

Referral to treatment consultant-led waiting times

How to Measure

DH INFORMATION READER BOX		
Policy	Clinical	Estates
HR / Workforce Management	Commissioner Development Provider Development	IM & T Finance
Planning / Performance	Improvement and Efficiency	Social Care / Partnership Working
Document Purpose	Best Practice Guidance	
Gateway Reference	17106	
Title	Referral to Treatment Consultant-led WaitingTimes How to Measure	
Author	Department of Health	
Publication Date	January 2012	
Target Audience	PCT Cluster CEs, NHS Trust CEs, SHA Cluster CEs, Care Trust CEs, Foundation Trust CEs , Medical Directors, Directors of Nursing, PCT Cluster Chairs, NHS Trust Board Chairs, Directors of Finance, GPs	
Circulation List		
Description	As set out in the NHS Operating Framework and NHS Constitution, patients have a right to start consultant-led treatment within a maximum of 18 weeks. This document provides further guidance on the measurement by the NHS of RTT pathways. Information is provided on capturing and recording data on clock starts, clock stops, clock pauses and on calculating RTT times. The structure of this document follows the six rules defined in the RTT clock rules.	
Cross Ref		
Superseded Docs	A How To guide to measuring referral to treatment consultant-led waiting times July 2010	
Action Required	N/A	
Timing	N/A	
Contact Details	Knowledge and Intelligence NHS Finance, Performance and Operations Room 4E60 Quarry House Quarry Hill, Leeds LS2 7UE	
For Recipient's Use		

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Executive summary

This Referral to Treatment (RTT) rules document sets out clear rules and definitions for RTT to ensure that each patient's RTT clock starts and stops fairly and consistently. The rules document does not provide detailed guidance on how the rules should apply in every situation, but provides the NHS with a framework to work within to make clinically sound decisions locally about applying them, in consultation between clinicians, providers, commissioners and patients.

This document provides further guidance on the measurement by the NHS of RTT pathways. Information is provided on capturing and recording data on clock starts, clock stops, clock pauses and on calculating RTT times. The structure of this document follows the six rules defined in the RTT clock rules.

The intended audience for this document is primarily NHS staff who are involved in any aspect of RTT measurement and data collection. This will include staff within acute trusts, NHS Foundation Trusts and in emerging Clinical Commissioning Groups (CCGs).

The NHS submits RTT data to DH via Unify, DH's online data collection system (supported by detailed definitions and guidance). This facilitates the collection of aggregate RTT data in a consistent way across the NHS. The format and content of the data collection was published in the data set change notice DSCN 17/2006 in August 2006 and remains unchanged in terms of content and size of data collection. [Note: DSCNs are now known as Information Standards Notices (ISNs)]

Capture of RTT data in local IT systems, either through clinic outcome sheets or local business processes, should be timely enough to allow for a weekly submission of activity data to SUS to support RTT measurement.

1. An overview of Referral to Treatment (RTT) measurement

1.1 Introduction

1.1.1 To calculate a patient's RTT time, you need to:

- Know the date of their original referral from primary care, or other clock starting event
- Be able to link the original referral to each stage of the patient journey
- Know when their RTT clock stopped

1.1.2 As a commissioner, for all the patients for whom you are responsible for commissioning care, you need to know:

- For every patient who has completed an RTT pathway, how long they waited from the initial referral or decision that started an RTT clock through to the end of their RTT period;
- For every patient currently waiting, whether they are on an RTT pathway and if so, how long they have waited since their RTT clock started.

1.1.3 As a provider of services covered by RTT consultant led waiting times, you need to know:

- For every patient who has completed an RTT pathway, how long they waited from the initial referral or decision that started an RTT clock through to the end of their RTT period;
- For every patient currently waiting, whether they are on an RTT pathway and if so, how long they have waited since their RTT clock started.

1.2 Assigning patient pathway identifiers (PPIs)

1.2.1 As well as capturing the clock start date, a patient pathway identifier (PPI) should also be assigned to a pathway arising from a referral for a particular condition where this is a referral within the scope of the RTT measure. The PPI may therefore be used to support reporting of pathways that include more than one RTT period where those RTT periods relate to the same underlying condition and the same original referral. This, when combined with the Organisation Code (of the provider that issued the PPI) will provide a unique identifier for the pathway allowing the patient to be tracked along their RTT pathway and events along the pathway (e.g. outpatient, diagnostic and inpatient events) to be linked so that the RTT time can be calculated.

1.2.2 DSCN 16/2009, published 27 August 2009, mandates that organisations flowing specific Commissioning Data Set (CDS) types must flow RTT data elements in the Patient Pathway Data Group of those CDS Types to SUS where those records relate to activity within scope of the RTT measure. Organisations are required to submit RTT data for events on RTT pathways that start on or after 1 December 2009 to the Secondary Uses Service. The mandate also applies to any new CDS flows as they are established.

1.2.3 The Patient Pathway Data Group is composed of the following data elements:

- unique booking reference number (converted)
- patient pathway identifier
- organisation code (patient pathway identifier issuer) – note that where the initial referral was received via Choose and Book and the UBRN is used as the basis of the PPI, then organisation code of PPI Issuer is expected to be X09.
- referral to treatment period start date (note that ideally this flows on the CDS record carrying the first CDS-reported activity of the pathway and does not have to be repeated on all subsequent events within the pathway so long as the PPI and Organisation Code of PPI Issuer are maintained and flow consistently).
- referral to treatment period end date (note this only flows on the CDS record carrying the activity where the patients RTT clock stopped.)

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- referral to treatment period status

1.2.4 These data items have been available in CDSv6 since 31st December 2007 (as detailed in DSCN 18/2007).

1.2.5 At the beginning of the patient journey, the first organisation receiving the referral should generate a Patient Pathway Identifier (which may be based on the Unique Booking Reference Number (UBRN)). This along with the Organisation Code of that organisation i.e. the Organisation Code of the PPI Issuer should be used consistently to record the unique identifier for the pathway. The clock start date should also be recorded. Where the patient's RTT pathway or individual RTT periods within that pathway are delivered by more than one organisation, it is essential that the same PPI and Organisation Code of PPI Issuer are applied i.e. they do not change even where the responsibility for patient care transfers to a different organisation.

1.2.6 Where Choose & Book is in place, it is recommended that the UBRN is used to create the basis of the identifier for the pathway. In the absence of Choose & Book, the trust should generate a PPI. Note that in CDS flows, the PPI and the Organisation Code of PPI Issuer are separate fields, therefore, if the organisation code forms part of the generated PPI, then the Organisation Code of the PPI Issuer must also flow in the separate specific field within the CDS record for this purpose.

1.2.7 The data item Patient Pathway Identifier (PPI) defined in DSCN 18/2006 is an alphanumeric field of length 20 characters. It is important to ensure that any locally defined PPI is of an appropriate format for this field. If the patient is transferred to another provider during their RTT period, the receiving provider should use the same PPI and the same Organisation Code of PPI Issuer. If the UBRN is used as the basis for the PPI, then the 12 character UBRN must be padded to ensure it meets the required 20-character format required for submission to SUS. Therefore, the full 20 characters, including any local padding, should be transferred between providers via the IPTAMDS. See section 6.1.

1.2.8 Some clinical pathways can have two or more RTT periods. For example, a patient with a long term condition who has an initial treatment is subsequently monitored for several years before it is then decided that further treatment is required. The decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan will start a new RTT period (rule 3c – see paragraph 2.5.5). However, this will be for the same condition that initial treatment was given several years earlier. It is important to ensure that each RTT period can be uniquely identified. Each RTT period on the pathway can be uniquely identified by:

- i. Patient pathway identifier (PPI) or UBRN- based PPI
- ii. Organisation code issuing the PPI or UBRN (if a UBRN is used the organisation code is X09, the Organisation Code for NHS Connecting for Health)
- iii. RTT Period Start Date
- iv. Accurate recording of the RTT Period Status Code for the event at the time of the event

The second (or subsequent) RTT period should not be associated with the original referral date for the first RTT period (as this would produce an incorrect elongated RTT time).

1.3 Use of RTT statuses and clinical outcome sheets

1.3.1 RTT status is defined as "the status of an activity (or anticipated activity) for the RTT period, decided by the lead care professional" or in other words:

- whether each activity is part of an RTT pathway or not
- whether the activity has started an RTT clock, stopped an RTT clock or continued an existing ticking RTT clock.

There are 17 RTT statuses defined in DSCN 18/2006. These are:

The first activity in a REFERRAL TO TREATMENT PERIOD where the first treatment that is intended to manage a PATIENT's disease, condition or injury will be a subsequent activity

10 - first activity - first activity in a REFERRAL TO TREATMENT PERIOD

11 - active monitoring end - first activity at the start of a new REFERRAL TO TREATMENT PERIOD following active monitoring

12 - consultant referral - the first activity at the start of a new REFERRAL TO TREATMENT PERIOD following a decision to refer directly to the CONSULTANT for a separate condition

Subsequent activity during a REFERRAL TO TREATMENT PERIOD

- 20 - subsequent activity during a REFERRAL TO TREATMENT PERIOD - further activities anticipated
- 21 - transfer to another Health Care Provider - subsequent activity during a REFERRAL TO TREATMENT PERIOD anticipated by another Health Care Provider

Activity that ends the REFERRAL TO TREATMENT PERIOD

- 30 - first treatment - the start of the first treatment that is intended to manage a PATIENT's disease, condition or injury in a REFERRAL TO TREATMENT PERIOD.
- 31 - start of active monitoring initiated by the PATIENT
- 32 - start of active monitoring initiated by the CARE PROFESSIONAL
- 33 - failure to attend - the PATIENT failed to attend the first CARE ACTIVITY after the referral
- 34 - decision not to treat - decision not to treat made or no further contact required
- 35 - PATIENT declined offered treatment
- 36 - PATIENT died before treatment

Activity that is not part of a REFERRAL TO TREATMENT PERIOD

- 90 - after treatment - first treatment occurred previously (e.g. admitted as an emergency from A&E or the activity is after the start of treatment)
- 91 - active monitoring - CARE ACTIVITY during period of active monitoring
- 92 - not yet referred - not yet referred for treatment, undergoing diagnostic tests by GP before referral
- 98 - not applicable - ACTIVITY not applicable to REFERRAL TO TREATMENT PERIODS
- 99 - not yet known

1.3.2 To allow RTT measurement, the RTT status should be recorded at each stage on the patient journey by capturing information about what happened during each event. Most decisions about a patient's treatment take place within an outpatient setting. Therefore recording the RTT status of each patient as they leave their outpatient attendance enables the majority of events to be captured.

1.3.3 This can be done using "clinical outcome sheets". The date of the event also needs to be captured to allow the RTT time to be calculated. The RTT status data items then enable RTT start and stop times to be determined and hence measurement of the length of the RTT period.

1.3.4. The format of the "clinical outcome sheets" varies but it is important to record detail on the outcome of the outpatient attendance in terms of what had actually happened at the attendance (e.g. treatment in outpatients) and any intended next step on the patient pathway.

1.3.5 The 17 RTT status codes listed above are those that should be used within information systems. You may wish to use a different description of the codes on clinical outcome sheets. Alternatively you may wish to use a different set of codes than those specified in the DSCN, as long as your locally defined set of codes can be locally mapped back to the 17 RTT status codes defined in DSCN 18/2006. The important point is to ensure that the wording and descriptions used on clinical outcome sheets are interpretable by clinical and administrative staff. Clinical involvement in the process of designing the forms is essential.

1.3.6 Some trusts found it useful to disaggregate further with their local outcome codes. This provided valuable clinical information for use locally. It may be helpful to provide "scenario" guidance to aid the clinician in completing the form e.g. giving specialty specific examples of each of the outcome options.

1.3.7 The data from clinical outcome sheets is then transferred into the local IT system. This is generally done by data clerks/administrators and often forms part of the standard "cashing up" and routine administrative tasks carried out during/after a clinic.

1.3.8 Examples of clinical outcome sheets can be found in the attached document:



Clinic Outcome
Sheets

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1.3.9 The Referral to Treatment Period Status indicates the status at the end of the event that is flowing. However some IT systems hold two fields - the 'intended' status, and the 'actual' status. So, for events where the attendance has already happened, the CDS record would need to hold the 'actual' status, i.e. the status at the end of the appointment.

1.3.10 This would not be the case, however, for prospective appointments. If you are flowing RTT information in the Elective Admissions List CDS records with a "To Come In" (TCI) date in the future, where it is anticipated that First Definitive Treatment will take place, these would need to hold the 'intended' status. For EAL CDS records WITHOUT a TCI, then the only RTT status these could hold is the 'current actual' status.

1.3.11 The NHS Data Dictionary does not differentiate between 'actual' status and 'intended' status - the definition of Referral to Treatment Period Status allows both:

"The status of an activity (or anticipated activity) for the Referral to Treatment Period decided by the lead care professional".

However, system suppliers would need to hold both statuses in order to report accurately on historical activity, whilst also indicating that there is an anticipated First Definitive Treatment in the future.

2. Clock starts

2.1 Capturing clock starts

2.1.1 ***"RULE 1 - An RTT clock starts when any care professional or service permitted by an English NHS commissioner to make such referrals, refers to:***

a) 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 health professional or general practitioner;

b) an interface or referral management or assessment service, which may result in an onward referral to a consultant led service before responsibility is transferred back to the referring health professional or general practitioner."

2.1.2 Any organisation or service that receives referrals that fall into the criteria above will need to capture information about these patients and submit a referral to treatment (RTT) monthly return. This includes not only acute trusts but also specialist trusts, mental health trusts and local commissioners acting as providers.

2.1.3 The RTT clock start date is defined as the date that the provider receives notice of the referral. This date needs to be recorded so that the RTT time of the patient can start to be tracked. For Choose & Book referrals, this will be the date that the patient converts their UBRN (Unique Booking Reference Number), including where the referral is rejected by the chosen provider and subsequently re-referred. Where the slot unavailability process has operated, this will be the date that the provider receives electronic notification from the national Choose and Book Appointments Line that the patient has experienced slot unavailability. (Note that this is NOT the date that the Health Care Provider opens or actions the electronic notification.) For non-Choose & Book referrals, the clock starts on the date that the referral is received by the provider organisation.

2.1.4 It is important that clock starts can be accurately identified for all patients on an RTT pathway, including pathways that involve more than one provider organisation. Providers will need to ensure that they identify all inter-provider referrals clearly, as the clock start date for these referrals will **NOT** be the date the provider receives the referral (see section 6.1).

2.1.5 For RTT pathways that start within an interface service ("all arrangements that incorporate any intermediary levels of clinical triage, assessment and treatment between traditional primary and secondary care"), the correct clock start date will be the date that the interface service received the original GP referral and **NOT** the date that the onward referral from the interface service was received by the secondary care provider.

2.1.6 For Choose & Book patients who are referred to secondary care via an interface service, there may be two UBRNs (Unique Booking Reference Numbers) associated with the same pathway. When a second UBRN is created along the same RTT period this will be linked with the first UBRN and the date of conversion of the first UBRN will be the date of the RTT clock start. The RTT clock keeps ticking whilst the patient converts the second UBRN. The interface service should monitor the "Activity List" Worklist to ensure that patients have booked their second onward appointment in a timely manner. The identifier for the pathway will be the first UBRN and **NOT** the second UBRN.

2.1.7 There may also be the situation where the GP refers to an interface service not through Choose & Book but as a paper referral and the interface service refers on to a Provider using Choose & Book. In this scenario, the UBRN conversion date would **not** be the RTT start. The Inter Provider Transfer Administrative Minimum Data Set (IPTAMDS) should be attached with the Choose & Book referral so that the correct start date (i.e. the date that the original GP referral was received by the interface service) can be obtained by the receiving provider (see section 6.1).

2.1.8 All pathways reported should have a known clock start.

2.2 Clock starts for self referrals

2.2.1 ***"RULE 2 - An RTT clock also starts upon a self referral by a patient to the above services, where these pathways have been agreed locally by commissioners and providers and once the referral is ratified by a care professional."***

2.2.2 For self referrals that fulfil the criteria above, the clock should start on the date that the self referral is received by the provider. Please refer to section 2.1 for further details on capturing and recording clock starts.

2.3 Other clock starts

2.3.1 ***"RULE 3 - Upon completion of an RTT period, a new RTT 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 in to 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.

e) when a patient rebooks their appointment following a first appointment DNA that stopped and nullified their earlier clock."

2.3.2 Organisations must be able to capture RTT clock starts in the five situations described above.

2.3.3 Rule 3a – A bilateral procedure is defined as "a procedure that is carried out on both sides of the body, at matching anatomical sites". Examples include cataract removals and joint replacements. The first bilateral procedure will have its own RTT clock, which will stop on the date that the procedure is carried out (or the date that the patient is admitted for the procedure if it is to be carried out as an inpatient/day case admission). A new clock will start when the patient becomes fit and ready for the second bilateral procedure.

2.3.4 Rule 3b –Where further (substantively new or different) treatment may be required that was not already planned, a new RTT clock should start. This new clock will often start at the point the decision to treat is made and communicated to the patient. However, where a patient is referred for diagnostics or specialist opinion with a view to treatment it may be more appropriate to start the new clock from the point that the decision that diagnostics or specialist opinion is made – i.e. when it is decided to start the patient off on a new 'treatment pathway'. The clock will stop when this treatment is carried out (or when a clinical decision is made that the treatment is no longer required). A clock start of this type can occur at any follow-up outpatient appointment including during a routine follow-up of a patient with a long term condition. Therefore, clinical outcome sheets should be used for all outpatient appointments and not just those appointments for patients on an RTT pathway. Further information on clinical outcome sheets can be found in section 1.3.

2.3.5 Rule 3c – If a patient is re-referred in to a consultant-led; interface; or referral management or assessment service as a new referral, then this will start a new RTT clock. The clock starts on the date that the new referral is received by the provider. For Choose & Book referrals, this will be the date that the patient converts their UBRN (Unique Booking Reference Number), including where the referral is rejected by the chosen provider and subsequently re-referred. Where the slot unavailability process has operated, this will be the date that the provider receives electronic notification from the national Choose and Book Appointments Line that the patient has experienced slot unavailability. (Note that this is NOT the date that the Health Care Provider opens or actions the electronic notification). For non-Choose & Book referrals, the clock starts on the date that the referral is received by the trust (e.g. GP letter received by consultant's secretary).

2.3.6 Rule 3d – A patient's RTT clock will stop when commencing a period of monitoring in secondary care or at an interface service without clinical intervention or diagnostic procedures at that stage. If, subsequently, perhaps at a follow up outpatient appointment, a decision to treat is made, then a new RTT clock should start from the date that that decision is made and communicated to the patient. As with new clock starts for substantively new or

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different treatments, in some cases it may be appropriate to start a new clock before a 'decision to treat' is made, where, for example, there has been a decision to refer a patient for diagnostics/specialist opinion with a view to starting treatment. The clock will stop when this treatment is carried out (or when a clinical decision is made that the treatment is no longer required). A clock start of this type can occur at any follow-up outpatient appointment including during a routine follow-up of a patient with a long term condition. Therefore, clinical outcome sheets should be used for all outpatient appointments and not just those appointments for patients on an RTT pathway.

2.3.7 Rule 3e – If a patient DNAs their first appointment following the initial referral that started their RTT clock, provided that the provider can demonstrate that the appointment was clearly communicated to the patient, this will stop and nullify the RTT clock (for further information, refer to section 5.4). If the patient subsequently contacts the trust to rebook their first appointment, this will start a new RTT clock. The clock starts on the date that the patient contacts the trust and rebooks their new appointment.

2.3.8 If the patient has had one or more previous RTT periods for the same condition, it is important that the new clock start is identified and not linked to a previous RTT start date. Please refer to paragraph 1.2.6.

3. Clock pauses

3.1.1 ***"RULE 4 - A clock may be paused only where a decision to admit has been made, and the patient has declined at least 2 reasonable appointment offers for admission. The clock is paused for the duration of the time between the earliest reasonable offer and the date from which the patient makes themselves available again for admission."***

3.1.2 It is recognised that for some patients, being seen quickly is inconvenient or clinically inappropriate. Specifically, this relates to the following three types of patients:

- i. Patient choice – patients who choose not to accept earliest offered appointments along their pathway or choose to delay treatment
- ii. Co-operation - patients who do not attend appointments along their pathway
- iii. Clinical exceptions - patients with clinically complex conditions and/or co-morbidities unsuitable to be treated within the standard.

3.1.3 These three categories of patients will be dealt with by a combination of adjustments and an operational tolerance. Use adjustments/clock pauses to reflect patient choices during the admission for treatment phase of an admitted pathway. Adjustments **cannot** be applied to diagnostic admissions, on non-admitted pathways or during the non-admitted phase of an admitted pathway. The other elements above (patient choice for non-admitted activity, patient co-operation and clinical exceptions) will be covered by the operational tolerance. RTT performance will be judged on this basis across the whole of the NHS.

3.1.4 RTT clocks for admitted patients may be **paused** to take into account **delays** introduced because patients turn down offers of admissions (for treatment) made with reasonable notice. Adjustments do not apply to non-admitted pathways and do not apply to admissions which are not related to first definitive treatment.

3.1.5 Defining reasonableness – A reasonable offer of admission is defined as "an offer of a time and date three or more weeks from the time that the offer was made". Two or more reasonable offers should be made before a clock is paused. The offers should be on different days, rather than two slots offered on the same day.

3.2 When can adjustments be made?

3.2.1 An RTT clock may be paused only where a decision to admit for treatment has been made, and the patient has declined at least two reasonable offers for admission. Adjustments cannot be applied for a diagnostic or other admission prior to the admission for first definitive treatment.

3.2.2 Where a decision to admit for treatment has been made, many patients will choose to be admitted at the earliest opportunity. However, not all will. It would not be appropriate to *pause* a clock for patients who cannot commit to come in at short notice. A clock may only be paused therefore when a patient has turned down two or more 'reasonable offers' of admission dates.

3.2.3 If a patient declines these offers and decides to wait longer for their treatment, then their clock may be paused from the date of the earliest reasonable offer and should restart from the date that a patient makes themselves available again for admission.

3.2.4 If a patient cancels their appointment in advance, this has no effect on the RTT time. The RTT clock should continue to tick and no adjustment should be made.

3.3 Monitoring of adjusted RTT times

Monthly RTT data

3.3.1 The submission of adjusted monthly RTT data in addition to unadjusted data has been mandatory since March 2008.

3.3.2 Data for completed admitted pathways should be submitted on the adjusted data form. Where a clock pause was applied along the pathway, the adjusted RTT time should be reported. For pathways where no clock pause occurred, the unadjusted RTT time should be reported. The total number of completed pathways reported in the adjusted data monthly form should equal the total number of completed pathways reported in Part 1a (completed admitted pathways) of the usual monthly RTT return.

Options for identifying the duration of the pause

3.3.3 An RTT clock may be paused only where a decision to admit for treatment has been made, and the patient has declined at least two reasonable offers for admission. Patient Pauses only apply to activity where First Definitive Treatment is expected to take place during an admission – they cannot be applied to outpatient waits.

3.3.4 If a patient has declined two or more reasonable offers of admission dates, the RTT clock may be paused from the date of the earliest reasonable offer. The RTT clock should restart from the date that a patient makes themselves available again for admission.

3.3.5 The "Earliest Reasonable Offer Date" (EROD) data item, which was introduced into Commissioning Data Sets v6 from October 2007 (see Data Set Change Notice 09/2007 for further information), can be used to record the earliest reasonable offer given to the patient. The value in this field can then be used as the start date of the clock pause, where a pause is applicable. The Patient Pause lasts from between the EARLIEST REASONABLE OFFER DATE that the patient was offered to attend for an admission, until the patient makes themselves available for treatment again.

3.3.6 The clock restart date (i.e. the end of the pause) should be the date that the patient makes themselves available again. The date of admission accepted by the patient can be used but only if:

- The clock restart date is clearly communicated to the patient.
- The time between the patient becoming available and the admission date is limited

3.3.7 Within SUS, earliest reasonable offer date is used to apply a Patient Pause and hence 'adjust' the waiting time in this way. However, the duration of the Patient Pause is calculated as the difference between the earliest reasonable offer date and the start date (hospital provider spell). This means that providers should make every effort to ensure that the guidance in 3.4.4 above is followed in respect of communication with patients and the time between the patient becoming available and the date of their admission.

3.3.8 An RTT clock cannot be paused because of a patient cancellation. However, the rebooking process resulting from a patient cancellation may result in a clock pause. Details are given in paragraphs 3.3.9 to 3.4.11.

3.3.9 If a patient has previously agreed to a reasonable offer date for admission for treatment which they subsequently cancel (prior to the admission date), the patient cancellation does not stop or pause the RTT clock. However, as part of the rebooking process, the patient should be offered alternative dates for admission. If at the rebooking stage the patient declines two or more reasonable offers, then the RTT clock can be paused. The clock is paused on the date of the earliest reasonable offer given as part of the rebooking process.

3.3.10 If a patient's clock is already paused (because they have previously declined two or more reasonable offers of admission for treatment) and the patient wishes to cancel their previously agreed admission date, then the patient's clock should still be paused and the start of the pause will remain unchanged (it will still be the earliest reasonable offer given as part of the original booking process). The end of the pause will be the new date that the patient states they are now available from.

3.3.11 From a technical perspective, if the Earliest Reasonable Offer Date (EROD) field is already populated and the patient cancels their admission, then EROD remains the same (i.e. clock pause unchanged). If the EROD field

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is blank and the patient declines two or more reasonable offers following a patient cancellation, then EROD becomes the earliest reasonable offer given as part of the rebooking process following the patient cancellation.

3.3.12 If the Health Care Provider wishes to apply a patient pause to a referral to treatment period as calculated within SUS, then the earliest reasonable offer date field must be populated in the Admitted Patient Care General Episode CDS record where the patients RTT clock stops (the record that also carries the referral to treatment period end date and a referral to treatment status indicating a clock stop, codes 30-36). If a Patient Pause is NOT to be applied, then earliest reasonable offer date must not be populated in the CDS record containing the referral to treatment period end date or referral to treatment status 30-36, as this would cause an erroneous adjustment to the calculated waiting time within SUS.

4. Clock stops for treatment

4.1 "RULE 5 - A clock stops when:

a) First definitive treatment starts. This could be:

- i. Treatment provided by an interface service;*
- ii. Treatment provided by a consultant-led service;*
- iii. 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."

4.2 Capturing clock stops for treatment in outpatients or other consultant-led services

4.2.1 The use of clinical outcome sheets will enable these clock stops to be captured. Further information on clinical outcome sheets can be found in section 1.3 above. The clock stop date will be the date of the appointment at which first definitive treatment started. An outcome signifying treatment should be recorded on the clinical outcome sheet. The RTT status code "30 – first treatment – the start of the first treatment that is intended to manage a PATIENT's disease, condition or injury in a REFERRAL TO TREATMENT PERIOD" should be recorded in systems.

4.3 Capturing clock stops for treatment as inpatient/day case

4.3.1 Generally, an inpatient or day case admission for a patient on a RTT pathway will signify a clock stop. However, the following situations would not stop the clock:

- Patient admitted for diagnostic test or procedure only
- Patient admitted for pre-treatment prior to first definitive treatment
- Patient admitted for pre-op assessment only
- Patient admitted for first definitive treatment but intended procedure is not carried out during admission.

4.3.2 In addition, a proportion of inpatient admissions will be for patients that are not on an RTT pathway (e.g. emergency admissions from A&E or follow-up regular planned admissions for dialysis etc.).

4.3.3 Therefore, it is necessary to identify if:

- i. the patient is on an RTT pathway
- ii. the admission is for first definitive treatment

4.3.4 Once clinical coding has taken place, it will be possible to definitively identify which inpatient admissions are for diagnostic purposes only. However, clinical coding may not be timely enough for the purposes of RTT measurement. Therefore, business processes should be put in place to allow the identification of diagnostic admissions.

4.3.5 If definitive treatment is given during what had originally been intended as a diagnostic admission, an outcome signifying treatment should be recorded. The RTT status code "30 – first treatment – the start of the first treatment that is intended to manage a PATIENT's disease, condition or injury in a REFERRAL TO TREATMENT PERIOD" should be recorded in systems.

4.3.6 For inpatient/day case admissions for first definitive treatment, the clock stops on the date that the admission occurs. It is recognised that in some cases treatment may not start until the day after admission (or possibly later). However, for simplicity and pragmatism, the clock stop should be recorded as the admission date.

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4.3.7 If the patient is admitted for first definitive treatment but the treatment is not carried out, then the clock should not be stopped unless a clinical decision is made that the patient no longer requires treatment. Examples include:

- i. Patient admitted for first definitive treatment on 1 February. Surgery cancelled (due to lack of theatre availability). Patient sent home with new TCI date of 5 February. RTT clock should not stop until the day of admission for the surgery when it is eventually carried out.
- ii. Patient admitted for first definitive treatment on 1 February. Surgery cancelled (patient is temporarily unfit due to chest infection). Patient sent home with a new TCI date of 10 February. RTT clock should not stop until the day of admission for the surgery when it is eventually carried out.
- iii. Patient admitted for first definitive treatment on 1 February. After admission, it is discovered that patient is not clinically suitable for operation. Situation is discussed with patient and it is agreed that the surgery will not be carried out. Patient is discharged back to primary care. In this scenario, this is a clock stop when a clinical decision not to treat is made and communicated to the patient.

4.4 Capturing clock stops for treatment in interface service

4.4.1 An interface service is defined as "All arrangements that incorporate any intermediary levels of clinical triage, assessment and treatment between traditional primary and secondary care." Paragraph 1b of the national clock rules states that a referral to an intermediate service starts an RTT clock. If the interface service subsequently provides first definitive treatment for the patient, then this will be an RTT clock stop. The clock stops on the date that first definitive treatment starts within the interface service.

4.4.2 The provider organisation that runs the interface service is responsible for recording and reporting RTT times for all relevant patients. This data should then be reported on the organisation's provider-based RTT return.

4.4.3 Therefore, business process and systems should be in place to capture RTT clock stops that occur within the interface service. This may be achieved using "outcome sheets" for all attendances at the service. Further guidance on outcome sheets can be found in section 1.3 above.

4.5 Capturing clock stops due to the patient being added to a transplant list

4.5.1 If a clinical decision is made to add the patient to a transplant list, this will stop the RTT clock. The clock stops on the date that this decision is made and communicated to the patient. The patient's GP and/or other referring practitioner should also be informed without undue delay.

4.5.2 It is likely that such a clock stop will occur during an outpatient appointment. If this is the case, then the use of clinical outcome sheets will enable these clock stops to be captured. Further information on clinical outcome sheets can be found in section 1.3 above. The clock stop date will be the date of the appointment at which the decision was made and communicated to the patient. The RTT status code "34 – Decision not to treat – decision not to treat made or no further contact required" should be recorded in systems. The use of code 34 does not signify that the patient should necessarily be discharged or returned to primary care – in this scenario, it simply indicates that the patient is no longer waiting electively (i.e. on a waiting list) but is waiting for a transplant.

5. Clock stops for “non-treatment”

5.1.1 ***RULE 6 - An RTT 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 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 RTT clock, provided that the provider can demonstrate that the appointment was clearly communicated to the patient . (DNAs for a first appointment following the initial referral that started an RTT clock nullify the patient's clock (i.e. it is removed from the numerator and denominator for Referral to Treatment time measurement purposes)).

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

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, publicly available, policies on DNAs;

iv) These local policies are clearly defined and specifically protect the clinical interests of vulnerable patients (e.g. children) and are agreed with clinicians, commissioners, patients and other relevant stakeholders.”

5.2 Decisions in outpatients that stop an RTT clock

5.2.1 Clinical decisions made during outpatient appointments may stop an RTT clock without treatment. These include the four described at a) to d) above, namely when it is communicated to the patient 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 a period of active monitoring;

c) A patient declines treatment having been offered it;

d) A clinical decision is made not to treat.

5.2.2 These decisions should be captured on the clinical outcome sheet. Section 1.3 provides further information on the use of clinical outcome sheets. The clock stop will be the date that the decision is made and communicated to the patient, i.e. the date of the outpatient attendance.

5.3 Capturing clock stops that occur outside an outpatient attendance or inpatient admission

5.3.1 Although the majority of clinical decisions take place during face to face consultation with the patient (e.g. during an outpatient attendance), some decisions do not. Specific examples of such events include:

- i. Patient with current RTT status of 20 (subsequent activity during an RTT period) attends appointment for diagnostic tests. Test results are normal and therefore no further treatment required. This information is communicated to the patient via a telephone call from the consultant's secretary. RTT status now needs updating to 34 (decision not to treat made).
- ii. Patient with current RTT status of 10 (first activity in an RTT period) attends first outpatient appointment. Consultant suggests surgery will be the best option and patient is added to inpatient waiting list. Several days later, patient decides they do not want to go ahead with surgery and calls the hospital to cancel their proposed treatment and also declines any other treatment. RTT status now needs updating to 35 (patient declined offered treatment).
- iii. Patient with current RTT status of 20 (subsequent activity during an RTT period). Patient dies and relative informs hospital that the death has occurred. RTT status now needs updating to 36 (patient died before treatment).

5.3.2 An event which results in a clock stop that occurs outside of the events that are defined in the CDS output (typically Outpatient or Inpatient encounters) is termed an "administrative event". DSCN 03/2009 introduced CDSv6-1. This CDS version includes support for the Administrative Event introducing new code values for First Attendance which allow submission of an Administrative clock stop via the Outpatient CDS type 020 where activity takes place outside a face-to-face or telemedicine patient contact.

5.3.3 Non-outpatient clinical outcomes may be captured using outcome sheets. Clock stops resulting from 'administrative events' may then be recorded on PAS systems where this is possible or imported into a data warehouse to be matched to, and stop the clock of, the relevant RTT pathway.

5.3.4 The introduction of the ability to submit a Commissioning Data Set type 020 Outpatient record with an additional value of 5 for 'first attendance' will enable these administrative events to be recorded uniformly within the Commissioning Data Set and hence within SUS.

5.3.5 The additional value 5 for first attendance means that the National codes for first attendance are:

- | | |
|---|---|
| 1 | First attendance face to face |
| 2 | Follow-up attendance face to face |
| 3 | First telephone or telemedicine consultation |
| 4 | Follow-up telephone or telemedicine consultation |
| 5 | Referral to Treatment administrative clock stop event |

5.3.6 The RTT clock stop administrative event functionality within SUS is such that an administrative event record must be part of a record containing the required fields for accurate SUS RTT reporting and the fields mandated by CDS schema. Details of these required fields may be found in the NHS Data Dictionary. For example, a record flowing such an event which does not carry populated Patient Pathway Identifier, Organisation Code of PPI Issuer, RTT Period End Date and RTT Period Status Code attributes (see 5.3.6 below) will not be applied in SUS RTT processing.

- The administrative event will only be used to close open RTT periods (i.e. it is not possible to retrospectively adjust the end date of closed RTT periods).
- An administrative event that cannot be matched to an existing open RTT period will not be applied.

5.3.6 The addition of the new value of '5' for the First Attendance field is designed to be used to allow the identification of an RTT clock stop in order to avoid an unnecessary appointment taking place and would encompass the specific reasons list below:-

- | | |
|----|--|
| 31 | Active monitoring initiated by the patient |
| 32 | Active monitoring initiated by Care professional |
| 34 | Decision not to treat or no further contact required |

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35	Patient declined offered treatment
36	Patient died

5.4 Clock stops for DNAs (Did Not Attends)

5.4.1 If a patient DNAs their first appointment following the initial referral that started their RTT clock, provided that the provider can demonstrate that the appointment was clearly communicated to the patient, this will nullify the RTT clock (i.e. it is removed from the numerator and denominator for Referral to Treatment time measurement purposes).

5.4.2 If a patient DNAs any other appointment and is subsequently discharged back to the care of their GP, this will stop the RTT clock, provided that:

- 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, publicly available, policies on DNAs;
- iv. These local policies are clearly defined and specifically protect the clinical interests of vulnerable patients (e.g. children) and are agreed with clinicians, commissioners, patients and other relevant stakeholders.

5.4.3 If the above criteria are fulfilled, then the RTT clock stops on the date that the patient is discharged back to the care of their GP.

5.4.4 Previous guidance on RTT rules referred to the special case of children who DNA. These rules do not distinguish between adults and children. Provided that local DNA policies are clearly defined and specifically protect the clinical interests of vulnerable patients, such as children, and that these policies are agreed with clinicians, commissioners, patients and other relevant stakeholders, then the DNA rules above apply to all patients, including children.

6. Other Measurement Issues

6.1 Inter-provider transfers / multi-provider pathways

6.1.1 If a patient is referred from one provider to another during their RTT period (e.g. a pathway that includes a referral to a tertiary centre), these patients should still be reported on the RTT return. The provider trust who holds current clinical responsibility for the patient (i.e. at the time when the data snapshot is taken) should report the RTT time. If a patient is referred from one provider to another as part of their RTT period, their RTT clock continues to tick until they are treated within the receiving provider (or a decision is made that treatment is no longer required).

6.1.2 It is important that the correct start date is captured for patients who are received as inter-provider transfers. For example, patient's original referral from GP was received by an interface service on 2 January. After carrying out initial assessment, the interface service decided to refer patient on to an acute trust for treatment. The acute trust receives referral on 28 January. The acute trust should record the RTT start date for this patient as 2 January, not 28 January.

6.1.3 The "Inter-Provider Transfer Administrative Minimum Data Set" (IPTAMDS) aids providers receiving patients mid-way along their RTT pathway, including tertiary centres. The purpose of the IPTAMDS is to ensure that the administrative RTT data required to enable the receiving provider to report on the patient pathway, is transferred from the referring provider to the receiving provider when responsibility for a patient's care has transferred. In particular, the referring provider must ensure that the patient's initial RTT clock start date forms part of the onward referral information.

6.1.4 An IPTAMDS is mandated for completion when:

- i. The care of a patient on an RTT pathway transfers between healthcare providers. This includes transfers to and from Independent Sector providers where this transfer is part of NHS commissioned care.
- ii. A request for a clinical opinion results in the patient's care being transferred to an alternative provider.
- iii. RTT pathways commissioned by English NHS commissioners independent of location.

6.1.5 For RTT pathways, use of the IPTAMDS is mandatory for transfers between interface services and secondary care providers, as well as transfers between secondary and tertiary providers.

6.1.6 Consider the example of a patient with knee pain who sees their GP and is referred to an orthopaedic surgeon in secondary care. The consultant sees the patient, diagnostic tests are performed and the consultant agrees with the patient that based on the diagnostic results that their care should be transferred to a specialist centre:

- The IPTAMDS must be completed and is populated with the mandated data items including:
- 20 character locally generated Patient Pathway Identifier – note that the member of staff responsible for completing the IPTAMDS must be aware that although on screen, he/she may be viewing, for example, a 15 character PPI, the PAS holds a 20 character PPI and the IPTAMDS must show the full 20 characters.
- Organisation Code of the provider issuing the PPI.
- RTT Status Code – the referring provider should enter Status Code 20 on the form to the receiving provider. This allows the receiving provider to ensure that they are aware that the RTT period remains open.
- The referring provider should also enter RTT Status Code 21 on the local PAS in order to nullify the clock for PTL purposes at the referring organisation since responsibility for the patient and the RTT period has now passed to the receiving (tertiary) provider.

6.1.7 On receipt of the IPTAMDS, the tertiary centre edits the PPI field in their PAS to ensure that the 20 character PPI present on the IPTAMDS is entered, the Organisation Code of the PPI Issuer is entered and the RTT start Date is entered from the IPTAMDS as the date the referral was received by the secondary care provider from the GP.

6.1.8 The tertiary centre enters RTT Status Code 20 on the PAS unless the patient is added directly to an admission list for treatment or it is known that the patient will receive their first definitive treatment at the first outpatient attendance within the tertiary centre. Either of these will allow the 'intended status' of 30 to be added to

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PAS. Subsequent Admitted Patient Care or Outpatient CDS flows will carry the actual RTT Status 30 in these examples.

6.1.9 Section 2.2 described the use of Patient Pathway Identifiers (PPIs). It is important to ensure that PPIs used for pathways that involve more than one provider transferable between providers. The data item "Patient Pathway Identifier" defined in DSCN 18/2006 should be used to store the PPI. This field is of length 20 and is alpha numeric. If you are defining PPIs locally, it is important to ensure that they are in the right format for this field so that they are transferable between providers. Where Choose & Book is in place, the UBRN can be used instead of a locally generated PPI. In the absence of Choose & Book, a locally defined PPI should be defined by the originating provider (i.e. the first provider on the pathway).

6.1.10 Further information on the IPTAMDS can be found in ISB standard 0112 (replacing Data Set Change Notices (DSCN) 44/2007 and 07/2008), which can be found at: <http://www.isb.nhs.uk/library/all>

6.2 Ensuring accurate reporting

6.2.1 Providers are responsible for the proper validation of any patient who may have an incomplete RTT pathway.

6.2.2 It is important that clock starts can be accurately identified for all patients on an RTT pathway. However, in the unlikely event that the provider may not be able to accurately identify the RTT clock start date, patients can be reported on the RTT return in the "unknown clock start" column. It is important that receiving providers ensure that initiating providers supply adequate information when transferring patients via IPTAMDS (see 6.1 above)

If the validation of pathways establishes that some RTT pathways have already been completed (i.e. clock stop in a previous month), **these should not be added to the monthly reporting of completed RTT pathways reporting** unless the clock stops in that reporting period.

7. Fulfilling national reporting requirements

7.1 Monthly RTT data

7.1.1 For the national data collection, all NHS Trusts that provide services that fall within the scope of RTT are mandated to provide RTT data to DH. Primary Care Trusts (PCTs) are required to check and sign off the data for their commissioned patients through Unify2, DH's online data collection system.

7.1.2 The national data collection looks at RTT waiting times in weeks, split by treatment function. The data collection template is in three sections:

Part 1a - Completed pathways – admitted patients

RTT times for patients whose RTT clock stopped during the month with an inpatient or day case admission.

Part 1b - Completed pathways – non-admitted patients

RTT times for patients whose RTT clock stopped during the month for reasons other than an inpatient or day case admission.

Part 2 - Incomplete pathways

RTT times so far for patients whose RTT clock is still running at the end of the reporting month. This is a "snapshot" on the last day of the reporting period.

7.1.3 Further information and guidance on the RTT data collection can be found via the following link:

<http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Perfomedataandstatistics/ReferraltoTreatmentstatistics/index.htm>

NHS users can find further details on the Unify2 forum at:

<http://nww.unify2.dh.nhs.uk/InstantForum414/Forum10000540-1.aspx>

8. Further information

8.1 Further information on RTT measurement and data collection can be found on the DH website:

<http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Perfomedataandstatistics/ReferraltoTreatmentstatistics/index.htm>

And for Unify2 users at:

<http://www.unify2.dh.nhs.uk/Unify/interface/homepage.aspx>

Information on Data Set Change Notices (DSCNs) can be found at:

<http://www.isb.nhs.uk/library/isn>

8.2 How to contact us:

For queries on RTT measurement and data collection:

RTTdata@dh.gsi.gov.uk

For queries on NHS data standards:

datastandards@nhs.net

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First published 2006

Published to Delphi, in electronic format only.