Referral to treatment
consultant-led waiting times
Rules Suite
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Executive summary

In England, under the NHS Constitution, patients ‘have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible’. NHS England collects and publishes monthly referral to treatment (RTT) data which are used to monitor NHS waiting times performance against the standards set out in the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012\(^1\).

The rules suite aims to set out clearly and succinctly the rules and definitions for referral to treatment consultant-led waiting times to ensure that each patient’s waiting time clock starts and stops fairly and consistently. It does not attempt to provide detailed guidance on how the rules should apply in every situation, but to provide the NHS with a framework to work within to make clinically sound decisions locally about applying them, in consultation between clinicians, providers, commissioners and, of course, patients.

The rules suite includes:

- national waiting time rules
- definitions
- guidance on applying the national rules locally
- guidance on reviewing the pathways of patients who have waited longer than 18 weeks before stating their treatment
- guidance on clinical exceptions to the NHS Constitution right to access services within maximum waiting times.

\(^1\) As amended by the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) (Amendment) (No.2) Regulations 2015.
National clock rules

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;
   
   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 patient²;

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;

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² DNAs for a first appointment following the initial referral that started a waiting time clock nullify the patient’s clock (i.e. it is removed from the numerator and denominator for RTT time measurement purposes).
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.

From 1 October 2015, there is no provision to pause or suspend an RTT waiting time clock under any circumstances.
How to apply the national waiting time rules locally

There are very few national waiting time rules. Models of service provision vary across the country, and each patient will be different. It is for the NHS locally to decide how these rules are applied to individual patients, pathways and specialties, based on clinical judgement and in consultation with other NHS staff, commissioners and, of course, patients.

The following guidance is intended to support the NHS on how to apply the national waiting times rules locally. It outlines the principles that underpin the national waiting times rules, provides explanation of and rationale behind the rules, and gives worked examples of how they may be applied locally.

Patients’ experience of the NHS can be improved by ensuring they receive high quality care, in the right place, and minimising the time they wait for treatment and care. The underlying principle in relation to consultant-led waiting times is that patients should receive high quality care without unnecessary delay.

In the majority of cases, it will be clear how the rules should apply. However, where there is doubt, or where decisions on their application are finely balanced, then local decisions should be made within the framework of national rules and in line with what is in the best clinical interests of the patient, and considering how the patient would perceive their waiting time.

For example: recording a decision to refer the patient back to primary care as a decision not to treat where a patient wishes to spend a few days thinking about their treatment options would not be likely to make clinical sense, nor would it make sense from the patient’s perspective to stop their 18 week clock, only for a new one to start days later when they have to ask their GP to refer them back in. It might, however, be appropriate both clinically and from a patient’s perspective to stop a waiting time clock and refer back to primary care where a patient asks to think about their options for several months to see how they cope with their symptoms over that period.

In summary, national waiting time rules provide a framework within which the NHS has the autonomy to make sensible, clinically sound decisions about how to apply them, in a way that is consistent with how patients experience or perceive their wait. They also ensure that waiting times are recorded and reported consistently across the NHS in England.
Clock starts

RTT consultant-led waiting times only apply to services commissioned by English NHS commissioners and for those patients that English commissioners are responsible.

Many waiting time clocks will start with a referral from a GP. However, a referral from any care professional, provided that it is in line with locally agreed referral practices, to the following types of services should start a waiting time clock. This may include referrals from:

- Nurse Practitioners
- GPs with a special interest
- Allied Health Professionals
- A&E
- Consultants
- Dentists (although not for referrals to primary dental services provided by dental undergraduates in hospital settings)

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.

A consultant is defined as ‘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. The definition of a consultant does not, however, include non-medical scientists of equivalent standing (to a consultant) within diagnostic departments.

A consultant-led service is one where ‘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 takes overall clinical responsibility for patient care.

Case Study 1

Mrs T was referred using the NHS e-Referral Service to the consultant-led glaucoma service at her local provider. At the first outpatient appointment, Mrs T was examined by the ophthalmic nurse practitioner who diagnosed glaucoma and commenced treatment.

In this scenario, although Mrs T saw a nurse practitioner rather than a consultant, her waiting time clock started on the day that she converted her Unique Booking Reference Number (UBRN). This is because there was an ophthalmic consultant who took overall clinical responsibility for Mrs T’s care, even though he/she was not physically present, and retained overall clinical responsibility for the service, team or treatment.
The setting of the consultant-led service is immaterial. A referral to a consultant or consultant-led service starts a waiting time clock irrespective of setting. For example, a referral to a hospital based consultant starts a clock in the same way as does a referral to a consultant-led team based outside of a traditional secondary care environment, such as in an outreach clinic in a GP practice.

**Case Study 2**

Mr S visited his GP on 3 January complaining of bladder problems. The GP suspected prostatism and recommended that Mr Smith see a consultant. On 5 January, Mr S booked an appointment through the NHS e-Referral Service to see a urology consultant at his local NHS Trust for 15 January.

In this scenario, as the referral is being made to a consultant-led service, Mr S’s waiting time clock started when the Trust received the referral, in this case, when Mr S converted his NHS e-Referral UBRN on 5 January.

If Mr S had rung The Appointments Line (TAL) to find that there were no appointments at his chosen provider, the clock would start on the date that TAL electronically sent the booking request to the provider.

**Case Study 3**

Mrs J visited her GP on 17 March complaining of back pain. The GP recommended that Mrs J sees a physiotherapist. Mrs J is seen by the physiotherapist at her local Trust on 3 April.

In this scenario, the referral is a direct access referral into a non-consultant-led service and therefore no waiting time clock is started.

Mrs J found that the physiotherapy helped her symptoms. However, some months or years later she found that her condition was deteriorating and her physiotherapist decided to refer her to an orthopaedic consultant for a specialist opinion.

In this case a waiting time clock would start when the provider received the referral from the physiotherapist to the consultant-led orthopaedic service.

**Case Study 4**

Mr B visited his GP on 4 August complaining of difficulties hearing. Mr B’s GP decided to refer him to a non-consultant-led audiology service for hearing tests with a view to potentially needing a hearing aid.

In this scenario, no waiting time clock starts, as the GP has made a direct access referral into a non-consultant-led service, although a direct access audiology RTT clock should start.
Case Study 5

Mr K has already been referred to a consultant-led orthopaedic service for a hip condition, for which a waiting time clock has been started. At an outpatient appointment, the orthopaedic service identify angina and decide to refer the patient to a cardiologist for further investigation.

Referrals do not have to come from primary care for a waiting time clock to start. In this instance, a consultant has identified a separate condition that requires the specialist opinion of another consultant. Therefore, subject to local commissioning rules on non-urgent new conditions, a new, separate waiting time clock should start from the date that the provider receives the referral. The original waiting time clock is unaffected.

A referral to a consultant includes referrals to diagnostics services, provided the 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 (i.e. ‘straight-to-test’). Direct access referrals to diagnostic services are excluded if the referral is not part of a ‘straight-to-test’ arrangement.

Case Study 6

Mrs T visited her GP on 22 November complaining of breathlessness and palpitations. Her GP decided to refer her for an echocardiogram to help inform her of the best way to manage her condition.

In this scenario, no waiting time clock starts, as the GP has made a direct access referral for diagnostic test with the intention that the responsibility for the patient remains with the GP and there is no intention for the patient to go on to see a consultant or consultant-led service at that stage.

On the same day, the GP also sees a patient with severe stress incontinence. The GP decides to refer the patient for urodynamics. Locally, the pathway of care commissioned enables the GP to send the patient directly to urodynamics as the first stage along their consultant-led pathway, without the need to first visit the consultant.

In this instance, a waiting time clock would start on the date that the provider receives the referral.

Case Study 7

Mr C visited his GP suffering from a painful shoulder. The GP refers Mr C for a course of physiotherapy. The physiotherapist service is based within a secondary care hospital.

In this case there is no waiting time clock started as Mr C is referred direct to physiotherapy and not to a consultant-led service. Were the GP to refer Mr C to see an orthopaedic consultant who subsequently recommended physiotherapy treatment, a waiting time clock would have started at referral and stopped when physiotherapy treatment was provided.
Case Study 8

Mr R presents at his GP complaining of a change in bowel habit. The GP refers Mr R to the hospital service for a colonoscopy. Depending on the results of the colonoscopy Mr R will either be discharged back to primary care or will receive treatment under the care of secondary care consultant.

In this scenario, the colonoscopy is accessed under a straight to test arrangement, such that, once the referral has been reviewed by the consultant the patient is booked to have a colonoscopy without the need for an outpatient appointment. A waiting time clock will start with the GP referral for a colonoscopy.

Also included are referrals to obstetrics, although pregnancy referrals should only start a consultant-led waiting time clock when there is a separate condition or complication requiring medical or surgical consultant-led attention.

Case Study 9

Mrs C, who is 4 months pregnant has a glucose tolerance test in the antenatal clinic and is found to have suspected gestational diabetes so is referred to a consultant diabetologist.

In this instance, a consultant-led waiting time clock should start for the referral to the consultant diabetologist.

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.

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

- where a patient is referred by their GP (or other referrer) to an intermediate service, which may, as a result, onward refer the patient to a consultant-led service, then the patient is most likely to perceive their wait as starting from the point that the GP made the original referral;

- where consultant-led services have been brought out of their traditional setting, often with a view to treating patients closer to home, outside of hospital, these services should also be recorded and reported, because they are consultant-led.

Excluding these services from consultant-led waiting times would not provide an accurate picture of the services provided by the NHS or an incentive to bring services closer to home where this is clinically appropriate.
An interface service is defined as being ‘all arrangements that incorporate any intermediary levels of clinical triage, assessment and treatment between traditional primary and secondary care’.

The definition of the term ‘interface service’ within the context of consultant-led waiting times 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.

What this means is that, when making a local decision about whether a particular service meets the definition of an ‘interface service’, the following should be considered:

- is the service consultant-led? If so, then it is not an ‘interface service’ by definition, although a consultant-led waiting time clock should start in any case (see rule 1a);

- 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;

- 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;

- is the service one that has been established to bring solely non-consultant-led services (e.g. 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…

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

- 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.

Referrals to referral management or assessment services should also start a consultant-led waiting time clock. A referral management or assessment service is defined as a service that does not provide treatment, but accepts GP (or other) referrals and may 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 consultant-led 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. If one of the intended outcomes of the service is that some patients will require such onward referral to a consultant-led service, then a consultant-led waiting time clock should start for all patients referred to the service.

**Case Study 10**

Over several years, a local practice has been commissioned to undertake vasectomies. The local commissioner considered that, as the entire management of these patients remains in primary care with no real potential for active consultant involvement this did not meet the definition of an ‘interface service’ and referrals should not therefore start a waiting time clock.

**Case Study 11**

In this area, GPs were enabled to refer directly to a locally commissioned integrated consultant and GP with special interest (GPwSI) dermatology service to help manage waiting times. Whilst the service is able to manage a proportion of the patients it has the ability to refer on to the local acute trust when they are unsure of diagnosis or the patient requires more specialist treatment.

In this case, the local commissioner and local providers agreed that the dermatology service constituted met the definition of an interface service, as it both brought in an element of traditionally provided consultant-led activity and some patients would subsequently go on to require consultant-led care after being seen by the dermatology service. A consultant-led waiting time clock should therefore start on referral by the GP (or other referrer) to the dermatology service.

Consultants also refer from the acute trust to this service if they think the patient could be appropriately managed by the service. In these instances, the service agreed that the clock continues to tick until the patient receives their treatment, either in the interface service or in the acute trust.

**Case Study 12**

A local commissioner has established an orthopaedic Integrated Clinical Assessment and Treatment Service (ICATS) where a GPwSI or Nurse Consultant sees, screens and works up patients who may need to see a consultant. Only those with serious pathology may need to see a consultant, and those who do not are rapidly assessed, treated and discharged back to their GPs.
Patients who do need to see the consultant are fully investigated, so decisions on treatment can be made at first consultant appointment. 75% of referrals are managed without the need to see a consultant.

The service and commissioner have agreed, as the service involves both an element of taking referrals that would otherwise have traditionally gone directly to a consultant-led orthopaedic service, and that some patients will subsequently require onward referral for consultant-led care, then the ICATS met the definition of an ‘interface service’. Therefore, a consultant-led waiting time clock should start for all patients referred to that service and stop at the point the patient receives the treatment either in the ICATs service or in the acute trust, as appropriate for the condition and patient.

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

- mental health services that are not led by a medical consultant;
- referrals to ‘practitioners with a special interest’ (PwSIs) for triage, assessment and possible treatment, except where they are working as part of a wider interface service type arrangements as described above.

Therefore, much mental health activity will be outside the scope of consultant-led waiting times.

However, consultant-led waiting times do 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, i.e. where a consultant retains overall clinical responsibility for the service, team or treatment.

**Case Study 13**

A GP refers Mrs C to a Community Mental Health Team (CMHT) run by the local Mental Health Trust which screened and assessed the patient and subsequently referred her to a consultant-led adult dementia treatment service.

In this instance, the local commissioner considered that the CMHT was not medical consultant-led as, although a consultant was involved in the running of the service, they did not take overall clinical responsibility at any stage for Mrs C’s care. Therefore, Mrs C’s clock did not start until the referral from the CMHT was received by the consultant-led adult dementia treatment service.
As noted above, decisions must be taken locally about whether a particular service model falls within the definition of an interface service or not. We recognise however, that this may be a finely balanced judgement, particularly when deciding if a practitioner with a special interest is working as part of a wider interface service type arrangement or not. Referrals to individual PwSIs (although they, in principle, meet the definition of an interface service in that they triage, assess and treat patients) are excluded from consultant-led waiting times for two reasons:

- to recognise that measuring clock starts for referrals to PwSIs would be prohibitively difficult and expensive to implement;
- to avoid extending the scope of consultant-led waiting times into the delivery of primary care services.

**Case Study 14**

A local GP has an interest in neurology and so has developed some extended skills. Other GPs in the area have therefore been calling the GP for some advice on the best treatment and management for the patient. This has meant that they have been able to either manage the patient appropriately in primary care or ensure the patient is referred onto the right pathway.

The local commissioner decided that this did not constitute an ‘interface service’, as the clinical responsibility for the patient remained with the GP; the GP with an interest in neurology was providing a service within primary care in order to help other GPs better manage the care of their patients with no intention for the GPwSI to make onward referrals to a consultant; and the service was one that had been traditionally provided over a number of years within the local health economy, and as such did not involve an element of taking referrals that otherwise would have gone directly to a consultant-led service.

2) A waiting time clock also starts upon a self-referral by a patient on to a consultant-led treatment pathway, 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.

Where local pathways are such that patients are able to self-refer onto a consultant-led treatment pathway, then the self-referral, once ‘ratified’ by a clinician should start a waiting time clock. Self-referrals can take the form of:

- a patient attending a consultant-led walk in centre;
- a patient who has already had a waiting time clock which has been stopped (for example because they declined an earlier offer of treatment) but with agreement that they can refer themselves back into the service at a future date (for example if they change their mind to have treatment, or if their condition worsens).
Case Study 15

Ms A turns up at her local community-based (consultant-led) cardiology service complaining of symptoms of breathlessness. The nurse specialist that sees her agrees that her self-referral into this service was appropriate and in line with local commissioning arrangements and starts a waiting time clock.

However, it may not have been appropriate to start a waiting time clock if the nurse specialist that saw her decided that the cardiology service was not the appropriate service to treat her, but instead advised Ms A to visit her GP, with a view to onward referral into secondary care, if the GP felt this necessary.

Case Study 16

Six months ago Mrs H decided she wanted time to consider her consultant's advice about having a hysterectomy as she had recently undergone investigations for breast lumps (that waiting time clock was stopped for patient activated active monitoring). Six months later Mrs H contacts the hospital and advises them that she would like to proceed with the hysterectomy. On 1 October, she agrees a time with the consultant’s secretary to come in for an outpatient appointment to discuss things further.

In this instance, Mrs H’s waiting time clock would start from the date that the patient agreed the appointment with the consultant’s secretary – in this case, 1 October.

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;

Where patients are undergoing a bilateral procedure, i.e. a procedure that is performed on both sides of the body, at matching anatomical sites (for example, removal of cataracts from both eyes), then the initial waiting time clock will stop at first definitive treatment for the first procedure. Once the patient is fit and ready for the second procedure then a new waiting time 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 (not from the date that the provider has the capacity to admit/treat them).

Case Study 17

Mr B is referred to a consultant ophthalmologist and books an appointment (converts his UBRN) though the NHS e-Referral System on 1 March (clock start). After seeing the consultant as an outpatient it is agreed that he would benefit from operations on both eyes to remove cataracts. He is admitted for a day case procedure on his left eye to remove a cataract on 28 March (clock stop). After a short period of recovery, Mr B contacts the hospital on 15 April to arrange a time for the operation on his right eye to be performed (new clock start). The procedure is undertaken on 10 May (clock stop).
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;

Many patients will require further planned stages of treatment after their waiting time clock has stopped. This treatment should be undertaken without undue delay and in line with when it is clinically appropriate and convenient to the patient to do so.

However, where further (substantively new or different) treatment may be required that was not already planned, a new waiting time clock should start. This new clock will often start at the point the decision to treat is made. However, where a patient is referred for diagnostics or specialist opinion with a view to treatment it may be more appropriate to start the new clock from the point that the decision that diagnostics or specialist opinion is made – i.e. when it is decided to start the patient off on a new ‘treatment pathway’.

Scenarios where this might apply include:

- where less ‘invasive/intensive’ forms of treatment have been unsuccessful and more ‘aggressive/intensive’ treatment is required
- patients attending regular follow up outpatient appointments, perhaps as part of managing a long term condition, 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 decision to refer the patient for therapy or surgery could.

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

**Case Study 18**

Mr A was treated for cancer some time ago. He subsequently attended a follow up appointment at his local hospital with a consultant surgeon on 17 October. The consultant suspects the patient has recurrent disease and so admits the patient for assessment on 18 October. The patient is then referred for discussion at the multi-disciplinary team. The patient is seen by the oncologist on 28 November who agrees with the patient that a further course of treatment is required.

As the patient is on long term follow up for their cancer a new waiting time clock should start on the date the patient was admitted for diagnostic assessment (18 October) which will stop on the date the course of treatment starts.
Case Study 19

Mrs L was referred to an orthopaedic consultant suffering from frozen shoulder. The consultant recommended a course of physiotherapy to see if this alleviated the symptoms. Following the course of physiotherapy Mrs L’s frozen shoulder was no better, and at a follow up outpatient appointment it was agreed that a surgical procedure was needed to treat this condition.

In this scenario, the physiotherapy was intended to be definitive treatment and would have stopped the first waiting time clock. Unfortunately the physiotherapy did not relieve Mrs L’s symptoms so further intervention was required. When it was agreed that surgery was necessary this would start a new waiting time clock which would stop when the surgery was carried out.

c) upon a patient being re-referred in to a consultant-led; interface; or referral management or assessment service as a new referral;

Where a patient has already been on a consultant-led treatment pathway, but is subsequently referred back into the service by their GP or other permittedreferrer, then a new waiting time clock should start.

Case Study 20

Some time ago, Mrs B was referred by her GP to a consultant physician who prescribed a course of medication and provided the GP with a treatment plan for management of her condition in primary care. Recently, Mrs B’s condition had worsened and her GP felt it necessary to refer her back to the consultant for further opinion.

In this instance, a waiting time clock should start on the date that the provider receives Mrs B’s referral (i.e. either when Mrs B converts her UBRN via the NHS e-Referral System, or when the provider receives the referral letter from the GP).

d) when a decision to treat is made following a period of active monitoring;

A patient’s waiting time 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 waiting time clock should start from the date that decision is made.

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.
Case Study 21
A child in a family at risk of familial breast cancer is referred to the genetics service for possible pre-symptomatic testing. It is not appropriate to proceed until the child is old enough to consider for themselves the implications of having a genetic test as there is no risk until they are adult. (Clock stops as active monitoring (or alternatively as a no treatment required stop)). A new clock will start at the point it becomes appropriate for the service to see the patient (or where a new referral is made by the patient's GP if the patient had been discharged back to the care of their GP).

Case Study 22
Mr F is referred to an orthopaedic consultant by his GP. The consultant decides that a hip replacement operation may be the best course of action. Mr F however wishes to wait to see how he continues to cope with his condition before going down the route of surgery and his waiting time clock is stopped as active monitoring (patient initiated). A year later, at a follow up outpatient appointment, Mr F is finding his condition harder to cope with, and after discussion with the consultant agrees to undergo surgery.

A new waiting time clock therefore starts on the date that the decision to treat was made at the follow up outpatient appointment.

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

Where a patient fails to attend the first appointment after the initial referral that started their waiting time clock, their clock will be nullified (i.e. it is as if the referral never existed). Where the provider decides that it is appropriate to contact the patient to rebook the appointment (i.e. the patient is not referred back into primary care), then a new waiting time clock should start from the date that a new appointment date is agreed with/communicated to the patient.

A DNA 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 and therefore should not have their clocks nullified (see rule 6 (f)).
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;

First definitive treatment is defined as being an intervention intended to manage a patient’s disease, condition or injury and avoid further intervention. The date that first definitive treatment starts will stop the clock. This may be either in an interface service or a consultant-led service.

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. In all cases, what constitutes first definitive treatment is a matter for clinical judgement, in consultation with others as appropriate, including the patient. If there is doubt about what first definitive treatment is for any given patient or pathway, then the key determining factors should be: a) what do the care professionals in charge of the patient’s care consider start of treatment to be; and b) when does the patient perceive their treatment as being started.

It is vitally important that clinical decisions on what is first definitive treatment mirror patients’ perceptions of their care. To do so will ensure that patient-reported experiences of their care reflect NHS reported referral to treatment times.

      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;

Where a consultant-led or interface service decides that therapy or a healthcare science intervention should be the first definitive treatment for the patient, then the patient’s clock should keep ticking until the start of that treatment. Where, however, a decision is made to refer back to primary or community care for therapy or healthcare science intervention, then the clock does not keep ticking until start of treatment, but stops on the date that the decision to refer back to primary or community care for treatment is made and communicated to the patient.

In summary, once a waiting time clock has been started for a referral to an interface service, then the clock should continue until the start of any non-consultant-led first definitive treatment provided by the interface service, including therapies or healthcare science interventions. Where a patient is on a consultant-led treatment pathway (either directly referred or referred on by an interface service) and is referred on for non-
consultant-led treatment in primary or community care, then the clock should stop on the date that this decision is made. That said, commissioners will want to assure themselves that such services outside the scope of consultant-led waiting times are delivering comparable levels of access to similar services in interface services or within secondary care.

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.

There is often a period of time between the need for a transplant being identified, and a suitable organ for transplantation becoming available. Therefore, where first definitive treatment requires the patient to be added to a transplant list, then the patient’s clock should stop on the date that they are added to the list, and when this is communicated to the patient. Where a donor has already been identified (e.g. a family member), then first definitive treatment would usually be the start of treatment itself.

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;

As previously noted, the act of referring a patient back to non-consultant-led primary care for treatment (and communicating this with the patient in a way which is auditable to agreed local standards) stops a consultant-led waiting time clock. Although the patient’s care continues, it is appropriate to stop their consultant-led waiting time clock at this point, as this represents the end of their wait for specialist/consultant/ hospital care. Commissioners will, of course, need to assure themselves that access to care prior to and post consultant-led waiting time clock starts and stops is delivered equitably and without undue delay.

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

In many pathways there will be times 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 decision to commence a period of active monitoring is made and communicated with the patient, then this stops a patient’s waiting time clock.
Active monitoring may be applied where it is clinically appropriate to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures at that stage.

Active monitoring may apply at any point in the patient’s pathway, but only exceptionally after a decision to treat has been made. If such a decision has been made but subsequently it becomes apparent that there is a clinical reason to delay treatment/admission then a waiting time clock would usually continue.

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.

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

However, it would not be appropriate to use patient initiated active monitoring to stop patients’ clocks where a patient does want to have a particular diagnostic test, appointment or other intervention, but wants to delay the appointment. Where such patient initiated delays prior to admission mean that 18 weeks cannot be delivered for that patient, then the minimum operational standards for 18 weeks allow for patients for whom starting treatment in 18 weeks would not be appropriate.

**Case Study 23**

Mr D is seen by the cardiologist and given a diagnosis of an aortic aneurysm. Mr D and the consultant discuss the possibility of surgery, but it is agreed that at this stage it is too small for surgery. The patient is therefore put on a period of active monitoring. During this time regular ultrasound tests will be carried out to measure the size of the aneurysm and lifestyle changes (weight, exercise) are addressed to minimise the risk of rupture to the patient (which would then result in emergency surgery). As the risk of death from surgery is higher than the risk of death from a rupture, not all aneurysms result in surgery and this patient may be monitored and then perhaps discharged back to the GP, or if the aneurysm increases in size then surgery will be required.

**Case Study 24**
Mrs R is referred to general medicine with undefined respiratory disease. The consultant has no clear plan of treatment and wants to monitor the patient before any intervention. There are two options, to discharge back to the GP for monitoring (clock stop) or to start a period of active monitoring, with the patient having a follow up appointment in three months, but to contact the hospital before if her condition deteriorates.
Case Study 25

Mrs B is referred by her GP to an orthopaedic consultant. The consultant undertakes a number of diagnostic tests which indicate that the patient requires surgery. However as the patient also has angina they are referred for a cardiac opinion to assess their fitness for surgery. The cardiac opinion comes back 4 weeks later that the patient is fit for surgery. Surgery takes place three weeks later.

In this scenario the use of active monitoring may not be appropriate, as the referral for cardiac opinion indicates that clinical interventions or diagnostic procedures may be appropriate at that stage. Therefore, Mrs B’s clock should stop when the patient is admitted for surgery. The clock carries on ticking while the cardiac opinion is being obtained.

c) a patient declines treatment having been offered it;

This is, hopefully, self-explanatory. Only stop a clock where a patient declines treatment having been offered it. This does not include situations where a patient wants to delay the treatment.

d) a clinical decision is made not to treat;

Where a decision not to treat is made then this decision (and communication with the patient) stops a waiting time clock. Usually, this will be a decision not to treat, which results in the patient being discharged back to the care of their GP (and/or other initial referrer). Where there is a decision made not to treat, but to retain clinical responsibility for the patient within the provider organisation (for regular outpatient follow-ups etc.) then it may be more appropriate to record this as active monitoring although both have the same effect of stopping the patient’s clock.

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;\(^3\);

The act of a patient failing to attend their first appointment following the referral that started their waiting time clock (i.e. not the first appointment in a different provider for multi-provider pathways) stops and nullifies a patient’s waiting time clock (provided that the provider can demonstrate that the appointment was clearly communicated to the patient, an example of which is that the appointment was made through the NHS e-Referral Service).

Where it is considered appropriate to refer the patient back to primary care then a new waiting time clock would only start if the patient were referred back to the service. Where

\(^3\) DNAs for a first appointment following the initial referral that started awaiting time clock nullify the patient’s clock (i.e. it is removed from the numerator and denominator for Referral to Treatment time measurement purposes).
the provider feels it more appropriate to offer the patient a new appointment, then a new
clock would start on the date that the patient agrees the new appointment date (not the
date of the rescheduled appointment itself).

A clock is nullified on first appointment DNA as, effectively, the patient has chosen not to
start their pathway.

A DNA is defined strictly as a patient failing to give notice that they will not be attending
their appointment. Patients who give prior notice, however small, are not classed as DNAs
and their clocks should not be stopped and nullified.

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, 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.

Unlike a first appointment DNA, it is not the act of DNAing a further appointment that stops
a waiting time clock, but the act of discharging the patient back to primary care where it is
deemed appropriate to do so, and where the above criteria are met. Where it is more
appropriate to continue to retain clinical responsibility for the patient in the provider
organisation, then the patient’s waiting time clock should continue ticking.

Also unlike first appointment DNAs, the patient’s clock is not nullified, but is stopped, and
reported in the commissioner’s and provider’s RTT returns. This is to reflect the fact that it
is likely that significant NHS resource has been used in getting the patient to that point (at
least one prior appointment) and that the NHS should be credited with their success in
delivering these pathways.

Local access policies on DNAs should be: drawn up in consultation with clinicians,
commissioners, patients and other relevant stakeholders; published; protect the interests
of vulnerable patients; and ensure that discharging a patient due to them DNAing is not
contrary to their best clinical interests. Care is also needed in drawing up and applying
local access policies to ensure that patients’ perceptions of their wait from referral to start
of treatment mirrors that of NHS reported RTT times.
Clinical exceptions to the NHS Constitution right

Under the NHS Constitution patients have the right to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of alternative providers if this is not possible and the patient requests it. There will always be some patients who choose to wait longer or for whom this is clinically appropriate, i.e. where waiting longer than 18 weeks is in the patient’s clinical interest (rather than clinically complex patients who nevertheless can and should start treatment within 18 weeks).

Ultimately, it is for the professionals in charge of the patient’s care to decide whether waiting longer than 18 weeks is in the patient’s best interests, and to communicate this to the patients concerned. However, the following points, developed in discussion with clinicians, may be useful to the NHS in identifying clinical exceptions to the 18 weeks standard:

- At its simplest, the definition of ‘clinical exception’ is where waiting longer than 18 weeks is in the patient’s clinical interest. However, this does not include clinically complex patients who nevertheless can and should start treatment within 18 weeks. Neither does it include patients who choose to delay their treatment beyond 18 weeks for personal or social reasons.

- Where a patient’s treatment does not begin within 18 weeks simply because it has been difficult to reach a potential diagnosis and a number of tests have been tried, this would be an example of clinical complexity, rather than a clinical exception.

- Where a patient’s treatment has not begun within 18 weeks due to a necessary sequence of diagnostic tests that for medical reasons could not be performed within a shorter period, this would be considered a clinical exception.

- Where a patient’s operation has to be rearranged for a short-term reason, such as a cold, this would not be a clinical exception. Providers who find this is a regular occurrence should examine their pathways.

- Where clinically complex patients have multiple conditions or co-morbid factors that can delay the start of treatment, these are not clinical exceptions and in many of these patient pathways, it may be appropriate to stop the 18 weeks clock for these patients and start a new one when the patients are medically fit and ready to start their treatment.

Case studies 23 to 24 above are useful illustrations of clock stops for ‘non-treatment’, where it is clinically appropriate to return a patient to primary care, or a clinical decision is made to start active monitoring.
Definitions

The aim of this document is to provide clear rules and definitions for RTT waiting times for consultant-led services. The guide on how to apply national rules locally provides further advice, including case studies, on applying the National Clock Rules which set many of the terms used in context.

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.

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.

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. |
| Consultan-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 (see definition of UBRN). |
| 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 | 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 e.g. as an outpatient. |
| 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 | 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. |
| Healthcare science intervention | See Therapy or Healthcare science intervention. |
### 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 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.

### NHS e-Referral System

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-consultant-led

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

### Non consultant-led interface service

See interface service.

### 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 or 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.
<table>
<thead>
<tr>
<th><strong>Referral to treatment period</strong></th>
<th>The part of a patient’s care following initial referral, which initiates a clock start, leading up to the start of first definitive treatment or other clock stop.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Straight to test</strong></td>
<td>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.</td>
</tr>
</tbody>
</table>
| **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 was not already planned, 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 (e.g. 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. |
<table>
<thead>
<tr>
<th><strong>Therapy or healthcare science intervention</strong></th>
<th>Where a consultant-led or interface service decides that therapy (for example physiotherapy, speech and language therapy, podiatry, counselling) or healthcare science (e.g. hearing aid fitting) is the best way to manage the patient's disease, condition or injury and avoid further interventions.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>UBRN (Unique Booking Reference Number)</strong></td>
<td>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.</td>
</tr>
</tbody>
</table>