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# Re-stating RTT Rules

**v1.3**

**March 2022**

## Referral To Treatment (RTT) Waiting List Rules: An opportunity to re-state

- The purpose of the RTT Waiting list should be to record those patients who are waiting to see a clinician or to start treatment.
- We will reinforce the importance of adherence to existing rules and we will strengthen communications and support to systems to ensure greater understanding and consistent application of rules.
- Our focus is:
  - **Patient availability**
  - **Fitness for treatment/surgery**
  - **Patient compliance (Non-attendance and cancellations)**
  - **Offer of choice which will have two approaches:**
    - **Strengthening offer of “informed” choice at point of referral**
    - **Embed proactive offer of choice for long-waiters**
- Health Inequalities, particularly around access, will be an important part of this work, ensuring any changes fully consider how they may impact upon different patient groups.

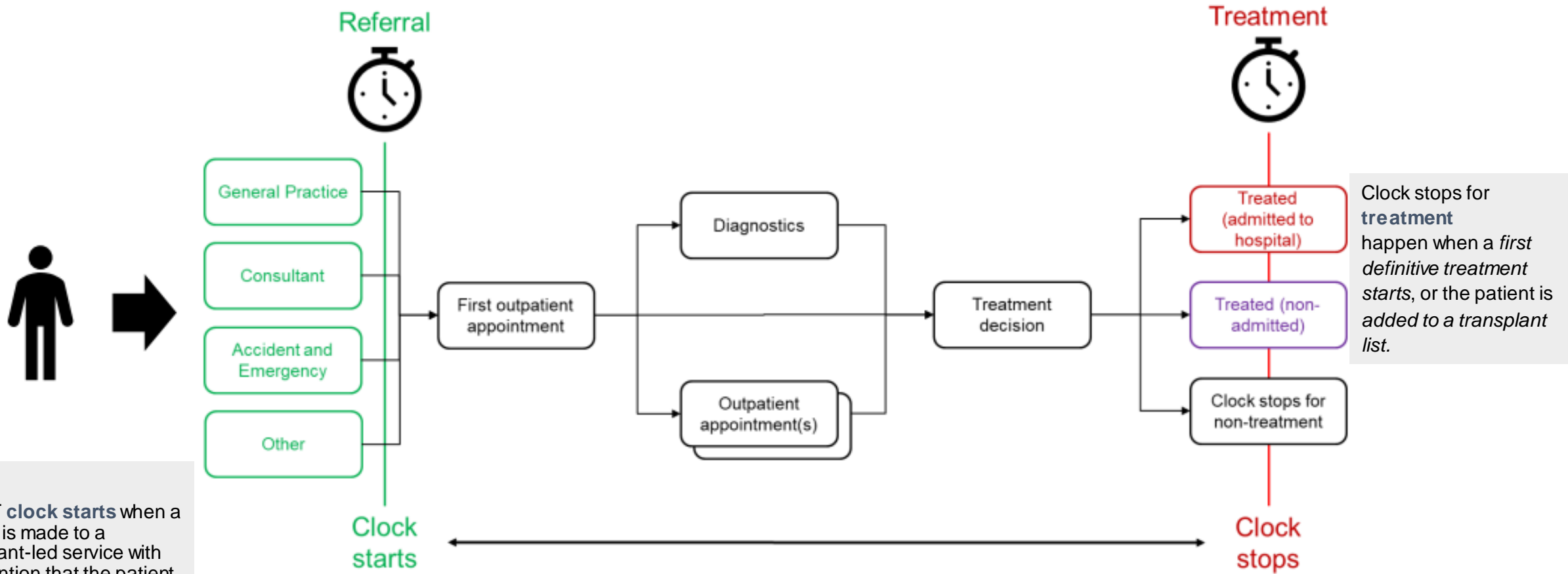
### Tools and resources

[Statistics » Consultant-led Referral to Treatment Waiting Times Rules and Guidance \(england.nhs.uk\)](#)

[Recording-and-Reporting-guidance-April\\_2021.pdf \(england.nhs.uk\)](#)

[Version 7.0 June 21 Addendum to Elective care Model Access Policy - Elective Care IST Network - FutureNHS Collaboration Platform](#)

## 1. RTT pathway overview



An RTT **clock starts** when a referral is made to a consultant-led service 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.

The NHS constitution commits to patients that referral to treatment should be within 18 weeks.

A patient should only be added to the waiting list if they are **fit and able to have their treatment**.

Clock stops for **non-treatment** happen when:

- it is *clinically appropriate to return the patient to primary care*
- a *clinical decision is made to start a period of active monitoring*
- a *patient declines treatment having been offered it*
- a *clinical decision is made not to treat*
- The *DNA rules apply*

## 2. Fitness for treatment/surgery (Short-Term: to be rebooked)

### Current Fitness for treatment rules

Where patients either attend at hospital or are admitted for treatment, or contacted with a treatment date, but are **found to be unfit** then, if the condition is considered transitory in nature the clock should continue and the patient be rebooked 2 to 3 weeks later.

### Example 1: short-term conditions

Patient presents with a short term illness such as a chest infection or a UTI that requires treatment prior to surgery.

### Example 2: short-term conditions

Patients presents with a medical condition that requires further pre-operative tests

This might be a patient with known heart disease has had recent episode/s of angina that requires a cardiac echo or other cardiac investigations prior to surgery.

The patient should remain on the WL and be rebooked at an appropriate time.

### Specific Covid Position:

Current Royal College guidance is that patients who test positive for Covid should have their treatment/procedure delayed for seven weeks. However, clinical prioritisation can overrule this guidance if the consultant feels it is in the best interest for the patient.

## RTT Waiting List Rules

### 3. Fitness for treatment/surgery (Long-Term: Move to active monitoring)

#### Current Active Monitoring rules

If a patient is **unlikely to be fit for treatment within the foreseeable future – (> 3 months)**

- discharging to primary care for optimisation
- or discharging with a decision not to treat
- Placed on **active monitoring**

In all three scenarios this would stop the RTT clock

#### Example 1: Long-term conditions

Following diagnosis it is agreed with the patient that a hip replacement required. However the BMI of the patient is too high and patient needs to lose weight before surgery can take place. Place on active monitoring for condition of hip and discharge to primary care to manage weight loss. This is because it is unclear how long the weight loss programme will take.

#### Example 2: Long-term conditions

Patient undergoes preoperative assessment and a previously undiagnosed heart condition is identified. Patient placed on active monitoring for condition requiring surgery. Patient referred to cardiology for management

#### Best Practice

The current rules guidance indicates that active monitoring should only be applied exceptionally once a decision to admit has been made. This was originally written in the context of much shorter waits for surgery. In the current context it is much more likely that patients will be placed on active monitoring due to the deteriorating pathology of most conditions and because of the length of wait other conditions will have developed.

## 4. Patient Compliance

### Current Patient Compliance Rules

- Current RTT rules do not stop a waiting time clock where patients DNA, cancel or refuse reasonable\* offers of appointments.
- After two instances of the same pathway events occurring, a clinical review of the case should be triggered. This will determine the appropriate next steps which could include a return to the referring clinician providing the following guidance is adhered to:
  - the provider can demonstrate that the appointment was clearly communicated to the patient.
  - discharging the patient is not contrary to their best clinical interests, which may only be determined by a clinician.
  - discharging the patient is carried out according to local, publicly available, policies on DNAs.
  - these local policies are clearly defined and specifically protect the clinical interests of vulnerable patients (for example, children) and are agreed with clinicians, commissioners, patients and other relevant stakeholders.
- Patients who DNA their first appointment on an RTT pathway may have their clock nullified (stopped and not reported) as long as the provider can demonstrate that the appointment was clearly communicated to the patient. Patients who cancel an appointment in advance are not considered a DNA and would not have clocks nullified.

(\* An offer is reasonable where the offer for an outpatient appointment or an offer of admission is for a time and date 3 or more weeks from the time the offer was made)

- The above is a more explicit and consistent interpretation of the existing RTT rules associated with patient compliance.

### Example 1:

Patient is booked to attend a first outpatient appointment on a date more than 3 weeks ahead, but does not attend. No prior notice has been given. A DNA would be recorded and the clock nullified. The referral should be returned to the GP to explain the patient has been removed from the clinic waiting list. Any decision to return a patient to primary care should be subject to the caveats set out in RTT rules and best practice outlined below.

### Example 2:

Patient is booked to attend a pre-assessment clinic appointment ahead of planned hip surgery. The patient contacts the hospital to cancel the appointment. Patient should be re-booked for another pre-assessment clinic and remain on the waiting list for surgery.

### Best Practice

Consideration should be given to the impact of multiple hospital cancellations on likelihood of DNA events. Providers should avoid multiple cancellation and rebooking wherever possible as this has a negative impact on patient experience and efficiency. Equally, patients who refusing multiple reasonable offers of appointment should be reviewed to assess whether discharge to GP is appropriate.

## 5. Patient Choice

### Current Patient Choice Rules

- If you are referred for consultant-led treatment, you have the right to choose which provider (and the team within that provider) you are referred to from all those who have a contract to provide the service.
- You can ask to be referred to a different hospital if:
  - you have to wait more than 18 weeks before starting treatment for a physical or mental health condition, if your treatment is not urgent
  - you have to wait more than 2 weeks before seeing a specialist for suspected cancer
  - Patients do not have to move to another provider. There is no consequence to the patient if they choose not to change.

### Example 1: Point of referral

Richard has been suffering from pain when he moves his knee. His GP decides he should be referred to a consultant for further investigation for a possible knee replacement. She makes sure that Richard is aware of his legal entitlement to choose to receive his treatment in any hospital appointed by the NHS to provide this service: including some private hospitals at no greater cost to the NHS. She asks him what factors are important to him in choosing where to go for treatment and then uses the online NHS e-Referral Service to show him the choices available. She also tells him about the search tools on the NHS website that can be used to look up information on hospitals and their consultants. Richard uses the NHS website to look up the quality ratings of the hospitals on his shortlist and to see how their consultants perform for the procedure that the GP considers he might need. He also uses the NHS website to see how different hospitals compare

### Example 2: Waiting more than 18 weeks

Emily becomes concerned that she will not be seen by the consultant within 18 weeks of her initial referral. She contacts the hospital that will be providing her treatment to tell them that, if the hospital cannot treat her within the maximum waiting time expected, she would like to ask to change hospital and be seen sooner elsewhere. The hospital provides Emily with information on other organisations that could treat her sooner than her original appointment. There are a number of suitable organisations for this, so she is offered a choice between these. She uses the NHS website for further information about each hospital to help her decide which one she would like to choose. Emily selects a suitable alternative hospital and her transfer is sent to them by the hospital that she had originally chosen.

### Best Practice

- Strengthening the offer of “informed” choice to patients at point of referral – working with primary care to ensure that patients are made aware of the providers available to them including the independent sector
- Embed proactive offer of choice of alternative providers for long-waiters through offering better advice and options, and proactively contacting long wait patients

## 6. Clinical Prioritisation of Surgical Waiting Lists

### Overview (Guidance)

The clinical prioritisation programme is part of the third phase of the NHS response to COVID-19 and is designed to support the prioritisation of waiting lists as part of the recovery of elective activity. The priority is to ensure that all patients on an admitted patient care pathway have been reviewed and clinically prioritised to support discussions with patients about their planned care, to give greater clarity of the number of patients awaiting procedures at each priority level, to inform service capacity planning, and support the booking of patients.

Waiting lists should be validated in two or three stages:

1. Technical validation: To ensure the waiting list is accurate and up to date.
2. Patient discussion: Patients are contacted by a locally determined competent team to establish their wishes.
3. Clinical Validation: Via remote clinical consultation, for patients who wish to discuss their situation in more detail using shared decision making (SDM).

### Example 1: Clinical Prioritisation determines patient should not delay treatment

Patients who do not wish to delay treatment, will be prioritised based on clinical review as follows:

P2: Procedure to be performed < 1 month from review

P3: Procedure to be performed < 3 months from review

P4: Procedure to be performed > 3 months from review

### Example 2: Clinical Prioritisation determines patient would prefer to delay treatment and agreed clinically appropriate

Patients who have been offered two dates for treatment and have declined to accept for non-Covid reasons, but still wish to remain on the waiting list will be coded as P6. This is if the reason given to continue to wait is not COVID-19 related. P6 to be assigned to patients who wish to defer treatment for “social” reasons.

### Best Practice

NHSE/I have published a suite of guidance setting out core principles to be applied to all patient communications, these include enabling shared decision making and using clear, accessible and easy to understand language. The guidance, along with an aide memoire and template patient letters, can be found online here:

<https://www.england.nhs.uk/coronavirus/publication/good-communication-with-patients/>



# RTT Waiting List Rules

## Appendix 1: Quarterly Waiting List Audit - Proposal



Can the provider assure themselves, the system and regulators that they have taken all reasonable steps to maintain “clean” waiting lists and apply RTT rules appropriately?

Clean validated W/L	Comments
Missing codes including RTT status, Treatment Function Code, latest RTT outcome code (RTT pathways only)	Identify relevant cohorts from PTL & understand why data is missing / incomplete. Use information from review to correct recording practice.
Use national DQ tool (LUNA) to support identification of and correction of patient records e.g. TCI in the past, outcome discharge but still on list etc.	List of indicators to be prioritised for maximum impact i.e. where likely to affect pathway management & reporting
Planned admissions – only patients meeting the criteria correctly are recorded as planned.	Check Planned list for specialties and procedure codes usually part of RTT but recorded as planned; check that planned patients have due date recorded
Rules assurance	Comments
Reporting of eRS Appointment Slot Issues / Referral Assessment Service patients included in local and national waiting list data sets. Clock starts must reflect date of first attempted UBRN conversion.	All referrals should be visible on internal PTL reports for pathway management and included in local and national reporting (if not registered on PAS within 24 hours, referral with wait time must be accounted for and actively managed through other means)
Patients with multiple DNAs and patient cancellations are clinically reviewed and actioned.	Assurance provided through process review
Active Monitoring (watchful wait) applied appropriately.	Metrics to be agreed

### Issue

Clarification of the RTT rules relating to where providers offer support through provision of mutual aid, in particular to treat long waiting patients, and to confirm that responsibility for reporting of the long wait is not passed to the receiving provider.

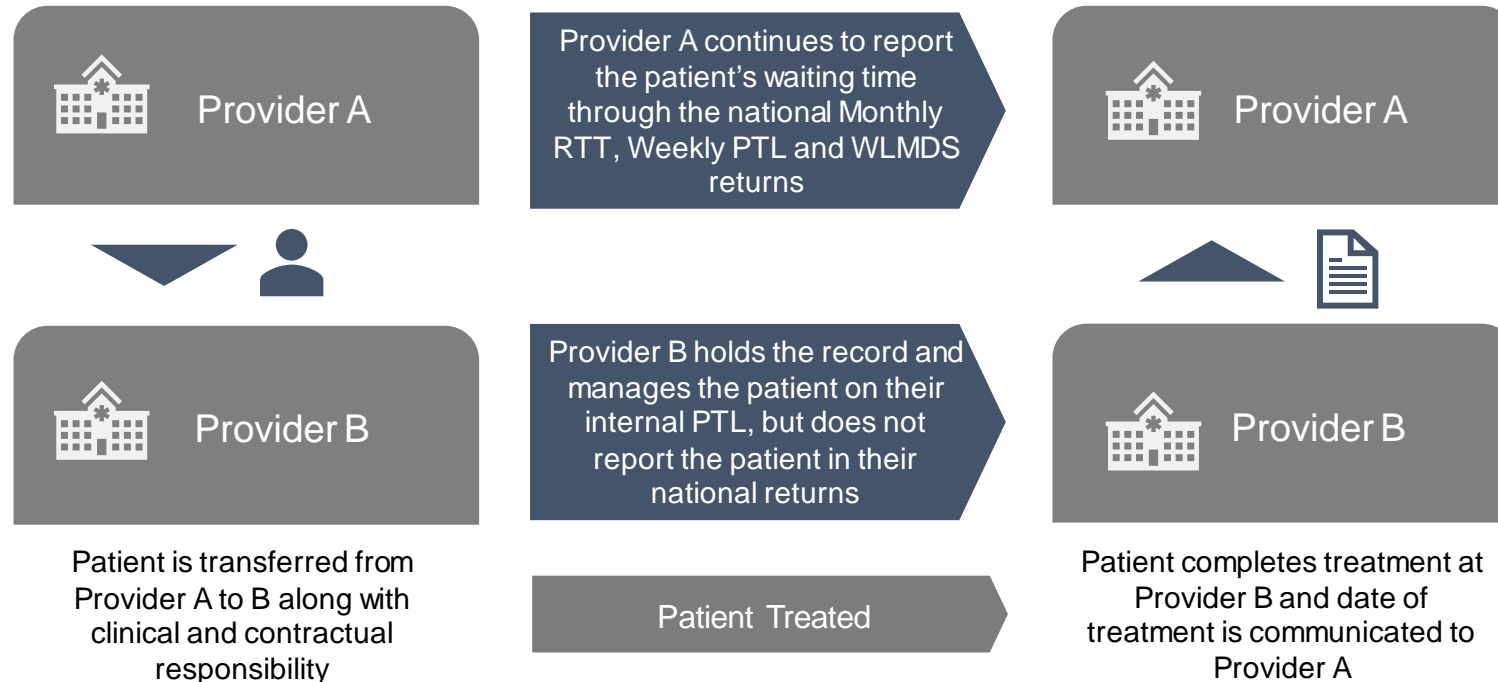
### Solution

There is currently provision in the “Recording and Reporting Referral to Treatment (RTT) Waiting Times for Consultant-Led Elective Care” guidance section 10.1.2 to remove the disincentive for an alternative provider to accept and treat long waiting patients in terms of the impact that this might have on its reported performance (subcontracting relationships and RTT reporting).

### Practical Application

Where provider A has a backlog of cases and chooses to subcontract additional capacity from provider B, provider A will remain responsible for any breaches and sanctions, even if it intends that the relevant patients should, in time, be treated at provider B. If a patient is simply transferred, in terms of clinical and contractual responsibility, from provider A to provider B and is to be treated under provider B’s contract with the commissioner, the normal position under the guidance is that any subsequent breach will be the responsibility of provider B.

However, the guidance makes clear that – where this arrangement might otherwise result in long-wait patients being disadvantaged due to an alternative provider being unwilling to take them on – then the originating provider can instead continue to report the patients’ RTT wait on an **exceptional basis**. These arrangements require formally agreed local contracts covering reporting, governance and local management. This includes a flow of information between providers that is sufficient to ensure that weekly WLMDS and monthly RTT data returns are also accurate while the patient is still waiting.



**Exceptional basis:** If the transfer is in the best interests of the patient and there is a provider-to-provider agreement this guidance allows flexibility for local arrangements on who reports the patient’s waiting time. This covers situations of mutual aid and individual or cohorts of patients that would be disadvantaged otherwise.