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

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1 Referral To Treatment (RTT) and diagnostic pathways general principles

1.1. Introduction and Purpose

Ramsay Health Care ("Ramsay") is committed to delivering high quality and timely elective care to patients.

This policy:

- Applies to all Ramsay hospitals undertaking elective surgery and receiving referrals through eRS
- Sets out the rules and principles under which Ramsay manages elective access to outpatient appointments, diagnostics and elective inpatient or day case treatment
- Is designed to ensure the management of elective patient access to services is transparent, fair, equitable and managed according to clinical priorities
- Gives staff clear direction on the application of the NHS Constitution and NHS choice framework in relation to elective waiting times

Ramsay's elective 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.

This policy will be read by all applicable staff once they have successfully completed the relevant elective care training. It will not be used in isolation as a training tool.

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

1.2 Roles and responsibilities

Although responsibility for achieving standards lies with the Senior Leadership Team of each Ramsay hospital and ultimately the Ramsay Executive Board, all staff with access to and a duty to maintain elective care information systems are accountable for their accurate upkeep. For example:

- **Head of NHS Services - Operations** is accountable for implementing, monitoring and ensuring standardised compliance with the policy across all Ramsay hospitals
- The **Head of Data & Analytics** is responsible for the timely production of patient tracking lists (PTLs) which support the Ramsay hospitals in managing waiting lists and RTT standards
- **Hospital Directors amd the hospital's Senior Leadership Team** are responsible for the effective and efficient management of the waiting lists within their hospital and the compliance to RTT policies and associated guidance

- **Waiting list administrators, clinic staff, secretaries and booking clerks**, are responsible to operational managers for standardisation in its application and compliance with all aspects of Ramsay's elective access policy
- **Waiting list administrators** for outpatients, diagnostics and elective inpatient or day care services are responsible for the day-to-day management of their waiting lists and are supported in this function by the operational managers
- **Operational managers** are responsible for ensuring the NHS e-referral service Directory Of Services (DOS) is accurate and up to date and are supported by other Senior Leadership Team members who are responsible for achieving access standards
- The **Data & Analysis team** is responsible for producing and maintaining regular reports to enable divisions to accurately manage elective pathways and ensure compliance with this policy
- **General practitioners (GPs)** and other referrers play a pivotal role in ensuring patients are fully informed during their consultation of the likely waiting times for a new outpatient consultation and of the need to be contactable and available when referred. GPs should ensure quality referrals are submitted to the appropriate provider first time
- **Clinicians with responsibility for patient pathways** must have an appropriate level of understanding of RTT rules and application with specific focus on clinic outcoming
- **Integrated Care Boards (ICBs)** are responsible for ensuring all patients are aware of their right to treatment at an alternative provider in the event that their RTT wait goes beyond 18 weeks or if it likely to do so. In this instance ICBs must take all reasonable steps to offer a suitable alternative provider/s able to see or treat patients more quickly than the provider to which they were referred. A suitable alternative provider is one that can provide clinically appropriate treatment and is commissioned by a ICB or NHS England. The ICBs are responsible for ensuring there are robust communication links for feeding back information to GPs

1.4. Governance

All Ramsay hospitals will actively manage their own elective waiting lists in line with local and national guidance and targets.

All Ramsay hospitals are encouraged to have a nominated RTT/ elective waiting list lead who will have day-to-day responsibility for managing waiting lists. The RTT/ elective waiting list lead will work with the hospital's Senior Leadership Team to have assurance that RTT core principles are being applied consistently by both clinical and non-clinical staff.

It is encouraged that the position of units' elective waiting list and diagnostic waiting list form part of the SLT's routine management meetings, including treatment plans for longer-waiting patients.

At a national level, Ramsay's Head of NHS Services – Operations, is responsible for ensuring that as an organisation Ramsay complies with all RTT rules and core principles, the monitoring against KPIs and exception reporting at both a local and national level.

1.5. 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.

Further detail can be found in the following location:

The NHS Constitution for England - GOV.UK (www.gov.uk)

The NHS Choice Framework states that patients can choose where they go for their first appointment as an outpatient. The Framework states a patient can be asked to be referred to a different hospital if they have to wait more than 18 weeks before starting treatment and / or if you wait more than 2 weeks before seeing a specialist for suspected cancer. These are legal rights, there are exceptions to be aware of detailed in the NHS Choice Framework.

Further detail is found in the following location:

NHS Choice Framework - what choices are available to you in your NHS care - GOV.UK (www.gov.uk)

1.5.1 Military veterans

In line with the Armed Forces Covenant published in 2015, all veterans and war pensioners should receive priority access to NHS care for any conditions related to their service, subject to the clinical needs of all patients.

1.5.2 Prisoners

In most circumstances Ramsay hospitals is not perceived to be an appropriate setting for the treatment of prisoners. However, where prisoner referrals are accepted all

elective standards and rules continue to be applicable. 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.

1.6. Patient eligibility

Ramsay has 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 guidance /rules.

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

Further information is provided in the following link, or staff within Ramsay hospitals should refer to the specific guidance on such patients issued from the central team.

Healthcare for visitors to the UK from the EU - GOV.UK (www.gov.uk)

Healthcare for EU citizens living in or moving to the UK - GOV.UK (www.gov.uk)

1.7. Patients moving between NHS and private care

Patients can choose to move between NHS and private status at any point during their treatment without prejudice. 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. The RTT clock starts at the point at which the patient would be on the waiting list if they had originally been referred by the GP or original referrer on the NHS.

The RTT pathways of patients who notify the Ramsay hospital of their decision to revert to a private pathway will have their NHS pathway closed, with a clock stop applied on the date of this being disclosed by the patient.

1.8. Commissioner approved procedures and Evidence Based Interventions (EBI)

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 ICB. Clinicians should be aware of the list of procedures to ensure it is appropriate to offer the procedure prior to listing the patient.

All Ramsay units must be aware of the relevant commissioning policies and procedures defined by their local ICBs, NHS England (as they apply to the treatment for members of the Armed Forces) and nationally through Evidence Based Interventions.

1.9. Communication

All communications with patients and anyone else involved in the patient's care pathway (e.g. GP or a person acting on the patient's behalf), whether verbal or written, must be informative, clear and concise. Copies of all correspondence with the patient must be uploaded and held in the patient's Electronic Patient Record for auditing purposes.

GPs or the relevant referrer must be kept informed of the patient's progress in writing.

Regular two-way communication with the patient is key to ensure that patients are fully informed and aware of any appointments for their care. Where patients are unable to attend or do not attend (DNA) their appointment there should be locally agreed processes to explore the causes. The responsible clinician must be advised so they can make an informed decision about the patient's RTT pathway and whether it is appropriate to offer further appointments.

Patients should be made aware of their responsibility to attend agreed appointments.

1.9.1 Reasonableness

A reasonable offer for any appointment or admission for any service is one that is made with at least three weeks' notice. When offers are made verbally or via email a *minimum of two dates* with at least three weeks' notice will be offered to patients from which they can choose. However, if dates at short notice become available these will be offered to patients but can only be considered reasonable if the patient accepts them. If they decline these short notice offers there is no impact on the patient's pathway.

1.9.2 Uncontactable

A patient's demographics should always be checked at any appointment or when any contact is made. Where a patient cannot be reached by the initial phone call, three further attempts on different days at different times (ideally one out of hours) should be made to contact the patient. There should also be efforts made to contact the original referrer (e.g. GP) to confirm the patient's demographics. If the patient still cannot be reached a letter should be sent giving the patient three weeks to make contact to book their appointment. If the patient does not make contact within those three weeks they can be returned to their referrer if there is a clinical decision to discharge.

1.10. Non-activity related RTT decisions

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

1.11. Attendance and outcomes (new and follow-up clinics, diagnostics, and admissions)

Every patient, with an outpatient appointment, whether attended or not, will have an outcome recorded in the EPR. For Admissions, an attendance status will be recorded.

1.12. 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 the Ramsay's patient tracking lists (PTLs) only. They will **not** be selected from any paper-based systems.

2 National referral to treatment and diagnostic standards, rules application

Referral to treatment	
Incomplete	92% of patients on an incomplete pathway (ie 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 (DNA) previously agreed appointment dates or admission offers (TCI) and this prevents Ramsay from treating them within 18 weeks

2.1. Overview of national referral to treatment rules

Figure 1 below provides a visual representation of the chronology and key steps of a typical RTT pathway.

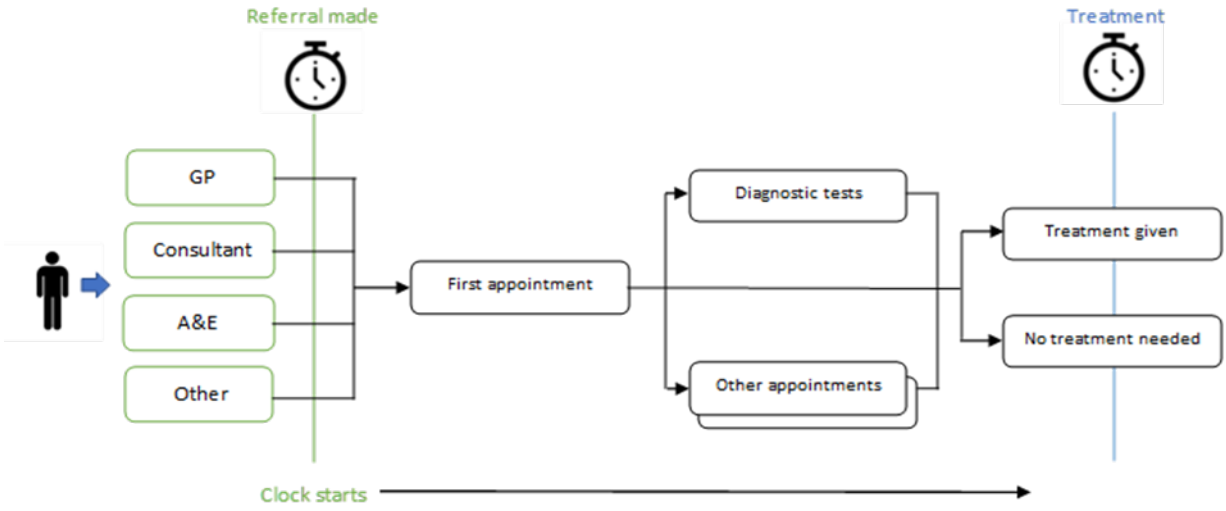

Figure 1: The chronology and key steps of a typical RTT pathway

2.1.1 Clock starts (Rules 1- 3)

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

Rule 1: Referrals by care professionals or services

a) a referral is received into a consultant-led service, regardless of setting, with the intention that the patient will be assessed and if appropriate, treated before clinical responsibility is transferred back to the referrer

b) a referral is received into an interface or referral management assessment centre which may result in an onward referral to a consultant-led service before clinical responsibility is transferred back to the referrer

Rule 2: Self-referrals

A patient self-refers into a consultant-led service for pre-agreed services agreed by providers and commissioners.

Rule 3: The need for a new clock

Upon completion of a consultant-led RTT period, a new waiting time clock only starts:

a) when a patient becomes fit and ready for the second of a consultant-led bilateral procedure

b) upon the decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan

c) upon a patient being re-referred into a consultant-led, interface or referral management or assessment service as a new referral

d) when a decision to treat is made following a period of 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)

e) when a patient rebooks their appointment following a first appointment did not attend (DNA) that stopped and nullified their earlier clock

2.1.2 RTT clock stops (Rule 4 and 5)

Rule 4: clock stops for treatment

a) first definitive treatment starts. First definitive treatment is defined as 'an intervention intended to manage a patient's disease, condition, or injury and/or avoid further intervention'. This could be:

- treatment provided by an interface service
- treatment provided by a consultant-led service
- therapy or healthcare science intervention provided in secondary care or at an interface service, if this is what the consultant-led or interface service decides is the best way to manage the patient's disease, condition or injury and avoid further interventions

b) a clinical decision is made and has been communicated to the patient, and subsequently their GP and/or other referring practitioner without undue delay, to add a patient to a transplant list.

Rule 5: Clock stops for non-treatment

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

a) it is clinically appropriate to return the patient to primary care for any non consultant-led treatment in primary care

b) a clinical decision is made to start the patient on a period of active monitoring

c) a patient declines treatment having been offered it

d) a clinical decision is made not to treat

e) a patient DNAs their first appointment following the initial referral that started their waiting time clock, provided that the provider can demonstrate that the appointment was clearly communicated to the patient[1]

f) a patient DNAs any other appointment and is subsequently discharged back to the care of their GP, provided that:

- the provider can demonstrate that the appointment was clearly communicated to the patient
- discharging the patient is not contrary to their best clinical interests
- discharging the patient is carried out according to local, publicly available or published policies on DNA
- these local policies are clearly defined and specifically protect the clinical interests of vulnerable patients (for example, children) and are agreed with clinicians, commissioners, patients, and other relevant stakeholders

2.1.3 Exclusions

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

- Planned patients
- Referrals to a non-consultant led service
- Referrals for patients from non-English commissioners

[1] DNAs for a first appointment following the initial referral that started a waiting time clock nullify the patient's clock (that is, it is removed from the numerator and denominator for RTT time measurement purposes).

2.2. Non consultant-led pathway and RTT clocks

Referrals to therapy or healthcare science interventions (e.g. physiotherapy, dietetics, orthotics, and surgical appliances) 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 or healthcare science interventions could constitute an RTT clock stop. Equally the clock could continue to tick.

It is critical that staff in these services know if patients are on an open pathway and if the referral to them is intended as first definitive treatment.

Physiotherapy

For patients on an orthopaedic pathway referred for physiotherapy 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.

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.

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 could continue to tick.

2.3. Did Not Attend (DNA)

A clinical review must occur for any pathway DNA. A clinician can decide to discharge the patient back to the original referrer (stopping the clock) where this is not contrary to the patients best clinical interests. Where another appointment is offered, the RTT clock continues to tick.

2.3.1 Outpatients

All DNAs 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.

First appointment DNAs

The RTT clock is stopped and nullified in all cases (Rule 5e[2]), as long as the hospital can demonstrate the appointment was clearly communicated to the patient. If the clinician indicates another first appointment should be offered, a new RTT clock will be started on the date that the patient contacts Ramsay to rebook their new appointment. If the patient is unable to book an appointment due to capacity pressures or lack of available appointment slots, then the clock should start when there is a decision to add the patient to a waiting list as an alternative to booking their appointment.

Subsequent (follow-up) appointment DNAs

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. As long as Ramsay can demonstrate the appointment was booked in line with the criteria listed in the RTT rule suite Rule 5f[3]. This is detailed in Appendix 3.

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.

If the subsequent DNA is within a support service e.g. Pre-operative assessment and or diagnostics the decision about rebooking should be made by the requesting clinician.

2.3.2 Admissions

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.

[2] DNAs for a first appointment following the initial referral that started a waiting time clock nullify the patient's clock (that is, it is removed from the numerator and denominator for RTT time measurement purposes).
[3] i) the provider can demonstrate that the appointment was clearly communicated to the patient, ii) discharging the patient is not contrary to their best clinical interests, iii) discharging the patient is carried out according to local, published, policies on DNAs iv) these local policies are clearly defined and specifically protect the clinical interests of vulnerable patients (for example, children) and are agreed with clinicians, commissioners, patients and other relevant stakeholders

2.4 Appointment cancellations initiated by the patient

Patients should be made aware of their responsibility to attend agreed appointments. 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.

Cancellations in themselves do not stop clocks. A clock stop should only be applied following a clinical review and decision to discharge (where this is in the patient's best clinical interest) or where there is agreement between the clinician and the patient to initiate a period of active monitoring.

Where a patient cancels at short notice (less than 48 hours before appointment) or where a patient has cancelled two appointments on the same pathway, Ramsay hospitals should ensure that reasons are understood and a clinical review undertaken.

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 after a clinical review and the pathway nullified. The patient and GP (or other referrer) will be informed of this.

2.4.1 Patients who cancel or decline TCI offers.

If patients decline TCI offers or contact Ramsay to cancel a previously agreed TCI, this will be recorded on the PAS. The RTT clock continues to tick until a clinical decision is made about the next steps.

When a patient declines two reasonable offers of treatment dates and the second date is within 6 weeks of the first offer, and wishes to delay treatment, the consultant should review the patient. The consultant may agree a period of active monitoring with the patient, which should include an appropriate timeframe for further follow up or review. At the point that the patient indicates their availability, or at the agreed follow up review, if there is agreement to proceed to treatment, a new decision to admit will be recorded and a new RTT clock will start.

Although the patient's clock will start from zero as normal, the service will offer a new TCI date in line with clinical prioritisation and act as if the patient is on the waiting list at the point they were prior to the active monitoring period.

Patients persistently refusing to accept reasonable offers of a TCI date risk being discharged back to the care of their GP.

2.4.2 Patients declining earlier treatment at an alternative provider

It may be necessary to offer patients choice to be treated at another provider. The same process and clock rules apply as above (Patients who cancel or decline TCI offers). However, TCI offers must include date, provider and team and meet reasonableness criteria. This includes situations where a patient is offered an appointment with another private provider, including an alternative Ramsay hospital, as part of an outsourcing arrangement.

It is important to fully understand both social and clinical factors in order to assist patients in making a decision to move to an alternative provider. This may include access to transport, carer assistance etc.

2.5. Active monitoring

Active monitoring is where a decision is made that the patient may not require treatment at this time but should be monitored in secondary care. When a decision by a clinician to begin a period of active monitoring is made, agreed and communicated with the patient, the RTT clock stops.

Where a patient indicates that they wish to delay their appointment or treatment a discussion with their clinician should be arranged.

Within the scope of the Access Policy it is not possible to specifically define compulsory timescales for delayed treatment before activity monitoring is applied as each decision is individual. However, for example, it would be unlikely to make clinical sense to initiate a period of active monitoring and stop a clock for a short period of a few days, nor would this make sense to a patient. Conversely, in instances where patients wish to delay their appointment or treatment for a longer period, Ramsay will ensure ongoing clinical review to consider whether the best option is to commence a period of active monitoring or whether the patients' clock should remain ticking. Each decision should be made on an individual patient basis.

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.

Active monitoring may be appropriate in the following situations:

Hospital initiated:

- when the most clinically appropriate option is for the patient to be actively monitored over a period of time, rather than to undergo any further tests, treatments or other clinical interventions at that time

- when a patient wishes to delay their treatment (e.g. teacher wishes to wait for treatment in school holidays) and declines two offers for reasonable[4] treatment dates the clinician may decide to commence a period of active monitoring, following a clinical conversation and agreement with the patient

- when a patient[5] declines two reasonable[6] offers for earlier treatment dates at an alternative provider – the clinician may decide to commence a period of active monitoring, following a clinical conversation and agreement with the patient. The TCI date offered must include date, provider and team

Patient initiated:

- Patients may also initiate the start of a period of active monitoring– for example, by choosing to decline treatment to see how they cope with their symptoms

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When patients make a decision to delay their treatment there should be clinical oversight, and steps should be taken to ensure that the patient fully understands the clinical implications of the delay. At the point that a decision to commence a period of active monitoring is made, the RTT clock will stop. In the majority of cases, it will be clear how the rules should apply. However, where there is doubt, or where decisions on the application of the RTT rules is finely balanced, then local clinical decisions should be made within the guidance of national rules.

The discussion with the patient regarding commencing a period of active monitoring should include an appropriate timeframe for further follow up or review. Patients can request delays of any length but should be regularly reviewed in case their condition deteriorates. As a minimum clinical review must take place every 12 weeks. Where active monitoring extends past 12 weeks a clinical review should be undertaken to check the patients' condition and confirm that active monitoring remains appropriate. The pathway should be visible on a relevant PTL or waiting list report for non-RTT pathways.

When a patient is placed on active monitoring, they should be provided with written contact details and a clear process for two-way communication between them and the clinician in the event that their condition or circumstances change.

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[4] 'Reasonable' will be defined by each NHS England region recognising the variance in the geography. Provision should be made to support patients with transport or travel costs if required at the discretion of the integrated care board

[5] Patients included within this cohort should be clinically validated to be appropriate (clinically and socially) to be offered earlier treatment at a reasonable alternative provider

[6] 'Reasonable' will be defined by each NHS England region recognising the variance in the geography. Provision should be made to support patients with transport or travel costs if required at the discretion of the integrated care board.

In all scenarios a new waiting time clock will start when a new decision to treat is made with the patient following a period of active monitoring. For patients who have been placed on active monitoring due to unavailability, once the patient wishes to go ahead with treatment, the provider should offer a new treatment date, acting as if the patient is on the waiting list at the point that they previously left.

2.5.1 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. Where a patient states that they do not anticipate making a decision for a longer period, such as a matter of months, it may be appropriate to agree a period of active monitoring with the patient. This decision can only be made by a clinician and on an individual patient basis with their best clinical interests in mind.

A clinical discussion with the patient should take place where more than fourteen days have passed without next steps being agreed.

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

If a patient contacts the hospital to communicate a period of unavailability for social reasons (e.g. holidays, exams), this period should be recorded on PAS and a clinical decision taken as to the next best step, which may be active monitoring.

For any patient request to delay there should be a clinical review to assess the potential impact on the patient's condition and treatment plan. This review is to support the clinical decision on next steps, of which the following may be considered:

- **Clinically safe for the patient to delay:** Planning for the patient's treatment may continue if only a short delay is requested, or active monitoring may be appropriate where agreed with the patient, including regular review
- **Clinically unsafe length of delay (patient initiated):** clinician to contact the patient with a view to persuading the patient not to delay. In exceptional circumstances if a patient decides to delay their treatment it may be appropriate to place the patient under active monitoring (clock stop) if the clinician believes the delay will have a consequential impact on the patient's treatment plan. If there is a shared decision made by the clinician and the patient to start active monitoring this should include a future date for review within at least 12 weeks, so that the patient's condition and treatment options can be re-assessed following the period of active monitoring

- **Clinically unsafe length of delay (clinician initiated):** clinical assessment that it is in the patient's best clinical interests to return the patient to their GP. The patient is discharged and their RTT clock stops on the day this is communicated to the patient and their GP

2.6. Appointment changes initiated by the hospital

Hospital-initiated changes to appointments for reasons such as staff availability, suspension of services, equipment failure, will be avoided as far as possible as they are poor practice and cause inconvenience to patients.

Furthermore, clinicians are actively encouraged to book annual leave and study leave as early as possible.

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 as quickly as possible. Equally, this will allow patients not on open pathways to be reviewed as near to the clinically agreed timeframe as possible.

In these instances, there is no effect on the RTT waiting time and the clock should continue to tick.

3 Pathway-specific milestones

3.1. Non-admitted pathways

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

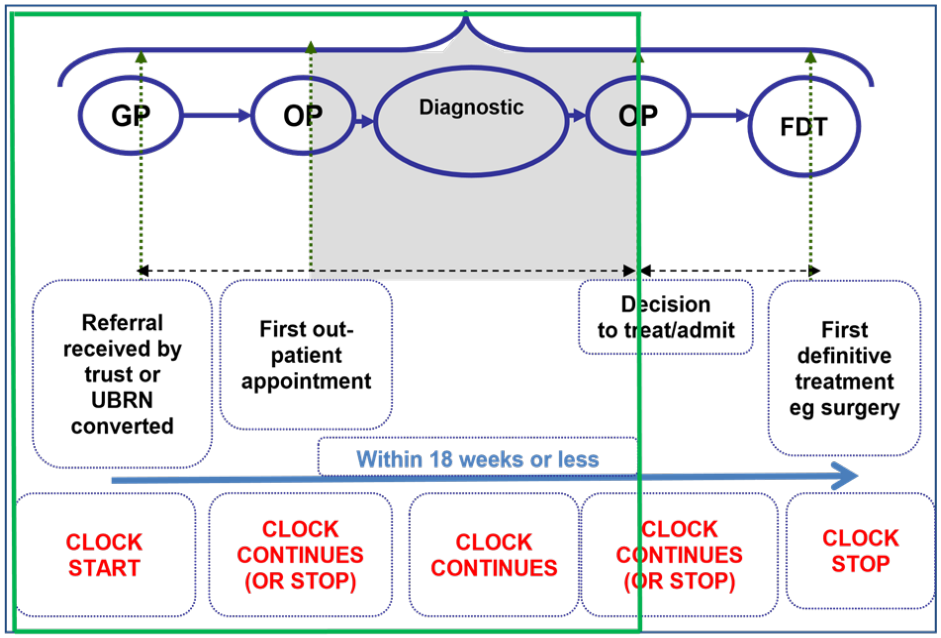


Figure 3: Non-admitted stages of the patient pathway

3.2 Methods of receipt

It is expected that all referrals from GPs to consultant-led services should be made electronically through the national e-Referral Service (e-RS). Only in exceptional circumstances should paper-based referrals be received and accepted.

3.3 Referral types

Ramsay should ensure they detail any unique local referral types or services which may have differing processes and ensure that there is sufficient guidance in the form of a SOP. The section below provides some examples.

3.3.1 Clinical assessment and triage services (CATS), referral management centres (RMCs) and Referral Assessment Centres (RAS)

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 Ramsay having not received any treatment in the service, Ramsay inherits the 18-week RTT wait for the patient.

A minimum dataset (MDS) form must be used to transfer 18-week information about the patient to Ramsay.

This is different to Advice and Guidance (A&G) which does not start an 18-week RTT clock unless the consultant converts the request or receives notice of the referral.

The reasons why a clinician may wish to seek advice and guidance include:

- Asking for advice on a treatment plan and/or the ongoing management of a patient
- Asking for clarification regarding a patient's test results
- Seeking advice on the appropriateness of a referral for their patient

3.3.2 Inter-provider transfers (IPTs)

Incoming IPTs

All IPT referrals will be received electronically via secure email.

Ramsay expects an accompanying Minimum Data Set (MDS) pro-forma with the IPT, detailing the patient's current RTT status (Ramsay will inherit any RTT wait already incurred at the referring provider 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 Ramsay). The patient's pathway identifier (PPID) should also be provided. If the IPT is for a diagnostic test only, the referring provider retains responsibility for the RTT pathway.

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

Outgoing IPTs

Ramsay 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 will be sent with the IPT, detailing the patient's current RTT status (the receiving provider 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 provider. The patient's patient pathway identifier (PPID) will also be provided.

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

Referrals and the accompanying MDS will be emailed securely. The central booking office will verify (and correct if necessary) the correct RTT status for the patient. If the patient has not yet been treated, the RTT clock will be nullified. They will then forward to the receiving provider within one working day of receipt by secure email.

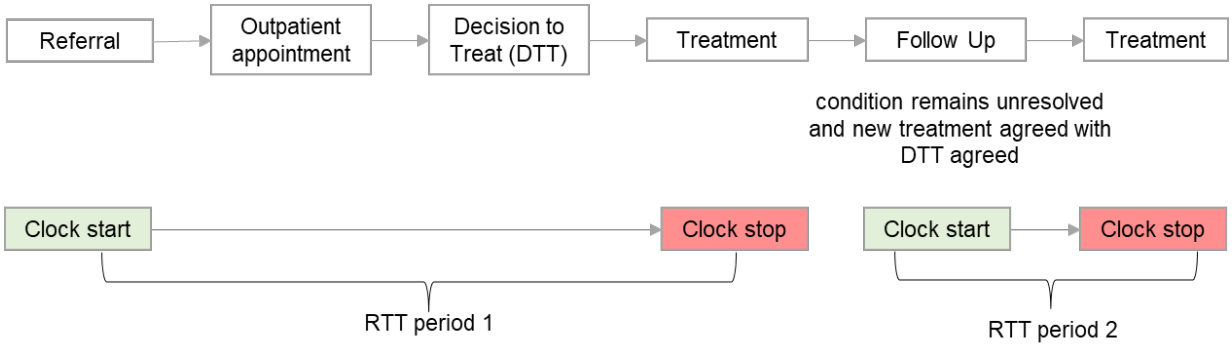
3.4 Appointment Slot Issues (ASIs)

ASIs present a clinical risk as an RTT clock does not start on a provider's patient administration system (PAS) while the patient's referral is on an ASI worklist, and patients may not be visible on the Ramsay hospital's PTL.. It is important to resolve these ASIs promptly as they will move from the worklist if not actioned after 26 weeks and then only be visible on another report within e-RS. They should be monitored closely so that action can be taken to prevent referrals being lost and supported by an SOP.

When patients are unsuccessful in directly booking their first outpatient appointment via e-RS, the RTT clock should be started from the date the patient attempted to book their appointment, for example, when the hospital receives the referral on their ASI worklist.

3.5 Multiple RTT periods on the same pathway

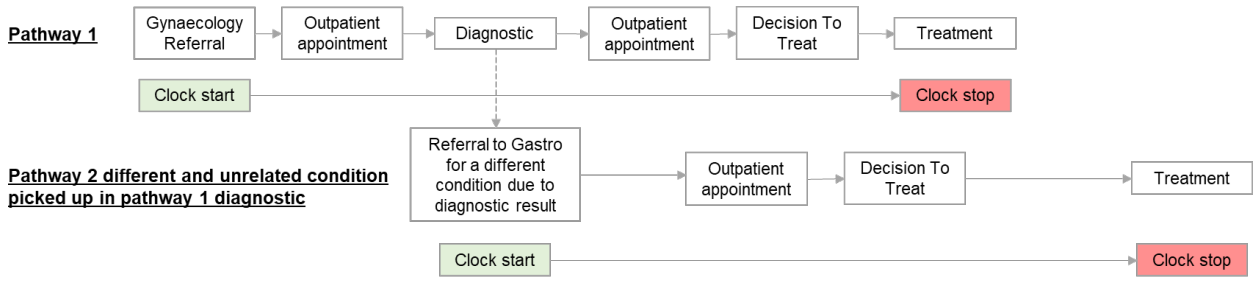
A patient can have multiple RTT periods along one patient pathway with the same original referral. This is where it relates to the same underlying condition (eg: chronic or recurrent) where the patient pathway will continue beyond the point at which first definitive treatment starts, as it will include further treatment for the same condition. In this instance the RTT clocks are not concurrent and instead sequential following one after each other as new treatment decisions and plans are made. There may also be some periods of active monitoring between these decisions.



3.6 Multiple RTT pathways

Where a patient has more than one referral for unrelated clinical reasons, each referral will have its own patient pathway and separate RTT clocks. In this instance it is important to understand any impact on the management of their different conditions, for example where treatment for one condition affects the planning of another treatment, or

where a period of recovery is needed before undergoing treatment for another condition. Clinical and operational teams should implement co-ordinated care pathways as appropriate for patients on multiple pathways. There may be cases where it's appropriate for a period of active monitoring to be agreed on one pathway while the patient undergoes and recovers from treatment on another pathway that's considered to be the clinical priority.



3.7 Diagnostics

The section within the green border on Figure 4 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.

Where a patient is referred to another provider for a diagnostic test whilst on an active RTT pathway, the host provider will retain overall responsibility and reporting.

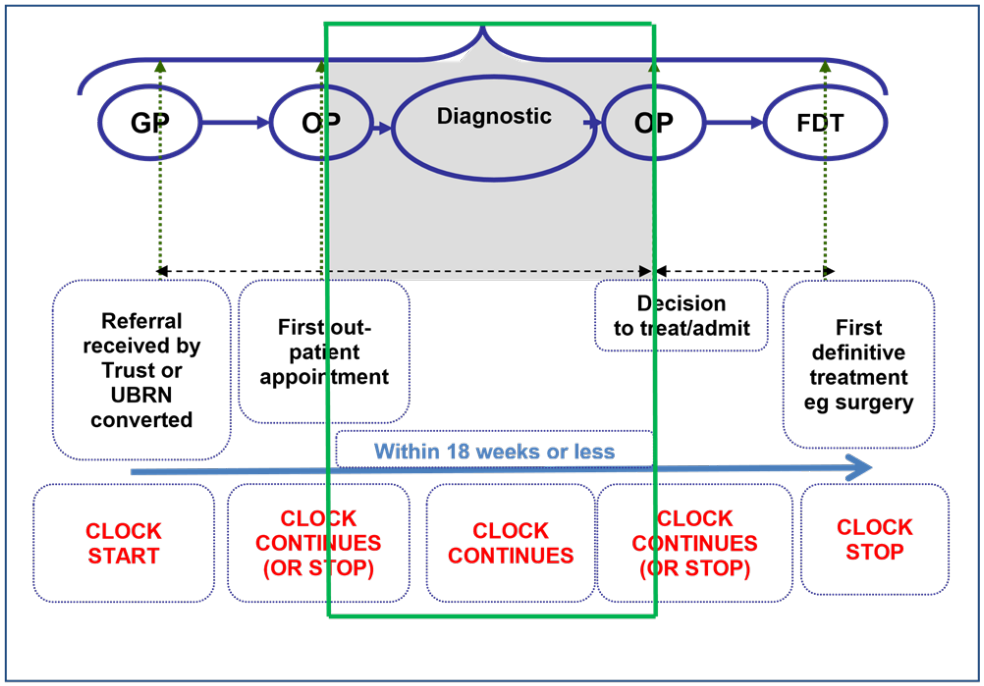


Figure 4: Diagnostic phase of the patient pathway

3.8. Patients with a diagnostic and RTT clock

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

Their RTT clock which started at the point of receipt of the original referral.

Their diagnostic clock which starts at the point of the decision to refer for diagnostic test.

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.

3.9. Straight-to-test arrangements

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

3.10. Direct access diagnostics

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

3.11. National diagnostic clock rules

All patients referred for a diagnostic test that is not planned or part of a screening programme are expected to be dated within 6 weeks of referral.

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 (day 0).

Diagnostic clock stop: the clock stops at the point at which the patient undergoes the test.

Patients referred for planned diagnostics must be offered a date by their due date, patients that are not dated by their due date will have a 6-week clock started on their due date.

If a patient declines a reasonable offer, cancels an appointment offered with reasonable notice or misses an appointment offered with reasonable notice the diagnostic 6 week waiting time clock can be re-set to zero and the waiting time starts again from the date of the appointment declined, cancelled or missed. This has no effect on the RTT clock and so all patients should be offered the next available appointment.

3.12 Pre-operative assessment (POA)

All patients with a Decision To Admit (DTA) requiring a general anaesthetic will require a pre-operative assessment (POA). Assessment, or as a minimum, initial screening should take place as soon as possible after the DTA to assess the fitness of the patient for surgery. 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 in POA.

Many patients can be assessed by Ramsay's dedicated POA nurses. For patients with complex health issues requiring a POA appointment with an anaesthetist, Ramsay will aim to agree this date with the patient before they leave the clinic. Ramsay will aim to agree an appointment no later than seven working days from the decision to admit. If additional tests are required to ascertain a patient's fitness, the RTT clock continues while these are arranged.

3.12.1 Patients who are unfit for surgery

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

Short-term illnesses

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

Longer term illnesses

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

- If the patient requires optimisation within secondary care or treatment for another condition or a period of recovery before proceeding, they should be placed on active monitoring
- If the patient is being optimised or otherwise managed within primary care they should be discharged back to the care of their GP (clock stop)

If a clinical decision is made to stop the RTT clock for active monitoring, the patient's next steps should be agreed, including timescale for further review or follow up to assess the patient's condition. The pathway should remain visible on the relevant PTL or waiting list report to support ongoing management

3.13 Admitted pathways

Ramsay will ensure that patients requiring an admission pathway are captured and monitored on waiting lists. It is worth noting the difference between active RTT patients and planned patients (awaiting admission at a specific clinically defined time).

3.14 Active waiting list

Patients added to the admitted waiting list will be assessed to ensure that they are fit, ready and available for treatment. They will be added to the admitted waiting list without delay following a decision to admit, regardless of whether they have undergone preoperative assessment or whether they have declared a period of unavailability at the point of the decision to admit.

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.

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
- Start a new RTT clock if the patient's previous clock had been stopped for active monitoring

The RTT clock will stop upon treatment following admission.

3.15 Patients requiring more than one procedure

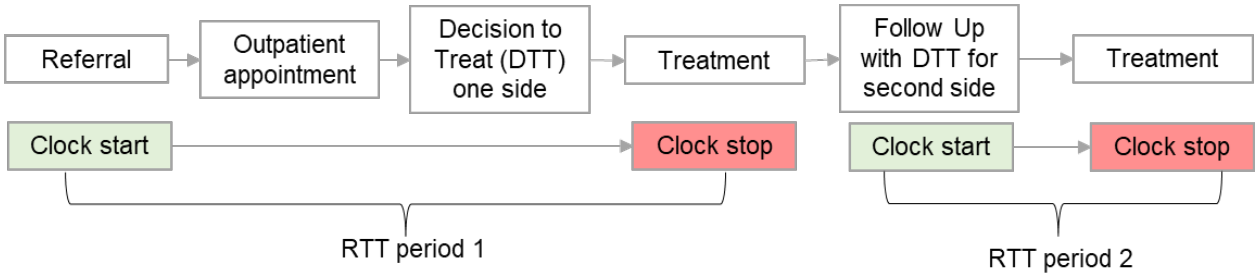
If more than one procedure will be performed in the same scheduled slot by the same surgeon, the patient should be added to the waiting list with extra procedures noted. If different surgeons will work together to perform more than one procedure, the patient will be added to the waiting list of the consultant surgeon for the priority procedure with additional procedures noted.

If a patient requires more than one procedure performed on separate occasions such as first definitive treatment followed by a new decision to treat for a 2nd or subsequent treatment or bilateral procedures that are completed separately, this is an example of multiple RTT periods on the same patient pathway:

- 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 and able to proceed with 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.

NOTE: RTT clocks for bilateral procedures are sequential and not concurrent (nor listed as 'planned') as stated in Rule 3a.

The below figure is an example of a bilateral pathway:



3.16 Planned waiting lists

Patients will only be added to an admitted planned waiting list where there is a clinical reason requiring them to undergo a procedure at a specific time or repeated at a specific frequency e.g. such as a repeat colonoscopy.

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.

Patients who require a diagnostic test to be carried out at a specific point in time for clinical reasons (such as for post-treatment surveillance) 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 their due date for the test, they will be transferred to an active waiting list and a new diagnostic clock and RTT clock will be started.

3.17. Clinical Prioritisation

When a patient is added to the waiting list they should be assigned a clinical prioritisation code by the clinician.

Clinical prioritisation criteria for each elective speciality should be agreed by clinical leads following by guidance from respective Royal Colleges. These follow a standard format as detailed below:

P code	Booking timescale	Review timescale
P1a	Emergency procedures to be performed in <24 hours - **would not usually apply to patients awaiting elective admission and so should not be used within Ramsay**	
P1b	Procedures to be performed in <72 hours - **would not usually apply to patients awaiting elective admission and so should not be used within Ramsay**	
P2	Procedures to be performed in <1 month	1 month
P3	Procedures to be performed in <3 months	3 months
P4	Procedures to be performed in >3 months	6 months

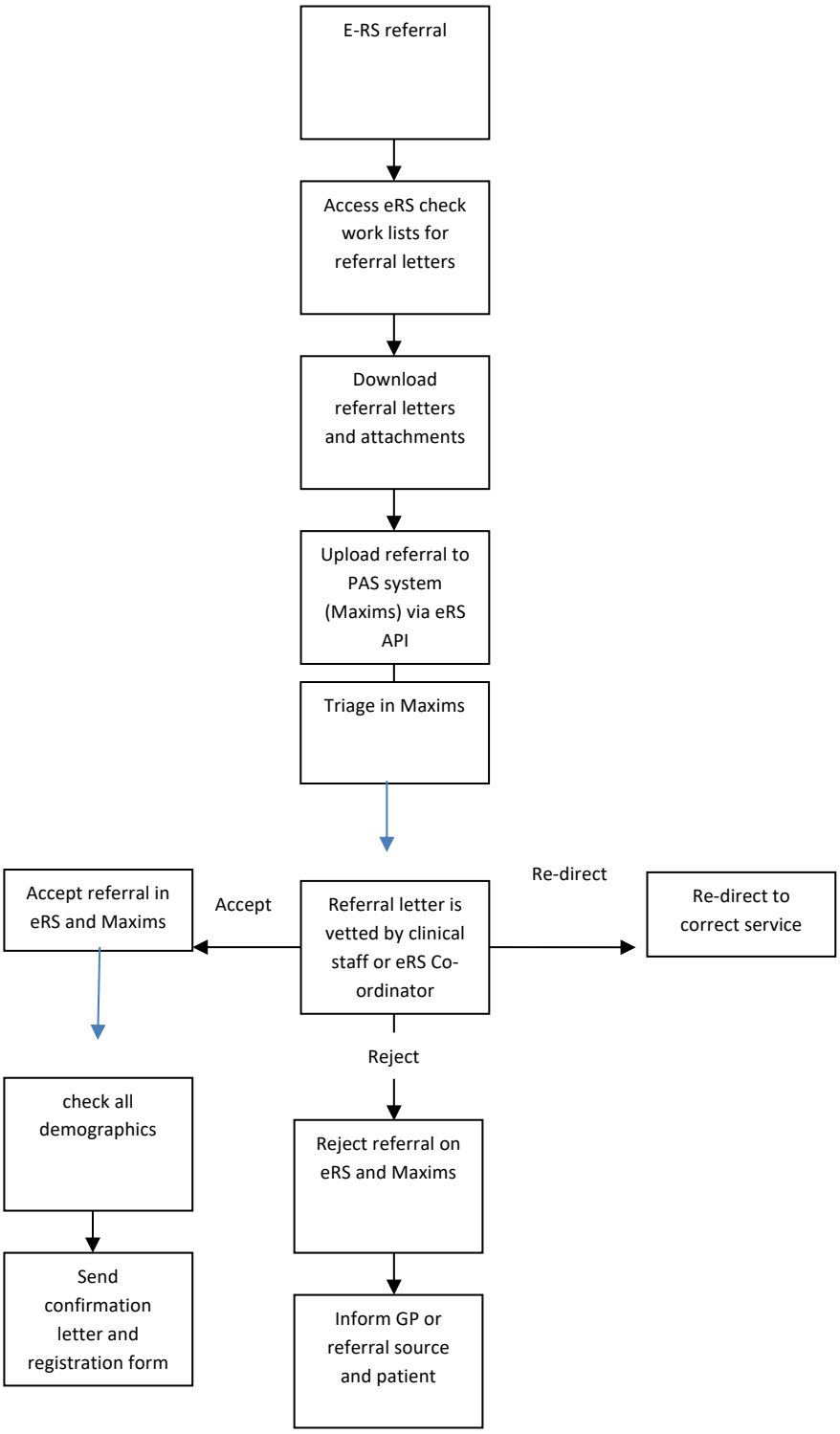
Given the nature of the services and treatment provided at Ramsay hospitals, it is not expected that any patient referred to a Ramsay hospital will be classified as either P1a or P1b.

All patients, including those who have chosen to delay treatment should be reviewed to make sure their condition or preference has not changed. Reviews should ideally be undertaken every twelve weeks, or sooner if appropriate (for example if a change in the patient's condition has been highlighted). The information derived from this Validation process should be recorded in the PAS.

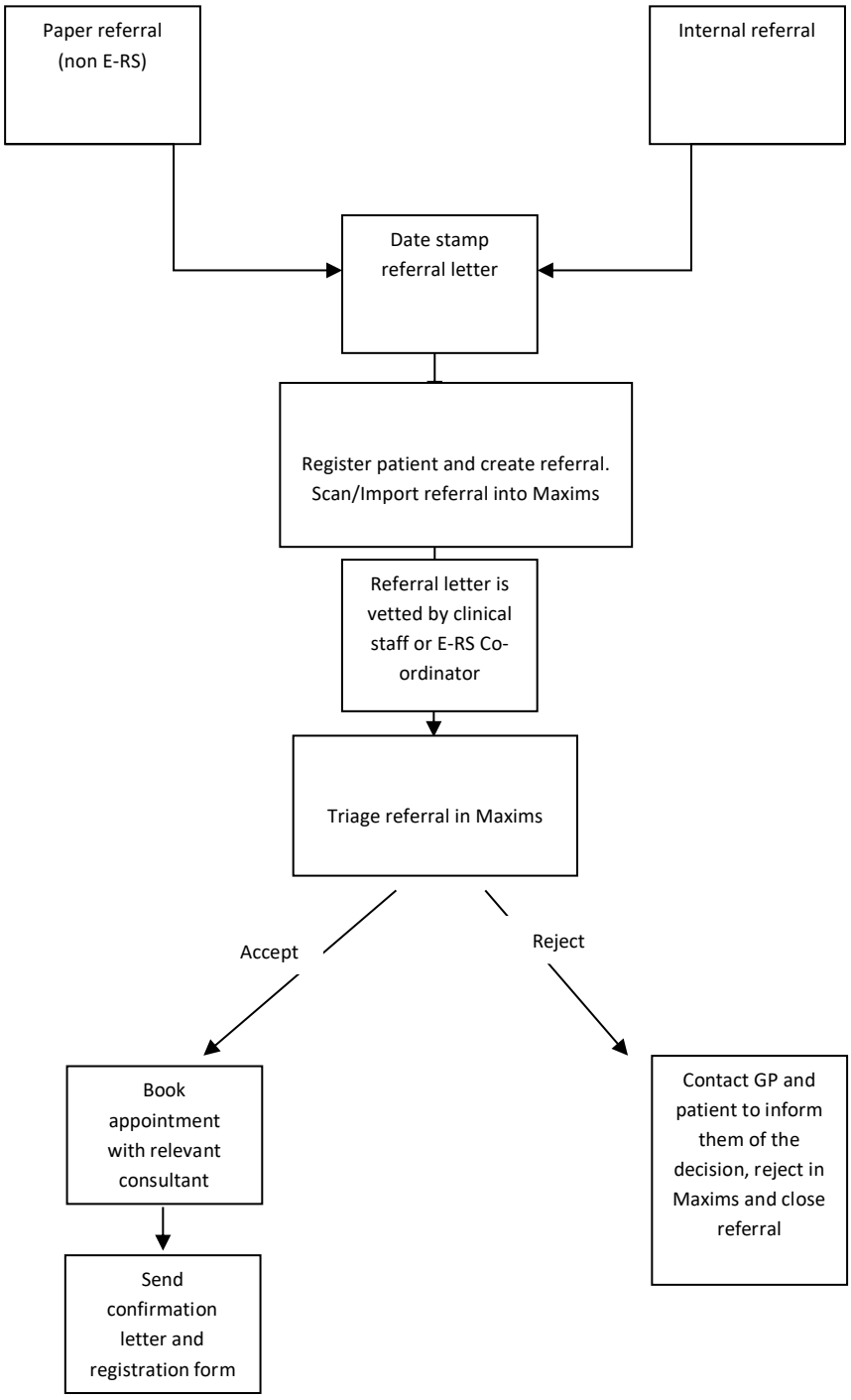
3.18. On-the-day cancellations

Where a patient is cancelled on the day of admission or day of surgery for non-clinical reasons, they will be rebooked within 28 days of the original admission date and the patient must be given reasonable notice of the rearranged date. The patient may choose not to accept a date within 28 days. If it is not possible to offer the patient a date within 28 days of the cancellation, Ramsay will offer to fund the patient's treatment at the time and hospital of the patient's choice where appropriate.

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

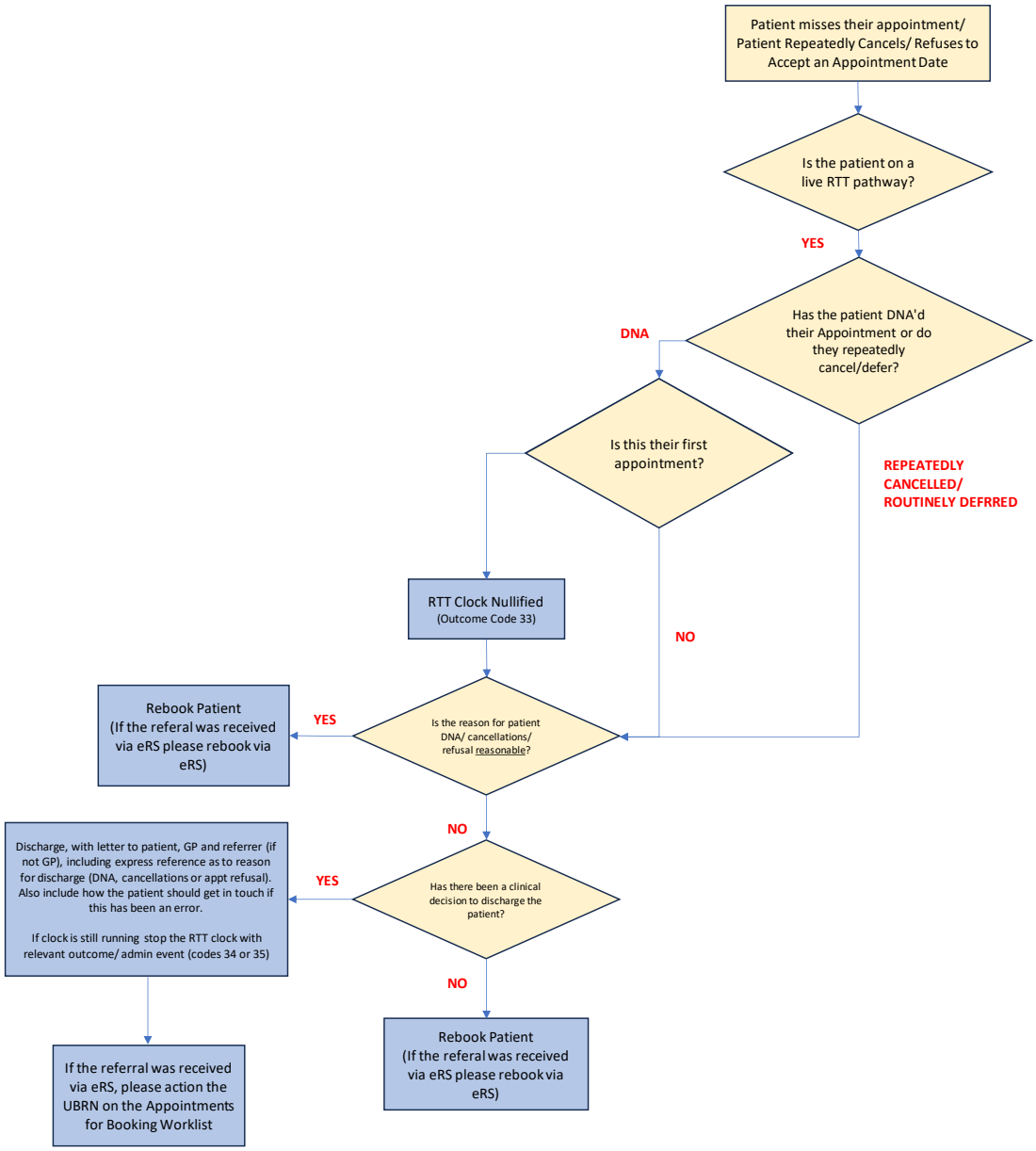


Appendix 2: Paper referral process



Appendix 3: DNA Process

DNA PROCESS (MISSED APPOINTMENTS)/ PATIENT REPEATEDLY CANCELS OR REFUSES TO TAKE AN APPOINTMENT



Appendix 4: 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
Advice and Guidance (A&G)	By providing a digital communication channel, A&G allows a clinician (often in primary care) to seek advice from another (usually a specialist) prior to or instead of a referral
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
Breach	A pathway where the period waited to be seen or receive treatment exceeds the access standard, national or local target time
Can Not Attend (CNA)	Patients who, on receipt of reasonable offer(s) of admission, notify the hospital that they are unable to attend.
Carestream/WIM	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 Assessment and Treatment Service (CATS)	Clinical assessment and treatment service
Clinical Outcome Form (COF)	Used to record the RTT outcome and other clinical information after an outpatient appointment
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
Inter Provider Transfer (IPT)	Inter-provider transfer is when a patient is transferred to another provider
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.
Minimum Data Set (MDS)	Minimum information required to be able to process a referral either into another provider or for referral out to other providers
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.
Partial Booking	Where an appointment or admission date is agreed with the patient close to the time it is due
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.
Patient Initiated Follow-up (PIFU)	PIFU is when a patient initiates an appointment when they need one, based on their symptoms and individual circumstances
Patient Pathway Identifier (PPID)	A unique identifier which together with the provider code uniquely identifies a patient pathway
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 Management Centre (RMC)	The Referral Management Centre (RMC) provides a single point of access for professionals to make referrals into providers
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

Appendix 5: Acronyms

Term	Definition
A&G	Advice and Guidance
ASIs	Appointment slot issues (list)
CATS	Clinical assessment and treatment service
CNA	Can Not Attend
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
IPT	Inter Provider Transfer
PAS	Patient Administration System (known as Maxims at Ramsay)
PIFU	Patient Initiated Follow Up
MDS	Minimum Data Set
PAS	Patient Administration System
PID	Patient Initiated Delay
PTL	Patient Tracking List
RMC	Referral Management Centre
RTT	Referral To Treatment
STT	Straight to Test
TCI	To Come In (date)

Appendix 6: References and further reading

Title	Publication date	Link
Referral to treatment consultant-led waiting times Rules Suite	Oct-22	https://www.gov.uk/government/publications/right-to-start-consultant-ledtreatment-within-18-weeks
Recording and reporting referral to treatment (RTT) waiting times for consultant led elective care	Feb-24	https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2024/02/Recording-and-reporting-referral-to-treatment-RTT-waiting-times-for-consultant-led-elective-care-v4-1.pdf
Recording and reporting referral to treatment (RTT) waiting times for consultant led elective care: frequently asked questions	Oct-23	https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2023/10/20231020-Accompanying-FAQs-v7.34-October2023-Choice-Update-Final-2.pdf
Evidence-based interventions N/A **programme**		NHS England » Evidence-based interventions programme
The NHS Constitution	Aug-23	https://www.gov.uk/government/publications/the-nhs-constitution-for-england
The NHS Choice framework	Aug-23	https://www.gov.uk/government/publications/the-nhs-choice-framework
Diagnostics waiting times and N/A **activity**		https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waitingtimes-and-activity/ https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/datacollections/diagnostics-waiting-times-and-activity-dm01