Frequently Asked Questions on the Referral to Treatment (RTT) data collection

How to use this document

This document contains answers to frequently asked questions on RTT measurement and the RTT data collection. It does not attempt to provide guidance on how RTT should apply or be measured in every situation.

The RTT rules suite provides a framework to make clinically sound decisions locally about applying them, in consultation between clinicians, providers, commissioners and patients.

Further information/help

Further information on RTT measurement can be found on Unify. Additional guidance queries should be sent to RTTdata@dh.gsi.gov.uk

Version 1 – published November 2006
Version 2 – published December 2006
Version 3 – published April 2007
Version 4 – published July 2007
Version 5 – published March 2008
Version 6 – published March 2009
Version 7 – published May 2009
Version 8 – published July 2010
Version 9 – published January 2012

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Q1. What is the process for submitting RTT returns?
The data is collected online via Unify2 (the Department of Health's online data collection tool). Providers (including acute trusts, non-acute trusts, PCTs as providers and independent sector providers) download a spreadsheet form and enter their data broken down by commissioner. There is functionality in the form which semi-automates this and which produces a "total" sheet for the provider. Providers then upload their completed spreadsheet online. After a designated cut-off date, Unify will then pull together all provider returns, aggregate the data and produce commissioner returns at PCT level. PCTs will then need to review their data online, make any amendments/validations, including adding in any data relating to the independent sector (where independent sector providers have not submitted) or patients waiting at non-English trusts. The PCT will then sign off the return and it will then be submitted online to DH.

Q2. I don't have access to Unify2. What should I do?
To request a user account for Unify2 you should click on the "Request a Unify account" from the Unify2 front page (http://nww.unify2.dh.nhs.uk/Unify/interface/homepage.aspx). Please make sure you select "Knowledge & Intelligence" as the domain. Your local user manager will then be able to process these requests.

Q3. Which organisations should submit returns?
The data collection is provider and commissioner based. Any organisation that provides NHS services that fall within the scope of RTT should complete a provider return. This will include acute trusts and some non-acute trusts, mental health trusts and primary care trusts acting as providers.

Q4. Are Mental Health Trusts required to submit RTT returns?
Much mental health activity will be outside the scope of the RTT collection as it is not consultant led. However, RTT does apply where a referral is made to a medical consultant-led mental health service, regardless of setting. It also applies where a GP (or other referrer) makes their intention to refer to a medical consultant (e.g. a consultant psychiatrist) known, even though they may refer through a mental health interface service.

Decisions about which services are medical consultant-led are ones that must be made locally, in line with the national definition of consultant-led (see Q42 below). i.e. where a consultant retains overall clinical responsibility for the service, team or treatment.

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

Q5. How should PCTs validate the data on their commissioner return?
Commissioner returns will be produced within Unify from the data submitted by providers. PCTs should review their data online and satisfy themselves that they are content to sign off the data. The PCT may choose to make amendments to the data, including adding in any data relating to the independent sector or patients waiting at non-English trusts. The PCT will then sign off the return and it will then be submitted online to DH.

Q6. How can Independent Sector (IS) providers submit RTT data to commissioners if they do not have access to data collection systems?
DH encourage IS providers to engage in the RTT data collection process by monitoring RTT times for NHS patients being seen/ treated within their trust and by submitting this information on Unify in the same way as NHS provider organisations. Please refer to Q2 about requesting a Unify account for your organisation.

Q7. How can I view RTT data for my organisation/other organisations?
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.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/ReferraltoTreatmentstatistics/index.htm

Q8. What do the terms "admitted" and "non-admitted" mean?
Admitted pathways are those that end in an admission to hospital (either inpatient or day case) for treatment.

Non-admitted pathways are those that end in treatment that did not require admission to hospital or where no treatment is required.

Q9. What treatment functions should we report against?
When completing the spreadsheet form, please submit data for the 18 treatment functions listed. Data for any other treatment function should be aggregated and reported on the "other" treatment function line at the bottom. 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.

Q10. For the purposes of the RTT data collection, do we only submit data relating to say 300 General Medicine or should 300 incorporate all sub-medical specialties?
For the RTT data collection, please report using the new definition of the Treatment Function. For example, for General Medicine (300) just report 300, i.e. exclude sub-specialties 306, 307, 308 and 309. Please include these in the "Other" line on the data collection spreadsheet form. The only exception to this rule is cardiothoracic surgery, which can be either specialty 170 (cardiothoracic) or an aggregation of 172 (cardiac) and 173 (thoracic).

Q11. What are the data requirements for the RTT return?
The main RTT data collection return (unadjusted data) has three parts:

- Part 1a – Completed RTT waiting times for admitted patients – i.e. RTT waiting times for patients whose RTT clock stopped during the month with an inpatient/day case admission
- Part 1b - Completed RTT waiting times for non-admitted patients – i.e. RTT waiting times for patients whose RTT clock stopped during the month for reasons other than an inpatient/day case admission
- Part 2 - Incomplete RTT waiting times – i.e. RTT waiting times for patients whose RTT clock is still running at the end of the month

The adjusted RTT data collection return has one part:

- Completed RTT waiting times for admitted patients on an adjusted basis – i.e. RTT waiting times for patients whose RTT clock stopped during the month with an inpatient/day case admission including adjustments for legitimate clock pauses

The RTT data collection has ISB approval. It also has Monitor approval, which means that the data collection is also mandatory for NHS Foundation Trusts.

Q12. What is the DH expectation of the RTT data?
Organisations should provide as accurate data as possible by the submission deadline. Provider organisations are responsible for ensuring that the completed pathways they submit are an accurate representation of the waiting times of the RTT patients treated during the month and that the incomplete pathways are an accurate representation of the RTT patients still waiting for 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 10 working days between the provider deadline and the commissioner sign-off deadline to query the data with their providers.

DH will also run monthly central validation checks on the submitted RTT data. When providers are aware of data quality issues, they should inform the RTT measurement team (RTTdata@dh.gsi.gov.uk) 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.

Q13. What validation will DH be doing on the data returns?
As with all central returns, it is the responsibility of submitting organisations to ensure that they are content with the quality of the data they have submitted. In addition, PCTs are responsible for ensuring that the commissioner data they sign off is accurate. DH carry out basic validation on the data centrally. This includes:

- checking that all expected organisations have submitted an RTT return
- comparisons with data from last month
- comparisons with other data sources
- checks on waiting list size (incomplete pathways) compared to RTT clock stop activity (completed pathways)
- checks on distribution of waiting list (incomplete pathways) and RTT clock stop activity (completed pathways)

Q14. I have submitted incorrect RTT data for my provider return. What should I do?
If it is before the submission deadline and you have not signed off your return, you can simply make the appropriate amendments within Unify. Uploading an amended return will automatically overwrite the previous return.

As a provider, it is important that you carefully review and check your data before signing off within Unify. Once signed off, no amendments can be made unless your return is uncollected by the relevant commissioner or, if this is not possible, by DH.

If after signing off, you discover an error, please contact the relevant commissioner or email us at RTTdata@dh.gsi.gov.uk with a brief description of the error. If it is on or shortly after the submission deadline, we will uncollect your Unify return so that you can make appropriate amendments to correct the data.

If it is significantly after the submission deadline, please email us to discuss options.

Q15. I am trying to sign off my commissioner monthly RTT return in Unify but not all providers have signed their returns off. What should I do?
Commissioners are unable to sign off their return until all constituent providers have signed off their returns. If some providers have not signed off, commissioners will need to contact the relevant provider organisations to request that they sign off their returns.

Q16. Is the RTT data publicly available?
Yes. The monthly RTT data are published routinely each month. The published data set includes data for all providers and all commissioners and can be found at:
http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/ReferraltoTreatmentstatistics/index.htm

Q17. What is the timetable for submitting returns?
The timetable is available on Unify. The provider deadline for submission is 13 working days after the final day of the reference period, and the commissioner deadline for sign-off is 23 working days after the end of the reference period.

Q18. When will the source of RTT data switch from Unify to Secondary Uses Service (SUS)?
The Department of Health is committed to moving over to the use of SUS for RTT data and is working with Connecting for Health to ensure that SUS RTT reporting meets the standard required to allow this change to be made .

Q19. Which timeband does a wait of 7 days go into, 0-1 weeks or 1-2 weeks?
A wait of 7 days should go into the 0-1 week timeband. Waits of over 1 week go into the 1-2 weeks category.

Q20. Should we calculate the effects of any adjustment to the RTT time for the central return?
Adjustments can only be applied for patient initiated clock pauses. Further details on calculating, reporting and submitting adjusted RTT times can be found in the "How to Measure" guide at: http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/ReferraltoTreatmentstatistics/DH_089757

There should be no adjustments made to completed non-admitted pathways and incomplete pathways.

Q21. If a patient states they are unavailable for a set period of time (for example a patient who is a teacher who wishes to delay their admission until the summer holidays) before two reasonable dates for admission have been offered to the patient, is it still legitimate to pause the clock?
Yes. Where a patient makes themselves unavailable for admission for a long period of time, then this may mean that offering actual dates which meet the reasonableness criteria would be inappropriate (as the patient would be being offered dates that the provider already knew they couldn't make). In these circumstances, the clock should be paused from the date of the earliest reasonable offer that the provider would have been able to offer the patient.

Q22. Can adjustments be applied prior to diagnostic admissions?
No. Adjustments can only be applied after a decision to admit for treatment and the adjustment can only be applied to the pathway once the patient has started treatment as an admission.

Q23. What are the DNA (Did Not Attend) rules for RTT measurement?
In the context of RTT measurement, a DNA (sometimes known as FTA – failed to attend) is defined as where a patient fails to attend an appointment/admission without prior notice. Patients who cancel their appointments in advance should not be classed as a DNA.

If a patient DNAs their first appointment following the initial referral that started their RTT clock, then their RTT clock should be nullified (i.e. removed from the numerator and denominator for RTT measurement purposes) provided that the provider can demonstrate that the appointment was clearly communicated to the patient.

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. This 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;

iii) discharging the patient is carried out according to local, publicly available, policies on DNAs;
iv) These local policies are clearly defined and specifically protect the clinical interests of vulnerable patients (e.g. children) and are agreed with clinicians, commissioners, patients and other relevant stakeholders.

Trusts should agree and publish local DNA policies that are in line with the spirit of the guidance. For example, some trusts may operate a "two strikes and out" policy. Measurement of RTT times would then follow on from the local policy so that:

1. 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.
    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.

2. 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.

Local DNA policies must be clearly defined and published, and specifically protect the clinical interests of vulnerable patients (e.g. children) and be agreed with clinicians, commissioners, patients and other relevant stakeholders.

Q24. If a patient cancels their appointment in advance, can we pause or stop their RTT clock?
No. If a patient cancels their appointment, this has no effect on the RTT time. The RTT clock should continue to tick and the rules are clear that no adjustment should be made.

Q25. If a patient is admitted for first definitive treatment but does not have the treatment carried out, can we stop their RTT clock?
No. If the treatment is cancelled by the provider after admission because of resource constraints (e.g. 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 (e.g. 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 is made not to treat. 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.

Q26. How do patient cancellations affect adjustments/clock pauses? How do provider cancellations affect adjustments/clock pauses?
Patient Cancellations
As per Q24 above, an RTT clock cannot be paused because of a patient cancellation. However the rebooking process resulting from a patient cancellation of admission for treatment may initiate

the start of, or extension of, a clock pause. Details are given below.

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

A reasonable offer is an offer of a time and date three or more weeks from the time that the offer was made.

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

From a technical perspective, if the Earliest Reasonable Offer Date (EROD) field is already populated and the patient cancels their admission, then EROD remains the same (i.e. start of clock pause is unchanged). If the EROD field is blank and the patient declines two or more reasonable offers following a patient cancellation, then EROD becomes the earliest reasonable offer given as part of the rebooking process following the patient cancellation. The following must also be true:

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

If the time between the patient becoming available and the admission date is not limited, then a patient pause should not be applied. It is the responsibility of the provider organisation to minimise the time between the patient making themselves available and date of admission

Provider Cancellations

If a patient's clock has been paused (because they have previously declined two or more reasonable offers of admission for treatment) and the hospital then cancels the agreed admission date then the pause should be removed and no adjustment should be made to the patient's clock, which will stop when they are actually admitted for treatment.

Q27. If a patient chooses to wait for an appointment at their local community outreach clinics which runs infrequently, does the RTT clock continue to tick?

Yes. The RTT clock will continue to tick for patients who choose to wait longer for community outreach services provided by PCTs.

Q28. Is it acceptable for hospitals to refuse to accept referrals?

No. NHS providers should accept all clinically appropriate referrals made to them. Patients choosing a particular NHS provider must be treated by that provider as long as this is clinically appropriate and in accordance with the patient's wishes. Managing to meet the demand for popular services is a shared responsibility between commissioners and providers and they need to work together to ensure that, where clinically appropriate, patients are treated at their choice of provider.

Locally, commissioners and providers may have agreements about the clinical criteria for providers to accept patients to ensure that they are accepting clinically appropriate referrals for

the services they provide. In the case of highly specialised services it may be legitimate to apply further criteria in assessing whether a referral is clinically appropriate, so that the service is available to those for whom it is most needed. Any referrals from outside the local area would also need to meet these criteria, but trusts should not impose differing criteria according to where patients come from. The criteria should be open and transparent and be published on the Choose and Book system.

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

Q29. What happens when a patient chooses a specific provider or a specific consultant to treat them - can their RTT clock be paused if they have not been offered two reasonable offers of treatment with their chosen provider/provider site/consultant?

No. A clock may be paused only where a decision to admit has been made, and the patient has declined at least 2 reasonable appointment offers for admission. The clock is paused for the duration of the time between the earliest reasonable offer and the date from which *the patient makes themselves available again* for admission. Clocks may be paused for social reasons only, for example, because a patient has a holiday booked at the time of the admission date offered. There is no facility for pausing clocks in any other circumstances.

Patients can be offered the choice of receiving treatment by a different hospital/hospital site/consultant but their waiting time clocks cannot be paused if they choose not to accept this opportunity.

Q30. If a patient is given "thinking time" by the consultant, does this stop the RTT clock?

This depends 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.

If a longer period of "thinking time" is agreed, then active monitoring is more appropriate. An example is where the patient and clinician agree that the patient's symptoms are not severe at the moment. The patient does not want surgery at this stage. A review appointment is agreed for 3 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.

Q31. If a patient is colonised with MRSA, does this affect their RTT clock?

No. There are patients referred on to RTT pathways for whom it is clinically appropriate to undertake treatment even if they are colonised with MRSA, and these cases just need to be managed correctly. Since April 2009 all relevant elective patients have been screened for MRSA, and positive patients will have to be decolonised and treated within the RTT pathway.

Trusts need to predict and then manage the demand and capacity for single rooms and other

facilities. They need to appropriately re-design systems and processes to care for patients following decolonisation which will need to be integrated into the patient pathway.

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

A new RTT clock should start when/if a patient is referred back into consultant-led care.

Q32. What is "active monitoring"?

An RTT 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. 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 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 stops an RTT clock.

Q33. If a patient on active monitoring is sent for diagnostic tests, does this start a new RTT clock?

Not necessarily. For patients on active monitoring, routine or regular diagnostic check-ups (e.g. 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.

Q34. Where further treatment is required that was not already planned, what date should the new RTT clock start?

Where further (substantively new or different) treatment may be required that was not already planned, a new RTT clock should start.

This new RTT clock will often start when a decision to treat is made. However, where a patient is referred for diagnostics or specialist opinion with an expectation that this will be followed by treatment, it may be more appropriate to start the new clock from the point that the decision that diagnostics or specialist opinion is required is made.

In common with other referrals, the clock should start on the date that the new referral is received.

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.

Q35. What is an interface service or referral management centre?

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.

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.

The definition of the term "interface service" 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.

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.

Q36. Are referrals to interface services or referral management centres covered by RTT?

Yes. A referral to an interface service (as defined in Q35 above) starts an RTT clock. The clock starts on the date that the referral is received by the interface service.

Q37. When does the clock stop for pathways that involve interface services?

Where a patient is referred to an interface service:

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

Q38. Are pathways that end in interface services covered by RTT measurement?
Yes. A referral to a referral management centre starts an RTT clock. If the patient is subsequently treated within the referral management centre, then this would stop the RTT clock (on the date that treatment starts). If it is decided that no treatment is required and the patient is referred back to their GP, this would also stop the clock (on the date that this decision is made and communicated with the patient). Alternatively, the patient may be referred on to secondary care by the referral management centre – in which case the RTT clock would continue to tick until the patient is eventually treated (or a decision is made that no treatment is required) within secondary care.

Q39. If an interface service refers a patient on to a non-consultant led service for treatment, does this stop the RTT clock?
If the non-consultant led service is within a primary care setting, then the clock will stop – on the date that the decision to refer back to primary care is made and communicated to the patient. If the non-consultant led service is within the interface service itself or is within secondary care, then the RTT clock will not stop until first definitive treatment commences within this service.

Q40. If a GP refers a patient to a GPwSI (GP with a special interest) within a referral management centre, does this start an RTT clock?
Yes - a referral to a GPwSI (or other practitioner with a special interest) within a referral management centre (or other intermediate service) starts an RTT clock. The clock starts on that date that the referral management centre receives notice of the patient's referral.

Q41. How does Mental Health fit into RTT measurement?
A referral from primary care to a mental health medical consultant or medical consultant-led service starts an RTT pathway. However referrals from primary care to mental health services that are not consultant-led (this may include multi-disciplinary teams and community teams run by mental health trusts) irrespective of setting do not start an RTT clock.

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

Q42. What does "consultant-led team" mean?
A "consultant" is 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. RTT measurement excludes non-medical scientists of equivalent standing (to a consultant) within diagnostic departments.

"Consultant-led" means that 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.

Q43. Are patients on planned waiting lists covered by RTT measurement?
No - such patients are outside the scope of RTT measurement. By planned, this 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". Examples include 6-month repeat colonoscopy following removal of a malignancy, tumour or polyp.

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. When a patient on a planned list does not have their consultant-led treatment procedure on or around the planned date they should be transferred to an active list and an RTT clock should start i.e. an RTT clock should start if the due date for the planned consultant-led procedure is reached and the patient has not yet received treatment. Thereafter, 'normal' RTT rules should apply.

Patients who are on a referral to treatment 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. There is no facility in the referral to treatment rules to pause a patient's clock for clinical reasons.

Q44. How should bilateral procedures (e.g. bilateral cataract removals) be handled under RTT measurement rules?

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

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

Q45. If an RTT pathway starts and stops on the same day, should we include these pathways in RTT monitoring returns?

Yes. All valid RTT pathways should be included in monitoring returns, regardless of their length. It is possible that a pathway may have an RTT time of 0 days, if the clock started and stopped on the same day. These should still be recorded as completed pathways in the RTT data collection and should be reported in the 0-1 weeks timeband 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.

Q46. How should we report on RTT pathways that involve more than one provider?

If a patient is referred from one provider to another during their RTT period (e.g. a pathway that includes a referral to a tertiary centre), these patients should still be reported on the RTT return. The provider trust who holds current clinical responsibility for the patient (i.e. at the time when the data snapshot is taken) should report the RTT time. If a patient is referred from one provider to another as part of their RTT period, their RTT clock should keep ticking and the originating provider should ensure that the patient's initial RTT clock start date forms part of the onward referral information.

The Inter Provider Transfer Administrative Minimum Data Set (IPTAMDS) was mandated by the Information Standards Board from January 2008 and is designed to support the transfer of administrative data from the referring provider to the receiving provider, thus allowing the

receiving provider to report on the patient pathway. When clinical responsibility for a patient is transferred, there is a danger that the administrative data on the patient does not pass to the new organisation. By sharing information via the minimum data set for inter provider transfers, all parties involved can be fully aware of the patient's pathway.

Q47. For multi-provider pathways (e.g. pathways that involve a transfer to a tertiary centre), which organisation should monitor and report the patient's RTT time?

The measurement 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. Trust A should use RTT status code 21 to signify that the patient is no longer "on their books". There is no longer any central requirement for trust A to track the patient's RTT time. 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.

Q48. What about the use of patient pathway identifiers (PPI) for multiple provider pathways?

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

DSCN 17/2006 stated that for the tactical solution *"Where Choose & Book is in place, the UBRN can be used to create the basis of the pathway identifier. In the absence of Choose & Book, the trust generates a unique number (e.g. by concatenating patient NHS number and referral date) or uses an existing identifier already in their PAS."* If you are using locally defined PPIs in the absence of C&B, by taking your locally defined PPI and prefixing with your organisation code, this will ensure uniqueness when transferring to another provider.

Q49. How should non-contract activity (formerly referred to as OATs/Out of Area Treatments) be reported?

RTT data for non-contract activity should be recorded against the commissioning PCT, not the host PCT (in line with PbR). This was announced in a Data Set Change Notice published in 2005 (DSCN ref: 19/2005).

Q50. When does the RTT clock start for patients who transfer in from other parts of the UK (or from outside the UK)?

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

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

Q51. Do self referrals start an RTT clock?
Yes. Where these pathways have been agreed locally by commissioners and providers and once the referral is ratified by a care professional, an RTT clock starts upon a self referral by a patient to any service covered by RTT measurement.

Q52. Should we report patients waiting for National Commissioning Group (NCG) or Specialised Commissioning Group (SCG) commissioned services on our RTT return?
Yes. Most services provided in the NHS are commissioned by PCTs. However, there are also NHS services that provide treatments for a number of rare conditions that affect only a small number of patients and are usually very expensive. These services are commissioned separately on a national level by NCG (National Commissioning Group) who act on behalf of all the PCTs in the UK. Other specialised services are commissioned by the ten Specialised Commissioning Groups (SCGs), which are coterminous with the Strategic Health Authorities.

RTT measurement applies to services commissioned by the NCG and SCGs in the same way as it applies to PCT-commissioned services. Therefore patients on an RTT pathway who are waiting for services commissioned by NCG or SCGs should be reported on as part of the RTT data collection.

Unify allows providers to pick NCG (code YDD82) from the drop down list of commissioners.

Pathways commissioned by SCGs should be reported using UNIFY against the PCT of residence from the drop down list of commissioners.

Q53. Are audiology patients included within RTT measurement?
Some audiology patients are covered by RTT measurement, however, most audiology and adult hearing services are not consultant-led, are accessed directly from primary care and are outside the scope of RTT. These patients should not be reported on the RTT return.

"Improving Access to Audiology Service in England" (published in March 2007) set out an aspiration to transform audiology services; as a result, two new collections of data on audiology services were introduced in 2008/09. These data collections were introduced to ensure progress on reducing waiting times for hearing aid fitting.

The data required consists of referral to treatment times for patients using direct access audiology services - that is, data for those patients who are directly referred from primary and community care to the audiology service for both diagnostic assessment and treatment, and are therefore not referred to, and under the care of, a medical consultant. This brings the data collected for these patients in line with the requirements for patients accessing audiology services by means of a consultant referral on an RTT pathway.

The collections have clearance from Information Standards Board (ISB), and the Review of Central Returns (ROCR), and is a requirement of the new standard national contract.

Further information on the audiology data collections can be found on the DH website:
http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/Directa

Q54. Are referrals for healthy pregnant women covered by 18weeks?
No. Referrals from primary care for healthy pregnant women are not covered by RTT. Pregnancy referrals should only start an RTT clock when there is a separate condition or complication requiring medical or surgical consultant-led attention.

Q55. Are referrals to orthodontics services covered by RTT measurement?
A referral from primary care to an orthodontic consultant starts an RTT pathway. However, a large proportion of orthodontics work is carried out by non-consultants and referrals from primary care to such non-consultant services would not start an RTT clock.

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

If a patient on an orthodontic pathway is not yet ready for treatment (e.g. child will require a dental brace but their teeth are not yet developed enough), then a period of active monitoring should commence and the RTT clock stops at the point that the clinical decision is made and communicated to the patient and their GP (or other original referrer) to commence active monitoring. Once the patient has reached the appropriate age/stage of development as identified in their care plan, a new RTT clock should start.

Q56. What about orthodontic patients who require general anaesthesia. Are they covered by RTT measurement?
Yes. Dental care provided under general anaesthesia in secondary care (even where the treatment is carried out by a primary care dentist) is covered by RTT. For these dental pathways, the decision to include them within the scope of RTT was taken on the basis that these patients are typically from vulnerable groups (mainly children but also some adults with learning disabilities etc.) and it would be appropriate for them to be included in RTT. The rationale is that there has to be a consultant involved in their care as by law, general anaesthesia must be carried out in a hospital setting under the care of a consultant anaesthetist. This approach has received support from dental colleagues within the NHS.

Q57. What happens when an orthodontist returns a patient to the dentist for say, teeth extractions, which will be required before the orthodontic treatment can take place. Does the clock stop?
Yes. The clock will stop if there is a decision to return the patient to the dentist in primary care. A new clock starts if/when the decision is made and communicated with the patient that they should be referred for further treatment with the orthodontist.

Q58. Are direct access diagnostics covered by RTT measurement?
Direct referrals from primary care to diagnostic services in secondary care do not start an RTT clock unless they are "straight to test" referrals.

"Direct access" diagnostics is any arrangement where a GP can refer a patient directly to secondary care for a diagnostic test/procedure (i.e. without the patient having to attend a consultant OP appointment first). The GP is managing the patient's ongoing care and sends the

patient for a diagnostic test/procedure at a local provider. The GP will use the results of the test to inform his decision making around the patient's continuing care. For example, if the test results were adverse, the GP may then refer the patient to secondary care but alternatively if the results are normal, he may continue to manage the patient within primary care.

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

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

Q59. Are referrals to sexual health services/GUM (Genito-urinary medicine) clinics covered by RTT measurement?
Referrals to sexual health services would only start an RTT clock if these are consultant led services.

Q60. Is IVF and/or fertility treatment covered by RTT measurement?
Yes. NHS IVF treatment under a consultant is covered by RTT. The RTT clock stops when first definitive treatment starts. For IVF, this can include less invasive treatments, such as intra-uterine insemination. A consultant referral for IVF at a later date could then start a new clock. Privately funded IVF patients are not covered by RTT.

Q61. Is bariatric surgery excluded from RTT measurement?
Bariatric surgery is not excluded from RTT measurement. However because of the nature of these pathways and the fact that bariatric surgery is often classed as a "last resort" treatment, it may be that a period of active monitoring has occurred and in a routine follow-up appointment, the consultant and patient agree that bariatric surgery is now the best option. This clinical decision would start a new RTT clock on the date that the decision is made and communicated to the patient.

Q62. Are gender dysphoria services covered by RTT measurement?
Consultant-led gender dysphoria services are covered by RTT measurement to the extent that they are commissioned locally. A referral to a consultant led gender dysphoria service will start an RTT clock.

The RTT clock stops at the start of first definitive treatment, which for most gender dysphoria patients will be the start of initial counselling. If gender reassignment surgery is proposed at a later date, then a new RTT clock would start on the date that the decision is made by the consultant and patient that they are fit and ready for such surgery and they are added to the waiting list for the procedure.

Q63. Does a referral for an organ transplant stop a clock?
Yes. If an RTT clock is running, the decision to add a patient to a transplant list stops the RTT clock. The clock stops on the date that this decision is made and communicated to the patient

(and subsequently their GP and/or other referring practitioner without undue delay).

Q64. Are clinical genetics services covered by RTT measurement?
Yes, clinical genetics services are covered by RTT. The RTT clock starts on the date that the provider receives the referral. The clock stops on the date that the patient starts their first definitive treatment (which may be counselling in the case of genetics).

There is no facility to pause or delay starting a patient's clock to exclude the time required for family history gathering where this is done after referral.

Q65. Should patients on a 31-day or 62-day cancer pathway be reported on the RTT return?
Yes. Patients who are covered by the 31-day or 62-day cancer standards are also covered by the RTT measurement. Therefore, the waiting times of these patients should be reported on the RTT return.

Q66. Are dialysis appointments covered by RTT measurement?
Routine dialysis appointments would not be part of an RTT pathway. However, a decision to start a substantively new or different treatment that does not form part of the patient's agreed care plan resulting from a dialysis session would start an RTT clock. Therefore, processes would need to be in place within the trust to capture any such clock starts. This may be through clinic outcome slips or another locally agreed process.

Q67. In the NHS Data Dictionary, there are two RTT status codes related to active monitoring. What is the difference?
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

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.

Q68. If a non-consultant working in secondary care refers a patient to a consultant led service within secondary care, does this start an RTT clock?
Yes, this would start an RTT clock if this is a referral mechanism approved locally by the commissioning PCT.

Q69. Are military personnel covered by RTT measurement?
The RTT commitment is made to all patients of English PCTs including military personnel to the extent that the PCT commissions their care. RTT does not apply to MOD-commissioned care unless stated in commissioning agreements with providers.

Q70. Does RTT measurement apply to prison health services?
Yes. All patients of English PCTs, including prisoners are included in the return.

DH expects prisoners to be treated within the same waiting time as all other NHS patients. However, we accept that in some cases there will be circumstances unique to the prison population which may lead to longer waits.

Q71. If a patient on an RTT pathway is admitted as an emergency, then does this stop the RTT clock?
If the patient has the procedure that they were waiting for electively carried out after the emergency admission, then the RTT clock would stop.

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

- If as a result of their emergency admission, the patient is no longer fit to have the original procedure they were waiting for and a clinical decision is made to refer the patient back to primary care, then this decision would stop the original RTT clock. The clock stops on the date that the decision is made and communicated to the patient.
- If the patient is deemed to be temporarily unfit due to the circumstances around their emergency admission (e.g. patient admitted as an emergency overnight with a chest infection), but the consultant decides to retain the patient for the procedure that they were originally waiting for. In this case, the RTT clock would continue to tick. A clock pause is not applicable as pauses cannot be applied for clinical reasons (please see Q21).

Q72. Does a new clock start if less intensive treatment has failed and more aggressive treatment is necessary for the same condition?
Yes, a new clock would start if this additional treatment did not form part of the patient's agreed care plan. The new clock starts on the date that the decision to refer for additional treatment is made and communicated to the patient. Paragraph 3b of the rules document refers.

It should be noted that the initial clock will not stop if the purpose of the first treatment was to administer pain relief for a condition before a surgical procedure takes place as part of management of a patient's condition.

Q73. How do we identify clock stops for first definitive treatment on complex pathways where multiple treatment options are carried out or considered?
The RTT clock stops at the start of first definitive treatment. First definitive treatment is defined as "an intervention intended to manage a patient's disease, condition or injury and avoid further intervention."

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

specific pathways.

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

Q74. For cardiac pathways that include warfarin prescription in advance of a procedure, when does the RTT clock stop?
Whilst this is ultimately a local clinical decision, it seems legitimate to define the prescription of warfarin as the start of first definitive treatment and hence stop the RTT clock at this point.

Q75. When an injection is required prior to surgical intervention, which procedure stops the RTT clock?
In general, an injection that is preparation for treatment or provides pain relief does not stop an RTT clock.

However, what constitutes first definitive treatment is a matter for clinical judgement, in consultation with others as appropriate, including the patient.

In cases where treatment is a two-stage process which begins with an injection, the clock should stop when the injection is administered, providing that the consultant clearly explains to the patient that treatment is a two-stage process. The patient should be in no doubt that the injection is the start of treatment and causes their RTT clock to stop.

Q76. Does the prescription of drugs stop an RTT clock?
An RTT clock stops when first definitive treatment takes place (this could be either in an interface service or a consultant-led service). First definitive treatment is defined as being an intervention intended to manage a patient's disease, condition or injury and avoid further intervention.

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

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

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

Q77. Private patients who transfer to NHS care – when does the RTT clock start?
For patients that are seen privately but then transfer to the NHS, if they are transferring on to a RTT pathway, the RTT clock should start at the point at which the clinical responsibility for the patient's care transfers to the NHS. i.e. the date when the NHS trust accepts the referral for the patient.

Q78. NHS patients who choose to transfer to the private sector, when does their RTT clock stop?
The RTT clock stops for patients who choose to leave NHS-funded care and to fund their own care in the private sector. The clock stops on the date that the patient informs the provider of this decision. For patients who are treated in the private sector under NHS commissioning arrangements (i.e. they are NHS patients whose care has been funded by the NHS and commissioned by the NHS from the private sector), the clock continues to run until one of the clock stop events outlined in RTT rules suite takes place (for example, first definitive treatment commences or the patient is referred to primary care for non consultant-led treatment in primary care).

Q79. How should we deal with inpatient admissions for diagnostic procedures?
Generally, an inpatient/ day case admission signifies the start of treatment and hence an RTT clock stop. However if the inpatient/ day case admission is for a diagnostic procedure only, then this does not stop the RTT clock.

Q80. Are referrals from A&E covered by RTT measurement?
Elective referrals to consultants from A&E (e.g. patient attends A&E after a fall at home, A&E consultant suspects patient also has a cataract and refers them for an ophthalmology consultant outpatient appointment) are covered by RTT measurement.

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

Q81. Are fracture clinics covered by RTT measurement?
No. In general, activity carried out in fracture clinics is planned care following initial treatment/stabilisation of the fracture in A&E and so is out of scope of RTT measurement. By planned care, this means an appointment /procedure or a series of appointments/ procedures as part of an agreed programme of care which is required for clinical reasons to be carried out at a specific time or repeated at a specific frequency. Examples include a check up x ray two to three weeks after the fracture has occurred to check that it is healing as intended.

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

Q82. On the clinic outcome sheet, if the RTT status is code 12 (patient is referred for a separate condition), should another outcome be recorded for the current pathway?
Yes. In this example, 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.

Q83. If we use the UBRN as the patient pathway identifier (PPI) and a patient has more than one RTT period on that pathway, what identifier should we use for the second (or greater) RTT period?

Each RTT period on the pathway can be uniquely identified by:

1. Patient pathway identifier (PPI)
2. Organisation code issuing the PPI
3. RTT Period Start Date

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).

Q84. How can you ensure locally defined PPIs are unique nationally?

The unique pathway identifier should be Alphanumeric and 20 characters in length, as defined in DSCN 18/2006.

If the booking is generated through Choose & Book then the Unique Booking Reference Number (UBRN) will be nationally unique and the organisation code part of the Unique pathway identifier will be X09 (i.e. the choose and book identifier). For non Choose and Book 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 PPI still contains the organisation code of the initial trust.

In the event of a trust generating a unique number already assigned by C&B the organisation code element of the PPI differentiates the locally generated PPI from the C&B generated PPI.

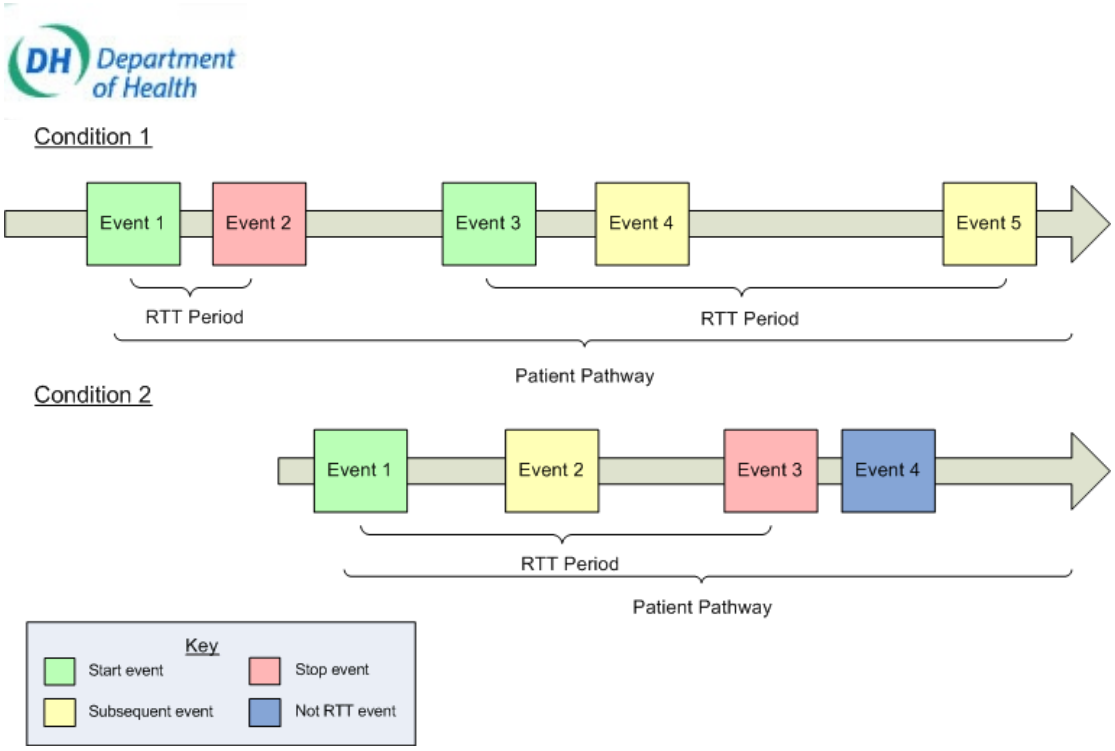
Q85. What is the relationship, in NHS data dictionary terms, between pathways and RTT periods?

A pathway can have more than one RTT period. Each RTT period can be uniquely identified by the pathway ID plus the RTT clock start date.

We often use the term "RTT pathway" in our published reports and guidance and this is the same as an "RTT period". However, this is not the same as a patient pathway. A patient may have multiple RTT periods along their patient pathway.

A patient pathway is the specific route that a particular patient takes for a given condition from the first Referral Request Received Date (or the Activity Date of the first emergency activity). A patient pathway will continue for chronic or recurrent conditions and it will also continue even if the patient declines treatment as they may have treatment for the same condition at a future date.

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. This diagram 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:



In the national aggregate monthly RTT reports that are submitted to Unify2 we require:

1. Incomplete pathways at month end - these are open RTT periods and the number of weeks the clock has been running so far in a census count taken at the end of the month
2. Admitted pathways during the month - RTT periods that closed during the month where the clock stop was an admission for treatment and the length in weeks of the RTT period from start to stop
3. Non-admitted pathways during the month - RTT periods that closed during the month where the clock stop was not an admission for treatment and the length in weeks of the RTT period from start to stop

Q86. 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.

Q87. For Choose & Book patients who are referred to secondary care via an interface service, which UBRN should we use for the pathway identifier if there is more than one?

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 “Activity List” Worklist to ensure that patients have booked their second onward appointment in a timely manner.

Q88. We are not able to capture and record events that occur outside of a patient attendance on our PAS system. However, some of these events result in RTT clock stops. How should we record them?

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

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

An event which results in an update to the RTT status that occurs outside of the events that are defined in the CDS output (typically Outpatient or Inpatient encounters) is termed an "administrative event".

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

Q89. Is there still a maximum RTT waiting time standard?

In England, under the NHS Constitution, patients 'have the right to access services within maximum waiting times', or to request 'the NHS to take all reasonable steps to offer a range of alternative providers if this is not possible'.

The NHS Operating Framework and supporting technical guidance for the relevant financial year set out the operational standards for RTT waiting times that the NHS is expected to deliver.

In order to ensure that waiting times do not rise, we will ensure transparency by continuing to publish and monitor hospital waiting times - and GPs and commissioners of health services can use this information locally to ensure that they can continue to improve access to services for their patients by addressing clinically unjustified waits and tackling unnecessary variation.

Commissioners should also continue to enforce the clauses related to waiting times within NHS Standard contracts and GPs and commissioners will want to ensure that any flexibility to improve access reflects local clinical priorities.