

18 Weeks Referral to Treatment Guidance (Access Policy)

CATEGORY:	Guidelines
CLASSIFICATION:	Clinical
PURPOSE:	To provide guidance on the management of the 18 week referral to treatment pathway
Controlled Document Number:	018
Version Number:	3.2
Controlled Document Sponsor:	Chief Operating Officer
Controlled Document Lead:	Head of Service Improvement
Approved By:	Chief Operating Officer
On:	November 2016
Review Date:	November 2017
Distribution:	
<ul style="list-style-type: none"> • Essential Reading for: 	Operational Managers, Consultants, Matrons, Booking Centre, Medical Secretaries
<ul style="list-style-type: none"> • Information for: 	All Staff

1. Introduction

This document serves as direction and guidance for the management of patient pathways that fall under the scope of the 18 week Referral to Treatment (RTT) waiting time rules. It sets out the expectations and obligations of University Hospitals Birmingham NHS Trust in providing access to treatment in line with patients' rights under the NHS Constitution (DH 2015). It assures the Trusts compliance with national and local contractual and performance standards.

2. 18 Weeks Referral to Treatment

In 2008 the Department of Health mandated that patients should wait no longer than 18 weeks for treatment from the date of the original referral. Previously this was measured through the operational standards of admitted, non-admitted and incomplete pathways. From 1st October 2015 the admitted and non-admitted standards became redundant and performance is now measured solely on the incomplete standard which states:

“92% of patients should wait no longer than 18 weeks from referral to first definitive treatment”

3. Underpinning Principles

The progression of patients through 18 week pathways should occur without unnecessary delay, with patients best interests at the centre of all decisions and should not be influenced by performance against an 18 week clock.

Patients should be treated in order of clinical priority and then in order they were added to a waiting list (NHSE 18 weeks RTT Rules Suite 2015).

References for national guidance documents can be found on page 7.

4. General Rules

4.1 Referrals

An 18 week clock starts when a referral is made to:

- a) A Consultant led service with the intention to assess, and treat if possible, or
- b) An assessment or interface service which may result in a referral to a Consultant-led service

It may also start when:

- c) A patient already on an 18 week pathway has a substantively different treatment to the one in the original care plan, or
- d) When a patient is fit for the second of a bilateral procedure, or
- e) When a decision to treat is made following active monitoring, or
- f) When a patient rebooks an appointment they did not attend (DNA)

4.1.1 *NHS E-Referrals (Choose and Book)*

The clock start will be the date the Unique Booking Reference Number (UBRN) is converted and the referral is received into the Trust.

Where a patient is unable to book in to a slot via e-referrals notification of this will be sent to the Booking Centre. A list of unbooked e-referral appointments is sent daily by the Booking Centre and the appropriate action should be taken by the specialty administration teams to ensure capacity is made available for the appointment to be made in the e-referrals system.

4.1.2 *Tertiary referrals/inter hospital transfers*

Clock rules are applicable to tertiary referrals for elective assessment or treatment. However, not all tertiary referrals should be on an active clock and care should be taken to review the referral and ensure the patient is on the correct pathway.

If the patient is yet to receive first definitive treatment and their referral is applicable to the 18 week RTT rules, the clock will begin from the date that the original referral was received by the referring provider. This date should be detailed on the inter-provider transfer document. Where it is not it is the receiving Trust's (UHB) responsibility to obtain this date, including discussing with the patient or GP if necessary. If this cannot be determined easily then the date the referral was received by the Trust can be used.

If a patient is being referred for a continuation of care (i.e. they have received first definitive treatment and/or are on follow-up), then the patient should not have a clock

started on receipt of the letter and should be recorded as having had treatment previously. For example, the transition of care from child to adult services or when a patient relocates from a different part of the country

4.1.3 *Patients transferred from the private sector*

If the patient is yet to receive first definitive treatment and their referral is applicable to the 18 week RTT rules, the clock start will be the date the referral is received into the Trust.

If a patient is being referred for a continuation of care (i.e. they have received first definitive treatment and/or are on follow-up), then the patient should not have a clock started at referral and should be recorded as having had treatment previously.

Private patients should not circumvent standard NHS waiting list rules.

4.1.4 *Consultant to Consultant referrals (Internal)*

Where a patient is referred to another specialty as part of the management of the condition for which they were referred, the 18 week clock should continue ticking. For example to request a diagnostic test such as endoscopy, or to transfer the patient to a sub-specialty Consultant.

A new clock should not be started in these scenarios and first treatment should commence within 18 weeks from the date of the original referral. The patient should remain on the same pathway (PPID) and no additional pathway should be created by the referrer or referred to specialty.

The same management principles are applied as above for patients referred to another clinician within the same specialty, for example for management under a sub-specialty Consultant. Subsequent appointments in the same specialty should be made as follow-up not new appointments. Where a longer appointment is required in order to assess the patient fully, a double follow-up slot should be booked rather than a new slot.

Where an internal referral is made for management of a new condition, unrelated to the original condition for which the patient was referred, a new 18 week clock and patient pathway should be created from the date of referral.

For all referrals, it is the responsibility of the referring specialty to enter the referral on to ERHA, or other appropriate referral system used within the specialty. This ensures the referral does not become lost.

4.1.5 *Self-referral*

A clock can also start when a patient self refers to a service, where this is an agreed pathway and the referral is subsequently approved by a healthcare professional. The clock starts from the date the self-referral is received by the Trust.

4.1.6 *Referral and Assessment Services (including MDTs)*

Referral management and assessment services are those that receive referrals with the intention to provide advice on treatment and management of the patient. They do not have to physically see the patient as part of this process.

MDT meetings within the Trust that accept referrals from other sources for review and opinion on those patients should be considered as referral management and assessment services.

If the MDT meeting has the option to onwards refer the patient to a Consultant-led service prior to transferring the care back to the referrer, then an RTT waiting time period can be started for this referral. The clock should be stopped if a decision is made transfer the care back to the original referrer. If a decision is made to onwards refer the patient to a Consultant led-service, or continue to see and/or provide treatment for the patient, then the clock should continue to tick until first definitive treatment is provided.

4.1.7 *Advice and Guidance (or second opinion) referrals*

The start of an 18 week RTT clock for second opinion referrals will depend upon where the responsibility for the patient's care lies. If the referrer retains responsibility for the care and management of the patient then no 18 week clock should be started. In this scenario the patient may be reviewed and then discharged with a letter to the referrer offering advice regarding treatment. The patient would continue their follow-up in the referring Trust.

If however the care of the patient is being transferred to the Trust, then this should be managed in accordance

with the rules outlined in this guidance, ie a clock would normally start.

Where a patient is referred for a second opinion by another Trust clinician (internal referral) and the patient has already had a previous clock stopped, a new clock should only be started if there is an intent to treat the patient as part of this second opinion.

4.1.8 *Management of 'pending' referrals*

Pending referrals are those that have been referred to the Trust and are awaiting triage by an appropriate clinician.

Pending referrals should be reviewed and either accepted or rejected within a maximum of one week of them being received. It is the responsibility of the divisional clinical and administrative teams to ensure these referrals are managed appropriately. Failure to do so may result in delays to the patient's waiting time and treatment.

4.2 Additional Clock starts

On occasions it is appropriate for a further clock period to be initiated despite a previous clock start and stop period having already occurred. Guidance on circumstances where these additional periods should be applied, in accordance with the 18 week rules, are detailed below.

4.2.1 *Substantively different treatment*

Where there is a decision to further treat a patient, if the treatment is significantly different or new, and did not form part of the original treatment plan then this should start a new 18 week clock. The clock should be started from the date the decision is made to treat.

This is likely to be, although not exclusively, where a previous treatment has been unsuccessful and a more aggressive or intensive treatment is required. Clinician advice should be sought on these occasions to confirm that the new treatment is different to the previously planned course of action.

4.2.2 *Bilateral procedures*

Bilateral procedures (i.e. those that involve both left and right sides) that do not take place at the same time should have two separate clock periods. The first procedure

should have a clock start from the original referral date and be stopped when the procedure takes place. During this time the patient should be placed on a planned waiting list for the second procedure (with an expected treatment date, see 4.2.3). When the patient is deemed medically fit for the second procedure (this will usually be at an outpatient follow-up appointment), a new clock should be started. The second clock stops when the second procedure takes place.

4.2.3 *When a decision to treat is made following active monitoring*

See section 4.3.1

4.3 Clock stops

18 week clocks can only start or stop. There are no suspensions or pauses. Stops can be initiated for the following:

For treatment;

- a) At first treatment (this includes treatment by interface service or intervention provide in secondary care that avoids further interventions and is deemed to be the best course of treatment by the consultant led service); or
- b) When a decision is made to add a patient to a transplant waiting list.

For non-treatment;

When it is communicated to the patient that:

- c) They are to be discharged back to the GP;
- d) When commencing a period of active monitoring;
- e) When a patient declines treatment;
- f) When a patient dies before commencing treatment;
- g) When there is a decision made not to treat the patient; or
- h) Where a patient DNA's an appointment

4.3.1 *Active monitoring*

There are occasions when a period of monitoring with no intervention or diagnostics is the most appropriate course of action for a patient. This can sometimes be known as watchful waiting. A period of active monitoring may be initiated by the consultant or the patient themselves (for example if the patient wishes to see if they can manage symptoms without intervention). On these occasions a clock will stop on the date that this decision is made and discussed with the patient. A new RTT clock will commence when there is a decision to treat.

Routine investigations are acceptable during a period of active monitoring; however active investigation of a patient should not occur. For example a patient may be on active monitoring to see if they can manage their symptoms on their current treatment regime. During this period they may have blood tests or scans to monitor their condition. However, if a decision is made to undertake unplanned investigations on a patient who is in a period of active monitoring, then a new clock should be started. Furthermore, if routine monitoring prompts changes to the patient's treatment plan, then active monitoring should be ended and a new clock started.

It is not appropriate to use active monitoring to stop a clock where a patient wishes to delay treatment for a short period (choice) or when waiting for a diagnostic procedure.

4.3.2 *Medically unfit for treatment*

Patients should only be added to a waiting list if they are fit and ready for treatment. Patients who require thinking time may be considered appropriate for active monitoring by their clinician.

Sometimes a patient is identified as unfit for treatment after they have been placed on a waiting list and there are several options available to manage this. The decision should be based on clinical advice and what would be least detrimental to the patient's progression through the pathway.

Where a patient is identified as temporarily unfit for treatment the clock will continue to tick.

Patients identified as medically unfit for a longer period of time for a condition that can be managed in primary care or one that requires further investigation, should be discharged back to their GP, to be re-referred when they have been assessed as medically fit.

Alternatively a clinician can make a decision to commence active monitoring

4.3.3 *Patient Did Not Attend (DNA) (also known as Failure to Attend (FTA))*

Where a patient fails to attend an appointment, without sufficient notice (within 24 hours prior to the appointment) this should be recorded as a DNA.

All DNAs should be reviewed by an appropriate member of the clinical team. The clinician should identify those patients that should be seen again and those where care can be transferred back to primary care (discharged). This decision must be a clinical one and no blanket rules should be applied to DNAs. This is to ensure that decisions are made in the best clinical interest of the individual patient. This is particular important for vulnerable patients.

Where a patient DNAs the clock is stopped and nullified. The patient will be notified in writing along with the GP and original referrer, if this is not the GP. Patients should be informed via their appointment letter of the Trust's policy for managing DNAs.

If the patient is not discharged, a new 18 week clock will start from the date the appointment is re-booked and the previous clock should be stopped and nullified. If a GP or other provider re-refers a patient, a new 18 week clock will start on the date the new referral was made.

Subsequent DNAs by the same patient may indicate that the patient's contact details are not correct. Efforts should be made to check the patient's address and if necessary, contact should be made with the GP. This is especially important for vulnerable patients.

This DNA policy only applies if the Trust can demonstrate that the appointment was clearly communicated to the patient. If this cannot be demonstrated then patient contact details should be confirmed and a new appointment issued. Text message reminder services,

whilst are helpful, do not constitute a reasonable offer of an appointment and are therefore not applicable to this policy.

Patients who cancel a first appointment at very short notice (within 24 hours of the appointment) may be offered another appointment if requested. However, a new clock should start and the original clock should be nullified.

4.4 Patient initiated waits

There is no provision for clocks to be paused or stopped should a patient wish to wait for their treatment (unless the patient has requested to “wait and see” in which case an active monitoring clock stop would be more appropriate). A patient can be suspended on the Trust’s waiting list to enable management of that list until the planned appointment date, however the clock will continue to tick.

Where a patient indicates they wish to wait for a period of time, a date should be set with the patient for that procedure in the future and where possible a TCI date agreed. If the patient does not wish to commit to a date and it is clinically appropriate and agreed by the consultant, then they can be discharged to back to the original referrer and re-referred when they wish to continue with treatment.

4.5 Patient Cancellations

A patient should not be penalised for rearranging or cancelling an appointment as long as they have provided more than 24 hours’ notice. If more than 24 hours’ notice has been given the 18 week clock should continue to tick. “Patients should not be discharged back to their GP because they have cancelled or rearranged appointments”. (NHSE 18 week RTT Rules Suite, 2015).

Steps should be taken however to monitor where a patient re-arranges an appointment on more than two occasions. Advice should be sought from the Consultant to ensure that the patient is managed appropriately and that they still wish to continue with diagnosis or treatment.

A patient has the right to a reasonable amount of time between the time the appointment is offered and the date of the appointment. A reasonable offer is defined as “one for a time and date three or more weeks from the time that the offer was made” (NHSE 18 week RTT Rules Suite, 2015).

See 4.3.3 for guidance on short notice (less than 24 hours) patient cancellations.

4.6 Cancellations by the Trust

If an appointment or planned procedure (TCI) is cancelled for operational reasons then there is no effect on the clock and it continues to tick.

For appointments or TCIs cancelled due to a patient being medically unfit please refer to section 4.2.7

Please note that a minimum 6 weeks' notice is required for a clinic cancellation and all Trust clinic cancellations must have evidence of Director of Operations approval.

4.7 Patients who arrive late for an outpatient appointment

If a patient arrives after their appointment time every effort should be made to provide the consultation, although it may be necessary for the patient to wait until other patients have been seen. A patient should not be recorded as a DNA unless they arrive after the clinic has been cashed up. If the patient arrives too late to be seen, another appointment should be made for as soon as possible and no adjustment should be made to the 18-week clock.

5. **Managing patients undergoing investigations**

Where a patient has been sent for further investigations, if an RTT clock was active it should continue to tick. Pathways of patients undergoing investigations should be monitored by specialty administration and clinical teams to ensure they are reported and results communicated to the patient promptly.

Where there is a decision not to treat after the results of investigations, the clock should be stopped from the date this decision is made and communicated to the patient. In practice this will be the date the letter is sent to the patient, however should the patient be contacted prior to this date for example via phone, then this date can also be used.

If results indicate treatment or further investigations are required then the clock will continue to tick until first definitive treatment is provided.

On occasion more invasive investigations may also provide first definitive treatment, for example a biopsy which removes a mass. If this occurs then it would be acceptable to stop a clock. Not all procedures of this kind will deliver first definitive treatment so blanket

rules should be applied and each case should be reviewed and clocks applied appropriately.

6. Managing patients on follow-up

Patients on follow-up care would ordinarily be on an inactive pathway (previous clock stopped). There will be occasions where a new clock should be started (section 4.2).

Appropriate follow-up time frames should be indicated by the clinician at the time of the patient's outpatient appointment or on discharge. These patients should be monitored within divisional administrative teams to ensure they receive appointments as clinically appropriate.

7. Patients on a planned waiting list

Patients should be added to a planned waiting list where the date of admission is determined by the needs of the treatment, rather than the availability of resources. Often this is part of a planned sequence of clinical care, which is determined by clinical criteria, for example a check cystoscopy or a series of injections. Other examples include admissions arising from other treatments, eg the planned removal of an internal fixation after 3 months. If the treatment requires a set delay before initiation it can be considered as planned.

Where a patient is on a planned waiting list and treatment does not commence on the planned date, a new RTT clock should commence from the time the planned procedure was due.

Patients should not be on a planned waiting list because they are unfit for treatment or for social reasons.

8. Armed Forces Covenant

The Armed Forces Covenant is a national "promise" that those who serve, have served and their families, will face no disadvantage by their service. It further agrees that special consideration may be given in some cases, particularly to those that are bereaved or injured.

For the NHS this means ensuring the same access and provision of treatment to that of a civilian. In practice for the Trust this means the following should be ensured:

- Patients under the armed forces covenant are placed appropriately on waiting lists; where it becomes known that a patient on a waiting list has previously waited at another healthcare provider, the patient should be moved to that same position on the waiting list (provided this does not lengthen the pathway).

- Patients injured on operations should be treated in conditions that recognise their specific needs as armed forces personnel.
- Veterans should receive priority treatment (subject to the clinical needs of other patients), where this care relates to a condition brought about as a result of their service.

9. Specific Exclusions to 18 week RTT reporting - General

9.1 NHS Screening Programmes

Patients referred on an NHS Screening programme are outside of the 18 week RTT rules. Should a subsequent decision be made to treat or further investigate the patient then this would start a new 18 week clock period.

9.2 Clinical Complexity

Cases where a number of diagnostic tests could not be performed within 18 weeks for medical reasons or a diagnosis has been difficult to reach are deemed to be clinically complex and can be excluded. Guidance should be sought from the operational performance team if there is any doubt about applying such an exclusion.

9.3 Clinical Exception

Cases where waiting longer than 18 weeks is in the patient's interests are deemed clinical exceptions and can be excluded.

10. Specific Exclusions to 18 week RTT reporting – Specialty Pathways

Neurosurgery Spines

There is a commissioner-approved local health economy referral pathway for neurosurgery spines which requires referrers to provide an MRI scan with any referral to an acute Trust consultant-led service. Referrals to neurosurgery spines without an MRI scan should be returned to the referrer with a request that the agreed pathway is followed.

11. Further Information

Further advice and guidance on management of the 18 week pathway can be requested from the Operational Performance team.

12. Supporting Documentation

Armed Forces Covenant – Ministry of Defence, June 2016

Elective Care Guide, Referral to Treatment Pathways: A Guide for Managing Efficient Elective Care, 2nd Ed. – Elective Care Intensive Support Team, NHS January 2014

Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care (DRAFT) – NHS England, September 2015

Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care: Frequently Asked Questions (DRAFT) – NHS England, September 2015

Referral to treatment consultant-led waiting times, Rules Suite – Department of Health, October 2015

The NHS Constitution for England – Department of Health, July 2015