NHS England

Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care:

Frequently Asked Questions

Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care: Frequently asked questions

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Introduction

This document contains frequently asked questions to support the *Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care* guidance (Gateway reference 04113).

Frequently asked questions

1.1 Clock starts

Q1. When does the RTT clock start for patients who transfer in from other parts of the UK (or from outside the UK)?

For patients whose pathway has already started outside of England but subsequently become the responsibility of an English commissioner (for example, where the patient moves from Scotland to England), the RTT clock will start on the date that the new provider receives the referral, after clinical responsibility for the patient's care has transferred to an English NHS commissioner.

Whilst a patient's RTT clock cannot be back dated to start from the time that they were originally referred for treatment by a non-English commissioner, English commissioners should be aware of how long patients have already waited and look to treat them without undue delay and according to their clinical need.

Q2. If a non-consultant working in secondary care refers a patient to a consultant led service within secondary care, does this start an RTT clock?

Yes, a waiting time clock starts when any care professional or service permitted by an English NHS commissioner refers to a consultant-led service.

Q3. Private patients who transfer to NHS care – when does the RTT clock start?

For patients that are seen privately but then transfer to the NHS, if they are transferring on to a RTT pathway, the RTT clock should start at the point at which the clinical responsibility for the patient's care transfers to the NHS, in other words, the date when the NHS trust accepts the referral for the patient.

Q4. Are referrals from A&E covered by RTT measurement?

Elective referrals to consultants from A&E (for example, patient attends A&E after a fall at home, A&E consultant suspects patient also has a cataract and refers them for an ophthalmology consultant outpatient appointment) are covered by RTT measurement.

However, emergency admissions from A&E (e.g. heart attack patient admitted to critical care unit following initial treatment in A&E) or planned follow-ups at A&E (e.g. patient to attend A&E clinic in two weeks for removal of stitches) would not start an RTT clock.

Q5. Are fracture clinics covered by RTT measurement?

No. In general, activity carried out in fracture clinics is planned care following initial treatment/stabilisation of the fracture in A&E and so is out of scope of RTT measurement. Planned care means an appointment /procedure or a series of appointments/ procedures as part of an agreed programme of care which is required for clinical reasons to be carried out at a specific time or repeated at a specific frequency. Examples include a check-up x-ray two to three weeks after the fracture has occurred to check that it is healing as intended.

Although activity in fracture clinics is out of scope of RTT measurement, an attendance at a fracture clinic could initiate a new RTT clock start if an elective referral is made at a fracture clinic to a service that is covered by RTT measurement.

Q6. How should bilateral procedures be handled under RTT measurement rules?

A bilateral procedure is a procedure that is performed on both sides of the body at matching anatomical sites. Examples include cataract removals and hip or knee replacements.

Consultant-led bilateral procedures are covered by RTT measurement with a separate clock for each procedure. The RTT clock for the first consultant-led bilateral procedure will stop when the first procedure is carried out (or the date of admission for the first procedure if it is an inpatient/day case procedure). When the patient becomes fit and ready for the second consultant-led bilateral procedure, a new RTT clock will start.

Q7. What should I do for referrals which are booked having been on the Appointment Slot Issues (ASI) worklist, with regards to reporting RTT clock starts?

The date on which the UBRN appears on the ASI work list is the consultant-led RTT clock start. Under an ASI scenario providers are required to book an appointment when capacity is available. In these circumstances, if the booking is made electronically through the NHS e-Referral Service, the date of the booking transferred to the PAS may be used as the RTT clock start date in some systems. If the appointment is booked more than a day after receipt of the referral, the (later) date sent to the PAS will not be correct for RTT clock start and a manual adjustment will need to be made to show the correct clock start. This will be either the date on which the referral appeared on the ASI work list, or the date of any earlier booking if, for example, the referral had come through an interface service.

1.2 Clock stops

Q8. NHS patients who choose to transfer to the private sector, when does their RTT clock stop?

The RTT clock stops for patients who choose to leave NHS-funded care and to fund their own care in the private sector. The clock stops on the date that the patient informs the provider of this decision. Seeking a second opinion from an independent sector clinician will not stop a clock, unless the patient informs the NHS provider that they have chosen to leave NHS-funded care. For patients who are treated in the private sector under NHS commissioning arrangements (in other words, they are NHS patients whose care has been funded by the NHS and commissioned by the NHS from the private sector), the clock continues to run until one of the clock stop events outlined in the RTT Rules Suite takes place (for example, first definitive treatment commences or the patient is referred to primary care for non consultant-led treatment in primary care).

Q9. If a patient on an RTT pathway is admitted as an emergency, does this stop the RTT clock?

If the patient has the procedure that they were waiting for electively carried out after the emergency admission, then the RTT clock would stop.

If the patient is admitted as an emergency but does not have the procedure they were waiting for electively carried out, then their original RTT clock does not stop.

Three scenarios may now apply:

- If, as a result of their emergency admission, the patient is no longer fit to have the original procedure they were waiting for and a clinical decision is made to refer the patient back to primary care, then this decision would stop the original RTT clock. The clock stops on the date that the decision is made and communicated to the patient.
- If the patient is deemed to be temporarily unfit due to the circumstances around their emergency admission (for example, patient admitted as an emergency overnight with a chest infection) but the consultant decides to keep the patient under review, pending a return to fitness, then the patient could be classified as being under active monitoring, and if so, the RTT clock would stop (see section 4.4.1.4 of the main guidance).
- If the patient is deemed to be temporarily unfit due to the circumstances around their emergency admission (for example, patient admitted as an emergency overnight with a chest infection), but the consultant decides to retain the patient for the procedure for which they were originally waiting. In this case, the RTT clock would continue to tick.

Q10. How do we identify clock stops for first definitive treatment on complex pathways where multiple treatment options are carried out or considered?

The RTT clock stops at the start of first definitive treatment. First definitive treatment is defined as 'an intervention intended to manage a patient's disease, condition or injury and/or avoid further intervention'.

In complex pathways, such as genetics pathways or mental health pathways, it may be difficult to identify the start of first definitive treatment. However, what constitutes first definitive treatment is a clinical decision and must be decided locally. It would not be appropriate for NHS England to issue guidance centrally on what constitutes first definitive treatment for individual patient pathways.

Where multiple treatment options are considered along a pathway, once first definitive treatment has started and the initial RTT clock has stopped, a new clock should start if there is a decision to do something new or substantively different to what has already been agreed in the patient's care plan.

Q11. What is the difference between a clock stop for active monitoring and a clock stop because of a decision not to treat?

Some patients will receive a clinical diagnosis, and may well require treatment in the future, but the precise nature and timescale of any treatment is not yet known (for example, surgery to correct a spinal deformity is likely to be necessary but cannot take place until a certain level of skeletal maturity has been attained). If these patients are kept under review by the secondary care clinician, then the clock should stop for active monitoring on the date that the clinical decision is made and communicated with the patient.

Some patients will definitely require (and have agreed to) a specific procedure which clinically can only be carried out at a clearly defined point in the future (for example, a child will require a dental brace but their teeth are not yet developed enough). These patients should be added to the planned waiting list, and the RTT clock stops at the point that the clinical decision not to treat is made and communicated to the patient and their GP (or other original referrer).

In between these two categories there are a number of other possible situations, for example:

- patients who are told they will definitely need treatment at a point in their disease progression, which has no specific date attached;
- patients who are told they will probably need treatment when they reach a certain age, but the exact nature of the treatment will be decided then, or;
- patients who have been offered treatment but wish to wait for a defined period to see how they get on.

In these situations, as well as taking a clinical view, providers should consider the patient's view in deciding whether a clock stop for a decision not to treat (and adding the patient to a planned list) or a clock stop for active monitoring is appropriate, i.e.

does the patient think that the next step is a specific treatment in x months' time, or a review/decision about treatment?

Q12. For cardiac pathways that include warfarin prescription in advance of a procedure, when does the RTT clock stop?

Whilst this is ultimately a local clinical decision, it seems legitimate to define the prescription of warfarin as the start of first definitive treatment and hence stop the RTT clock at this point.

Q13. When an injection is required prior to surgical intervention, which procedure stops the RTT clock?

In general, an injection that is preparation for treatment or provides pain relief does not stop an RTT clock. However, what constitutes first definitive treatment is a matter for clinical judgement, in consultation with others as appropriate, including the patient.

In cases where treatment is a two-stage process which begins with an injection, the clock should stop when the injection is administered, providing that the consultant clearly explains to the patient that treatment is a two-stage process. The patient should be in no doubt that the injection is the start of treatment and causes their RTT clock to stop. Additionally, there should be no undue (non-clinical) delay for the second stage of the treatment. If second or subsequent stages of treatment are delayed, then a new clock should start (see section 5 of the main guidance).

Q14. Does the prescription of drugs stop an RTT clock?

An RTT clock stops when first definitive treatment takes place (this could be either in an interface service or a consultant-led service). First definitive treatment is defined as being 'an intervention intended to manage a patient's disease, condition or injury and avoid further intervention'.

Often, first definitive treatment will be a medical or surgical intervention. However, it may also be judged to be other elements of the patient's care, for example, the start of counselling or the prescription of drugs to manage a patient's disease, condition or injury.

The prescription of drugs to prepare a patient for definitive treatment (for example, pain relief) does not stop an RTT clock.

In all cases, what constitutes first definitive treatment is a matter for clinical judgement, in consultation with others as appropriate, including the patient. Where the prescription of drugs is deemed to have stopped an RTT clock, this should be communicated to a patient.

Q15. Does a referral for an organ transplant stop an RTT clock?

When a clinical decision is made, and has been communicated to the patient and their GP, to add a patient to an organ transplant list this will stop the RTT clock:

- This applies to matched transplants (for example, kidney, liver) where the clock should stop at the point of adding the patient to a transplant list (after completion of work-up where relevant), and informing the patient and referring clinician of this. Once matched tissue becomes available, a new clock starts and is stopped at the point at which the patient is treated.

- For unmatched transplants (for example, many corneal grafts) the 18-week clock should stop when the transplant surgery takes place.

- For live kidney donor recipients who are not intending to go on the national waiting list for a deceased donor, the clock stops when they are considered fit for receipt of a live donor kidney (not the date of surgery).

The following advice applies for living organ donors:

Clock starts: When the person puts themselves forward to start formal work-up for donation (for example, blood taken for blood group). This would follow provision of education, information and so on which all precede the clock start.

Clock stops:

a) Donor work-up completed, Human Tissue Authority assessment done, transplant operation has taken place.
b) Donor work-up completed but recipient seriously unwell or not yet ready. Donor clock would then stop as 'active monitoring'. When the recipient is subsequently considered well enough to proceed, a new clock should start.
c) Donor work-up completed but recipient not suitable for transplantation. Donor clock would then stop as 'discharged'. Clocks shouldn’t stop necessarily for co-morbidities where patient is waiting for opinion from other consultant (for example, cardiac) for suitability of operation and so on.
d) Donor deemed not suitable for donation following work-up. Donor clock would then stop as 'discharged'.
e) Patient doesn't now want to donate ('discharge').
f) Patient wants to delay/take stock/think about it (‘active monitoring’).
g) Work-up completed but another family member is a more suitable donor. Clock would stop as either ‘discharged’, or ‘active monitoring’ if there is a chance the other donor won’t go through.

Q16. How are inpatient admissions for diagnostic procedures dealt with for RTT measurement?

Generally, an inpatient or day case admission signifies the start of treatment and hence an RTT clock stop. However if the inpatient/day case admission is for a diagnostic procedure only, then this does not stop the RTT clock, which continues to tick until a decision to treat or not treat is made.

Broadly speaking, there are three possible outcomes of an admission for a diagnostic procedure:

- non-admitted clock stop – for example, where test results are normal and it is decided that no further treatment is required;

- admitted clock stop – if definitive treatment is given during what had originally been intended as a diagnostic admission;
- clock continues to tick.

1.3 Recording RTT waiting times: interface services

Q17. Are referrals to interface services or referral management centres covered by RTT?

Yes. A referral to an interface service (as defined in section 6 of the main guidance) starts an RTT clock. The clock starts on the date that the referral is received by the interface service.

There are two main reasons why a referral to an interface service starts an RTT clock. These are:

- where a patient is referred by their GP (or other referrer) to an intermediate service, which may, as a result, onward refer the patient to a consultant-led service, then the patient is most likely to perceive their wait as starting from the point that the GP made the original referral;
- where consultant-led services have been brought out of their traditional setting, often with a view to treating patients closer to home, outside of hospital, these services should also be recorded and reported, because they are consultant-led.

Q18. Are pathways that end in interface services covered by RTT measurement?

Yes. A referral to an interface service starts an RTT clock. If the patient is subsequently treated within the interface service, then this would stop the RTT clock (on the date that treatment starts). If it is decided that no treatment is required and the patient is referred back to their GP, this would also stop the clock (on the date that this decision is made and communicated with the patient). Alternatively, the patient may be referred on to secondary care by the referral management centre – in which case the RTT clock would continue to tick until the patient is eventually treated (or a decision is made that no treatment is required) within secondary care.

The organisation that commissions the interface service is responsible for ensuring the correct recording and reporting of RTT waiting times for all relevant patients by all relevant providers. This includes the submission of data by interface services as set out in section 3.2.2 of the main guidance.

Q19. When does the clock stop for pathways that involve interface services?

Where a patient is referred to an interface service:

- If the patient is subsequently treated within the interface service, then this would stop the RTT clock (on the date that first definitive treatment starts).
- If it is decided that no treatment is required or that treatment will be delivered within primary care and the patient is referred back to their GP, this would also stop the clock (on the date that this decision is made and communicated with the patient).

- Alternatively, the patient may be referred on to secondary care by the interface service – in which case, the RTT clock would continue to tick until the patient is treated (or a decision is made that no treatment is required) within secondary care.

Q20. If an interface service refers a patient on to a non consultant-led service for treatment, does this stop the RTT clock?

If the non consultant-led service is within a primary care setting, then the clock will stop on the date that the decision to refer back to primary care is made and communicated to the patient. If the service the patient is referred on to is within the interface service itself or is within secondary care, then the RTT clock will not stop until first definitive treatment commences within this service.

1.4 RTT measurement inclusions and exclusions

Q21. Are audiology patients included within RTT measurement?

Some audiology patients are covered by RTT measurement, however, most audiology and adult hearing services are not consultant-led and so are outside the scope of RTT. Patient referred to non consultant-led audiology services should not be reported on the RTT return.

Referral to treatment times for patients using direct access audiology services – that is, those patients who are directly referred from primary and community care to the audiology services for both diagnostic assessment and treatment, and are therefore not referred to, or under the care of, a medical consultant – are collected via a separate audiology data collection. Further information on the audiology data collection can be found on the NHS England website:
http://www.england.nhs.uk/statistics/statistical-work-areas/direct-access-audiology/

Q22. Is bariatric surgery included within RTT measurement?

Bariatric surgery is covered by RTT measurement. However because of the nature of these pathways and the fact that bariatric surgery is often classed as a ‘last resort’ treatment, it may be that a period of active monitoring has occurred and in a routine follow-up appointment, the consultant and patient agree that bariatric surgery is now the best option. This clinical decision would start a new RTT clock on the date that the decision is made and communicated to the patient.

Where a patient is referred by a local consultant after initial treatment to a service for assessment or specialist opinion with a view to surgical treatment, a new RTT clock starts on the date the referral is received into that service.

Q23. Should patients covered by the cancer standards be included in RTT measurement?

Patients who are covered by the two-week, 31-day or 62-day cancer standards are also covered by RTT measurement. Therefore, the waiting times of these patients should be reported on the RTT return.

Q24. Are clinical genetics services covered by RTT measurement?

Clinical genetics services are covered by RTT. The RTT clock starts on the date that the provider receives the referral. The clock stops on the date that the patient starts their first definitive treatment (which may be counselling in the case of genetics). There is no facility to delay starting a patient's clock to exclude the time required for family history gathering where this is done after referral.

Q25. Are direct access diagnostics covered by RTT measurement?

Direct referrals from primary care to diagnostic services in secondary care do not start an RTT clock unless they are 'straight to test' referrals, as part of a consultant-led pathway.

'Direct access' diagnostics is any arrangement where a GP can refer a patient directly to secondary care for a diagnostic test/procedure (i.e. without the patient having to attend a consultant OP appointment first). The GP is managing the patient's ongoing care and sends the patient for a diagnostic test/procedure at a local provider. The GP will use the results of the test to inform his decision making around the patient's continuing care. For example, if the test results were adverse, the GP may then refer the patient to secondary care but alternatively if the results are normal, he may continue to manage the patient within primary care.

'Straight to test' diagnostics is a specific type of 'direct access' where there is a local agreement between primary and secondary care that if a GP is referring a patient to see an outpatient consultant, the GP can at the same time book the patient in for a diagnostic test at the provider so that by the time the patient attends their first OP appointment, they will have already had the test and the results can then be discussed at the OP appointment. In such instances, the RTT clock starts on the date that the provider receives the referral.

The key difference is whether the GP is intending to continue to manage the patient's care in primary care (and is simply using the diagnostic test to inform this process) or whether he or she has already taken the decision that secondary care will provide the continuing care.

Q26. Are dialysis appointments covered by RTT measurement?

Routine dialysis appointments would not be part of an RTT pathway. However, a decision to start a substantively new or different treatment that does not form part of the patient's agreed care plan resulting from a dialysis session would start an RTT clock. Therefore, processes would need to be in place within the trust to capture any such clock starts. This may be through clinic outcome sheets or another locally-agreed process.

Q27. Is IVF and other fertility treatment covered by RTT measurement?

Consultant-led NHS IVF treatment and/or fertility treatment is included in RTT measurement. The RTT clock stops when first definitive treatment starts. For IVF, this can include less invasive treatments, such as intra-uterine insemination. A consultant referral for IVF at a later date could then start a new clock. Privately-funded IVF patients are not covered by RTT.

A clock stop for active monitoring may be appropriate where a decision is made to repeat investigations after a specified period (for example, a decision to repeat semen analysis in three months) or where a decision to treat has been made but there is a clinical reason why treatment cannot start immediately.

It is not appropriate to use active monitoring to stop an RTT clock where there are capacity (or funding) restraints. For example, where a couple is referred for IVF and wish to proceed immediately with treatment but the trust cannot start treatment for six months due to capacity restraints, the clock should keep ticking until treatment starts.

Providers should consider the patient’s view in deciding whether active monitoring is appropriate. For active monitoring to be applied the patient should understand either:

- that they have taken an active decision to delay treatment for an extended period (patient initiated active monitoring), or;
- that a decision to treat has been made and the reason for delaying the start of treatment is clinical, not related to capacity or funding issues.

Q28. Are gender dysphoria services covered by RTT measurement?

Consultant-led gender dysphoria services (also known as Gender Identity Services) are covered by RTT measurement.

The RTT clock starts at the point of receipt of referral and stops at the start of first definitive treatment.

Q29. Is gender reassignment surgery covered by RTT measurement?

If gender reassignment surgery is proposed, then a new RTT clock would start on the date that the referral from the Gender Identity Clinic/Service is received by the surgical provider.

Q30. Are referrals for healthy pregnant women covered by RTT measurement?

Referrals from primary care for healthy pregnant women are not covered by RTT. Pregnancy referrals should only start an RTT clock when there is a separate condition or complication requiring consultant-led medical or surgical attention.

Q31. Are mental health referrals covered by RTT measurement?

Much mental health activity will be outside the scope of the RTT collection as it is not consultant-led. However, RTT does apply where a referral is made to a medical consultant-led mental health service, regardless of setting. It also applies where a GP

(or other referrer) makes known their intention to refer to a mental health medical consultant (for example, a consultant psychiatrist), even though they may refer through a mental health interface service. Referrals from primary care to mental health services that are not consultant-led (this may include multi-disciplinary teams and community teams run by mental health trusts) irrespective of setting do not start an RTT clock.

Decisions about which services are medical consultant-led are ones that must be made locally, in line with the national definition of consultant-led, that is where a consultant retains overall clinical responsibility for the service, team or treatment.

Mental health trusts that provide services/pathways that fall within the scope of RTT should submit a return.

First definitive treatment for mental health is defined as with all other specialties, that is 'an intervention intended to manage a patient's disease, condition or injury and avoid further intervention'. It is recognised that sometimes it is difficult to identify the start of first definitive treatment in mental health pathways. However ultimately this must be a local clinical decision and it would not be appropriate to issue prescriptive national guidelines defining the start of treatment in the context of mental health.

For more information on national waiting time standards for mental health services from April 2015, see:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/361648/mental-health-access.pdf

Q32. Are military personnel covered by RTT measurement?

All patients of English commissioners are included in RTT measurement, including personnel registered with Ministry of Defence (MoD) practices and for whom NHS England commissions their care. RTT measurement does not apply to care commissioned by MoD unless stated in commissioning agreements with providers.

More information is available at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/49469/the_armed_forces_covenant.pdf

Q33. Are referrals to orthodontic services covered by RTT measurement?

A referral from primary care to an orthodontic consultant starts an RTT pathway. However, a large proportion of orthodontics work is carried out by non-consultants and referrals from primary care to such non-consultant services would not start an RTT clock.

Dental care provided under general anaesthesia in secondary care (even where the treatment is carried out by a primary care dentist) is covered by RTT. For these dental pathways, the decision to include them within the scope of RTT was taken on the basis that these patients are typically from vulnerable groups (mainly children but also some adults with learning disabilities and so on) and it would be appropriate for them to be included in RTT. The rationale is that there has to be a consultant

involved in their care as, by law, general anaesthesia must be carried out in a hospital setting under the care of a consultant anaesthetist.

First definitive treatment is defined as ‘an intervention intended to manage a patient’s disease, condition or injury and avoid further intervention’. An example of first definitive treatment in orthodontics is the first fitting of a dental brace (sometimes referred to as ‘case start’). Treatment will often continue beyond the first definitive treatment and after the RTT clock has stopped.

If a patient on an orthodontic pathway is not yet ready for treatment (for example, a child will require a dental brace but their teeth are not yet developed enough), then the RTT clock stops at the point that the clinical decision not to treat is made and communicated to the patient and their GP (or other referrer). A future review appointment should be booked at an appropriate interval determined by the consultant. Once the patient has reached the appropriate age/stage of development, they should either start treatment or be transferred to an active waiting list and an RTT waiting time clock should start.

If there is a decision to return a patient to the dentist in primary care, the RTT clock will stop. For example, if an orthodontist returns a patient to the dentist for, say, teeth extractions, which will be required before the orthodontic treatment can take place, the RTT clock will stop at the point that the clinical decision is made and communicated to the patient. A new clock starts if/when the decision is made and communicated with the patient that they should be referred for further treatment with the orthodontist.

Q34. Are prison health services covered by RTT measurement?

All patients of English commissioners, including prisoners, are included in RTT measurement. Prisoners should be treated within the same waiting time as all other NHS patients. However, we accept that in some cases there will be circumstances unique to the prison population which may lead to longer waits.

Q35. Are referrals to sexual health services or GUM (Genito-urinary medicine) clinics covered by RTT measurement?

From April 2013, the responsibility for commissioning some public health services transferred to local authorities. This transfer included consultant-led sexual health services. Therefore, these services should not be included in the consultant-led RTT waiting times as they are not NHS commissioned.

Q36. How should RTT measurement be applied to specialised services?

RTT rules apply to all services that are consultant-led, including specialised services. In most cases, either an existing RTT clock continues to run for patients referred on to these services or (for those who have received previous treatment in a non-specialist service) a new clock will start at the point that the specialist service receives the referral. A new clock start would be appropriate because the referral to such services constitutes a ‘decision to start a substantively new or different treatment that does not already form part of that patient’s agreed care plan’ (Rule

3b). Section 3.4.2 of the main guidance states that: ‘this new clock will often start at the point the subsequent 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 at this point*’.

Though all clock starts and stops are ultimately clinical decisions, the patient perspective is also vital. Trusts should take into account that patients will perceive that they are waiting for an appointment, assessment or treatment of a substantively different nature from the time they were told they would be referred.

1.5 Other measurement issues

Q37. Can social or medical suspensions be applied to incomplete RTT pathways?

No. The Hospital Inpatient Waiting List statistics collected by the Department of Health before March 2010 allowed hospitals to exclude temporarily suspended patients from waiting lists for social reasons or because they were known to be not medically ready for treatment. Such suspensions cannot be applied to RTT incomplete pathways.

Q38. What if factors outside a hospital’s control put achievement of the 92% incomplete pathway operational standard at risk?

The tolerance of 8% set for achievement of the incomplete pathway waiting time operational standard is there to take account of the following situations that might lead to a longer waiting time:

- patients who choose to wait longer for personal or social reasons
- patients for whom it is clinically appropriate to wait longer (this does not include clinically complex patients who nevertheless can and should start treatment within 18 weeks)
- patients who fail to attend appointments they have agreed.

Q39. Is it acceptable for hospitals to refuse to accept referrals?

NHS providers should accept all clinically appropriate referrals for elective consultant-led services made to them. Patients choosing a particular NHS provider must be treated by that provider as long as this is clinically appropriate and in accordance with the patient’s wishes (see section 7.1.2 of the main guidance). Managing to meet the demand for popular services is a shared responsibility between commissioners and providers and they need to work together to ensure that, where clinically appropriate, patients are treated at their choice of provider.

Locally, commissioners and providers may have agreements about the clinical criteria for providers to accept patients to ensure that they are accepting clinically appropriate referrals for the services they provide. In the case of highly specialised services it may be legitimate to apply further criteria in assessing whether a referral is clinically appropriate, so that the service is available to those for whom it is most needed. Any referrals from outside the local area would also need to meet these criteria, but trusts should not impose differing criteria according to where patients

come from. The criteria should be open and transparent and be published on the NHS e-Referral Service (Choose and Book) system.

Providers are expected to accept all clinically appropriate referrals for elective consultant-led services and ensure that sufficient appointment slots are available to enable patients to book directly with the provider. These principles are also included in the NHS Standard Contract. This approach is also supported by the way in which the NHS e-Referral Service (Choose and Book) operates, where patients who use the appointments line are passed onto their chosen trust if no appointments are available on the NHS e-Referral Service (Choose and Book).

Where an RTT clock has already been started but the provider cannot accept the referral because it is not clinically appropriate (for example, where a referral is made to a trust that doesn't carry out the relevant procedure), this will nullify the RTT clock (in other words, it is removed from the numerator and denominator for RTT measurement purposes). The original referral request received date should be used when the patient is subsequently referred to another service so that patients are not unfairly disadvantaged when their waiting time calculations are made.

Q40. What is the effect on the RTT clock if there is a delay while a provider seeks funding from a commissioner for a procedure that is not routinely funded?

The RTT measurement rules are that if the patient has been referred to a consultant-led service and a funding approval is required before the consultant-led service can continue with the patient's pathway, then the 18 week clock will have started on receipt of referral and the clock will continue to tick during the process of approving funding.

However, where commissioners are asked to approve funding prior to a referral being made, and the patient is aware that they are waiting for funding approval rather than waiting for an appointment in consultant-led care, then an 18 week clock would only start once funding has been approved and the subsequent referral is received by the provider.

Q41. If a patient is colonised with MRSA, does this affect their RTT clock?

If a patient is colonised with MRSA, this does not affect their RTT clock. There are patients referred on to RTT pathways for whom it is clinically appropriate to undertake treatment even if they are colonised with MRSA, and these cases just need to be managed correctly. Since April 2009, all relevant elective patients have been screened for MRSA, and positive patients will have to be decolonised and treated within the RTT pathway.

Trusts need to predict and then manage the demand and capacity for single rooms and other facilities. They need to appropriately re-design systems and processes to care for patients following decolonisation which will need to be integrated into the patient pathway.

If the consultant makes a clinical decision that it is in the interest of the patient to refer them back to primary care, then the patient's RTT clock may be stopped, on the date that this decision is made and communicated to the patient. It is not expected that patients will be referred back to primary care just because they are MRSA positive, exceptional reasons will be needed to support such clinical decisions. Local systems should be used to provide assurance that all referrals back to primary care are clinically appropriate. A new RTT clock should start when/if a patient is referred back into consultant-led care.