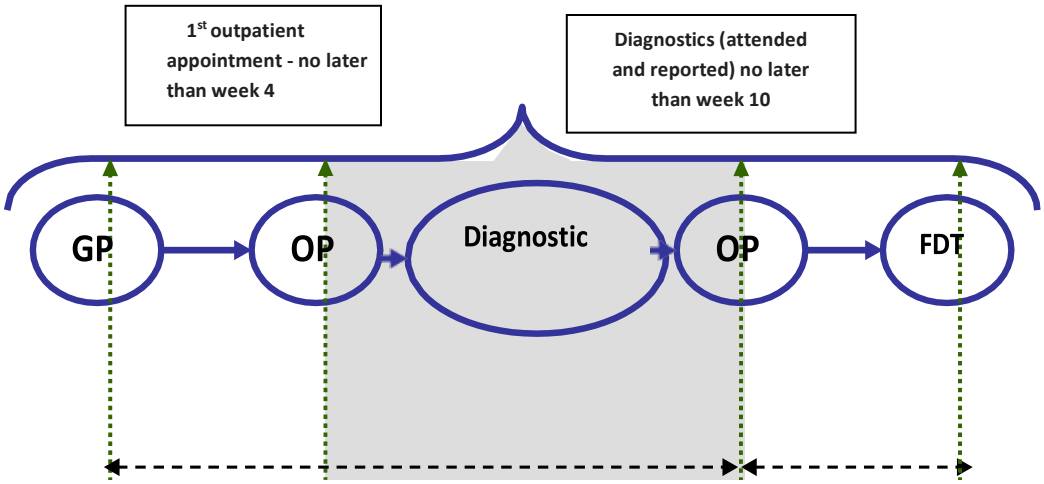


Figure 1: Headline RTT Patient Pathway

3.11 Reasonableness

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

3.12 Chronological Booking

Patients will be selected for booking appointments or admission dates according to clinical priority. Patients of the same clinical priority will be appointed/ treated in RTT chronological order, i.e. the patients who have been waiting longest will be seen first. Patients will be selected using Ramsay's Waiting List Monitoring report [also known as Patient Tracking Lists (PTLs)].

3.13 Communication

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

kept in the patient's clinical notes, but current and future correspondence must be stored electronically on Maxims for auditing purposes.

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

4.0 National Referral to Treatment and Diagnostic standards

The 18 Week Referral to Treatment pathway (RTT) measures the patient's journey from point of referral to the first definitive treatment.

Referral to treatment	
Incomplete	92% of patients on an incomplete pathway (i.e. still waiting for treatment) to be waiting no more than 18 weeks (or 126 days)
Diagnostics	
Applicable to diagnostics tests	99% of patients to undergo the relevant diagnostic investigation within 5 weeks and 6 days (or 41 days) from the date of decision to refer to appointment date

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

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

4.1 Impact of COVID-19

Notwithstanding national RTT rules and the NHS Constitution regarding the 18 Week pathway, the COVID-19 pandemic has materially impacted all providers' ability to consistently achieve the 18 Week standard for all patients.

Ramsay will use all reasonable endeavours to treat patients as soon as possible, in strict accordance with their clinical priority. Where delays to a patient's treatment does occur Ramsay will ensure that patients and their GPs are kept informed throughout the process. The Clinical Prioritisation assigned to each patient should be recorded in Maxims, including any changes made as a result of regular reviews.

5.0 Overview of National Referral to Treatment Rules

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

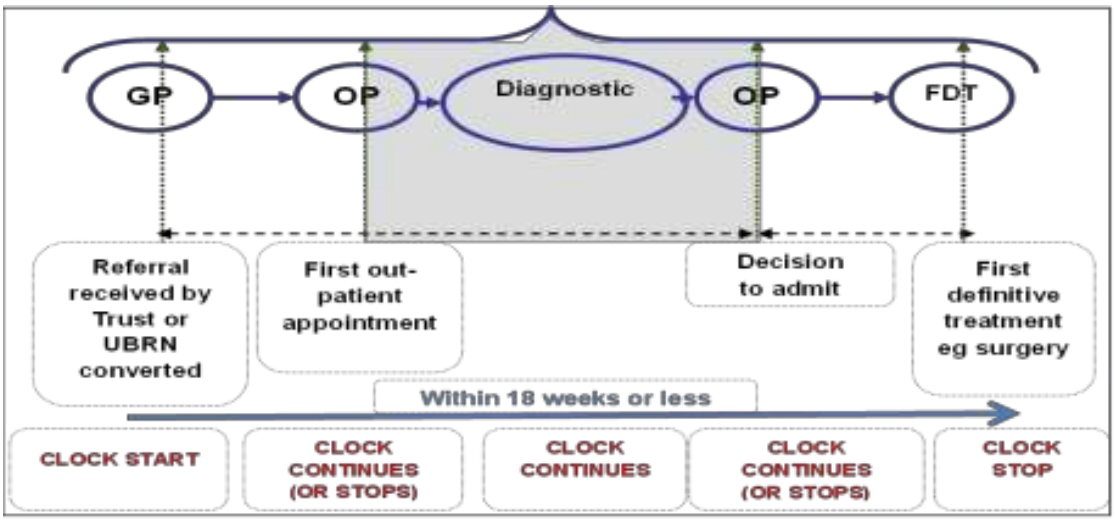


Figure 2: Typical RTT Pathway

Key
OP – outpatients
FDT – first definitive treatment

All aspects of the patient pathway to the point of being treated must be concluded within 18 weeks, including investigations and diagnostics (which should be completed within 6 weeks of such tests being requested). This may also include non-consultant led services as long as the patient is remaining under the care of a consultant and this is part of the patient's 18 Week pathway.

If a member of the Armed Forces is on an NHS waiting list and is moved around the country due to a new posting, any waiting time accrued will be carried forward with them.

5.1 Clock Starts

The RTT clock starts when any healthcare professional (or service permitted by an English NHS commissioner to make such referrals) refers to a consultant-led service. This will primarily be from a GP but may also come from other sources such as a dentist or an optometrist.

The RTT clock start date is the date the hospital receives the referral. For referrals received through the NHS e-Referral service (e-RS), the RTT clock starts the day the patient converts their unique booking reference.

An 18-week clock starts upon referral when:

- A referral is made to a consultant led service, regardless of setting with the intention that the patient will be assessed and if appropriate, treated before responsibility is transferred back to the referring healthcare professional or general practitioner

- A referral led management or assessment service, which may result in an onward referral to a consultant led service before responsibility is transferred back to the referring healthcare professional or general practitioner
- A patient self-refers into a consultant-led service for pre-agreed services agreed by providers and commissioners.

5.1.1 Exclusions

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

a) planned patients (where a patient has planned activity during a longer course of treatment, e.g. a patient having surveillance scope procedures every six months)
b) referrals to a non-consultant led service
c) referrals for patients from non-English commissioners
d) obstetrics and midwifery
e) genitourinary medicine (GUM) services
f) emergency pathway non-elective follow-up clinic activity

From Ramsay's perspective, only (a) to (c) above will apply as the others represent services not offered to NHS patients within Ramsay hospitals.

5.1.2 New Clock Starts for the Same Condition

Following Active Monitoring:

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

Following a decision to start a substantively new treatment plan:

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

For second side of a bilateral procedure:

A new RTT clock should be started when a patient becomes fit and ready for the second side of a consultant-led bilateral procedure (e.g. ophthalmic cataract procedures).

For a rebooked new outpatient appointment:

See first appointment DNAs on page 22.

5.2 Planned/Surveillance Patients

All patients added to the planned list will be given a due date by when their planned procedure/test should take place. Where a patient requiring a planned procedure goes beyond their due date, they will be transferred to an active pathway and a new RTT clock started. The detailed process for management of planned patients is described in the relevant standard operating procedure.

5.3 Clock Stops

The 18 Week RTT clock stops when:-

- **First definitive treatment**: the clock stops on the date that the patient receives the first definitive treatment intended to manage his/her condition. It should be noted that this may have been provided by an interface service. What is defined as being "First Definitive Treatment" is as per the judgement of the patient's clinician
- **When a clinical decision is made that treatment is not required**: the clock stops on the date that the clinical decision is communicated to the patient
- **For treatment inpatient and day case admission**: the clock stop on the day of admission, with the exception of patients who have their treatment deferred or otherwise not performed
- **When a patient declines treatment**: the clock stops on the date that the patient declines treatment, having been offered it. (Please note this does not mean that the clock stops if a patient declines a date for treatment, but instead declines treatment as a whole)
- **When a period of active monitoring commences**: the clock stops on the date that the decision of active monitoring is made and communicated to the patient and subsequently the GP and/or other referring practitioner without undue delay
- **When a decision is made to return the patient to primary care for non-medical/surgical treatment:** the clock stops on the date that this is communicated to the patient
- **The patient Does Not Attend (DNA) a First Attendance**: if a patient DNA's their First Attendance, the clock is technically nullified (i.e. as though it never existed), but in practical terms it is stopped
- **The Death of the patient**: where the patient dies, this will inevitably stop the clock

5.4 Active Monitoring

Active Monitoring is where a decision is made that the patient does not require any form of treatment currently but should be monitored in secondary care.

When a decision to begin a period of active monitoring is made and communicated with the patient, the RTT clock stops. Active Monitoring may apply at any point in the patient's pathway, but only exceptionally after a decision to treat has been made.

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

For example, a request made for a patient to receive Physiotherapy within secondary care prior to surgery would not constitute Active Monitoring. Whether it would constitute "first definitive

treatment" would be for the patient's clinician to determine. Similarly, a patient requesting "thinking time" or choosing to defer their treatment are not reasons to place a patient on Active Monitoring.

Patients may also be moved to Active Monitoring when they repeatedly choose to decline proposed treatment dates. See Section 5.5.2 for further details.

5.5 Patient-Initiated Delays

5.5.1 Clock stops for DNAs

Other than at first attendance, DNAs have no impact on reported waiting times. Every effort should be made to minimise DNAs, and it is important that a clinician reviews every DNA on an individual patient basis. The advent of Covid-19 has not changed this obligation.

The 18 Week clock stops when:

- **A patient DNAs their first appointment following initial referral that started their 18 Week clock:** The RTT clock is stopped on the day of the DNA appointment and nullified in all cases (providing the appointment was booked in line with reasonableness criteria). If the clinician indicates another first appointment should be offered, a new RTT clock will be started on the day the new appointment is agreed with the patient
- **A patient DNAs their follow up appointment:** The RTT clock continues if the clinician indicates that a further appointment should be offered. If patients wait more than 18 weeks as a result of such delays, the 8% tolerance is in place to account for this. The RTT clock stops if the clinician indicates that it is in the patient's best clinical interests to be discharged back to their GP/referrer

The above principles remain unchanged as a result of the Covid-19 pandemic. Patients who DNA should have their case reviewed by a clinician to determine next steps.

5.5.2 Cancelling, declining or delaying appointment and admission offers

Patients can choose to postpone or amend their appointment or treatment if they wish.. If a patient chooses to defer their treatment by not accepting a date for treatment, their Clinical Prioritisation code will be reassigned from a "P" code to a "C" code, aligned to their previous corresponding clinical priority. For example, P3 to C3.

Where patients repeatedly choose to defer their treatment, subject to clinician consent, they may be moved from the active waiting list to Active Monitoring. This will stop the patient's RTT clock. At this point patients will be offered further dates for surgery. When a patient accepts one of these dates, they will be moved back to the main active waiting list and a new RTT clock will be started. If the patient continues refuse reasonable offers of dates for surgery, then subject to clinician consent, patients may be discharged back to their GP.

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

5.5.3 *Impact of Covid-19*

If, as a result of the Covid-19 pandemic, patients are self-isolating in response to government advice, the above rules continue to apply. That is, their treatment is deemed to have been cancelled due to clinical reasons and as such their RTT clock should continue unaffected. The proposed treatment should be rescheduled as soon as possible once the period of isolation has ended in line with the remainder of this Access Policy whilst recognising clinical guidelines for surgery post-recovery from Covid-19.

Patients can choose to postpone or amend their appointment or treatment if they wish, but such a deferral may ultimately lead to the patient being discharged back to their GP in line with the principles outlined in 5.5.2 above.

5.6 Patients who are Unfit for Surgery

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

Short-term illnesses

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

For patients contracting Covid-19, current Royal College guidance is that treatment is deferred for seven weeks post recovery. A patient's RTT clock will continue to tick during this time.

Longer term illnesses

If the clinical issue is more serious and the patient requires either further diagnostics or treatment for it (a delay of > 3 months), clinicians should indicate to administration staff:

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

5.7 New 18 Week clock starts

Upon completion of an 18 Week pathway, a new clock would start in the instances listed:

- When a patient becomes fit and ready for the second of a consultant-led bilateral procedure
- Upon the decision to start a substantively new or different treatment that does not already form part of the patients agreed care plan
- Upon a patient being re-referred into a medical or surgical consultant led speciality or referral management service as a new referral
- When a decision to treat is made after a period of active monitoring

- When a patient is rebooked following a DNA of the first appointment following the initial referral that started the 18 Week clock, and the clinician deems appropriate for the patient to be seen in the clinic and not discharged back to the GP

6.0 Pathway-specific principles referral to treatment and diagnostic pathways

The non-admitted stages of the patient pathway (see Figure 3) comprise both outpatients and the diagnostic stages, as highlighted by the section with the green border around it in the diagram below.

It starts from the clock start date (i.e. the date the referral is received) and ends when either a clock stop happens in outpatients (this could be the first, second or a further appointment) or when a decision to admit is made and the patient transfers to the admitted pathway.

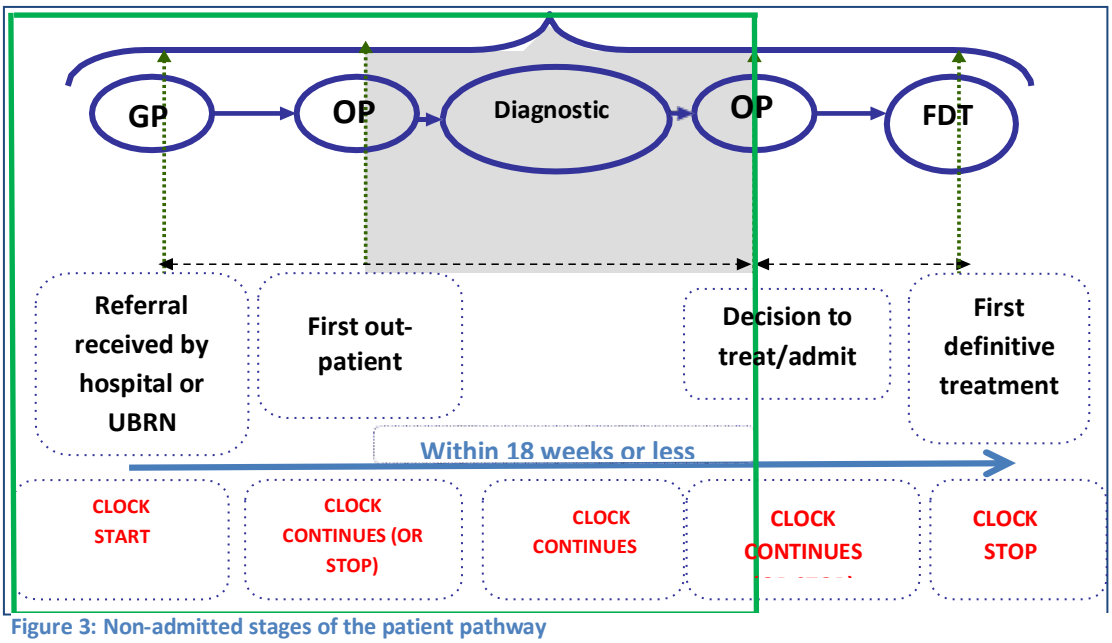


Figure 3: Non-admitted stages of the patient pathway

Key
OP – outpatients
FDT – first definitive treatment

Key Principles:

- All patients must be seen in order of clinical priority and length of wait
- Referrals must be registered onto PAS on the same working day
- Clinical review should take place within three working days of receipt of referral
- Patient contact should be made within four working days of receipt of referral
- Where patients cannot be contacted they will be discharged to their GP

6.1 Receipt of Referral Letters

Paper-based referrals are only accepted in very limited circumstances, with the vast majority of referrals now being made by the NHS e-Referral Service (e-RS). This is consistent with national policy which states that with effect from 1 October 2018 all referrals from GPs to consultant-led services should be made electronically through e-RS.

Where paper referrals are received from GPs, in most cases these should be returned to the GP for an e-RS referral. Referral Management Centres (RMCs) should also make referrals via e-RS wherever possible.

Where clinically appropriate, referrals should be made to a service rather than a named clinician. Services have agreed clinical criteria to support triage and vetting, and patients will then be allocated to the most appropriate clinician, taking into account waiting times. Referring to services is in the best interests of patients as pooling referrals promotes equity of waiting times and allows greater flexibility in booking appointments.

Where a referral is made to a named clinician rather than a generic service, where clinically appropriate, Ramsay will endeavour to respect these wishes wherever possible.

6.2 Methods of Receipt

6.2.1 NHS e-Referrals (e-RS)

All NHS e-referrals must be reviewed and accepted or rejected by clinical teams within one working day for urgent referrals or two working days for routine referrals. The patient's 18 Week RTT clock starts from the point at which the UBRN (Unique Booking Reference Number) is converted.

Where there is a delay in reviewing e-referrals this will be escalated to the relevant clinical / management team and actions agreed to address it. Where there are no appointments showing on the e-RS system for the service that the referrer has selected, the referrer can choose to 'defer to provider' which will then forward the patient's details as an Appointment Slot Issue (ASI) to Ramsay. Ramsay will use reasonable endeavours to contact patients who drop onto the ASI work list within four working days to arrange a mutually convenient appointment.

If an NHS e-Referral is received for a service not provided by Ramsay, it will be rejected back to the referring GP advising that the patient needs to be referred elsewhere. This will stop the patient's RTT clock. All rejected referrals, and the reasons for the rejection, will be recorded in e-RS within 24 hours of the decision to reject. The patient will be telephoned to inform them on the decision to reject and the GP will also be notified of the rejection.

In all instances three attempts should be made to contact the patient by telephone (two daytime and one after 5pm) if staff are unable to contact the patient by telephone, a letter will be sent to confirm an outpatient appointment.

6.2.2 Paper Based Referrals

All paper referrals must be date stamped on receipt at the Ramsay hospital and assessed to ensure they meet the hospital's clinical acceptance criteria and any commissioner prior approval policy. The patient's referral will then be registered on Ramsay's PAS within one working day for urgent referrals, two working days for routine referrals. This includes where such referrals have an incomplete minimum dataset ("MDS"). For patients referred by paper, the referral received date is the point that the RTT clock starts.

If a paper referral is received from a GP, these should normally be returned in line with Ramsay's and national NHS policy for such referrals. All rejected referrals, and the reasons for them, will be relayed back to the referring source and the patient will also be contacted to inform them on the decision.

There are some exceptions to the "no paper referrals" rule. This includes referrals received from non-GP referrers (e.g. dentists) and some triage/ RMCs. In these cases, such referrals should be managed in line with the above principles. Any missing NHS numbers or other data from the MDS should be sourced from e-RS or the patient's GP practice to avoid unnecessary delay in processing the referral.

Referrals should no longer be made or accepted via Fax.

6.3 Referral Types

Some specific types of referral need to be managed in unique ways.

6.3.1 Consultant-to-Consultant Referrals

Consultant-to-consultant referrals must follow the guidelines as agreed locally with commissioners.

In many cases commissioners will not accept consultant-to-consultant referrals for a non-related condition unless there is an urgent clinical need. Otherwise, patients are expected to be referred back to their GP for onward referral to a secondary care service of the patient's choice. In these circumstances a new 18-week clock will start, meaning the patient may have two distinct 18-week pathways running simultaneously with one another.

However, where the referral is a continuation of the diagnostic or treatment pathway for the same condition for which the patient was referred, including referrals to pain management where surgical intervention is not intended, then a new GP referral is not required. Under these circumstances the original 18 Week clock continues unaffected, with the patient's clock start date being the date of the original GP referral *not* the date of the secondary consultant referral. Such a referral should only be made where it falls within scope of an agreed pathway with the commissioner.

Consultant-to-Consultant referrals should result in the patient pathways being linked on Ramsay's PAS system and should be prioritised alongside standard external referrals.

If during the course of diagnostics and clinical investigations cancer is suspected, the patient should be referred to the local NHS oncology service in line with local cancer network treatment protocols.

6.3.2 Clinical assessment and triage services (CATS) and referral management centres (RMCs)

These services provide intermediary levels of clinical triage, assessment and treatment between traditional primary and secondary care. Local arrangements will apply where these services are applicable.

A referral to a CATS or an RMC starts an 18 Week RTT clock from the day the referral is received in the CAT/RMC. If the patient is referred on to the Ramsay hospital having not received any treatment in the service, the hospital will inherit the 18 Week RTT wait for the patient.

A minimum dataset (MDS) form should be used to transfer 18 Week information about the patient to the Ramsay hospital.

6.3.3 Inter-provider transfers (IPTs)

Ramsay hospitals should have agreed contracts with other hospitals (NHS or Independent Sector) to which they refer a significant number of IPTs, or from which they receive such. These IPTs should not be confused with "Outsourced" activity, where Ramsay performs activity on behalf of the host-Trust.

Incoming IPTs

All IPT referrals should be received electronically via secure email.

The Ramsay hospital should also receive an accompanying MDS pro-forma with the IPT, detailing the patient's current RTT status (the hospital will inherit any RTT wait already incurred at the referring hospital if they have not yet been treated) and if the patient has been referred for a new treatment plan for the same condition (where a new RTT clock will start upon receipt at this original hospital/Trust). The patient's pathway identifier (PPID) should also be provided, as should the clinical priority assigned to the patient. If the IPT is for a diagnostic test only, the referring Trust retains responsibility for the RTT pathway. All of this information should be recorded on the PAS.

If any of the above information is missing, the referral should be recorded on PAS and the information actively chased by the Ramsay hospital's business office.

A copy of the IPT pro-forma is available on the Ramsay Intranet for download.

Outgoing IPTs

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

An accompanying MDS pro forma should be sent with the IPT in line with locally agreed protocols, detailing the patient's current RTT status (the receiving hospital/ Trust will inherit any RTT wait already incurred if the patient has not yet been treated). If the patient has been referred for a new treatment plan for the same condition, a new RTT clock will start on receipt at the receiving hospital/ Trust. The patient's patient pathway identifier (PPID) will also be provided together with the clinical priority assigned to the patient.

Outgoing IPTs should have their referral pathway closed in Maxims.

If the outgoing IPT is for a diagnostic test only, the Ramsay hospital retains responsibility for the RTT pathway and both the six-week diagnostic clock and the overall 18-week RTT clock will continue to run.

6.4 Booking New Outpatient Appointments

All new patients, including e-RS, regardless of their method of booking must be sent:

- A letter confirming the time and date of their appointment, including which consultant they will be going to see
- Registration Form (or an electronic link to complete a secure version of the Registration form)
- Any additional information which is required for their appointment (e.g.) radiology information

6.4.1 Scheduling

The scheduling of patient's appointments will be undertaken in accordance with both clinical and chronological prioritisation in line with the 18 Week guidelines.

6.4.2 Referrals via E-Referral Service (e-RS)

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

If there are insufficient slots available for the selected service at the time of attempting to book (or convert their Unique Booking Reference Number UBRN), the patient will appear on the appointment slot issue (ASI) work list. The RTT clock starts from the point at which the patient attempted to book. Patients on the ASI list must be contacted within four working days by the hospital to agree an appointment.

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

6.4.3 Paper GP referrals

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

Patients will be selected for booking from the hospital's patient tracking list (PTL) only.

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

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

Referrals should not be received by fax.

6.4.4 Reasonable Offers

For written and verbal offers of an appointment to be deemed to have been "reasonable", the following waiting time guidance should be followed for referrals that have **not** come through e-RS:

- For a written appointment to be deemed reasonable, the patient is to be offered an appointment with a minimum of three weeks' notice
- In addition to the three weeks' notice, for a verbal appointment to be deemed reasonable, the patient should be offered an appointment on a minimum of two different dates
- If a patient chooses to accept an appointment that is earlier than three weeks' notice, this is still deemed reasonable
- All appointments will be confirmed in writing

6.4.5 Patient Choice/ Deferral

Prior to referral onto an 18 Week pathway, GPs should establish that patients are ready and available to receive treatment within this timeframe. Nonetheless some patients will turn down reasonable appointments because they prefer, for example, to go on an extended holiday or because or work/family commitments. Patients are permitted to plan their treatment around their personal circumstances, including after 18 weeks if they so wish. Delays as a result of patient choice are taken account of in the tolerance of 8% set for achievement of the incomplete pathway waiting time operational standard.

New patients will be offered a minimum of two reasonable offers of an appointment, where "reasonable" is determined to be three or more weeks from the date the offer was made. Ramsay expects patients in receipt of an appointment offer from the hospital to respond within 10 working days to book and/or confirm the appointment.

Patients will primarily be assigned one of the main "P" Prioritisation codes, depending upon the clinicians' determination of their priority. If a patient chooses to defer their treatment by not accepting a date for treatment, they will be reassigned a "C" code aligned to their previous clinical priority. For example, P3 to C3.

Where patients repeatedly choose to defer their treatment, subject to clinician consent, they may be moved from the active waiting list to Active Monitoring. This will stop the patient's RTT clock. At this point patients will be offered further dates for surgery. When a patient accepts one of these dates they will be moved back to the main active waiting list and a new RTT clock will be started. If however the patient continues to refuse reasonable offers of dates for surgery, then subject to clinician consent, patients may be discharged back to their GP. Referral back to the GP will stop the patient's 18 Week clock and a new 18 week clock would start at the point when the patient and GP agree to re-refer for treatment.

6.4.6 Patient Initiated Cancellations

Patients are able to cancel appointments without impacting the RTT pathway (i.e. the clock cannot be stopped). If a new patient needs to cancel their initial outpatient appointment, they must be available to accept another reasonable offer in line with their pathway.

If a patient cancels their appointment and they are not available to accept two or more reasonable offers, the patient's clinician will consider whether the patient should be referred back to their GP, in which case the patient's RTT clock will be stopped. The principles outlined in section 6.4.5 should be followed.

Patients who wish to change their initial appointment should be advised to ring the National Telephone Appointment line 0345 60 88 88 8. If this is not possible, then the rebooking should be initiated through the hospital's e-RS coordinator. Any declines of reasonable dates should be recorded into the PAS to allow a full audit trail. Re-bookings of initial appointment should not be actioned outside of e-RS as this will send a provider appointment cancellation message to e-RS without any reference to the new appointment.

Changes to follow-up appointments should be made by the patient directly contacting the hospital.

6.4.7 Provider initiated cancellations for non-clinical reasons

Patients should not be cancelled more than once.

Provider cancellations for new patients

Patients who are cancelled by Ramsay for non-clinical reasons will be rescheduled in line with the 18 week treat by date.

Provider cancellations for follow up patients

Patients whose appointments are cancelled by Ramsay for non-clinical reasons will be rescheduled within 28 days.

6.5 Appointment Slot Issues (ASIs)

Appointment Slot Issues (ASIs) arise when a patient's GP is unable to book an Outpatient appointment at the point of referral due to a lack of appointment "slots" being available at the chosen Provider. Ramsay will use all reasonable endeavours to minimise the number of ASIs and make available appointments to patients at the earliest opportunity.

The patient's RTT 18 Week clock will start from the date at which the patient attempted to book their appointment at the Ramsay hospital, for example when the hospital received the referral on to their local ASI list.

6.6 Clinic Attendance and Outcomes (New and Follow-up clinics)

Every patient, new and follow-up, whether attended or not, will have an attendance status and outcome recorded on PAS at the end of the clinic. Clinic outcomes (e.g. discharge, further appointment) ~~and the patient's updated RTT status will be recorded by clinicians into the PAS~~. The patient's RTT status will be automatically updated with the recording of these outcomes in the PAS.

When they attend the clinic, patients may be on an open pathway (i.e. waiting for treatment with an RTT clock running) or they may already have had a clock stop due to receiving treatment, a decision not to treat being agreed or the patient having previously been assigned to Active Monitoiring. It is possible for patients to be assigned any one of the following RTT statuses at the end of their outpatient attendance, depending on the clinical decisions made or treatment given/started during the consultation:

Patients on an open pathway:

- Clock stop for treatment
- Clock stop for non-treatment
- Clock stop for move to Active Monitoring
- Clock stop for a DNA of an Initial Appointment
- Clock continues if requiring diagnostics, therapies or being added to the admitted waiting list
- Clock continues if the patients DNAs a follow-up attendance and following clinical review the decision is made to re-book

Patients already treated or with a decision not to treat:

- New clock start if a decision is made regarding a new treatment plan
- New clock start if the patient is fit and ready for the second side of a bilateral procedure
- No RTT clock if the patient is to be reviewed following first definitive treatment
- No RTT clock if the patient is to continue under active monitoring

Accurate and timely recording of these Outcomes (and hence the associated RTT statuses that result) at the end of the clinic are therefore critical to supporting the accurate reporting of RTT performance

6.6.1 Active Monitoring

A clinical decision can be made to start a period of Active Monitoring.

There will be occasions when the most clinically appropriate option for a patient will be that they are actively monitored over a period of time, rather than undergoing any further investigations, treatments or surgical interventions at that time. When the decision is made to start a period of Active Monitoring, this is communicated to the patient and this stops a patient's 18 Week clock.

Patients may initiate the start of a period of Active Monitoring themselves (for example, choosing to decline treatment whilst they manage their symptoms). However, it would not be appropriate for Ramsay to use patient initiated Active Monitoring to stop patient clocks where a patient does want to have a particular diagnostic test/appointment or other intervention but wants to delay their appointment. Similarly, a referral of a patient for physiotherapy prior to surgery would also not represent an appropriate use of active monitoring.

Where such patient initiated delays prior to admission mean that the 18 Week target cannot be achieved for the patient, this may constitute an exception to 18 weeks, which is reflected in the 18 week tolerance.

If at the end of period of Active Monitoring a decision is made to proceed to treatment, a new 18 Week RTT clock is started from the data that this decision was made.

6.6.2 Did not attends (DNA)

Patients (with the exception of paediatrics and vulnerable adults) who do not attend their Initial outpatient appointments will have a second appointment booked within two weeks. A second DNA will result in a clinical review by the patient's consultant with a view to them being potentially discharged back to their GP.

6.7 Booking Follow-up Appointments

6.7.1 Patients on an open pathway

Follow up appointments for such patients should be made where they are in line with the agreed clinical pathway. Such appointments must be booked to a timeframe that permits treatment by week 18 (unless the patient choses a later date).

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

6.7.2 Did not attends (DNA)

All Did Not Attends (DNAs) (new and follow-up) will be reviewed by the clinician at the end of clinic in order for a clinical decision to be made regarding next steps. Vulnerable patient DNAs should be managed with reference to Ramsay's safeguarding policy.

6.8 Appointment changes and cancellations initiated by the patient

If the patient gives any prior notice that they cannot attend their appointment (even if this is on the day of clinic), this should be recorded as a cancellation and not a DNA.

If the patient requires a further appointment, this will should booked with the patient at the time of the cancellation. The appointment must be rescheduled in line with the 18 week treat by date, where applicable.

If the patient is on an open RTT pathway, the clock continues to tick. Contact with patient must be made within two working days to agree an alternative date.

If the patient has never been seen and advises they do not wish to progress their pathway, they will be removed from the relevant waiting list and a clock stop and nullification applied. The patient will be informed that their consultant and GP will be informed of this.

If as a result of the patient cancelling, a delay is incurred which is equal to or greater than a clinically unsafe period of delay (as indicated in advance by consultants for each specialty), the patient's pathway should be reviewed by their consultant. Upon clinical review, the patient's consultant should indicate one of the following:

- Clinically safe for the patient to delay: continue progression of pathway. The RTT clock continues

- Clinically unsafe length of delay: clinician to contact the patient with a view to persuading the patient not to delay. The RTT clock continues.
- Clinically unsafe length of delay: in the patient's best clinical interests to return the patient to their GP. The RTT clock stops on the day this is communicated to the patient and their GP

6.9 Appointment changes initiated by the hospital

Hospital-initiated changes to appointments will be avoided as far as possible as they are poor practice and cause inconvenience to patients.

Patients will be contacted immediately if the need for the cancellation is identified and offered an alternative date(s) that will allow patients on open RTT pathways to be treated within 18 weeks. Equally, this will allow patients not on open pathways to be reviewed as near to the clinically agreed timeframe as possible.

7.0 Diagnostics

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

It is important to note, however, that patients can also be referred for some diagnostic investigations directly by their GP where they might not be on an 18 Week RTT pathway. This will happen where the GP has requested the test to inform future patient management decisions, i.e. has not made a referral to a consultant-led service at this time.

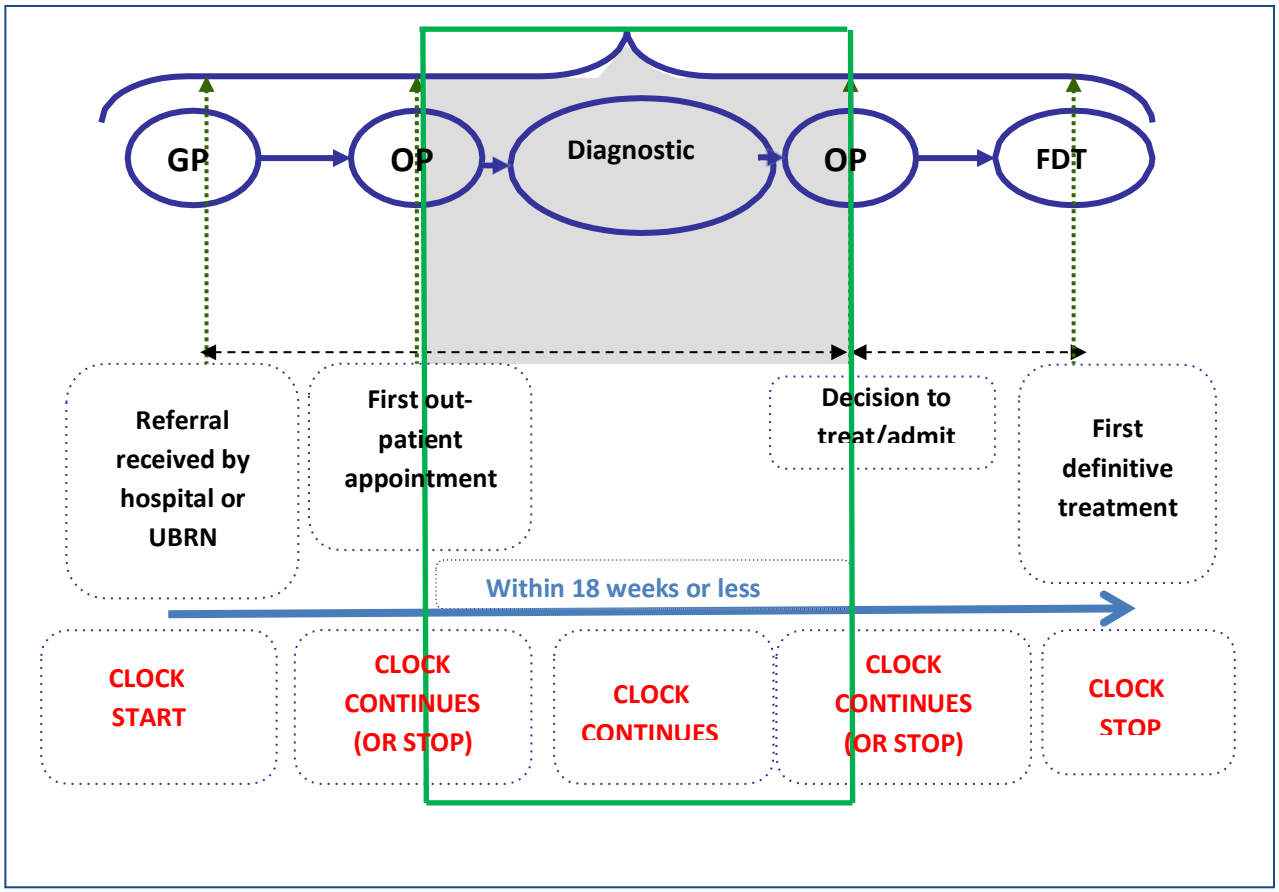


Figure 4: Diagnostic phase of the patient pathway

Key
OP – outpatients FDT – first definitive treatment

7.1 Patients with a Diagnostic and RTT Clock

The diagnostics section of an RTT pathway is a major pathway milestone. A large proportion of patients referred for a diagnostic test will also be on an open RTT pathway. In these circumstances, the patient will have both types of clock running concurrently although only the headline 18 week RTT clock will be reflected in Maxims:

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

7.2 Straight-to-Test Arrangements (also known as Direct Access Referrals)

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

7.3 Patients with a Diagnostic Clock Only

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

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

7.4 National Diagnostic Rules

When a patient is referred by a consultant for a diagnostic test, the following rules apply in relation to clock starts/stops.

- Diagnostic clock start: the clock starts at the point of the decision to refer for a diagnostic test by either the GP or the consultant, although this is not directly reflected in Maxims
- Diagnostic clock stop: the clock stops at the point at which the patient undergoes the test

The hospital should provide details on the diagnostic clock rules, including clock start, clock stop, reasonableness, DNA, cancellations, and any impact on the patient's RTT clock.

7.5 Booking Diagnostic Appointments

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

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

- The hospital must be able to demonstrate that the patient's original diagnostic appointment fulfilled the reasonableness criteria for the clock start to be reset (two dates, a minimum of three weeks in advance)
- Resetting the diagnostic clock start has no effect on the patient's RTT clock. This continues to tick from the original clock start date

7.6 Diagnostic cancellations, declines and/or DNAs for patients on open RTT pathways

Where a patient has cancelled, declined and/or not attended their diagnostic appointment and a clinical decision is made to return them to the referring consultant, the RTT clock should continue to tick. Only the referring consultant can make a clinical decision to stop the RTT clock, if this is deemed to be in the patient's best clinical interests, by discharging the patient or agreeing a period of active monitoring.

7.7 Active diagnostic waiting list

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

7.8 Planned diagnostic Appointments

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

7.9 Therapeutic Procedures

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

8.0 Pre-operative Assessment

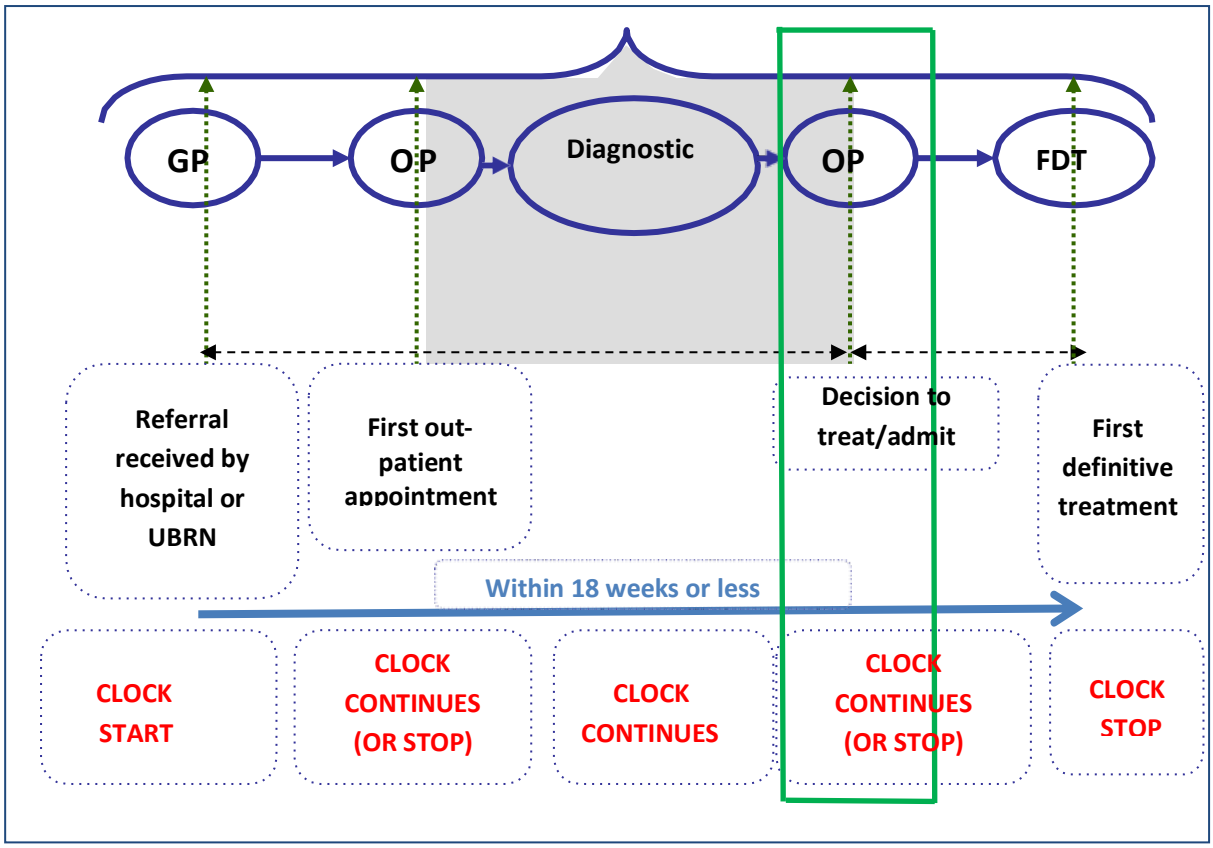


Figure 5: Stages in pre-operative assessment

Key
OP – outpatients
FDT – first definitive treatment

All patients should ideally have a Decision to Admit, Pre-operative triage and addition to the waiting list all to take place on the same day. If a same day pre-operative assessment service is not available, patients should still be added to the waiting list without delay following the decision to admit, regardless of whether the pre-operative assessment has taken place. Any pre-operative assessment should at the latest be booked two weeks prior to their admission date.

The decision as to whether a patient needs a pre-operative assessment will be made in accordance with Ramsay clinical policy. Generally speaking, all patients with a decision to admit (DTA) requiring a general anaesthetic will require a pre-operative assessment.

Where necessary, patients should be made aware in advance of their outpatient appointment that they may need stay longer on the day of their appointment for attendance at a pre-operative assessment clinic.

For patients with complex health issues requiring a pre-operative assessment appointment with a nurse consultant or anaesthetist, the hospital will aim to agree this date with the patient before they leave the hospital. The hospital will aim to agree an appointment no later than seven working days from the decision to admit.

Patients who DNA their pre-operative assessment appointment will be contacted and a further appointment agreed. If they DNA again, they will be returned to the responsible consultant. The RTT clock continues to tick throughout this process.

If the patient is identified as unfit for the procedure, the nature and duration of the clinical issue should be ascertained. If the clinical issue is short term (as a guide Ramsay defines "short term" as six weeks) and has no impact on the original clinical decision to undertake the procedure (e.g. cough, cold, UTI), the RTT clock continues.

However, if the clinical issue is more serious and the patient requires optimisation and/treatment, clinicians should indicate to administration staff if it is clinically appropriate for the patient to be removed from the waiting list, and if so whether the patient should be:

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

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

9.0 Acute Therapy Services

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

- directly from GPs where an RTT clock would NOT be applicable
- during an open RTT pathway where the intervention is intended as first definitive treatment or interim treatment

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

9.1 Physiotherapy

For patients on an orthopaedic pathway referred for physiotherapy as first definitive treatment the RTT clock stops when the patient begins physiotherapy.

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

Whether the physiotherapy is defined as “definitive” or not (and hence whether it will constitute a clock-stopping event) will be determined by the clinician in charge of the patient’s care, i.e. their consultant.

9.2 Surgical Appliances

Patients on an orthopaedic pathway referred for a surgical appliance with no other form of treatment agreed. In this scenario, the fitting of the appliance constitutes first definitive treatment and therefore the RTT clock stops when this occurs.

9.3 Dietetics

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

10.0 Non-activity Related RTT Decisions

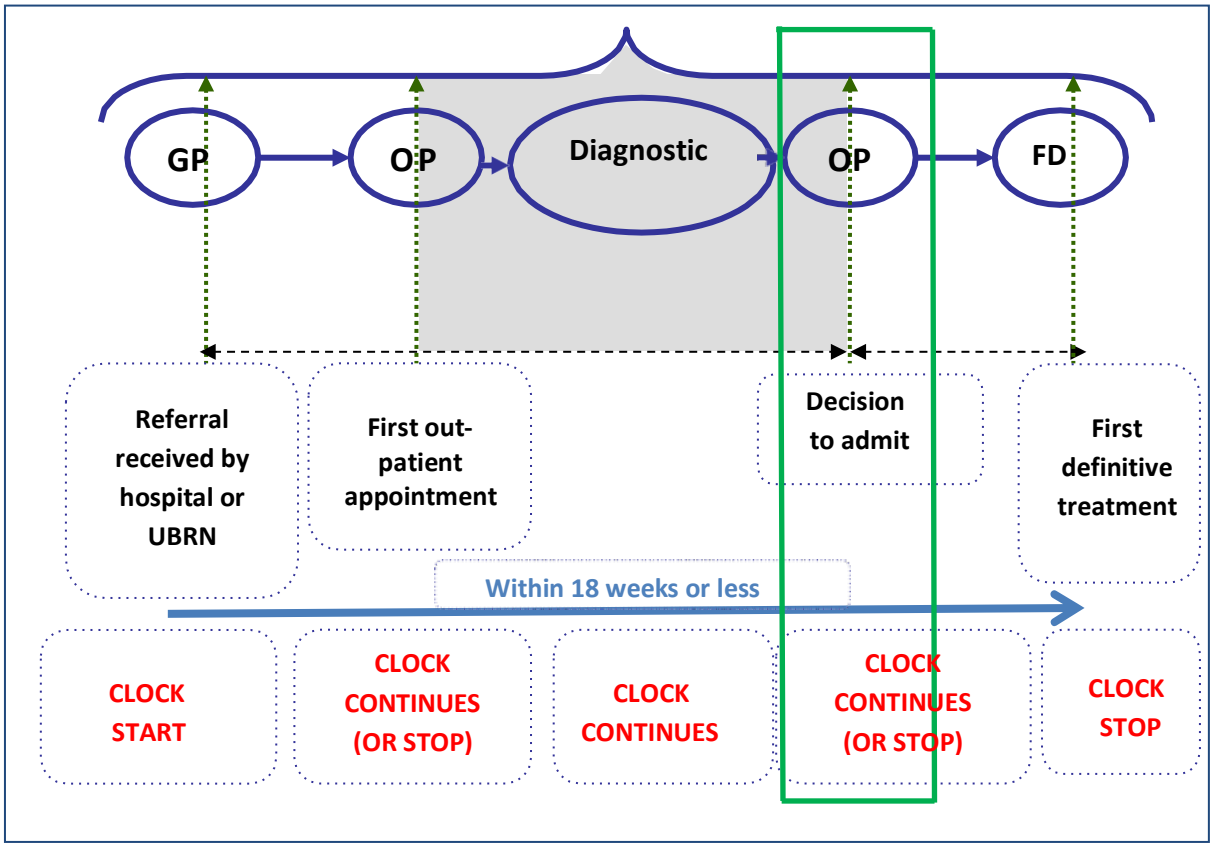


Figure 6: Stages in the management of non-activity related RTT decisions

Key
OP – outpatients
FDT – first definitive treatment

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

The clinician should contact the hospital's local RTT Manager with their decision so that an appropriate Admin Event can be added to the patients' referral within Maxims. The date recorded will be the day the decision not to treat is communicated in writing to the patient.

11.0 Admitted Pathways

All patients will be chronologically managed in accordance with the prevailing 18 Week guidance. Patients whose booking forms indicate that they require an urgent procedure will be clinically prioritised.

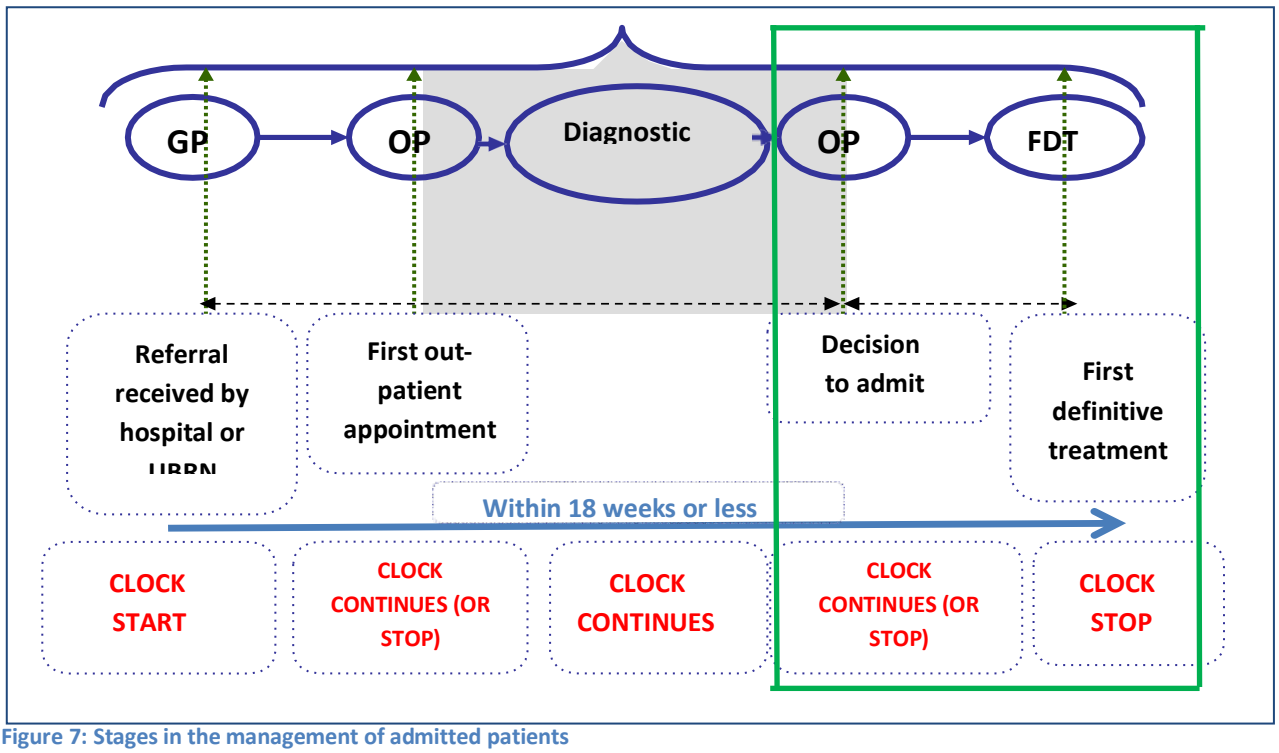


Figure 7: Stages in the management of admitted patients

Key
OP – outpatients
FDT – first definitive treatment

11.1 Adding patients to the active inpatient or day case waiting list

The decision to add a patient to an inpatient or day case waiting list must be made by a consultant, or under arrangement agreed with the consultant.

Patients must not be added if:

- They are unfit for procedure
- Further investigations are required first
- Not ready for the surgical phase of treatment
- They need to lose weight in line with Ramsay clinical policies and commissioner commissioning policies

Ideally patients will be fit, ready and available before being added to the admitted waiting list. However, they will be added to the admitted waiting list without delay following a decision to admit,

regardless of whether they have undergone pre-operative assessment or whether they have declared a period of unavailability at the point of the decision to admit.

All patients with a decision to admit will have a Clinical Prioritisation "P" score assigned. Patients will be treated in order of clinical priority, then in accordance of the length of wait.

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

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

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

11.2 Patients requiring more than one procedure

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

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

11.3 Patients requiring thinking time

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

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

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

11.4 Scheduling patients to come in for admission

Clinically urgent patients will be scheduled first, followed by routine patients (P1 to P4). All patients will be identified from the hospital's PAS, and subject to the clause above about clinical priorities, will be scheduled for admission in chronological order of RTT wait.

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

As soon as an appointment has been made, an appointment letter will be generated automatically by the PAS and sent as confirmation. The letter can be used as an audit trail of arrangements and will contain the following core details:

- Patient's name
- Date letter was sent to the patient
- Date and time of appointment
- Where to report on arrival
- Contact number for queries relating to the appointment
- Name of the clinician who is responsible for the clinic that they are booked into.
- Along with the letter should be sent any relevant information that the patient requires prior to appointment. (See Initial OP Booking SOPs)

Any admission offers declined by patients will be recorded on PAS. This is important for two reasons:

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

11.5 Patients declaring periods of unavailability while on the inpatient/day case waiting list

If patients contact the hospital to communicate periods of unavailability for social reasons (e.g. holidays, exams), this period should be recorded on the PAS. Their clinical priority should be reassigned to a "C" code, aligned to their previous clinical priority. For example, P3 to C3. They should remain on the waiting list and every attempt will be made to find a suitable date for admission.

Where patients repeatedly choose to defer their treatment, subject to clinician consent, they may be moved from the active waiting list to Active Monitoring. This will stop the patient's RTT clock. At this point patients will be offered further dates for surgery. When a patient accepts one of these dates, they will be moved back to the main active waiting list and a new RTT clock will be started. If the patient continues refuse reasonable offers of dates for surgery, then subject to clinician consent, patients may be discharged back to their GP.

The patient's best clinical interests should remain paramount throughout. If the patient's clinician determine that the proposed period of unavailability is clinically unsafe, this should be discussed with the patient and if need be with the patient's GP, in order agree the most appropriate next steps.

All patient initiated delays in treatment should be discouraged.

For all patient initiated delays the following guidance must be followed:

- Patients must be assigned a "C" clinical prioritisation code
- A record should be kept of all patients who have chosen to delay their treatment and it should be reviewed regularly
- A full audit trail must be kept on all patient initiated delayed pathways
- Open-ended delays with be discouraged; attempts will always be made to secure a date, even if someway in the future

11.6 Admissions and Covid-19

11.6.1 Patient Initiated Delays

If, when contacting a patient to agree a date of admission, the patient states that due to Covid-19 they are not willing to agree a date at this time, no pause should be applied to the patient's pathway.

If a patient chooses to defer their treatment by not accepting a date for treatment, their clinical prioritisation code should be reassigned to a "C" code aligned to their previous clinical priority. For example, P3 to C3.

Where patients repeatedly choose to defer their treatment, subject to clinician consent, they may be moved from the active waiting list to Active Monitoring. This will stop the patient's RTT clock. At this point patients will be offered further dates for surgery. When a patient accepts one of these dates, they will be moved back to the main active waiting list and a new RTT clock will be started. If the patient continues refuse reasonable offers of dates for surgery, then subject to clinician consent, patients may be discharged back to their GP.

Should the patient be deemed clinically urgent, the clinician must contact the patient to discuss the risks and benefits of attending for admission. Should the patient subsequently agree to the admission, due process for recording this on hospital systems will be followed.

As set out above these patients will require regular review until a date of admission can be agreed. The patient's record should be updated to reflect the decision to discharge the patient back to their GP if the patient repeatedly fails to accept reasonable offers of treatment dates.

On a regular basis all patients should be reviewed to check the patient's wishes have not changed regarding progressing with treatment nor about the severity of their condition. Where appropriate, discussions with the patient's clinician should be undertaken to agree next steps.

11.6.2 Cancellations Due to Covid-19 Infection

If a patient contracts Covid-19 prior to admission, the patient's admission will be cancelled. Current Royal College guidance is that patients should not be rebooked until a minimum of seven (7) weeks after a negative test. The patient's RTT clock will continue unaffected during this time.

11.6.3 Adherence to Covid-19 Infection Prevention Guidance

Where patients are unable or do not wish to follow the guidance prior to elective treatment it will be appropriate in most circumstances to consider them 'temporarily unfit' for treatment and the RTT clock will therefore continue to tick. This will ensure that they remain on an active RTT waiting list and their waiting times are visible; they can then be prioritised accordingly as the situation changes.

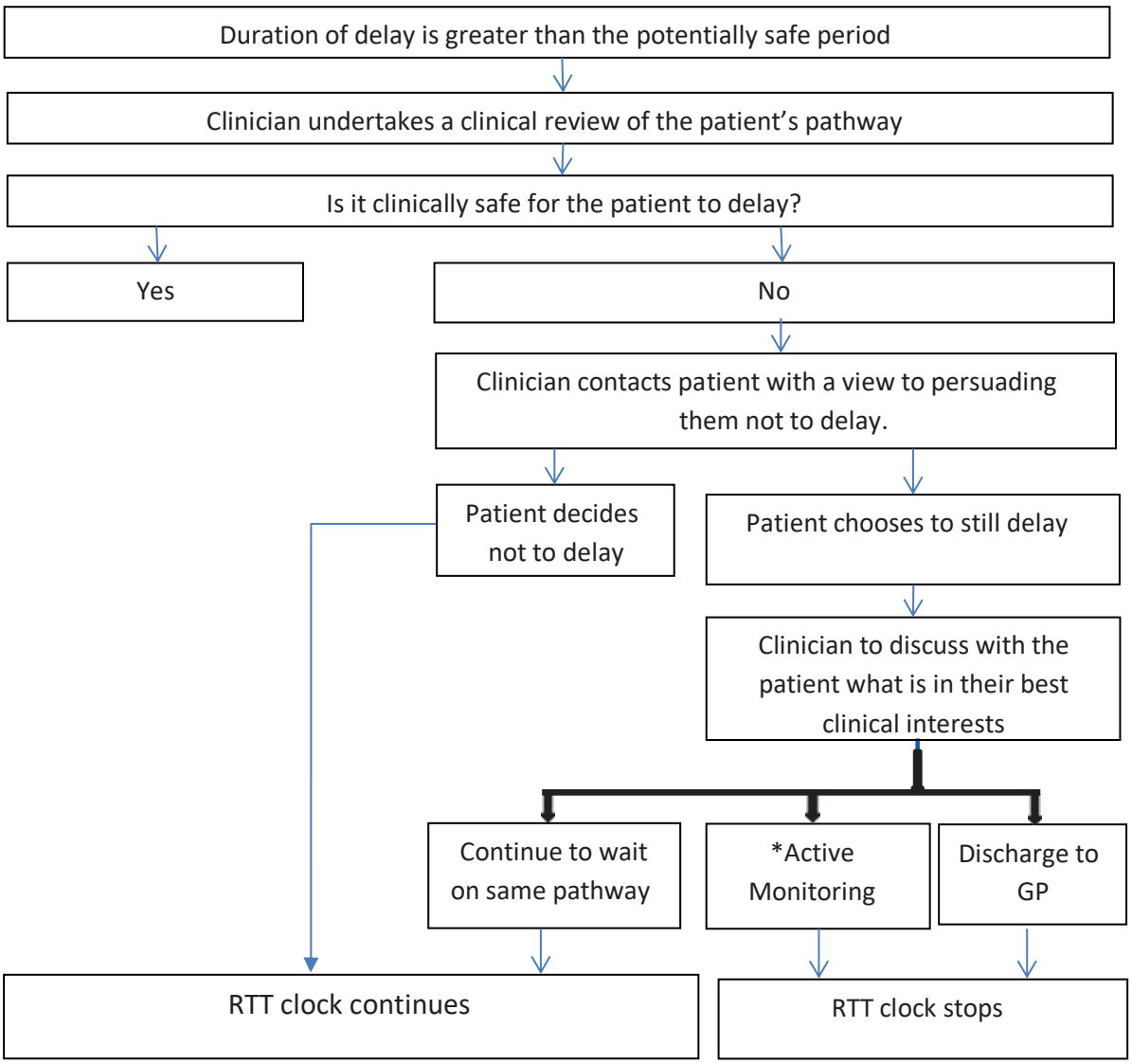
11.7 Reasonable Offers

For written and verbal offers of an admission to be reasonable, the following waiting guidance must be followed:

- For a written appointment to be deemed reasonable, the patient is to be offered an appointment with a minimum of three weeks' notice
- In addition to the three weeks' notice, for a verbal admission date to be deemed reasonable, the patient should be offered an appointment on a minimum of two different dates
- If a patient chooses to accept an admission date that is earlier than three weeks' notice, that is still deemed reasonable
- Any patient unavailability must be recorded on Maxims (see the Maxims Operational Access Policy document for more details)
- If two reasonable offers are declined the process outlined in 11.6.1 will be followed
- All appointments will be confirmed in writing
- Where a patient cannot be contacted they will be discharged back to their GP

11.8 Patients who decline or cancel TCI offers

If patients decline TCI offers or contact the hospital to cancel a previously agreed TCI, this will be recorded on Maxims. The RTT clock continues to tick. If, as a result of the patient declining or cancelling, a delay is incurred which is greater than a potentially clinically safe period of delay (as indicated in advance by consultants for each specialty), the patient's pathway will be reviewed by their consultant. The flowchart below outlines possible outcomes.



*Active Monitoring – this may be applicable where the clinician ascertains that the patient no longer wishes to proceed with the originally agreed procedure or where the length of the delay incurred has a consequential impact on the original agreed procedure. In either of these scenarios, a face to face appointment should be arranged to agree an alternative treatment plan with the patient

11.9 Information for Patients

The majority of patients will be sent an admission letter confirming their date of admission. If there is an Eido leaflet relevant to the intended procedure, this must be included with the letter or supplied at the time of the outpatient attendance.

As soon as the procedure has been booked, an admission letter is created on Maxims and sent as confirmation. The letter is an audit trail of the arrangements and will contain the following details:

- Patient's name and address
- Date letter sent to patient
- Date and time of admission
- Contact number for queries relating to the procedure
- Consultant who will be carrying out the procedure
- Any other relevant clinical information/advice

11.10 Patients who do not attend Admission

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

The determination as to whether the patient will be offered an alternative appointment or referred back to their GP will be assessed on a case-by-case basis and based upon the specific reason for the DNA and following discussion with the patient's consultant. If the patient DNAs a second TCI date, then the patient will be reviewed by the patient's clinician and where appropriate they will be returned to the care of their GP.

11.11 Patient cancellations

Patients who cancel their admission date for a valid reason must be given one re-arranged date at the time of the cancellation that is within the 18 week waiting time guidelines.

If a patient cancels twice or more,the patient's care should then be reviewed by their clinician and where appropriate the patient should be removed from the waiting list and sent back to the GP. The patient's referral will be closed within Maxims. A letter must be sent to the patient to inform them of the decision and that a re-referral would be needed for the patient to be seen again.

11.12 On the day cancellations by the hospital

Where a patient is cancelled on the day of admission or day of surgery for non- clinical reasons, they will be rebooked within 28 days of the original admission date and the patient must be given reasonable notice of the rearranged date. This must be recorded on the PAS.

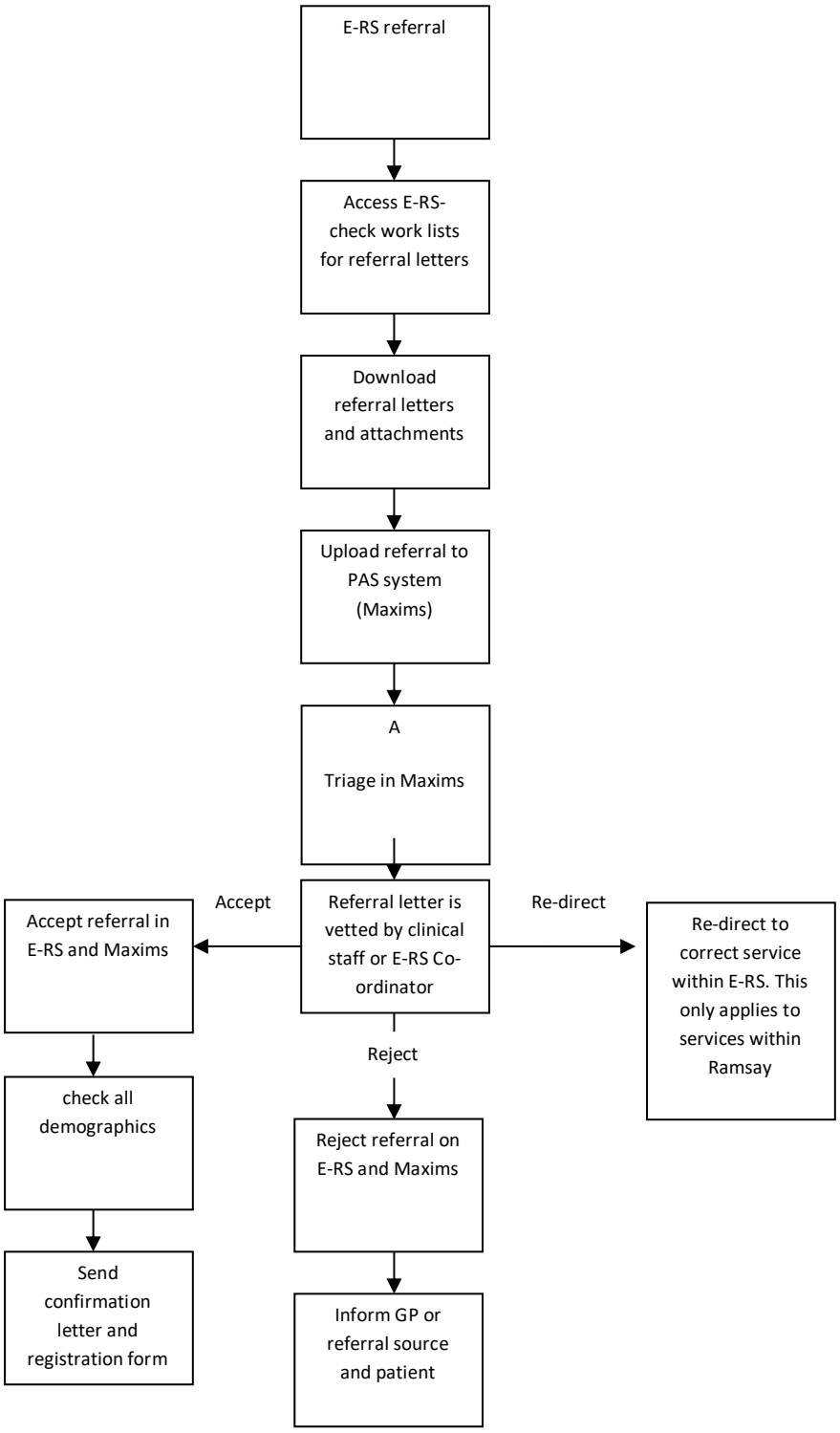
The patient may choose not to accept a date within 28 days.

11.13 Planned Waiting Lists

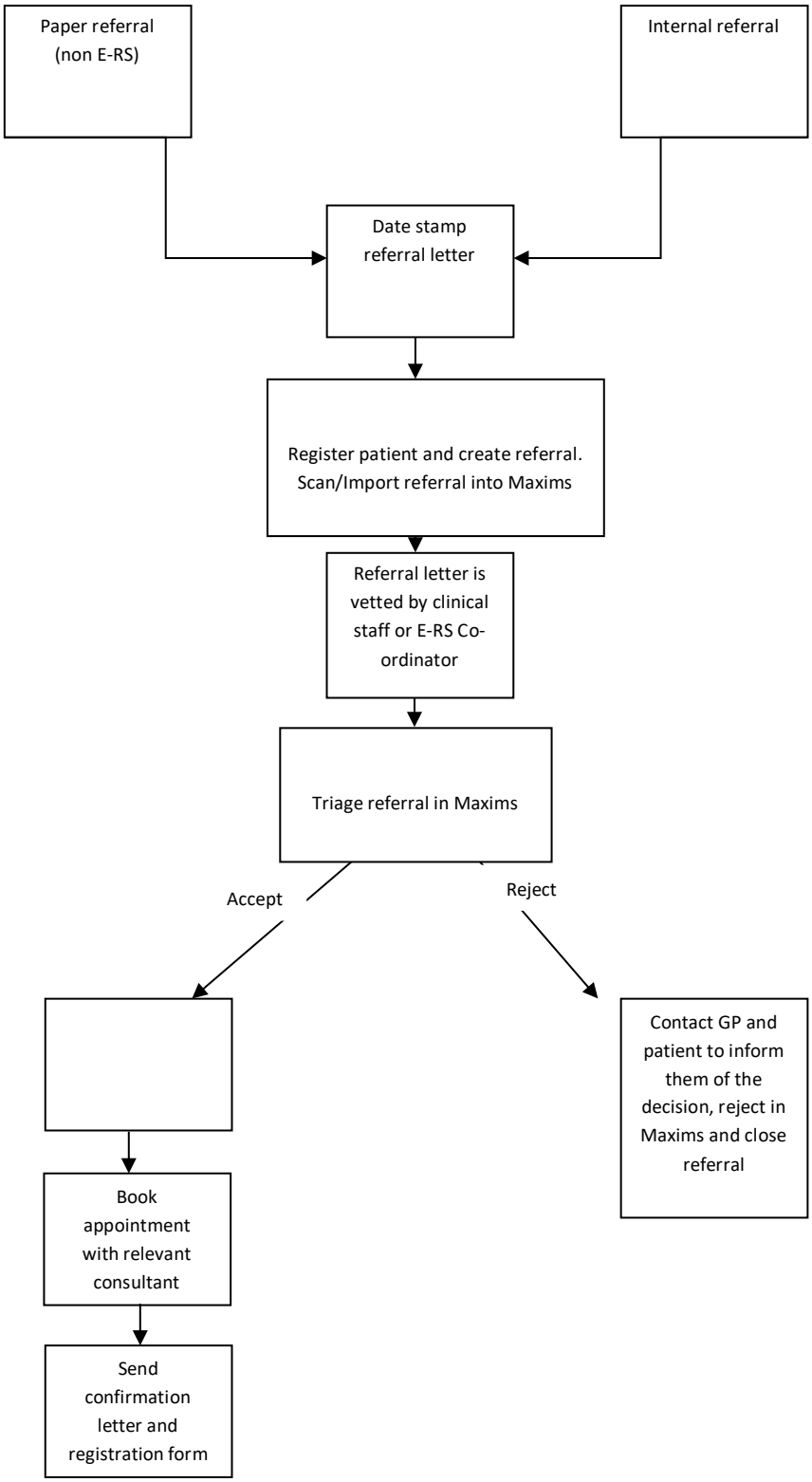
Patients will only be added to an admitted planned waiting list where clinically they need to undergo a procedure at a specific time. The due date for their planned procedure will be included in the planned waiting list entry. Patients on planned waiting lists will be scheduled for admission at the clinically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

When patients on planned lists are clinically ready for their care to begin and reach their due date for their planned procedure, they will either be admitted for the procedure or be transferred to an active waiting list and a new RTT clock will start. For some patients (e.g. surveillance endoscopies) a diagnostic clock would also start.

Appendix 1: The referral pathway E-Referral Service Referral Pathway



Paper referral process



Glossary

Term	Definition
Active Monitoring	An 18 Week clock may be stopped where it is clinically appropriate to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures. A new 18 Week clock would start when a decision to treat is made following a period of active monitoring.
Active Waiting List	The list of elective patients who are fit, ready and able to be seen or treated at that point in time. Applicable to any stage of the RTT pathway where patients are waiting for hospital resource reasons
Appointment Slot Issue (ASI)	When no clinic appointment is available for patients to book in e-RS, the referral can be forwarded or deferred to the patient's chosen hospital to enable the hospital to book the patient an appointment. When a referral is forwarded or deferred, it will appear on that hospital's appointment slot issues (ASI) worklist.
Bilateral Procedures	Where a procedure is required on both the right and left sides of the body.
Can Not Attend (CNA)	Patients who, on receipt of reasonable offer(s) of admission, notify the hospital that they are unable to attend.
Carestream	The name of Ramsay's administration system for diagnostic radiology
Chronological booking	Refers to the process of booking patients for appointments, diagnostic procedures and admission in date order of their clock start date.
Clinical Prioritisation	The process of reviewing patients by a clinician at the hospital to determine the clinical priority of the patient and hence, everything else being equal, the order in which patients should be seen or treated

Consultant-led service	A service where a consultant retains overall responsibility for the care of the patient. Patients may be seen in nurse-led clinics which come under the umbrella of consultant-led services.
Date Referral Received (DRR)	For paper referrals, the date on which a hospital receives a referral letter from a GP. For E-RS referrals it is the date a patient takes an action to book an appointment. The waiting time for outpatients should be calculated from this date.
Day Case	Patients who require admission to the hospital for treatment and will need the use of a bed but who are not intended to stay in hospital overnight.
Decision to Admit (DTA)	Where a clinical decision is made to admit the patient for either day case or inpatient treatment.
Did Not Attend (DNA)	A patient who, having previously accepted an agreed date for an appointment or surgery, fails to attend the hospital as agreed and without cancellation or notification.
Direct Access	Where GPs refer patients to hospital for diagnostic tests only. These patients will not be on an open RTT pathway.
E-Referral Service	A method of electronically booking a patient into the hospital of their choice.
Elective Care	Any pre-scheduled care which doesn't come under the scope of emergency care.
Evidence Based Interventions (EBI)	A list of national procedures/treatments which NHS England has determined to be only effective in certain circumstances or which have only limited clinical effectiveness. As such prior approval is required from the patient's commissioner before treatment can go ahead.

First Definitive Treatment	An intervention intended to manage a patient's disease, condition or injury and avoid further invention. What constitutes First Definitive Treatment is a matter for clinical judgment, in consultation with others as appropriate, including the patient.
Fixed appointments	Where an appointment or admission date is sent in the post to the patient without the opportunity to agree a date.
Full booking	Where an appointment or admission date is agreed either with the patient at the time of the decision or within 24 hours of the decision.
ICB (Integrated Care Board)	The local NHS commissioning body post 1 July 2022
Incomplete Pathways	Patients who are waiting for treatment on an open RTT pathway, either at the non-admitted or admitted stage.
Indirectly Bookable Services	Some provider services are not directly bookable through E-RS so patients cannot book directly into clinics from a GP practice. Instead they contact the hospital by phone and choose an appointment date. This is defined as an Indirectly Bookable Service.
Inpatients	Patients who require admission to hospital for treatment and are intended to remain in hospital for at least one night.
Maxims	The name of Ramsay's new Patient Administration System still used in some hospitals
Member of the Armed Forces	The Armed Forces Community includes: (1) regular personnel; (2) reservists; (3) veterans; (4) families of regular personnel, reservists and veterans and (5) the bereaved. For more information, refer to the Armed Forces Covenant or the NHS Choices: Healthcare for the Armed Forces websites.

Nullified	Where the RTT clock is discounted from any reporting of RTT performance.
Open Appointments	Open appointments are deemed to be 3 months unless requested as longer by the responsible clinician.
Outpatients	Patients referred by a General Practitioner or another health care professional for clinical advice or treatment.
Patient Administration System (PAS)	Ramsay's IT system that electronically records patients' referral details, clinical pathways, treatment dates, etc. Ramsay currently operates a single system called Maxims
Patient Initiated Delay (PID)	Where the patient cancels, declines offers or does not attend appointments or admission. This in itself does not the stop the RTT clock. A clinical review must always take place.
Planned Waiting List	Patients who are to be admitted as part of a planned sequence of treatment or where they clinically have to wait for treatment or investigation at a specific time. Patients on planned lists should be booked in for an appointment at the clinically appropriate time. They are not counted as part of the active waiting list or are on an 18-week RTT pathway.
Primary Tracking List (PTL)	The PTL is a list of patients (both inpatients and outpatients) whose waiting time is approaching the guarantee date, who should be offered an admission/appointment before the guarantee date is reached. Ramsay's internal name for this report is called the "Elective Care Monitoring Report"
Reasonable Offer	For an offer of an appointment to a patient to be deemed reasonable, the patient must be offered the choice of dates within the timescales referred to for outpatients, diagnostics and in patients.

Referral to Treatment (RTT)	Instead of focusing upon a single stage of treatment (such as outpatients, diagnostic or inpatients) the 18 week pathway addresses the whole patient pathway from referral to the start of treatment.
Straight to Test	Arrangements where patients can be referred straight for diagnostics as the first appointment as part of an RTT pathway.
TCI (To Come In) date	The offer of admission, or TCI date, is a formal offer in writing of a date of admission. A telephone offer of admission should not normally be recorded as a formal offer. Usually telephoned offers are confirmed by a formal written offer.

Acronyms

Term	Definition
ASIs	Appointment slot issues (list): a list of patients who have attempted to book their appointment through the national E-Referral Service but have been unable to due to lack of clinic slots.
CATS	Clinical assessment and treatment service
CNA	Can Not Attend
CNS	Clinical nurse specialists: use their knowledge of cancer and treatment to co-ordinate the patient's care plan and act as the patient's 'keyworker'.
COF	Clinic outcome form
DNA	Did Not Attend
DRR	Date Referral Received
DTA	Decision To Admit
DTT	Decision To Treat (date): the date on which the clinician communicates the treatment options to the patient and the patient agrees to a treatment.
E-RS	(National) E-Referral Service
EBI	Evidence Based Interventions
GDP	General dental practitioner
ICB	Integrated Care Board
MDS	Minimum Data Set
PAS	Patient Administration System
PID	Patient Initiated Delay
PTL	Patient Tracking List
RTT	Referral To Treatment