NHS England

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



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1. Executive summary

1.1 Background

Waiting times matter to patients. Most patients want to be referred, diagnosed and treated as soon as possible.

The accurate recording and reporting of referral to treatment (RTT) waiting times information is extremely important. Patients can and do use this information to inform their choice of where to be referred and also to understand how long they might expect to wait before starting their treatment.

NHS providers and commissioners also need to use this information to ensure they are meeting their patients' legal right to start consultant-led non-emergency treatment within a maximum of 18 weeks from referral[1] – and to identify where action is needed to reduce inappropriately long waiting times.

Feedback from providers and commissioners is that existing guidance on recording and reporting referral to treatment waiting times is comprehensive – but that it is long and published in different areas.

To respond to this, in 2015, NHS England produced refreshed guidance to consolidate and simplify the previous published guidance and related advice[2].

In June 2015, Simon Stevens and the Secretary of State for Health accepted a recommendation from Sir Bruce Keogh[3] that the incomplete pathway operational standard should became the sole measure of patients' constitutional right to start treatment within 18 weeks. As a result of the removal of the completed admitted pathway operational standard, there is no longer any provision to report pauses or suspensions in RTT waiting time clocks in monthly RTT returns to NHS England under any circumstances. This change is fully reflected in this refreshed guidance.

The changes to the reporting requirements effective from 2015 can be summarised as follows:

- there is no longer a requirement to submit admitted adjusted data to NHS England

[1] As stated in the NHS Constitution: https://www.gov.uk/government/publications/the-nhs-constitution-for-england
[2] A list of the documents consolidated into this refreshed guidance is available in Annex A.
[3] http://www.england.nhs.uk/wp-content/uploads/2015/06/letter-waiting-time-standards-sbk.pdf

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- unadjusted admitted and non-admitted completed pathway data is still required but will no longer be used for monitoring against operational standards
- the requirement to report incomplete pathway data remains unchanged – and has always been an unadjusted submission
- two new data items have been added: incomplete pathways for patients with a decision to admit for treatment and new RTT periods.

The 2015 refresh also emphasised that those patients who choose to wait longer should have their wishes accommodated without being penalised. 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 can and should start treatment within 18 weeks)
- patients who fail to attend appointments they have agreed.

This guidance now also outlines the requirements for the monthly aggregate data collection from April 2021 data onwards[4]..

The fundamental principle is that all decisions about a patient's waiting time should be made with the patient's best clinical interests in mind and in accordance with national legally binding RTT Rules[5]. NHS providers and commissioners are responsible for ensuring that both their local access policies and their standard operating procedures are in line with this guidance and the national RTT Rules[6]. This will ensure NHS staff record and report patients' waiting times correctly. Publication of local access policies will also ensure patients and relatives understand their waiting time rights and responsibilities – and what to do if they have waited too long.

This guidance continues to be essential reading for all staff responsible for managing the treatment of patients referred for non-emergency consultant-led treatment.

These include:

[4] See section 10.1.1.3 Changes to existing data collection template – from April 2021 for more detail.
[5] http://www.legislation.gov.uk/uksi/2012/2996/pdfs/uksi_20122996_en.pdf
[6] https://www.gov.uk/government/publications/right-to-start-consultant-led-treatment-within-18-weeks

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- referrers, who can advise patients how long they may wait before starting treatment at different providers. Referrers also have an important role to play in raising patients' awareness of their maximum waiting time right and what they can do if they are concerned that they will wait too long before starting treatment;
- service managers and commissioners, who need to ensure the data being reported is a true and honest reflection of waiting times and to assess whether the required standards are being delivered[7], and to highlight where action is needed to reduce inappropriately long waiting times;
- hospital staff who record and report waiting times data to ensure it is accurate and of high quality;
- chief executives of providers, who have primary responsibility for ensuring the waiting time data their organisation submits to NHS England is accurate[8].

[7] http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf
[8] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/321492/9781474106672_WEB.PDF

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1.2 Promoting equality and addressing health inequalities

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

- Given regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

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2. National Clock Rules (from October 2015)

2.1 General principles

Once a referral to treatment (RTT) waiting time clock has started it continues to tick until:

- the patient starts first definitive treatment
  or
- a clinical decision is made that stops the clock.

Trusts should ensure that all clock stops without treatment are made in the best clinical interest of the patient and are not influenced by the impact on incomplete pathway waiting time performance.

Patients should be allowed to choose their time of treatment taking account of clinical advice where undue delay may present a risk to them.

2.2 Referral to treatment consultant-led waiting times rules suite

Clock Starts

1) A waiting time 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) A waiting time 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 permitted to do so.

3) Upon completion of a consultant-led referral to treatment period, a new waiting time clock only starts:

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

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

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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 Did Not Attend (DNA) that stopped and nullified their earlier clock.

Clock Stops

Clock stops for treatment

4) 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.

Clock stops for 'non-treatment'

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

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

b) A clinical decision is made to start a period of active monitoring;

c) A patient declines treatment having been offered it;

d) A clinical decision is made not to treat;

e) A patient DNAs their first appointment following the initial referral that started their waiting time clock, provided that the provider can demonstrate that the appointment was clearly communicated to the patient[9];

[9] DNAs for a first appointment following the initial referral that started a waiting time clock nullify the patient's clock (in other words, it is removed from the numerator and denominator for Referral to Treatment time measurement purposes).

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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/published, 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.

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3. Recording RTT waiting times: Clock starts

3.1 Relevant sections of RTT Rules Suite [10]

Rules 1, 2 and 3 of the Rules Suite set out the rules and definitions relating to RTT clock starts.

Pages 7-20 of the Rules Suite document provide further information to support the NHS on how to apply the national waiting times rules relating to clock starts locally.

This guidance is written from the point of view of RTT data reporting via the Strategic Data Collection Service portal (SDCS); see Annex E for more detail on Referral to Treatment period status in Commissioning Data Sets (CDS) submitted through SUS.

3.2 RTT clock starts – rule 1

1) A waiting time 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.

Any organisation or service that receives referrals that fall into the criteria above will need to capture information about these patients and submit an RTT monthly return. This includes not only acute trusts but also specialist trusts, mental health trusts, any other provider of consultant-led services for NHS patients in England, and providers of interface services as defined in section 6.

3.2.1 Clock start date

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 waiting time of the patient can start to be tracked. For NHS e-Referral Service (formerly Choose and Book) referrals, this will be the date that the patient converts their UBRN (Unique Booking Reference Number),

[10] https://www.gov.uk/government/publications/right-to-start-consultant-led-treatment-within-18-weeks

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(including where the referral is rejected by the chosen provider and the patient is subsequently re-referred).

Where no appointments are available at the patient's chosen provider at the time they convert their UBRN, and their referral is deferred to the provider, the UBRN will immediately appear on that provider's Appointment Slot Issue (ASI) work list. The date on which the UBRN appears on this work list is the consultant-led RTT clock start. If there has been any previous activity against the UBRN (for example, a booking into a Clinical Assessment Service) it is the earlier date that starts the consultant-led RTT clock.

For referrals that are not made via the NHS e-Referral Service, the clock starts on the date that the referral is received by the provider organisation.

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 subsequent providers receive the referral (see section 11).

All pathways reported should have a known clock start. Patients with no known clock start should still be reported. It is the responsibility of the receiving provider to take appropriate action to identify a correct start date, which may include discussion with the patient.

3.2.2 Referral management services (interface services, assessment services)

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. Please see section 6 for a full definition of interface services and more information on how RTT applies to these services.

For NHS e-Referral Service patients who are referred to secondary care via an interface service, there may be two UBRNs 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 their Worklists 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.

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There may also be the situation where the GP refers to an interface service not through the NHS e-Referral Service but as a paper referral and the interface service refers on to a Provider using the NHS e-Referral Service. In this scenario, the URBN conversion date would **not** be the RTT start. The Inter Provider Transfer Administrative Minimum Data Set (IPTAMDS) should be attached with the NHS e-Referral Service referral so that the correct start date (the date that the original GP referral was received by the interface service) can be obtained by the receiving provider (see section 11).

3.3 Clock starts for self-referrals – rule 2

2) A waiting time 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 permitted to do so.

An RTT clock starts upon a self-referral by a patient that fulfils the criteria above to any service covered by RTT measurement. The clock should start on the date that the self-referral is received by the provider.

3.4 Other clock starts – rule 3

3) Upon completion of a consultant-led referral to treatment period, a new waiting time clock only starts:

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

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

c) upon a patient being re-referred 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.

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

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3.4.1 Bilateral procedures

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.

3.4.2 Treatment that did not form part of the patient’s original treatment plan

Where further (substantively new or different) treatment may be required that did not form part of the patient’s original treatment plan, a new RTT clock should start. This will include situations where less intensive treatment has failed and more aggressive treatment is necessary for the same condition (if the additional treatment did not form part of the patient’s agreed care plan).

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 (onward referral date).

Where the patient will be remaining under the care of the same consultant or under the care of a different consultant within the same provider, then the date of the decision to refer and the referral being received will be the same.

However, where a patient is referred to a different provider for the new treatment, then the RTT clock will not start until the referral is received by the receiving provider. As patients will perceive their wait as starting from the time that the consultant told them they were going to refer, there should not be a significant delay between the date the decision to refer was made (and communicated to the patient) and the date that the referral is received in the receiving provider.

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 Annex D.

The clock will stop when this treatment starts (or when a clinical decision is made that the treatment is no longer required). It should be noted that the initial clock will not stop if the

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purpose of the first treatment was to administer pain relief for a condition before a definitive treatment (for example, a surgical procedure) takes place.

3.4.3 Re-referred patients

Where a patient who has already been on a consultant-led treatment pathway is subsequently referred back into that service as a new referral, then this will start a new RTT clock.

3.4.4 Clock start following active monitoring

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.

Clinicians may also wish to stop a patient's waiting time clock if the patient wishes to delay their treatment after a decision to treat, through placing them into a period of active monitoring. If the patient wishes to go ahead with treatment, the provider should offer a new 'to come in' (TCI) date acting as if the patient is on the waiting list at the point which they previously left – that is, they should not be returned to the beginning of the waiting list but they will have a new clock start at the date of decision to treat following a period of active monitoring.

As with new clock starts for substantively new or 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. See Annex D for more information on the use of clinical outcome sheets.

3.4.5 Clock start following DNA (Does Not Attend) for first appointment

If a patient DNAs their first appointment following the initial referral that started their RTT clock, if the provider can demonstrate that the appointment was clearly communicated to the patient, this will stop and nullify the RTT clock (in other words, it is removed from the numerator and denominator for RTT measurement purposes). If the patient subsequently

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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 to rebooks their new appointment.

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 Annex C.

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4. Recording RTT waiting times: Clock stops

4.1 Relevant sections of RTT Rules Suite[11]

Rules 4 and 5 of the Rules Suite set out the rules and definitions relating to RTT clock stops.

Pages 21-26 of the Rules Suite document provide further information to support the NHS on how to apply the national waiting times rules relating to clock stops locally.

4.2 Capturing RTT clock stops

Organisations must be able to capture RTT clock stops in the situations described in the national clock rules. Please refer to Annex D for technical details on capturing and recording clock stops.

4.3 RTT clock stops for treatment (rule 4)

Clock stops for treatment

4) 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.

4.3.1 First definitive treatment

First definitive treatment is defined as 'an intervention intended to manage a patient's disease, condition or injury and avoid further intervention'.

[11] https://www.gov.uk/government/publications/right-to-start-consultant-led-treatment-within-18-weeks

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4.3.2 Capturing clock stops for treatment

4.3.2.1 Clock stops for treatment in interface services (referral management services, assessment services)

An interface service is defined as any arrangement that incorporates any intermediary levels of clinical triage, assessment and treatment between traditional primary and secondary care (see section 6 for more information on interface services).

Paragraph 1b of the national clock rules states that a referral to an interface 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.

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 to the patient).

If the patient is referred on to a consultant-led service, the RTT clock would continue to tick until the patient is treated (or a decision is made that no treatment is required).

If the interface service refers a patient on to a non consultant-led service within the interface service itself or within secondary care for treatment, (for example, a therapy or healthcare science intervention) then the RTT clock will not stop until first definitive treatment starts within this service.

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.

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 clinical outcome sheets for all attendances at the service. Further guidance on clinical outcome sheets can be found in Annex D.

4.3.2.2 Clock stops for treatment in outpatients or other consultant-led services

The use of clinical outcome sheets will enable these clock stops to be captured. Further information on clinical outcome sheets can be found in Annex D. The clock stop date will be the date of the appointment at which first definitive treatment started.

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4.3.2.3 Clock stops for treatment as inpatient/day case

Generally an inpatient or day case admission for a patient on an 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.

Note that where any of the above scenarios occurs and a decision is taken that no definitive admitted treatment is needed, this would constitute a non-admitted clock stop, not an admitted one.

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

Therefore it is necessary to identify if:

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

Once clinical coding has taken place, it will be possible to identify definitively which 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.

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.

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:

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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 non-admitted clock stop when a clinical decision not to treat is made and communicated to the patient.

4.3.2.4 Clock stops due to the patient being added to a transplant list

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.

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 Annex D. The clock stop date will be the date of the appointment at which the decision was made and communicated to the patient. See section 1.2 of the accompanying Frequently Asked Questions document for more detail on applying this rule.

4.4 RTT clock stops for 'non-treatment' (rule 5)

Clock stops for 'non-treatment'

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

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

b) a clinical decision is made to start a period of active monitoring;

c) a patient declines treatment having been offered it;

d) a clinical decision is made not to treat;

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

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/published, 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.

4.4.1 Capturing decisions that stop an RTT clock for 'non-treatment'

4.4.1.1 Decisions in outpatients that stop an RTT clock

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 all treatment having been offered it;
d) a clinical decision is made not to treat.

These decisions should be captured on a clinical outcome sheet. Annex D 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, in other words, the date of the outpatient attendance.

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4.4.1.2 Clock stops that occur outside an outpatient attendance or inpatient admission

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

i. Patient attends appointment for diagnostic test. 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.

ii. Patient 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.

iii. Patient on an RTT pathway dies and relative informs hospital that the death has occurred.

Non-outpatient clinical outcomes may be captured using outcome sheets. Clock stops resulting from administrative events may then be recorded on patient administration systems[12]. The clock stop date in these instances should be the date the decision is made, which should also be the date this is discussed with or otherwise communicated to the patient.

4.4.1.3 Clock stops for DNAs (Did Not Attend)

It is good practice for trusts to have publicly available access polices setting out the application of waiting time rules and the role and the rights and responsibilities[13] of the NHS and patients.

In the context of RTT measurement, a DNA (sometimes known as FTA or Failed to Attend) is defined as where a patient fails to attend an appointment/admission without prior notice. Patients who rearrange their appointments in advance (irrespective of how short the period of notice they give) should not be classed as a DNA.

[12] See Annex D for more information on the use of RTT Status Codes for clock stops resulting from administrative events.
[13] The NHS Constitution (https://www.gov.uk/government/publications/the-nhs-constitution-for-england) sets out the rights to which patients, public and staff are entitled, together with responsibilities, which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively.

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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 (in other words, it is removed from the numerator and denominator for RTT measurement purposes).

Patient DNAs at any other point on the RTT pathway will not stop the RTT clock, unless the patient is being discharged back to the care of their GP. The action of discharging the patient will stop the 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, which may only be determined by a clinician;
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 (for example, children) and are agreed with clinicians, commissioners, patients and other relevant stakeholders.

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.

Trusts should agree and publish local DNA policies that are in line with the spirit of the guidance. For example, a ‘two strikes and out’ policy applied without satisfying the above criteria would not be acceptable. Examples of the application of a local policy:

For first appointments on an RTT pathway:

i. if the patient DNAs, their RTT clock can be stopped and nullified on the date of the DNA'd appointment having fulfilled the criteria described above;
ii. if the patient DNAs but the trust chooses to rebook the patient, then their original RTT clock would be stopped and nullified on the date of the DNA'd appointment and a new clock would start (at zero) on the date that the trust rebooks the patient, having fulfilled the criteria described above.

For subsequent appointments on an RTT pathway:

i. if the patient DNAs and the trust returns the patient back to primary care (having fulfilled the criteria described above), then their RTT clock would stop on the date of the DNA'd appointment;
ii. if the patient DNAs but the trust chooses to rebook the patient, then their existing RTT clock would continue to tick.

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Local DNA policies must be clearly defined and published, and specifically protect the clinical interests of vulnerable patients (for example, children) and be agreed with clinicians, commissioners, patients and other relevant stakeholders. There should be no blanket rules that do not take account of the circumstances of individual patients, therefore, it is for clinicians to determine whether discharging a patient is or is not contrary to the patient's healthcare needs.

4.4.1.4 Clock stops for active monitoring

An RTT clock may be stopped where it is clinically appropriate to start a period of monitoring in secondary care without further clinical intervention or diagnostic procedures at that stage. The clock stops on the date that the clinical decision is made and communicated with the patient.

A new RTT clock would start when a decision to treat is made following a period of active monitoring.

Where there is a clinical reason why it is not appropriate to continue to treat the patient at that stage, but to discharge the patient back to primary care for ongoing management, then this constitutes a decision not to treat and should be recorded as such and stops an RTT clock.

Active monitoring may apply at any point in the patient's pathway, but only exceptionally after a decision to treat has been made.

Patient 'thinking time'

Stopping a patient's clock for a period of active monitoring requires careful consideration on a case by case basis and its use needs to be consistent with the patient's perception of their wait.

Where a patient is given 'thinking time'[14] by the consultant, the effect on the RTT clock will depend on the individual scenario. If the agreed 'thinking time' is short, then the RTT clock should continue to tick. An example is where invasive surgery is offered as the proposed first definitive treatment but the patient would like a few days to consider this before confirming they wish to go ahead with the surgery.

[14] It is good practice for patients to be given full information about all alternative treatments, including non-operative and for them to make an active decision to choose surgery. Please see https://www.england.nhs.uk/rightcare/ for more information.

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If a longer period of ‘thinking time’ is agreed, then active monitoring is more appropriate. An example is where the clinician offers a surgical intervention but the patient is not keen on invasive surgery at this stage, as they view their symptoms as manageable. A review appointment is agreed for three months’ time and the patient is placed on active monitoring. The RTT clock would stop at the point that the decision is made to commence active monitoring.

A new RTT clock would start when a decision to treat is made following a period of active monitoring.

Active monitoring and diagnostic tests

Where a patient is given or requests ‘thinking time’, the effect on the RTT clock will depend on the individual scenario.

For patients on active monitoring, routine or regular diagnostic check-ups (for example, six-monthly check cystoscopy) would not start a new RTT clock. However, if the outcome of a routine diagnostic check was that further treatment was now required, then this would start a new RTT clock, on the date that this decision was made and communicated to the patient.

In general, if, during active monitoring, a decision to start a substantively new or different treatment that does not already form part of the patient’s agreed care plan is made, then a new RTT clock would start. The clock starts on the date that the decision is made and communicated with the patient.

Reasons why patients may be placed into a period of hospital-initiated active monitoring which would stop their waiting clock include:

- when the most clinically appropriate option is for the patient to be actively monitored over a period of time, rather than to undergo any further tests, treatments or other clinical interventions at that time
- when a patient wishes to delay treatment and declines two offers for reasonable[15] treatment dates – the clinician may decide to commence a period of active monitoring, following a clinical conversation and agreement with the patient

[15] Patients should be given 3 weeks’ notice for appointments.

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- when a patient[16] declines two reasonable[17] offers for earlier treatment dates at an alternative provider – the clinician may decide to commence a period of active monitoring, following a clinical conversation and agreement with the patient

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

When patients make a decision to delay their treatment there should be clinical oversight, and steps should be taken to ensure that the patient fully understands the clinical implications of the delay. Throughout the agreed active monitoring period the patient should be advised of the process to follow should they wish to go ahead with treatment and be reinstated on the waiting list. Once the patient wishes to go ahead with treatment, the provider should offer a new offer for treatment date, acting as if the patient is on the waiting list at the point that they previously left.

Active monitoring may apply at any point in the patient's pathway. The definition of active monitoring was carefully drawn up with input from national clinical leads. It is designed to ensure that national measurement of patients' waiting times reflects the realities of clinical decision-making.

Stopping a patient's clock for a period of active monitoring requires careful consideration on a case-by-case basis and its use needs to be consistent with the patient's perception of their wait. For example, stopping a clock to actively monitor a patient knowing full well that some form of diagnostic or clinical intervention would be required in a couple of days is unlikely to make sense to a patient, as they are likely to perceive their wait as being one continuous period from the time of their initial referral. Its use may be more appropriate where a longer period of active monitoring is required before any further action is needed.

4.4.2 Cancelled and rearranged appointments

A cancelled or rearranged appointment, either patient-initiated or provider-initiated will not in itself stop an RTT clock.

4.4.2.1 Patient-initiated cancellations

If a patient cancels, rearranges or postpones their appointment, this has no effect on the RTT clock, which should continue to tick. Patients should not be discharged back to their GP

[16] Patients included within this cohort should be clinically validated to be appropriate (clinically and socially) to be offered earlier treatment at a reasonable alternative provider.
[17] 'Reasonable' will be defined by each NHS England region recognising the variance in the geography. Provision should be made to support patients with transport or travel costs if required at the discretion of the integrated care board.

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simply because they have cancelled or rearranged appointments; referral back to the GP should always be a clinical decision, based on the individual patient's best clinical interest.

4.4.2.2 Provider-initiated cancellations

If a provider cancels an appointment at any point in the RTT pathway, this has no effect on the RTT waiting time. The RTT clock should continue to tick.

If the treatment is cancelled by the provider after admission because of resource constraints (for example, lack of theatre time due to emergency procedures being carried out), then the RTT clock should continue to tick until the patient ultimately starts their treatment.

If the treatment is cancelled by the provider after admission for clinical reasons (for example, patient deemed temporarily unfit for surgery due to chest infection), then the RTT clock should continue to tick unless a clinical decision is made that the patient is unsuitable for surgery/treatment and they are discharged back to primary care or a decision not to treat is made. This scenario would be unlikely as issues such as this should be picked up at the pre-operative assessment stage or even earlier on the pathway.

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5. Recording RTT waiting times: Planned patients

5.1 RTT measurement and planned patients

Planned care means an appointment /procedure or 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. Planned activity is also sometimes called ‘surveillance’, ‘re-do’ or ‘follow-up’.

Patients on planned waiting lists are outside the scope of RTT measurement.

Patients should only be placed on a planned list when they are due to have a planned procedure or operation that is to take place in a specific time, such as a repeat colonoscopy, or where they are receiving repeated therapeutic procedures, such as radiotherapy.

Patients who are on an RTT pathway should not be placed on a planned list if they are unfit for a procedure or operation. Instead, their clock should keep running unless a clinical decision is made to discharge or start active monitoring.

5.2 RTT clock start for patients transferring from a planned list[18]

Patients on planned lists should be booked in for an appointment at the clinically appropriate time and they should not have to wait a further period after this time has elapsed. For example, a patient due to have a re-test in six months’ time should be booked in around six months later and they should not get to six months, then have to wait again for non-clinical reasons. This is not an acceptable use of a planned list.

When patients on planned lists are clinically ready for their care to commence and reach the date for their planned appointment, they should either receive that appointment or be transferred to an active waiting list and a waiting time clock should start (and be reported in the relevant waiting time return). The key principle is that where patients' treatment can be started immediately, then they should start treatment or be added to an active waiting list.

This principle applies equally to review or surveillance appointments with a consultant-led service that may lead to consultant-led treatment.

[18] A letter was sent to NHS Chief Executives from David Flory and Bruce Keogh on 25 November 2011 outlining the following guidance relating to patients on ‘planned’ waiting lists.

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5.2.1 Suggested good practice

It is for trusts locally to determine the appropriate arrangements for each individual patient case, applying this key principle on a common-sense basis to achieve the best possible clinical outcomes for the patient.

Commissioners and providers need to plan and manage their services so that new and planned patients are treated at the right time and in order of clinical priority. Patients requiring initial or follow-up appointments for clinical assessment, review, monitoring, procedures, or treatment must be given a clear expectation of the timeframe for this, as required by best clinical evidence. For example, where a patient is due to have a consultant-led planned procedure in six months' time, the patient should be added to the 'planned' list for six months' time and a firm date for the procedure booked in nearer the time. If the planned procedure is then delayed beyond the six month timeframe, a new RTT clock must start.

Trusts should have systems in place to review any planned lists regularly to ensure planned appointments are booked for the right time and that patient safety, and standards of care, are not compromised to the detriment of outcomes for patients. Patients should also be given written confirmation if they are placed on planned lists, including the review date. Effective communication removes uncertainty for patients and ongoing review ensures that patients' treatment is not delayed inappropriately.

There are very strong clinical governance and safety reasons why planned care should not be deferred. A significant proportion of this activity is done for surveillance of high risk groups of patients associated with high rates of mortality and poorer outcomes if not managed correctly.

It should also be remembered that many patients require structured follow-up to detect the need for further treatment at appropriate follow-up intervals for individual clinical conditions. Examples may be patients with diabetic eye disease, or other eye conditions, who need eye examination to detect progression requiring urgent treatment to prevent blindness, or patients with long term conditions who require planned monitoring including those on disease-modifying drugs (such as for rheumatoid arthritis) where both potential side-effects of the drugs and response to treatment must be assessed.

A service that allows planned activity to be deferred because of pressure on active waiting lists is not in control of its total demand. This is not sustainable and such services put

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patients at risk, are likely to build up backlogs of long waits and fail to deliver patients' right to maximum waiting times under the NHS Constitution.

Providers and commissioners should monitor how many new RTT clock starts within the month are as a result of planned /review patients who by virtue of not having their planned / review activity within the clinically defined time frame have been moved to an active waiting list.

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6. Recording RTT waiting times: interface services

6.1 Definition

An interface service is defined as being any arrangement that incorporates an intermediary level of clinical triage, assessment and treatment in or between traditional primary and secondary care.

RTT measurement relates to consultant-led care. Therefore, the definition of the term 'interface service' within the context of RTT does not apply to similar 'interface' arrangements established to deliver traditionally primary care or community provided services, outside of their traditional (practice or community based) setting.

This means that, when making local decisions about whether a particular service meets the definition of an 'interface service', you should consider:

a) is the service one that has traditionally existed to deliver primary or community care – in which case it does not meet the definition of an interface service, and a consultant-led waiting time clock should not start;

b) is the service one that has been established to deliver traditionally provided community or primary care, just in a different setting, in which case, a consultant-led waiting time clock should not start;

c) is the service one that has been established to bring solely non-consultant-led services (for example, direct access audiology services or therapies) outside of a hospital setting, in which case a consultant-led waiting time clock should not start.

However, if:

a) the service in question accepts referrals that would otherwise have traditionally been provided by a consultant or consultant-led team; and

b) the referrals may go on to be onward referred to a consultant-led service before responsibility is transferred back to the referring health professional or general practitioner…

…then this should be classed as an 'interface service', and a consultant-led waiting time clock should start on receipt of referral.

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The definition of the term ‘interface service’ does not apply to:

- non consultant-led mental health services run by mental health trusts (that is mental health services that are not consultant-led);
- referrals to ‘practitioners with a special interest’ for triage, assessment and possible treatment, except where they are working as part of a wider interface service type arrangements and have the ability to refer on to a consultant-led service.

Referrals to referral management or assessment services should also start a consultant-led waiting times clock. A referral management centre or assessment service is a specific type of interface service that does not provide treatment, but accepts GP (or other) referrals and provides advice on the most appropriate next steps for the place or treatment of the patient. Depending on the nature of the service they may, or may not, physically see or assess the patient.

Referral management centres and assessment services should only be in place where they carry clinical support and abide by clear protocols that provide benefits to patients. They must not be devices either to delay treatment or to avoid having clinical discussions with GP practices about good referral practice.

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7. Recording RTT waiting times: community health services

7.1 Non-consultant-led community services

Referrals to community services, and subsequent contacts, that are not consultant led are not in scope of RTT.

7.2 Consultant-led community services

Where a community service is consultant-led, this is considered to be an RTT pathway and is subject to relevant RTT regulations. To allow for consolidated reporting of community services activity, however, these pathways should be recorded in relevant Community datasets and should be **excluded** from the RTT data submissions.

This allows for consolidated reporting of consultant-led and non-consultant led community services data within one place for onward reporting and monitoring.

This would mean that all community services such as Community Paediatrics and Community Medicine should be recorded within community datasets and should not be reported within RTT data submissions.

7.3 Consultant-led acute activity delivered within a community setting

Where a service is a consultant-led service in a community setting, but is not classed as a community service itself (e.g. an orthopaedic consultant providing outpatient services within a community health centre), the pathway remains in scope of RTT regulations and RTT data submissions.

A consultant-led waiting time clock should start on receipt of referral, and these pathways should be recorded within RTT data submissions.

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8. Patient-initiated delays and RTT pathways

Many patients will choose to be seen at the earliest opportunity. However, patients are entitled to wait longer for their treatment if they wish. Patients must be allowed to plan their treatment around their personal circumstances. Delays as a result of patient choice are taken account of in the tolerance of 8% set for achievement of the incomplete pathway waiting time operational standard. In many trusts, we would expect delays as a result of patient choice to account for the bulk of this tolerance.

Trusts must ensure that Local Access Policies and Standard Operating Procedures are in line with the RTT Rules, protect the ability of patients to choose their time of treatment, and ensure that patients are not penalised through inappropriate actions in order to deliver the 92% incomplete pathway operational standard.

With effect from October 2015, the RTT Rules Suite has been updated to reflect the removal of the provision to apply adjustments to RTT pathways for patient-initiated delays. There is no longer any provision to report pauses or suspensions in RTT waiting time clocks in monthly RTT returns to NHS England under any circumstances. Trusts will, however, wish to maintain a local record of all patient-initiated delays, to aid good waiting list management and to ensure patients are treated in order of clinical priority. Trusts will also wish to identify those patients who chose to start treatment after 18 weeks, that is those who were offered a reasonable appointment within 18 weeks of referral but chose to wait longer, for personal or social reasons. A reasonable offer of an appointment is one for a time and date three or more weeks from the time that the offer was made. It is good practice to offer patients at least two reasonable offers.

8.1 Duration of patient-initiated delays

Trusts must not have blanket rules that apply a maximum length to patient-initiated delays that does not take account of individual patient circumstances. Trusts should have mechanisms in place to protect patients who may come to harm by choosing to delay their treatment. This applies equally to those patients who may come to harm by repeatedly cancelling or failing to attend appointments.

Clinicians should provide booking staff with guidelines as to how long (in general) patients should be allowed to defer their treatment without further clinical review.

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Patients requesting a delay longer than this should have a clinical review to decide if this delay is appropriate. If the clinician is satisfied that the proposed delay is appropriate then the trust should allow the delay, regardless of the length of wait reported.

If the clinician is not satisfied that the proposed delay is appropriate then the clinical risks should be clearly communicated to the patient and a clinically appropriate TCI date agreed.

If the patient refuses to accept the advice of the clinician then the responsible clinician must act in the best interest of the patient. If the clinician feels that it is in the best clinical interest of the patient to discharge the patient back to the care of their GP and inform them that treatment is not progressing then this must be made clear to the patient. This must be a clinical decision, taking the healthcare needs of each individual patient into account.

It is not acceptable to refer patients back to their GP simply because they wish to delay their appointment or treatment. However, it would be acceptable where referring patients back to their GP is in their best clinical interests. Such decisions should be made by the treating clinician on a case by case basis.

8.2 Patient choice

Patients have the legal right to choose the provider (trust) and consultant-led team for his or her first outpatient appointment. Patients may be offered the choice of an earlier appointment with another consultant-led team but, if a patient turns down this offer, their waiting time clock should continue to tick.

Sometimes a patient may wish to change to another consultant-led team for their treatment. If the locally-agreed referral pathway allows for a patient to switch their preferred consultant-led team without being referred back to their GP then their waiting time clock will continue to tick.

If the locally-agreed referral pathway for a patient-initiated change to their choice of provider requires a patient to be discharged back to their GP to make a fresh referral, the waiting time clock will stop at discharge back to the GP.

Some trusts/consultants provide services across a number of sites with a mixed provision of outpatient, day case and inpatient facilities. Where a trust has multiple sites, it is good practice for trusts to ensure that the patient is aware of site options when making their choice, so that they are aware of any limitations on the sites where their chosen consultant (or team member) can perform their procedure. Where a treatment is available on more than one site, patients should be asked whether they are willing to go to any site, and/or whether they have a preference – trusts should then only offer treatments on the site(s) that the patient has indicated that they would be willing to attend.

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In some cases the choices will be limited by the clinical appropriateness of the services available at the sites. This may include factors such as:

- requirement for general anaesthetic;
- inpatient beds;
- critical care;
- specialist staffing;
- specialist on-site equipment.

The general principle remains that patients can be offered the choice of receiving treatment by a different hospital/hospital site/consultant but their waiting time clocks should continue to tick if they choose not to accept this opportunity. This includes situations where a patient is offered an appointment with a private provider as part of an outsourcing arrangement.

8.3 Good practice for managing patient-initiated delays

- Trusts will wish to record patient-initiated delays locally, to aid good waiting list management and to ensure that patients are treated in order of clinical priority. For example, so that a patient who has chosen to wait until after the school holidays for an appointment is not overlooked when they are available again.

- Do not allow open-ended patient-initiated delays – always try to secure an available from date from the patient. Where a patient-initiated delay can be considered as patient ‘thinking time’ rather than a declared period of unavailability, it should be considered whether it is clinically appropriate to start a period of active monitoring. Trusts should make a common sense judgement to differentiate between a short period of thinking time whilst the patient is considering whether to proceed with the proposed treatment (no clock stop) versus wanting to see how their condition can be managed or progresses before making a decision as to whether to proceed with the proposed treatment (clock stop for active monitoring).

- Keep the list of patient-initiated delays under active review

- Maintain a full audit trail on pathways with a patient-initiated delay, in particular those where the overall wait is likely to be lengthy

- It is good practice to agree the dates of appointments/ admissions with patients rather than notifying them of an appointment, to avoid the risk of patient cancellations.

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8.4 Patients wishing to delay treatment

In circumstances where a patient wishes to delay their treatment the following approach may be considered:

- Following declining a first TCI, a second TCI should be offered which is within 6 weeks of the first TCI.
- TCIs offered should be reasonable (i.e. with 3 weeks-notice) - If a second TCI is declined it may be appropriate, following a clinical conversation and agreement with the patient, to consider placing a patient on hospital initiated active monitoring.
- Where it is appropriate to place a patient on active monitoring, this should be for a maximum period of 12 weeks.
- If a patient is placed on active monitoring the RTT clock should be stopped when there is a decision agreed by both the patient and clinician to start a period of active monitoring.
- Patients placed on active monitoring should be managed through local reporting and local clinical governance arrangements.
- Throughout the agreed active monitoring period the patient should be advised of the process to follow should they wish to go ahead with treatment and be reinstated on the waiting list.
- If a patient wishes to go ahead with treatment, the provider should offer a new TCI date acting as if the patient is on the waiting list at the point which they previously left i.e. they should not be returned to the beginning of the waiting list. A new clock should start on the date that the patient decides to go ahead with the treatment.

The TCI date offered must include date, provider and team. It is not appropriate to start a period of active monitoring and stop the clock on the basis of a patient declining earlier treatment at a provider for which the detail has not been confirmed.

8.5 Patients declining earlier treatment at an alternative provider (currently choice category)

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

In circumstances where a patient declines earlier treatment at an alternative provider the following approach may be considered:

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- Following declining a first TCI at an alternative provider, a second TCI should be offered which is within 6 weeks of the first TCI. - TCIs offered should be reasonable (i.e. with 3 weeks-notice)

- If a second TCI is declined it may be appropriate, following a clinical conversation and agreement with the patient, to consider placing a patient on active monitoring.

- If a patient is placed on active monitoring the RTT clock should be stopped.

- Patients placed on active monitoring should be managed through local reporting and local clinical governance arrangements.

- Throughout the agreed active monitoring period the patient should be advised of the process to follow should they wish to go ahead with treatment and be reinstated on the waiting list.

- Should a patient decline the subsequently offered TCIs at the existing provider, the guidance relating to cohort (a) above should be followed.

The TCI date offered must include date, provider and team. It is not appropriate to start a period of active monitoring and stop the clock on the basis of a patient declining earlier treatment at a provider for which the detail has not been confirmed.

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9. Local data assurance and governance

Accurate recording and reporting of RTT data is central to meeting the RTT operational waiting times standards, delivering the maximum waiting times right to all eligible patients and informing patients' choices of where they want to be referred.

All parts of the NHS have a role to play in ensuring waiting time data is recorded accurately. However, primary responsibility for accurate waiting time data starts with the chief executive of each trust and foundation trust who must take this responsibility seriously. Before it is submitted to NHS England, all provider data should be signed off by each trust and reviewed by their relevant commissioners.

To make certain that trusts have robust data recording systems and processes in place, NHS England;

- require all trust annual governance statements from April 2015 to include an explicit statement on how the Trust will assure waiting time data quality, accuracy and risks, and;
- mandated regular assurance of waiting times data within their respective accountability frameworks for trusts and foundation trusts from April 2015 through internal audit, external audit, or quality reports.

9.1 RTT data quality assurance checklist

The following checklist is a useful guide for all NHS organisations providing consultant-led services to assure the quality of the RTT data they submit. Organisations that cannot answer yes to each question will need to address the issues raised.

Have referral dates and other RTT clock starts been recorded for all your patients?

Without knowing clock starts for all patients NHS organisations will not know where each patient is on their RTT pathway. Good waiting list management – treating patients according to their clinical priority and then in the order in which they were added to the list – requires that clock starts are properly recorded. This includes referrals through eRS and RAS where they have not yet been booked but may appear on Appointment Slot Issue worklists or equivalent.

Do you know the original referral dates/clock starts for all patients transferred to you from other hospitals or interface services?

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The waiting times standards apply equally to patients who transfer between hospitals and from interface services. It is mandatory for all organisations to transfer the Inter Provider Transfer Administrative Minimum Data Set (IPTAMDS) for patients as they move between organisations, so that key information, for example about clock starts, transfers with them.

Do your systems capture the end of all RTT pathways?

An RTT clock stops when:

- the patient starts consultant-led treatment;
- the patient starts therapy or healthcare science intervention as decided by a consultant;
- the patient is added to a national transplant waiting list;[19]
- the patient is returned to primary care for non consultant-led treatment;
- a decision is made to start a period of active monitoring;
- the patient declines treatment;
- a clinical decision is made not to treat;
- the patient is discharged by their clinician back into the care of their GP.

Organisations must have mechanisms in place to capture and report the end of all pathways.

To record this information most providers have implemented systems which record clinical outcomes in outpatient clinics and also to capture clinical decisions made outside of clinics.

How many clock starts are due to planned patients not being seen in time?

When patients on planned lists are clinically ready for their care to commence and reach the date of their planned appointment, they should either receive that appointment or be transferred to an active waiting list and a waiting time clock should start. Ideally no new clock would start, as the patient should not wait beyond the clinically appropriate date.

Are any emergency admissions mistakenly being included in the RTT return?

Patients whose pathway commences as an emergency presentation (typically but not exclusively through an A&E or minor injuries department) should not be included within RTT reports, unless and until a decision to refer for further elective diagnostic tests or treatment is made.

[19] For unmatched transplants, where a patient is not on the national transplant list, the clock stops with the patient's admission for surgery.

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Do you review waits over 18 weeks?

This is important as it will inform you why these occurred and enable you to take action to avoid unnecessary long waits for your patients in the future.

Is your total list size increasing? Or are your clearance times increasing?

An increasing list size or clearance time may be an early warning sign for a commissioner and its provider that the number of patients being referred is out of balance with the capacity being provided - and that waiting times are at risk of increasing.

Clearance times provide a means for assessing the relative size of a waiting list, and are calculated by comparing the number of patients waiting, with a typical week's RTT activity. Clearance times are expressed as the number of weeks it would notionally take to treat the stock of incomplete pathways if no new clocks were started, and clocks continue to be stopped at the current rate. The NHS England Performance Analysis Team can provide advice on calculating clearance times and can be contacted via england.rtt@nhs.net.

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10. Reporting Referral to Treatment statistics to NHS England

This section is intended for staff involved in the preparation and submission of aggregate RTT data. The process to collect this data is managed by NHS Digital via the Strategic Data Collection Service (SDCS). The data owner is NHS England.

10.1 Submitting data

Performance against the operational standard for consultant-led (RTT) waiting times is monitored against aggregate monthly data submitted to NHS Digital via the SDCS online data collections tool and published on the NHS England website at http://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/.

However, organisations are also mandated to submit RTT data via the Secondary Uses Service (SUS). The SUS RTT reporting application is based upon the use of national standard Commissioning Data Sets (CDS) submitted through SUS. Commissioning Data Sets (CDS) are maintained and developed by NHS Digital. The CDS records reflect individual patient interactions, for example, individual appointments or consultant episodes. SUS constructs RTT pathways information by linking CDS records for individual patients, identifying the types of events represented by each record, grouping events into RTT pathways and calculating the duration of the pathway. NHS England is committed to moving over to the use of SUS for RTT data and is working with NHS Digital to ensure that SUS RTT reporting meets the standard required to allow this change to be made.

Because information recorded in Patient Administration Systems is therefore used for both SDCS and SUS reporting, this guidance includes some technical details relating to the use of CDS records that may not be relevant for all readers. These technical details have been separated from the main body of the text as annexes.

Advice on submission of CDS data via SUS may also be found at: http://webarchive.nationalarchives.gov.uk/+/http://www.isb.nhs.uk/library/standard/199.

10.1.1 Monthly data requirement to report RTT statistics via SDCS

10.1.1.1 Who should report data?

Any organisation that provides NHS services that fall within the scope of RTT should complete a provider return to NHS Digital's online SDCS portal. This includes acute trusts, specialist trusts, mental health trusts and any other provider of consultant-led services for NHS patients in England or provider of interface services as defined in section 6.

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The RTT data collection has DCB (Data Coordination Board) assurance, while .the NHS Standard Contract requires providers to report monthly RTT data.

The data collection is provider and commissioner based.

Where NHS care is funded and directly commissioned by a SUB-ICB or NHS England, Independent Sector (IS) providers are encouraged to engage in the RTT data collection process by monitoring RTT times for NHS patients being seen/treated at their sites and by submitting this information to SDCS in the same way as NHS provider organisations. Please see section 10.1.2 for guidance on requesting an SDCS account for your organisation.

Commissioners are required to check the data for their commissioned patients made available through an NHS Digital facility called SEFT (Secure Electronic File Transfer).

10.1.1.2 Format of the data collection

The national data collection looks at RTT waiting times in weeks, split by treatment function. Returns are submitted by providers, split by commissioner.

The RTT data collection template is in three sections:

Part 1a - Completed pathways – admitted patients

RTT waited 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 waited 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 waiting 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.

Part 2a – Incomplete pathways – patients with a decision to admit for treatment

RTT waiting times so far for patients whose RTT clock is still running at the end of the reporting month for whom a decision to admit has been made.

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Part 3 – New RTT periods – all patients

Number of new RTT periods during the month.

The submission of adjusted monthly RTT data, in addition to unadjusted data, was required for March 2008 to September 2015. From October 2015 data (submitted in November 2015), the adjusted RTT data collection return is no longer required and two new data items have been added.

The changes to the reporting requirements effective from October 2015 data onwards can be summarised as follows:

- there is no longer a requirement to submit admitted adjusted data to NHS England
- unadjusted admitted and non-admitted completed pathway data is still required but will no longer be used for monitoring against operational standards
- the requirement to report incomplete pathway data remains unchanged – and has always been an unadjusted submission
- two new data items have been added: incomplete pathways for patients with a decision to admit and new RTT periods.

10.1.1.3 Changes to existing data collection template – from April 2021

We are making some changes to the data collection template from April 2021 data onwards. The changes are as follows:

1. Phase out the use of X24 code entirely and move to the more granular NHS England commissioning codes.
2. Additional weekly time bands from 52-53 weeks to 104+ added to Parts 1A, 1B, 2 and 2A of the collection
3. Changes to the treatment function categories – to:
   a) reflect 21/22 changes as notified by NHS Digital. The changes fall into two categories:
      i. update to treatment function names
      ii. update to the guidance on reporting ‘exceptions’ in response to the introduction of new treatment function codes. Two new exceptions have been added:
         - orthopaedic Service (111) and Trauma Surgery Service (115) should be included in Trauma and Orthopaedics (110). Note this is in addition to the existing reporting exception that Spinal Surgery Service (108) should be included in Trauma and Orthopaedics (110).
         - oral and Maxillofacial Surgery (145) and Maxillofacial Surgery (144) should be included in Oral Surgery (140).

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b) Separate the ‘Other’ category into five groups:
   i. Other – Surgical Services
   ii. Other – Paediatric Services
   iii. Other – Medical Services
   iv. Other – Mental Health Services
   v. Other – Other Services

10.1.2 How to submit and review data

Provider submission via SDCS

The data is collected online via the SDCS portal. Providers (including acute trusts, specialist trusts, mental health trusts and any other provider of consultant-led services for NHS patients in England, including independent sector providers) download a spreadsheet-based form and enter their data broken down by commissioner. There is functionality in the form which semi-automates this and allows for CSV import of the data. Providers then upload their completed spreadsheet to the SDCS portal.

Commissioner review via SEFT

Once providers begin to submit, daily commissioner based files are automatically produced from the providers’ data and made available to Sub-ICBs by NHS Digital through their SEFT website. Following the provider deadline commissioners have five days to download and review their data, in particular to check for errors, inconsistencies and missing data. If any issues are identified, the commissioner should raise these with the relevant providers. Where a data provider resubmits their figures, this will be included in the next daily commissioner file available in SEFT. All changes will need to be completed prior to the commissioner review deadline.

More detailed guidance outlining the process for providers and commissioners is available here:

https://www.england.nhs.uk/statistics/guidance-prov-comms/

Sub-ICBs which require access to SEFT should contact england.nhsdata@nhs.net

10.1.3 Timetable for data submission

The timetable for data submission is available here:
https://www.england.nhs.uk/statistics/collections-timetable/

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The provider deadline for submission is 13 working days after the final day of the reference period, and the commissioner assurance deadline is 18 working days after the end of the reference period.

10.1.4 Reporting RTT data by treatment function

When completing the spreadsheet form, data should be submitted for the treatment functions listed below:

100	General Surgery Service
101	Urology Service
110	Trauma & Orthopaedics Service
120	Ear, Nose & Throat Service
130	Ophthalmology Service
140	Oral Surgery Service
150	Neurosurgery Service
160	Plastic Surgery Service
170	Cardiothoracic Surgery Service
300	General Internal Medicine Service
301	Gastroenterology Service
320	Cardiology Service
330	Dermatology Service
340	Respiratory Medicine Service
400	Neurology Service
410	Rheumatology Service
430	Elderly Medicine Service
502	Gynaecology Service
X02	Other – Medical Services (All other TREATMENT FUNCTIONS in the Medical Services group not reported individually)
X03	Other – Mental Health Services (All other TREATMENT FUNCTIONS in the Mental Health group not reported individually)
X04	Other – Paediatric Services (All other TREATMENT FUNCTIONS in the Paediatric group not reported individually)
X05	Other – Surgical Services (All other TREATMENT FUNCTIONS in the Surgical group not reported individually)
X06	Other – Other Services (All other TREATMENT FUNCTIONS in the Other group not reported individually)

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For more information on Treatment Function Code definitions, please refer to the NHS Digital web resource here: https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/dcb0028-treatment-function-and-main-specialty-standard

The 18 treatment functions listed out separately on the spreadsheet form were chosen as they were high volume areas with a large volume of RTT pathways. The form was amended from April 2021 to split the 'Other' category into five subgroups:

- Other – Medical Services
- Other – Mental Health Services
- Other – Paediatric Services
- Other – Surgical Services
- Other – Other Services

Data for any other treatment functions not separately reported should be aggregated and reported on these 'other' treatment function subcategories, depending on which treatment function group they fall under. NHS Digital's Treatment Function and Main Specialty Standard Code List Specification (accessed here: https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/dcb0028-treatment-function-and-main-specialty-standard) provides details of the treatment function group for all treatment function codes.

For example, General Medicine (300) should include data relating to 300 and exclude sub-specialties 306, 307, 308 and 309. These sub-specialties are all within the Medical Services group and should therefore be included in the 'Other – Medical Services' line on the data collection spreadsheet form.

The only exceptions to this rule are:

- Cardiothoracic Surgery, which can be either specialty 170 (Cardiothoracic) or an aggregation of 172 (Cardiac) and 173 (Thoracic);
- Spinal Surgery Service (108), Orthopaedic Service (111) and Trauma
- Surgery Service (115) should be included in Trauma and Orthopaedics (110).
- Oral and Maxillofacial Surgery (145) and Maxillofacial Surgery (144) should be included in Oral Surgery (140).

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A completed admitted or non-admitted RTT pathway should be reported against the treatment function of the activity that stopped the RTT clock. The treatment function against which an incomplete (open) RTT pathway is reported can change while the RTT pathway progresses. Incomplete pathway data should be submitted against the treatment functions based on its classification at the time of submission.

10.1.5 Unknown clock starts

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

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 the Inter Provider Transfer Administrative Minimum Data Set (IPTAMDS, see section 11).

If the validation of pathways establishes that some RTT pathways have already been completed prior to the current reporting period (in other words, the clock stopped in a previous month), these should not be added to the monthly reporting of completed RTT pathways for the current reporting period.

10.1.6 Revisions process

If an error is discovered before the submission deadline, providers can simply upload an amended version of their return to SDCS. Uploading an amended return will automatically overwrite the previous return.

If an error is discovered after the provider deadline, please email england.rtt@nhs.net with a brief description of the error. If it is on or shortly after the submission deadline, it is likely you can be granted an extension in order to correct the data. If it is significantly after the submission deadline, please contact england.rtt@nhs.net to discuss options.

NHS England will consider all requests for revisions to published RTT data in line with the NHS England Analytical Services revisions policy: http://www.england.nhs.uk/statistics/code-compliance/#Unifypolicy. Data revisions are normally published every six months (generally in January and July), alongside the latest release of new monthly data.

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10.1.7 Measuring the length of RTT pathways

Assigning RTT pathways to weekly time bands

Data should be allocated to the following time bands: 0-1 weeks, >1-2 weeks, >2-3 weeks, then for all weekly time bands through to >103-104 weeks, >104 weeks.

Waits should be allocated to the weekly time bands as follows:

- 0 to 1 weeks includes patients waiting/having waited 0, 1, 2, 3, 4, 5, 6 and 7 days
- 1 to 2 weeks includes patients waiting/having waited 8, 9, 10, 11, 12, 13 and 14 days
- 17 to 18 weeks includes patients waiting/having waited 120, 121, 122, 123, 124, 125 and 126 days
- 51 to 52 weeks includes patients waiting/having waited 358, 359, 360, 361, 362, 363 and 364 days
- 104+ weeks includes patients waiting/having waited 729 days and more

Note that this means there are eight reporting days in the 0-1 week time band as it includes waits of 0, 1, 2, 3, 4, 5, 6 and 7 days.

A patient who has waited exactly 18 weeks (126 days) is included in the 17-18 weeks time band.

Very short RTT pathways

All valid RTT pathways should be included in monitoring returns, regardless of their length. An RTT clock that started and stopped on the same day will have an RTT time of zero days. These should still be recorded as completed pathways in the RTT data collection and should be reported in the 0-1 week time band on the collection template. Examples of such pathways could include a patient who presents at a consultant-led drop-in clinic and subsequently starts first definitive treatment on that day.

However, patients whose pathway commences as an emergency presentation (typically but not exclusively through an A&E or minor injuries department) should not be included within RTT reports, unless and until a decision to refer for further elective diagnostic tests or treatment is made.

10.1.8 Assigning commissioner codes

The basic rules for assigning a commissioner code to RTT pathways are as follows:

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- where it is known that the commissioner is NHS England, use the relevant commissioner code as outlined in the NHS England Commissioning Responsibilities Matrix (see the latest Commissioner Assignment Method – Supporting Tables Spreadsheet at https://www.england.nhs.uk/data-services/commissioning-flows/);

- use the code NONC for non-English commissioners;

- use a SUB-ICB code for everything else:
  - SUB-ICB of GP practice if known;
  - then SUB-ICB of residence if no GP;
  - then 'host' SUB-ICB if no GP or resident postcode.

NHS England is aware of the issues around identifying specialist activity, especially for incomplete RTT pathways. Providers should assign pathways/activity as specialised to the best of their knowledge at the time of submission, the same principle that applies to applying pathways/activity to treatment functions.

10.1.9 Reporting data for patients who move between the countries of the UK

10.1.9.1 Patients who transfer to an English commissioner

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 take account of how long patients have already waited and look to treat them without undue delay and according to their clinical need.

10.1.9.2 Patients treated in England whose commissioner is in Wales or Scotland

RTT data for non-contract activity should be recorded against the commissioning organisation (in line with PbR)[20]. RTT pathways commissioned by non-English commissioners should be assigned to commissioner code NONC.

[20] This was announced in a Data Set Change Notice published in 2005 (DSCN ref: 19/2005).

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10.1.10 NHS England commissioned activity and RTT reporting

Most services provided in the NHS are commissioned by Sub-ICBs. However, some services are commissioned by NHS England. Nationally, NHS England commissions specialised services, offender healthcare and some services for members of the armed forces.

Specialised services are those provided in relatively few hospitals, accessed by comparatively small numbers of patients. These services tend to be located in specialised hospital trusts that can recruit a team of staff with the appropriate expertise and enable them to develop their skills.

For guidance on identifying specialised services activity please see the specialised commissioning 'Manual' and 'Identification Rules' published here:

http://www.england.nhs.uk/commissioning/spec-services/key-docs/

RTT measurement applies to consultant-led services commissioned by NHS England in the same way as it applies to Sub ICB-commissioned services. Therefore patients on an RTT pathway who are waiting for services commissioned by NHS England should be reported on as part of the RTT data collection. RTT pathways commissioned by NHS England should be submitted against the relevant commissioning code in the SDCS returns[21]. This will include:

- Patients registered with an English MoD Defence Medical Services (DMS) practice[22] and whose healthcare activity will be paid for via an NHS England commissioner.
- Prison-based patients, who can be identified on the basis of their usual place of residence being a permanent detention centre.
- Specialised health services commissioned by NHS England.
- From April 2013 to March 2023, NHS England had commissioning responsibility for all NHS dental services: primary, community and secondary, including dental out of hours and urgent care. This included commissioning dental services provided in high street dental practices, community dental services, and dental services at general hospitals and dental hospitals[23]. From April 2023, responsibility for

[21] See the latest Commissioner Assignment Method – Supporting Tables Spreadsheet at https://www.england.nhs.uk/data-services/commissioning-flows/)
[22] The NHS Digital Organisation Data Service (ODS) Sub-ICB lookup files map GP practice to Sub-ICB: https://digital.nhs.uk/services/organisation-data-service/data-downloads/gp-and-gp-practice-related-data. DMS practices have practice codes in the ODS *'epraccur'* GP practice code file that map to the commissioning hub code 13Q.
[23] See http://www.england.nhs.uk/2013/02/13/dental/ for more information.

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secondary dental provision was transferred from NHS England to Integrated Care Boards (ICBs).

10.2 Data quality

10.2.1 Responsibility for data quality

Organisations should provide as accurate data as possible by the submission deadline.

As with all central returns, provider organisations are responsible for ensuring that the completed pathways they submit are an accurate representation of the waited times of the RTT patients treated during the month and that the incomplete pathways are an accurate representation of the RTT patients still waiting to start treatment at the end of the month at their organisation. Commissioner organisations are responsible for ensuring that the data submitted against them is an accurate representation of the waiting times for the patients they have commissioned services for. If commissioners have concerns about the data they should use the five working days between the provider deadline and the commissioner assurance deadline to query the data with their providers. See section 8 for more information on local data assurance.

NHS England also runs monthly central validation checks on the submitted RTT data (see Annex B for details of the checks). When providers are aware of data quality issues, they should inform the Performance Analysis Team (england.rtt@nhs.net) as part of this validation process. This will ensure that where possible issues are resolved and data quality improved prior to publication, and where the issues require a longer-term solution the data can be improved as part of the six-monthly revisions process.

10.3 Non-reporting of data by trusts

NHS England published mandatory guidelines setting out the responsibilities of providers of NHS services who want to suspend the reporting of mandatory data, including RTT returns: https://www.england.nhs.uk/statistics/guidance-non-submissions/.

All providers should ensure that appropriate actions are taken to meet all reporting requirements and should have robust governance arrangements and contingency plans in place to support the continuing provision of monthly RTT data returns. However, in exceptional circumstances, where a trust has no confidence in the accuracy of its RTT data, it may be appropriate to suspend reporting.

The decision to suspend the submission of data needs to be a decision taken and owned by the board of a trust. The expectation is that the plan to resolve the problem and oversight of

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the associated mitigating actions, will be a key issue for the Board to monitor closely until the issues are completely resolved.

The decision by a trust not to submit data returns is a serious one and should not be taken lightly as the likely impact on an organisation can be significant. The NHS trust will be highlighted in any national publications as not being able to submit data.

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11. Reporting waiting times for patients who transfer between organisations

11.1 Reporting RTT waiting times for transferred patients

RTT waits should be reported by the NHS trust (provider) that has overall clinical responsibility for the patient. For multi-provider pathways (for example, pathways that involve a transfer to a tertiary centre), the RTT measurement and reporting baton passes with the clinical responsibility baton. So if trust A refers to trust B and clinical responsibility is transferring, trust B should start to monitor and report the patient's RTT time on their RTT return (and PTL where relevant). There is no longer any central requirement for trust A to track the patient's RTT time[24]. However, they may want to make a local arrangement that trust B keeps them informed of the patient's progress.

If trust A refers the patient to trust B simply for a diagnostic or opinion and trust A is retaining overall clinical responsibility, then trust A retains the measurement baton and should continue to report the patient on their RTT return and PTL.

11.2 Subcontracting relationships and RTT reporting[25]

The principle of RTT waits being reported by the NHS trust (provider) that has overall clinical responsibility for the patient also applies to any patients that are treated in another provider under a subcontract. This includes situations where providers agree to accept referrals from another provider for patients who will wait or already have waited longer than 18 weeks.

However, where this arrangement might result in patients being disadvantaged due to an alternative provider being unwilling to take on these patients who will wait or already have waited longer than 18 weeks, because of the impact on their performance, then the originating provider can continue to report the patients RTT wait on an exceptional basis provided that this is:

a) agreed explicitly and in advance by the patients' commissioning organisation – not least to ensure the alternative provider treating the patients has Clinical Negligence Scheme for Trusts (CNST) cover under the CNST indemnity;

b) supported by evidence that demonstrates that it is clinically appropriate and safe for the patients concerned;

[24] Trust A should use RTT status code 21 to signify that the patient is no longer 'on their books'.
[25] Guidance previously published with DH Gateway reference number 18016, August 2012

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c) based on evidence that patients would otherwise be disadvantaged (in other words, would have to wait longer) if flexibility around the reporting arrangements could not be agreed.

The Performance Analysis Team RTT measurement team (england.rtt@nhs.net) should be advised of any such arrangements.

This approach has no effect on commissioner reported RTT performance. Each commissioner must continue to report RTT performance for all of its patients regardless of which provider treats them.

The terms of any subcontract should set out which provider is responsible for reporting the RTT waits of the patients.

11.3 Inter-Provider Transfer Administrative Minimum Data Set (IPTAMDS)

It is important that the correct start date is captured for patients who transfer from interface services to secondary care providers and from provider to provider.

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 to ensure that patients' waiting times are correctly recorded and that they are treated within maximum waiting times.

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. In particular, 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 are commissioned by English NHS commissioners independent of location.

Example of the use of IPTAMDS for a patient transferring from an interface service:

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- 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.

Example of the use of IPTAMDS for a provider to provider transfer:

- patient's original referral from GP was received by trust A on 2 January; after carrying out initial assessment, trust A decided to refer patient on to a tertiary provider (trust B) for treatment;
- trust B receives referral on 28 January;
- trust B should record the RTT start date for this patient as 2 January, not 28 January.

Further information on the IPTAMDS can be found in Data Set Change Notices (DSCN) 44/2007 and 07/2008, which can be found at: https://digital.nhs.uk/isce/publication/dcb0095. Further information on the use of Patient Pathway Identifiers (PPIDs) and transferred patients and a worked example of how to handle PPIDs for transferred patients is in Annex C.

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12. Good practice and further information

12.1 Good practice

The Elective Care: Improvement Support Team

The Elective Care IST (Improvement Support Team) provide advice and support on elective pathway management including practical application of RTT rules in operational processes.

A range of resources, including improvement guides, support tools, and training materials are available on the Elective Care IST FutureNHS page:
https://future.nhs.uk/connect.ti/ElecCareIST/grouphome

For advice or to discuss how the Elective Care Improvement Support Team could help your organisation, please contact england.eeci@nhs.net

Elective Care Improvement Support Team (IST) Elective Care Guide

A guide to the management of elective care pathways for local health communities (LHCs) including provider organisations, focussed on practical advice that will help to ensure patients are treated in a timely way.

https://future.nhs.uk/ElecCareIST/view?objectId=39469968

NHS England capacity and demand tools

Through its experience of working with NHS Trusts and commissioners, the NHS England Demand & Capacity team has developed the Core Demand & Capacity Model, which is designed to help organisations achieve an appropriate balance between demand and capacity, and to ensure that waiting lists are of an appropriate size. The core model can be used for all types of elective services including outpatients, admissions, and diagnostics, and can act as a helpful starting point for organisations to better understand demand and plan capacity accordingly. The models are freely available via the NHS England website using the following link:

https://www.england.nhs.uk/ourwork/demand-and-capacity/

with further resources on the team's FutureNHS page

https://future.nhs.uk/Demand_Capacity

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Writing a Local Access Policy

Elective Care IST Model Access Policy and checklist, to help individuals in trusts involved in the development, sign off, and review of a local Elective Access Policy

https://future.nhs.uk/ElecCareIST/view?objectId=21368528

RTT PTL and other Waiting List Data Quality Improvement

Elective Care IST advice on improving the quality of waiting list information to support reporting and pathway management, including Waiting List Review Guide, Data Quality for Trust Boards and Non Reporting Guide:

https://future.nhs.uk/ElecCareIST/view?objectId=21496528 and
https://future.nhs.uk/ElecCareIST/view?objectId=80186501

Sign up for operational Waiting List Management training.

The team have developed a waiting list management massive open online course (MOOC) to introduce you to, and support you in, developing the core skills required to manage elective waiting lists.

The course introduces resources and tools through a practical, structured learning-in-action approach. You can work through the modules in the learning platform at your own pace and interact with peers and experienced tutors and operational leads from the Elective Care Improvement Support team. Modules cover RTT rules application, PTL management and governance, local policies, and relevant reports. Please note that courses run 3 times a year.

QIL (england.nhs.uk)

Principles and guidelines for delivering efficient elective care pathways

The NHS England guidance document on Operational Resilience and Capacity Planning for 2014/15 included principles and guidelines for delivering efficient elective care pathways developed by the Elective Care IST

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/320224/Operational_resilience_and_capacity_planning_for_2014-15.pdf

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12.2 Where to go for further information

Is RTT data publicly available?

The monthly RTT data is published routinely each month. The published data set includes data for all providers and all commissioners and can be found at:

http://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/

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13. Terminology and definitions

A

Active monitoring

A waiting time clock may be stopped where it is clinically appropriate to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures at that stage.

A new waiting time clock would start when a decision to treat is made following a period of active monitoring (also known as watchful waiting).

Where there is a clinical reason why it is not appropriate to continue to treat the patient at that stage, but to refer the patient back to primary care for ongoing management, then this constitutes a decision not to treat and should be recorded as such and also stops a waiting time clock.

If a patient is subsequently referred back to a consultant-led service, then this referral starts a new waiting time clock.

An RTT waiting time clock may be stopped where it is clinically appropriate to start a period of active monitoring when a patient wishes to delay treatment or if a patient declines two reasonable treatment date offers at their current or an alternative provider. This would be following a clinical conversation and agreement with the patient.

Admission

The act of admitting a patient for a day case or inpatient procedure.

Admitted pathway

A pathway that ends in a clock stop for admission (day case or inpatient).

B

Bilateral (procedure)

A procedure that is performed on both sides of the body, at matching anatomical sites. For example, removal of cataracts from both eyes.

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C

Care Professional

A person who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.

Clinical decision

A decision taken by a clinician or other qualified care professional, in consultation with the patient, and with reference to local access policies and commissioning arrangements.

Consultant

A person contracted by a healthcare provider who has been appointed by a consultant appointment committee. He or she must be a member of a Royal College or Faculty. Consultant-led waiting times exclude non-medical scientists of equivalent standing (to a consultant) within diagnostic departments.

Consultant-led

A consultant retains overall clinical responsibility for the service, team or treatment. The consultant will not necessarily be physically present for each patient's appointment, but he/she takes overall clinical responsibility for patient care.

Convert(s) their UBRN

When an appointment has been booked via the NHS e-Referral Service, the UBRN is converted. (Please see definition of UBRN).

D

DNA – Did Not Attend

DNA (sometimes known as an FTA – Failed to attend). In the context of consultant-led waiting times, this is defined as where a patient fails to attend an appointment/ admission without prior notice.

Decision to admit

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Where a clinical decision is taken to admit the patient for either day case or inpatient treatment.

Decision to treat

Where a clinical decision is taken to treat the patient. This could be treatment as an inpatient or day case, but also includes treatments performed in other settings, for example, as an outpatient.

F

First definitive treatment

An intervention intended to manage a patient's disease, condition or injury and avoid further intervention. What constitutes first definitive treatment is a matter for clinical judgement, in consultation with others as appropriate, including the patient.

Fit and ready (in the context of bilateral procedures)

A new RTT clock should start once the patient is fit and ready for a subsequent bilateral procedure. In this context, fit and ready means that the clock should start from the date that it is clinically appropriate for the patient to undergo that procedure, and from when the patient says they are available.

H

Healthcare science intervention

See Therapy or Healthcare science intervention.

I

Interface service (non consultant-led interface service)

All arrangements that incorporate any intermediary levels of clinical triage, assessment and treatment between traditional primary and secondary care.

Consultant-led referral to treatment relates to hospital/consultant-led care. Therefore, the definition of the term 'interface service' for the purpose of consultant-led waiting times does not apply to similar 'interface' arrangements established to deliver traditionally primary care

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or community provided services, outside of their traditional (practice or community based) setting.

The definition of the term does not also apply to:

- non consultant-led mental health services run by mental health trusts.
- referrals to ‘practitioners with a special interest’ for triage, assessment and possible treatment, except where they are working as part of a wider interface service type arrangements as described above.

N

NHS e-Referral Service (formerly Choose and Book)

A national electronic referral service that gives patients a choice of place, date and time for their first consultant outpatient appointment in a hospital or clinic.

Non-admitted pathway

A pathway that results in a clock stop for treatment that does not require an admission or for ‘non-treatment’.

Non consultant-led

Where a consultant does not take overall clinical responsibility for the patient.

Non consultant-led interface service

See interface service.

P

Patient pathway

A patient pathway is usually considered to be their journey from first contact with the NHS for an individual condition, through referral, diagnosis and treatment for that condition. For chronic or recurrent conditions, a patient pathway will continue beyond the point at which first definitive treatment starts, as it will include further treatment for the same condition. A person may therefore have multiple RTT periods (see Referral to treatment period) along one patient pathway. NHS England often uses the term ‘RTT pathway’ in published reports and in this document and this is the same as an ‘RTT period’.

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Planned care

An appointment /procedure or 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.

R

Reasonable offer

An offer is reasonable where the offer for an outpatient appointment or an offer of admission is for a time and date three or more weeks from the time that the offer was made.

Referral Management or assessment service

Referral management or assessment services are those that do not provide treatment, but accept GP (or other) referrals and provide advice on the most appropriate next steps for the place or treatment of the patient. Depending on the nature of the service they may, or may not, physically see or assess the patient.

Referral Management and Assessment Services should only be in place where they carry clinical support and abide by clear protocols that provide benefits to patients. They must not be devices either to delay treatment or to avoid local clinical discussions about good referral practice.

A waiting time clock only starts on referral to a referral management and assessment service where that service may onward-refer the patient to a surgical or medical consultant-led service before responsibility is transferred back to the referring health professional.

Referral to treatment period

An RTT period is the time between a person’s referral to a consultant-led service, which initiates a clock start, and the point at which the clock stops for any of the reasons set out in the RTT national clock rules, for example the start of first definitive treatment or a decision that treatment is not appropriate.

S

Straight to test

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A specific type of direct access diagnostic service whereby a patient will be assessed and might, if appropriate, be treated by a medical or surgical consultant-led service before responsibility is transferred back to the referring health professional.

Substantively new or different treatment

Upon completion of a consultant-led referral to treatment period, a new waiting time clock starts upon the decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan.

It is recognised that a patient's care often extends beyond the consultant-led referral to treatment period, and that there may be a number of planned treatments beyond first definitive treatment.

However, where further treatment is required that did not form part of the patient's original treatment plan, a new waiting time clock should start at the point the decision to treat is made.

Scenarios where this might apply include:

- where less 'invasive/intensive' forms of treatment have been unsuccessful and more 'aggressive/intensive' treatment is required (for example, where Intra Uterine Insemination (IUI) has been unsuccessful and a decision is made to refer for IVF treatment);
- patients attending regular follow up outpatient appointments, where a decision is made to try a substantively new or different treatment. In this context, a change to the dosage of existing medication may not count as substantively new or different treatment, whereas a change to medication combined with a decision to refer the patient for therapy might.

Ultimately, the decision about whether the treatment is substantively new or different from the patient's agreed care plan is one that must be made locally by a care professional in consultation with the patient.

T

TCI

To come in date or the date offered for admission to hospital.

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Therapy or Healthcare science intervention

Where a consultant-led or interface service decides that therapy (for example physiotherapy, speech and language therapy, podiatry, counselling) or healthcare science (for example, hearing aid fitting) is the best way to manage the patient's disease, condition or injury and avoid further interventions.

U

UBRN (Unique Booking Reference Number)

The reference number that a patient receives on their appointment request letter when generated by the referrer through the NHS e-Referral Service. The UBRN is used in conjunction with the patient password to make or change an appointment.

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Annex A: Previous RTT recording and reporting guidance

The following documents have been consolidated into this refreshed guidance and accompanying FAQs:

Title	Published
Referral to Treatment Consultant-led Waiting Times How to Measure	Updated January 2012
Frequently Asked Questions on the Referral to Treatment (RTT) data collection	V10 published October 2012
Policy for patients who require appointments for assessment, review and/or treatment - use of planned (pending or review) lists	January 2012
Reporting referral to treatment (RTT) waiting times for patients who wait longer than 18 weeks who transfer between NHS Trusts	August 2012
Referral to Treatment National Statistics – Assurance Checks	August 2012
Referral to treatment (RTT) waiting times - patient initiated clock pauses	October 2012
Unify2 forum post: ProvCom returns – assigning a commissioner	April 2013

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Annex B: NHS England data validation checks

The NHS England Performance Analysis Team runs monthly validation checks on the RTT data submitted each month to identify noticeable data errors, such as missing data and large volume changes. The checks are run between the provider submission deadline and the close of the collection. The Performance Analysis Team queries any issues with the data contact at trusts and the issues are often resolved prior to the close of the collection and publication.

The following routine checks are carried out each month:

- No negative or decimal numbers have been submitted
- Providers have submitted data against valid commissioner codes
- Missing data – including not submitting all or part of the RTT returns
- Incorrect totals – where the total is a sum over all treatment functions
- If a provider reports completed pathways, they also have incomplete pathways
- Large change in volumes compared to last month – large increase or decrease for trusts with more than a minimum number of pathways
- Return matches the previous month, which indicates that a trust has mistakenly re-submitted the previous month's return instead of the current month
- Larger than expected number of incomplete pathways
- Large changes in 52+ week waiters
- The number of incomplete pathways with a decision to admit is a subset of the total number of incomplete pathways
- The sum of incomplete pathways in first four time-bands (0-4 weeks) is lower than the number of new RTT periods
- Large proportion of short (0 to 1 week) pathways – where trusts provide evidence that they have services that result in higher than usual proportions of short pathways they can be excluded from future checks
- Large proportion of patients with an unknown clock start

The following table provides technical details for each of these checks.

Check	Details
Negative or decimal values	Negative and decimal values are not allowed in any numeric field

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Check	Details
Invalid commissioner codes	Commissioner codes must be a current SUB-ICB code, specialised commissioning code or NONC(non-English commissioner)
Missing data	Not submitted RTT18weeks return (neither Parts 1A, 1B, 2, 2A or 3)
	Non-zero Part 1A (admitted), Part 1B (non-Admitted), Part 2 (incomplete), Part 2A (incomplete with DTA), or Part 3 (new RTT periods) for the previous month, but have returned zero in relevant part this month
	No incomplete/open pathways (data in part 1A or 1B but zeros in Part 2)
Incorrect totals	Incorrect totals in Part 1A (admitted), Part 1B (non-admitted), Part 2 (incomplete), Part 2A (incomplete w/ DTA), or Part 3 (new RTT periods) of RTT18weeks return – this error is usually caused by corrupt templates
Large change in volumes compared to last month	Part 1A (admitted) large difference compared to last month
	Part 1B (non-admitted) large difference compared to last month
	Part 2 (incomplete) large difference compared to last month
	Part 2A (incomplete w/ DTA) large difference compared to last month
	Part 3 (new RTT periods) large difference compared to last month
No change in volumes compared to last month	Part 1A, 1B, 2, 2A or 3 totals are identical to previous month

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Check	Details
Large number of incomplete pathways	Part 2 (incomplete) total pathways is unexpectedly large
Large change in volumes of 52+ week waiters compared to last month	Part 2 (incomplete) large difference compared to last month
Large number of incomplete pathways with a decision to admit	Part 2A (incomplete w/ DTA) should be less than or equal to Part 2 (incomplete)
Low number of new RTT periods	Part 3 (New RTT periods) should be greater than or equal to sum of first for time-bands reported in Part 2 (incomplete)
Large proportion of short (0 to 1 week) pathways	Part 1A (admitted) in 0-1 week time band is a large proportion of total Part 1A (admitted) pathways
	Part 1B (non-admitted) in 0-1 week time band is a large proportion of total Part 1B (non-admitted) pathways
Large proportion of patients with an unknown clock starts	Part 1A (admitted) unknown clock starts is a large proportion of total Part 1A (admitted) pathways
	Part 1B (non-admitted) unknown clock starts is a large proportion of total Part 1B (non-admitted) pathways

The NHS England Performance Analysis Team also runs validation checks outside of the usual collection and publication timetable. These checks identify issues that are not immediately obvious from raw data (such as unusual waiting list shapes) and often use analysis over a longer period than the monthly validation checks. Examples of additional checks include looking at outliers, unexpected pathway distributions and consistency between completed and incomplete RTT pathways.

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Annex C: Patient Pathway Identifiers

Assigning Patient Pathway Identifiers (PPIDs)

A patient pathway identifier (PPID) should 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 PPID, when combined with the Organisation Code (of the provider that issued the PPID), will provide a unique identifier for the patient pathway allowing the patient to be tracked along their RTT pathway and events along the patient pathway (for example, outpatient, diagnostic and inpatient events) to be linked so that the RTT time can be calculated.

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 the Secondary Uses Service (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 SUS. The mandate also applies to any new CDS flows as they are established.

The Patient Pathway Data Group[26] 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 the NHS e-Referral Service and the UBRN is used as the basis of the PPID, then the organisation code of PPID Issuer is 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 PPID and Organisation Code of PPID 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);
- referral to treatment period status.

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 (the Organisation Code of the PPID 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

[26] These data items have been available since Dec 2007, as detailed in DSCN 18/2007 (superseded by ISB 0092 CDS6.2).

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RTT pathway or individual RTT periods within that pathway are delivered by more than one organisation, it is essential that the same PPID and Organisation Code of PPID Issuer are applied, in other words, they do not change even where the responsibility for patient care transfers to a different organisation.

Where the NHS e-Referral Service is in place, the UBRN should be used to create the basis of the identifier for the pathway. In the absence of the NHS e-Referral Service, the trust should generate a PPID. Note that in CDS flows, the PPID and the Organisation Code of PPID Issuer are separate fields, therefore, if the organisation code forms part of the generated PPID, then the Organisation Code of the PPID Issuer must also flow in the separate specific field within the CDS record for this purpose.

The data item Patient Pathway Identifier (PPID)[27] is an alphanumeric field of length 20 characters. It is important to ensure that any locally defined PPID 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 PPID and the same Organisation Code of PPID Issuer. If the UBRN is used as the basis for the PPID, 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 Inter-Provider Transfer Administrative Minimum Data Set (IPTAMDS). See section 11 for more information on inter-provider transfers / multi-provider pathways.

Patient pathways including more than one RTT period

A person may therefore have multiple RTT periods along one patient pathway. The PPID may be used to support reporting of patient pathways that include more than one RTT period where those RTT periods relate to the same underlying condition and the same original referral. See section 13 for more information on the terms RTT period and patient pathway.

Where a patient has more than one referral for unrelated clinical reasons, each referral will have its own patient pathway. The start of the patient pathway may start the first RTT period and there may be a number of subsequent RTT periods along the same patient pathway. Figure B illustrates how one patient could have multiple concurrent pathways and each pathway can have multiple RTT periods along it, but that the RTT periods in a pathway cannot be concurrent.

Where a patient pathway has 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

[27] Defined in DSCN 18/2006.

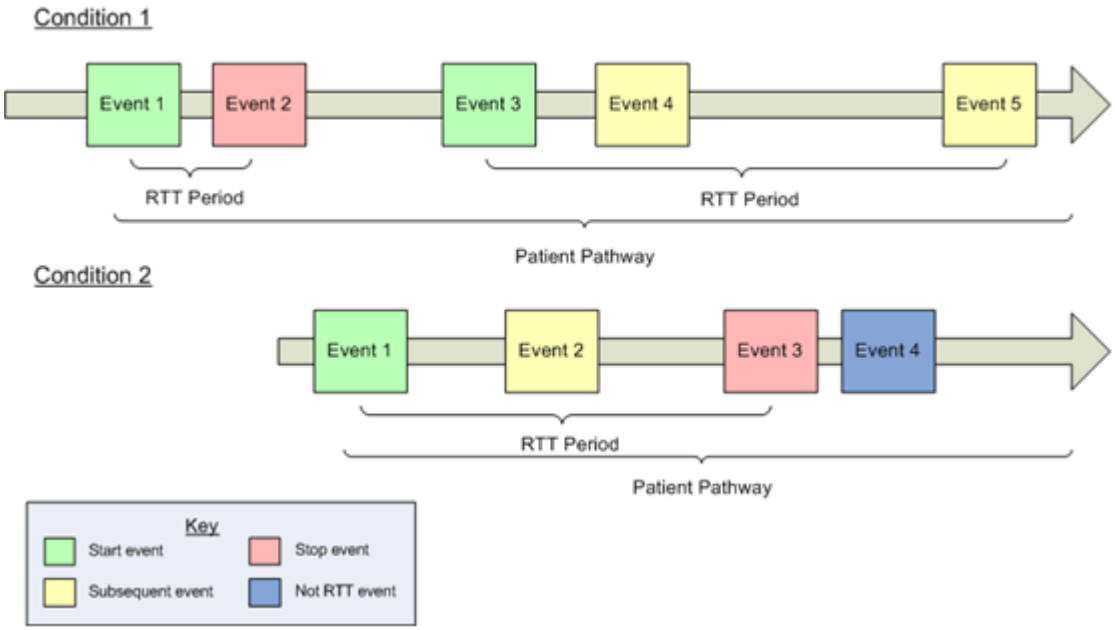
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before it is then decided that further treatment is required, the decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan will start a new RTT period (rule 3c – see section 3.4.2). 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 (PPID) or UBRN- based PPID;
ii. Organisation code issuing the PPID or UBRN (if a UBRN is used the organisation code is X09 [to be updated]);
iii. RTT Period Start Date;
iv. Accurate recording of the RTT Period Status Code for the event at the time of the event.

The start date for 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).

Figure B: the relationship between patient pathways and RTT periods



Ensuring locally defined PPIDs are unique nationally

For non-NHS e-Referral Service pathways, the trust receiving the referral needs to generate a number unique to the trust and then use its organisation code to assure uniqueness. These two parts stay with the patient through the pathway so if the patient gets a tertiary referral to another trust their PPID still contains the organisation code of the initial trust.

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In the event of a trust generating a unique number already assigned by the NHS e-Referral Service, the organisation code element of the PPID differentiates the locally-generated PPI from the NHS e-Referral Service generated PPID.

Patient Pathway Identifiers and transferred patients

When measuring RTT pathways in SUS, it is important to ensure that PPIDs used for pathways that involve more than one provider are transferable between providers.

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 (the Organisation Code of the PPID 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, for RTT measurement in SUS it is essential that the same PPID and Organisation Code of PPID Issuer are applied, in other words, they do not change even where the responsibility for patient care transfers to a different organisation.

The data item Patient Pathway Identifier defined in DSCN 18/2006 should be used to store the PPID. This field is of length 20 and is alpha numeric. If you are defining PPIDs locally, it is important to ensure that they are in the right format for this field so that they are transferable between providers. Where the NHS e-Referral Service is in place, the UBRN can be used instead of a locally generated PPID. In the absence of the NHS e-Referral Service, a locally defined PPID should be defined by the originating provider (the first provider on the pathway). If you are using locally defined PPIDs in the absence of the NHS e-Referral Service, by taking your locally defined PPID and prefixing with your organisation code, this will ensure uniqueness when transferring to another provider.

Worked example

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 should be 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 PPID, the PAS holds a 20 character PPID and the IPTAMDS must show the full 20 characters;

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- Organisation Code of the provider issuing the PPID;
- 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.

On receipt of the IPTAMDS, the tertiary centre edits the PPID field in their PAS to ensure that the 20 character PPID present on the IPTAMDS is entered, the Organisation Code of the PPID 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.

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

For Choose & Book patients who are referred to secondary care via an interface service, there may be more than one UBRN. 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 clock keeps ticking whilst the patient converts the second UBRN. The interface service should monitor the Appointment Slot Issue (ASI) work list to ensure that patients have booked their second onward appointment in a timely manner.

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Annex D: RTT status codes and use of clinical outcome sheets

RTT status codes

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, however, some trusts will use local codes which can be mapped to the codes defined in DSCN 18/2006.

The codes as defined by DSCN 18/2006 are:

Clock starts

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[28]

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

Clock still running

Subsequent activity during a REFERRAL TO TREATMENT PERIOD

20 - subsequent activity during a REFERRAL TO TREATMENT PERIOD - further activities anticipated

[28] Note that an event with an RTT status code of 10 is not needed to start an RTT period. The referral is the event that started the RTT period (with an RTT start date of the referral received date). The RTT status of 10 therefore indicates the ‘first care event’ (for example, first outpatient appointment), not the start event.

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

Clock stops

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[29]

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 (for example, 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, for example, not a consultant-led pathway

99 - not yet known

[29] DNAs for a first appointment following the initial referral that started a waiting time clock nullify the patient's clock (in other words, it is removed from the numerator and denominator for Referral to Treatment time measurement purposes).

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Use of clinical outcome sheets

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. Many decisions about a patient's treatment take place within an outpatient setting and therefore it is essential that trusts record the RTT status of each patient as they leave their outpatient attendance.

This can be done using clinical outcome sheets including electronic forms. 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.

The format of clinical outcome sheets varies depending on the particular clinic but it is important to record detail on the outcome of the outpatient attendance in terms of what had actually happened at the attendance (for example, treatment in outpatients) and any intended next step on the patient pathway.

Trusts should additionally consider the recording of RTT events that occur beyond the outpatient setting. Significant numbers of clinical decisions are taken without the patient being in attendance (for example, by the treating clinician following receipt of diagnostic test results) and consequently such RTT events are often missed. A simplified version of the outcome form may be helpful in such circumstances.

The 17 RTT status codes listed above are those that should be used within information systems. Local areas may wish to use a different description of the codes on clinical outcome sheets including electronic forms. Alternatively some areas may wish to use a different set of codes than those specified in the DSCN, ensuring that the locally defined set of codes can be locally mapped back to the 17 RTT status codes defined in DSCN 18/2006. For example, some trusts have found it useful to use more detailed local outcome codes than the 17 codes listed above as this has provided valuable clinical information for use locally.

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. It may be helpful to provide 'scenario' guidance to aid the clinician in completing the form, for example, giving specialty specific examples of each of the outcome options. Trusts should also ensure that clinical outcome sheets relate to the RTT training provided to staff.

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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.

See Annex E for more information on how Referral to Treatment Period Status is used in Commissioning Data Sets (CDS).

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Annex E: Referral to Treatment Period Status in Commissioning Data Sets (CDS) submitted through SUS

Which sources of referral codes start an RTT clock?

DSCN 16/2007, published in May 2007, introduced new source of referral codes for outpatients to support the implementation of RTT measurement. However, it is not possible to categorically state which source of referral codes do and do not start an RTT pathway. Additional information will also be required before this can be established. For example, code 05 - consultant to consultant referral: if this was a referral post-treatment or a referral part-way along an RTT pathway, then a new RTT clock would not start. However if this was a consultant to consultant referral for a new condition, then a new RTT clock would start.

By using clinic outcome sheets in outpatient clinics, this will allow you to capture the additional information required to determine when a new RTT clock starts, these may also be electronic forms.

Intended and actual status

For the purposes of RTT data submitted via the Secondary Uses Service (SUS), 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 Commissioning Data Set (CDS) record would need to hold the 'actual' status, in other words, the status at the end of the appointment.

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.

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 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.

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Referrals for another condition

If, on the clinic outcome sheet, the RTT status is code 12 (patient is referred for a separate condition), another outcome will also need to be recorded for the current condition. In other words, the clinic outcome sheet would record the RTT status for the original pathway, whether it is to be continued or ended. RTT status 12 starts a new RTT pathway and this will need to be recorded with a new pathway identifier. There may be space on the clinic outcome sheet to record both these outcomes, if this is thought to be useful. If not you would have to have a procedure for ensuring the new pathway is set up on the system and recorded. The referral letter to the other clinician should generate a new pathway identifier.

RTT Status Codes for RTT clock stops

For clock stops for treatment in outpatients or other consultant-led services, an outcome signifying treatment should be recorded on a clinical outcome sheet. Where the RTT status codes defined in DCSN 18/2006 are being used, 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.

If definitive treatment is given during what had originally been intended as a diagnostic admission, an outcome signifying treatment should be recorded. Where the RTT status codes defined in DCSN 18/2006 are being used, 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.

Where the RTT status codes defined in DCSN 18/2006 are being used, for clock stops due to the patient being added to a transplant list, 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 (on a waiting list) but is waiting on a transplant list.

Where the RTT status codes defined in DCSN 18/2006 are being used, there are two RTT status codes (as defined in Data Set Change Notice 18/2006) that refer to clock stops for the start of active monitoring:

31 - start of active monitoring initiated by the PATIENT

32 - start of active monitoring initiated by the CARE PROFESSIONAL

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Code 31 should be used in scenarios where further intervention has been suggested by the care professional but the patient decides that they do not wish to pursue this at this stage. An example is where a consultant offers a joint replacement operation to a patient with osteoarthritis. However the patient is not keen on invasive surgery at this stage as they view their symptoms as manageable. The patient and consultant agree to review the patient's condition after 6 months and the patient is placed on active monitoring.

Code 32 should be used in scenarios where the care professional suggests a period of active monitoring. For example, a patient with back pain attends an orthopaedic outpatient appointment. Spinal surgery is an option but at this stage, the patient's condition is not severe enough to require invasive surgery. The consultant wishes to monitor the patient's condition for a year with a check-up appointment every 3 months. This is agreed with the patient and a period of active monitoring commences.

For the purposes of RTT data submitted via the SUS, 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'. Administrative clock stops can be submitted via the First Attendance field in the Outpatient CDS type 020 where activity takes place outside a face-to-face or telemedicine patient contact (Code 5 for First Attendance is 'Referral to Treatment administrative clock stop event').

The use of '5' for the First Attendance field allows 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

35 Patient declined offered treatment

36 Patient died

For instance, for the examples given earlier in this section:

i. Patient attends appointment for diagnostic test. Test results are normal and therefore no further treatment required. This information is communicated to the patient via a

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telephone call from the consultant's secretary: update patient RTT status to 34 (decision not to treat);

ii. Patient 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: update patient RTT status to 35 (patient declined offered treatment);

iii. Patient on an RTT pathway dies and relative informs hospital that the death has occurred: update patient RTT status to 36 (patient died before treatment).

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 will not be applied in SUS RTT processing.

The administrative event will only be used to close open RTT periods (in other words, 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.

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