

Community Information Programme:

*Allied Health Professional Referral to Treatment
Revised Guide 2011*

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Introduction

1. This Allied Health Professional (AHP) Referral to Treatment (RTT) revised guide supersedes the previous guide published in March 2010. The guide revisions are focused on the feedback and comments received from stakeholders and provides greater clarity when applying the AHP RTT rules.
2. This guide sets out a framework of rules for clock starts and clock stops for AHPs delivering NHS funded care (either fully or partially funded) in an autonomous or multidisciplinary service, referred to throughout the guide as NHS AHP services. Applying the rules consistently will enable the measurement of patient waiting times for those accessing NHS AHP services, summarised in Appendices A, B, C, E and F.
3. Within this framework NHS AHP services, in discussion with patients, have the autonomy to make sensible, clinically sound decisions about how to apply these rules in a way that is equal and consistent with how patients experience or perceive their wait from referral to treatment.
4. The national reporting of NHS AHP RTT waiting times, via the Community Information Data Set for Secondary Uses (CIDS), will enable patients to use this information to make informed choices when accessing services that AHPs deliver, and improve patients' experiences of NHS AHP services. This will ensure that patients receive better health outcomes and high quality care through timely access to NHS AHP services.
5. There is **no** waiting time target attached to the AHP RTT period. By delivering transformational change across the NHS, long waiting times for patients accessing NHS AHP services can be reduced and the principles of improved access to the NHS realised.¹ Initiating quality, innovation and productivity within NHS AHP services, by minimising the likelihood of complaints caused by delays and preventing the need for referrals to secondary care, will improve patient experience. In all cases, the underlying principle is that patients should receive quality care without unnecessary delay.
6. Some NHS AHP services are already involved in treating patients on a consultant-led RTT waiting time pathway. When an AHP receives a referral for a patient, the AHP will need to be clear whether the treatment they provide is part of a consultant-led RTT waiting time pathway or whether an AHP RTT clock needs to start.
7. Models of service provision vary across England and patient needs will be different when accessing NHS AHP services. It is for the NHS locally to decide how the AHP RTT rules are applied equally to individual patients within their population, based on clinical judgement. This is achievable through effective involvement, engagement and

¹ Department of Health (2008) The NHS Constitution – The NHS belongs to us all. London

consultation with patients/carers, commissioners, providers and other key partners.

8. The Community Information Data Set for Secondary Uses (CIDS) incorporates the data items needed to flow data nationally on the time taken from referral to treatment. Technical guidance for data flow and reporting is available on the NHS Information Centre website

<http://www.ic.nhs.uk/services/in-development/community-information-programme/community-information-data-set-cids>

9. Work is ongoing to mandate the flow of AHP RTT data in the Commissioning Data Set for Outpatient attendances (CDS Type 020) for AHP activity funded by the NHS Standard contract for Acute Services. A similar mandate and development is anticipated around the Mental Health Minimum Data Set in order to allow the contribution of AHPs working with mental health services to be reflected. In both instances this will be subject to Review of Central Returns (ROCR) and Information Standards Board (ISB) approval.

Background

AHP Services

10. All AHPs have four common attributes:

- They are, in the main, first-contact practitioners;
- They perform essential diagnostic and therapeutic roles;
- They work across a wide range of locations and sectors within acute, primary and community care;
- They perform functions of assessment, diagnosis, treatment and discharge throughout the care pathway – from primary prevention through to specialist disease management and rehabilitation.

11. These characteristics are essential for transforming health and social care. The knowledge, skills and experience they bring will be crucial if we are to continue to provide a sustainable service that not only ‘adds years to life’ but also ‘adds life to years’

12. The AHPs required to collect RTT data, whether working autonomously or within a multidisciplinary team, are:

- > Art, Therapists
- > Drama Therapists
- > Music Therapists
- > Chiropodists/Podiatrists
- > Dietitians
- > Occupational Therapists
- > Orthoptists
- > Orthotists
- > Physiotherapists
- > Prosthetists
- > Radiographers – Diagnostic and Therapeutic
- > Speech and Language Therapists

13. **This includes mental health and learning disability services where the AHP could be a member of the multi-disciplinary mental health team or a non-consultant-led service in the acute setting.**

14. This guide will assist AHPs who provide services in community and acute healthcare settings, to measure equally and consistently the length of time patients wait from referral to treatment.

15. The scenarios within this guide reflect the variety of settings and the use of various methods of consultation i.e. face-to-face, telephone consultations and group sessions, to assist in clarifying how clocks start and stop to measure AHP RTT.

16. The length of waiting times for NHS AHP services should be aggregated, analysed, and monitored for the impact on different equality groups and communities, and used to develop and deliver services that promote equality and eliminate unlawful discrimination on the grounds of age, disability, ethnicity, sexual orientation, gender including transgender, religion or belief and human rights. The needs of carers, people in deprived communities and socially excluded, such as Asylum Seekers, Gypsies and Travellers, and homeless people should all be considered in the context of AHP RTT data collection.
17. By measuring AHP RTT waiting times, improvements to accessibility and service performance can be made to transform clinical services and reduce unnecessary waits for patients.
18. Pilot sites (Appendix D) have been involved throughout the development of the AHP RTT guide, testing the appropriacy of the rules for measuring AHP RTT and testing the ability to collect AHP RTT data.
19. An Expert Reference Group (ERG) was established to provide an additional resource for the project team to test the guide. Membership included representatives from the AHP Federation and clinical experts with an interest in data collection.

AHP Referral to Treatment (RTT) Rules

20. The following section sets out the rules for AHP RTT clock starts and stops, to be applied consistently and equally to all patient referrals to an AHP in:

- > Any NHS funded uni-professional AHP service e.g. Physiotherapy, Occupational Therapy;
- > Any NHS funded multi-disciplinary service with AHPs integrated within the team e.g. Child and Adult Mental Health service (CAMHS), Community Rehabilitation Team, Intermediate Care Team, Adult or Children's Learning Disability service.

AHP RTT Clock Starts

21. **An AHP RTT clock starts on the date that a self-referral is received by an NHS AHP service from a patient/carer where commissioners and providers have agreed these pathways locally.**

22. **An AHP RTT clock also starts on the date that a referral for a patient is received by an NHS AHP service from any health or social care professional permitted by an English commissioner to make such referrals.**

23. Patients can be treated in any setting appropriate to their medical need e.g. local health centre, GP surgery, patient's own home, hospital outpatient clinic, educational or mental health setting i.e.

- > Outpatient therapy services delivered in a hospital setting, where the treatment is not part of a consultant-led RTT waiting time pathway;
- > Outpatient therapy services, including multidisciplinary and mental health services, delivered in a community setting, where the treatment is not part of a consultant-led RTT waiting time pathway;
- > Outpatient therapy services in a Referral Management or Clinical Assessment Treatment service (CATs) delivered in a community setting, where the treatment does not contribute to a consultant-led RTT waiting time pathway.

24. For referrals made through Choose and Book the clock starts on the date the patient converts their unique booking reference number (see Glossary) either directly from the referral point e.g. GP practice or via the Appointments Line service.

Referrals that do not start an AHP RTT clock?

25. Referrals would not start an AHP RTT clock if the treatment to be provided is part of a consultant-led RTT waiting time pathway i.e.

- > Inpatient AHP services delivered in a hospital setting, where the treatment is part of a consultant-led RTT waiting time pathway (see scenario 9);
- > Inpatient AHP services delivered in a hospital setting where the treatment is follow up to first definitive treatment which has already stopped a consultant-led RTT waiting time clock e.g. the first definitive treatment of surgery has been undertaken and the AHP treatment is follow-up to the surgery (see scenario 10);
- > Referrals from primary care to referral management centres/CATS start a consultant RTT clock if:
 - a) The service receives referral that would otherwise have been sent to a consultant service or consultant-led team (prior to the CATS service being established), and
 - b) The service is able to refer on to consultant-led care before care transfers back to the referring healthcare professional or GP
- > The clock starts on the date that the referral management centre/CATS receives notice of the patient's referral.
 - If the patient is subsequently treated within the CATS, then this would stop the consultant 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 consultant-led RTT 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 RMC – the consultant-led 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.
- > Outpatient AHP services funded entirely through Local Authority funding. If the service is jointly funded AHP RTT should be collected (See Introduction, paragraph 2)

AHP RTT Clock Stops

AHP RTT clock stops for treatment

26. An AHP RTT clock stops when first definitive treatment starts.

This could be:

- > First definitive treatment provided;
- > Diagnostic test undertaken and the subsequent report dispatched to the referrer;
- > Receipt of first definitive advice;
- > Assessment and recommendations given, with no further clinical intervention required;
- > The supply of a medical device, with the clock stopping on the date on which definitive fitting, or where appropriate trial fitting, begins and there is no undue delay in subsequent fitting sessions thereafter;
- > The delivery of general equipment to the patient.

AHP RTT clock stops for non-treatment

27. Any one of the following reasons can stop an AHP RTT clock for non-treatment when the patient/carer, and subsequently their GP and/or other referrer is informed² of:

- > Decision not to treat;
- > Decision to start a period of active monitoring initiated by the patient and/or AHP (Appendix B);
- > Decision to return the patient to their GP for referral to a consultant-led service;
- > The patient declines the treatment they have been offered;
- > The patient dies before treatment;
- > A patient DNAs their first appointment following the initial referral that started their clock and the patient is discharged from the service and the clock is nullified (Appendix C). The provider

² Communication methods could include, for example: letter, face-to-face, translator/interpreters to include British Sign Language interpreters, telephone, text or email.

needs to establish the reason why the patient did not attend the appointment;

- > A patient DNAs a follow up appointment prior to first definitive treatment and the patient is discharged back to the care of their GP or other referrer provided that:
 - i. The provider establishes the reason why the patient did not attend the appointment;
 - ii. Discharging the patient is not contrary to their best clinical interests;
 - iii. Discharging the patient is carried out according to a local, publicly agreed and available policy on DNAs i.e. Local Access Policy.³

28. If it is not appropriate to discharge the patient, the clock continues to tick.

29. When a patient's AHP RTT clock has been stopped, a new AHP RTT clock for that patient only starts when:

- > A new referral is received for that patient following discharge. This could be for a new problem or recurrence of the same problem;
- > There is a decision to start a substantively new or different treatment that does not already form part of the patient's agreed care plan;
- > A decision to treat is made following a period of active monitoring (Appendix B);
- > A patient rebooks their appointment following a first appointment that they did not attend (DNA) that stopped and nullified their earlier clock (See Glossary).

³ Department of Health (2010) Referral to treatment consultant-led waiting time rules - A 'how to' guide to applying national waiting time rules locally. London

Applying AHP RTT rules

30. The following section provides a number of scenarios that NHS AHP community services could experience when applying the rules for clock starts and stops, which will enable the measurement of length of waits patients experience from referral to treatment. The scenarios, although detailing specific therapy professionals or teams as examples, can apply in principle to any NHS AHP service.

AHP RTT Clock Starts

31. **An AHP RTT clock starts on the date that a self-referral is made by a patient/carer to an NHS AHP service where commissioners and providers have agreed these pathways locally.**

Scenario 1

Ms M is experiencing pain in her shoulder and her carer telephones the local health centre on the 1st February regarding how to access the physiotherapy service. The physiotherapy service informs her carer that they can accept a referral from her over the phone and the relevant details are taken during the call.

In this situation, the commissioners and the providers have agreed that patients or carers can self-refer into the physiotherapy service. Therefore the clock starts on the 1st February on the date the patient or carer contacted the service and provided the relevant information required to process the referral.

32. **An AHP RTT clock starts on the date that a referral for a patient is received by an NHS AHP service from any health or social care professional permitted by an English commissioner to make such referrals.**

Scenario 2

Mr H, a Polish, non-English speaking resident, is referred by the community psychiatric nurse to the Community Mental Health occupational therapist (OT), who is part of a non-consultant-led team. On the referral, the community psychiatric nurse requests the need for a Polish interpreter. Although his wife who attends appointments with him can speak English, she requests that an interpreter is present at the appointment for him.

The AHP RTT clock starts on the date the referral is received by the OT. The OT arranges a suitable appointment for Mr H to attend with an interpreter.

Possible referrers to NHS AHP services are:

- > General practitioners (GPs)
- > Allied Health Professionals (AHPs)
- > Nursing staff – community and secondary care
- > Health Visitors (HVs)
- > School nurses
- > Education staff
- > Children Centres staff
- > Social services
- > Minor injuries units (MIU)
- > Walk-in centres (WiC)
- > National screening programmes
- > Prison health services
- > Probation services
- > Substance Misuse services
- > Referrals from consultant-led services specifically for conditions they are not treating on a consultant-led RTT waiting time pathway, where commissioners and providers have agreed these pathways locally (Scenario 3).

Scenario 3

Miss R has been referred to an orthopaedic consultant for a shoulder problem for which a consultant-led RTT waiting time pathway has started. Whilst under the consultant's care the patient complains of a knee problem and the consultant refers the patient to the physiotherapist.

In this situation, the physiotherapy service would start an AHP RTT clock as the referral is for a condition that is unrelated to the shoulder problem and so does not contribute to the consultant-led RTT waiting time pathway.

33. The patient could be treated in any community, hospital, educational or mental health setting i.e.

- > Outpatient NHS AHP services delivered in a hospital setting where the treatment is not part of a consultant-led RTT waiting time pathway;

Scenario 4

Mrs J is referred to the dietetic service by her GP. The dietitians' clinic is held in the outpatient department at the local hospital.

Although Mrs J is receiving treatment within the hospital, the referral was made directly from her GP to the dietetic service. The treatment to be delivered is not part of a consultant-led RTT waiting time pathway therefore an AHP RTT clock would start on the day that the dietitian received the referral.

- > Outpatient NHS AHP services, including multidisciplinary and mental health services, delivered in a community setting, where the treatment is not part of a consultant-led RTT waiting time pathway;

Scenario 5

Miss V, who has muscular pain, is referred by her GP to a physiotherapist, who is an Any Qualified Provider funded by the NHS to provide physiotherapy services at the GP practice. The referral states that Miss V is deaf and will require a British Sign Language (BSL) interpreter.

The physiotherapist is providing an NHS funded service. Therefore, the waiting times for the service are collected as AHP RTT data with the clock starting on the date they receive the referral. The physiotherapist arranges for a BSL interpreter to be present at the appointment.

NB: The patient may have benefited from a consultant-led RTT pathway and been discharged from consultant-led care but referred to AHP services, possibly for treatment of the same condition e.g. scenario 10.

- > Outpatient NHS AHP services in a Referral Management or Clinical Assessment Treatment service (CATs) delivered in a community setting, where the treatment is not part of a consultant-led RTT waiting time pathway.

Scenario 6

Mr F is referred by his GP to the local CATs service to see the physiotherapist with pain in his right leg. Following the assessment the following options are a possible outcome:

The physiotherapist treats Mr F and an AHP RTT clock stops;

The physiotherapist refers Mr F directly to a consultant and this forms part of a RTT consultant waiting time pathway.

NB: If the CATs does not need to refer back to primary care i.e. can refer on to consultant care directly, then it is an interface service and all to such a service will start a consultant-led RTT pathway regardless of whether they are referred on or not.

34. **For referrals made through Choose and Book the clock starts on the date the patient converts their unique booking reference number (UBRN) either directly from the referral point (e.g. GP practice) or via an Appointments Line service.**

Scenario 7

Mrs S attends her GP surgery on the 10th June with a foot problem affecting her walking. The GP decides that this requires a referral to the podiatry service for a biomechanical assessment. The GP provides Mrs S with an appointment request letter that includes a unique booking reference number (UBRN) and a password. Mrs S contacts the Appointment Line service on the 11th June and the service asks for the UBRN and password. This initiates the referral, referred to as converting the UBRN, and the AHP RTT clock starts on the 11th June.

Mrs S could have chosen to book the appointment before leaving the surgery and the AHP RTT clock would have started on 10th June, and a letter confirming the appointment would have been sent through the post but she chose to contact the Appointment Line service herself.

35. **If a referral to an NHS AHP service is addressed incorrectly, the AHP RTT clock keeps ticking**

Scenario 8

Mr B requires treatment to his left shoulder following a sports injury and the practice nurse makes a referral to a musculoskeletal physiotherapist and sends the referral through the post, addressed to the occupational therapy (OT) service. On receiving the referral on the 13th February, the OT service triage the referral and discover the referral states that the patient is to see a physiotherapist.

In event of such a situation arising, the OT service should write the received date of 13th February on the referral and redirect the referral to the physiotherapy service. On receiving the referral, the physiotherapy service would start the clock on the 13th February, irrespective of the date they received the referral.

Referrals that do not start an AHP RTT clock?

36. An AHP RTT clock does not start when treatment is part of a consultant-led RTT waiting time pathway

Scenario 9

Mrs A is attending an orthopaedic consultant for a hip condition for which a consultant-led RTT waiting time pathway has started, but first definitive treatment has not been provided by the consultant. The consultant refers the patient to the outpatient physiotherapy service at the hospital to provide the first definitive treatment.

As the referral is part of a consultant-led RTT waiting time pathway, an AHP RTT clock **does not** start. In this situation, the RTT data would be recorded as the first definitive treatment for the consultant-led pathway.

If the consultant had referred the patient to a physiotherapist in the community i.e. local health centre for first definitive treatment, the consultant RTT clock would stop on the date the decision to refer was made and the AHP would start an AHP RTT on the date that the service received the referral.

Scenario 10

Mr L has undergone surgery on his knee. This is the first definitive treatment on a consultant pathway of care and this stops the consultant-led RTT waiting time clock. Whilst recovering on the ward, Mr L receives treatment from a physiotherapist. This is follow up treatment to the consultant's care, and therefore part of the consultant-led RTT waiting time pathway. However, that clock has already stopped, so no RTT is collected.

Upon discharge from hospital, a referral is made to the Community Rehabilitation Team for Mr L to receive continued physiotherapy. Although the treatment required is for the same condition, an AHP RTT clock would start on the date that the Community Rehabilitation Team received the referral.

AHP RTT Clock Stops

AHP RTT clock stops for treatment

37. First definitive treatment is defined as an intervention intended to manage the patient's disease, condition or injury. The date that the first definitive treatment begins the AHP RTT clock stops.
38. For AHPs, first definitive treatment can be clinical intervention i.e. 'hands-on' treatment. However, other elements of AHP treatment constitute first definitive treatment, for example diagnostic tests and definitive advice which may be provided via a telephone consultation. First definitive treatment is a matter of clinical judgement in consultation with others, and where appropriate including the patient/carer. If in any doubt the key determining factor should be:
- > What does the AHP responsible for the patient's care consider the start of treatment to be?
 - > When does the patient perceive their treatment to have started?
39. **First definitive treatment could be:**

i. First definitive treatment provided;

Scenario 11

Mrs E is referred to the complex need OT team for support with occupational function. The AHP RTT clock starts on the day the referral is received. Following the functional assessment Mrs E is allocated to an OT and the clock stops on the date of the first definitive treatment.

If following assessment it was determined that Mrs E did not require any further intervention she would be discharged back to the referrer and the AHP RTT clock stops based on the decision not to treat and no further contact required.

ii. **Diagnostic test undertaken and the subsequent report dispatched to the referrer;**

Scenario 12

Mr V attends his GP complaining of an acutely painful ankle following a fall. The GP requires further diagnostic tests to be undertaken and refers Mr V to the Radiography service for an X-Ray of the ankle.

Mr V attends the Radiography service that same day on the 24th March and the diagnostic radiographer undertakes the x-ray and completes the x-ray report. This report is dispatched to the referrer at the end of the working day.

The AHP RTT clock stops when the report is dispatched to the referrer on the 24th March. If the report was not dispatched until the following day, the 25th March, the AHP RTT clock would not stop until the 25th March regardless of the x-ray being undertaken on the 24th March.

iii. **Receipt of first definitive advice;**

Various forms of advice exist and can be delivered to the patient in various formats, including face-to-face e.g. at a clinic appointment or non-face-to-face e.g. via the telephone. Within the context of this guide, advice will be defined as definitive or general advice:

- a) Definitive advice is specific and personalised that has been informed by clinical decision-making. The advice is documented in patient records and is auditable. This level of advice constitutes first definitive treatment and does stop an AHP RTT clock.

Scenario 13

Mr Z is diagnosed with Type 2 diabetes mellitus and is referred by his GP to a dietitian for dietary advice to manage his diabetes. The GP states on the referral that Mr Z is able to speak English, but he reads Urdu.

The dietitian receives the referral on the 21st March and an AHP RTT clock starts. The dietitian telephones Mr Z and they agree to have a telephone consultation for the 2nd April. The dietitian telephones Mr Z on the 2nd April and the dietitian reviews his diet. During the consultation with Mr Z is advised of specific changes he needs to make to his diet to manage the diabetes. The dietitian agrees to post out a diet sheet written in Urdu. Personalised and specific advice, informed by clinical decision-making was provided during the telephone consultation therefore the AHP RTT clock stops on the 2nd April.

Scenario 14

Child Y who has difficulty in speaking attends the local health centre with their parent for an appointment to see the speech and language therapist. At the first appointment, an assessment indicates the need for the child to attend a group therapy session. At the time of the assessment, specific advice is provided that is informed by clinical decision-making, a personalised exercise sheet given to the parent and the event documented in the child's treatment records along with a date for them to attend a group therapy session.

In this situation, the advice and exercise sheet provided are specific and personalised to child Y. This constitutes first definitive treatment therefore the clock stops on the date of the first appointment when the advice was provided.

Scenario 15

Mr L has been experiencing pain in his hip and visits his GP who refers him to a physiotherapist.

On receiving the referral the physiotherapy service starts an AHP RTT clock. The physiotherapy service undertakes the first consultation with Mr L over the telephone. A medical history including that of the referring problem is taken. Mr L complains of clicking noises in his hip when standing and sitting and that the pain is affecting his mobility. The physiotherapist questions Mr L to gain sufficient information to form a treatment plan and provides Mr L with specific, personalised advice with regards to exercises and pain relief for his hip. The physiotherapist documents Mr L's medical history, advice and exercises in the patient's treatment record.

At this time, the physiotherapist invites Mr L to attend a local health centre for future treatment, 6 weeks in advance, at a mutually appropriate time and date.

The AHP RTT clock will stop on the date that the non- face-to-face consultation occurs as specific, personalised advice was provided based upon the physiotherapist's clinical decision-making.

- b) General advice is non-personalised and is not based on clinical decision-making. This generalised level of advice does not constitute first definitive treatment and does not stop an AHP RTT clock.

Scenario 16

Child C who has difficulty in speaking attends the local health centre with their parent for an appointment to see the speech and language therapist. At the first appointment, an assessment indicates the need for the child to attend a group therapy session. At the time of the assessment, a general exercise sheet is given to the parent, with a date for their child to attend a group therapy session.

In this situation, the provision of the exercise sheet is not the first definitive treatment as the advice given is neither specific nor personalised. The group therapy session will be the definitive treatment, and therefore the clock stops on the date that the child attends the group therapy session.

- iv. **Assessment and recommendations given, with no further clinical intervention required;**

Scenario 17

An OT working in a community mental health team receives a referral for Mr H indicating potential risks at home with regard to functioning. The OT attends Mr H at his home on the 8th July and carries out a specific OT screening assessment.

On the 10th July the OT provides an assessment report and recommendations that state there is no need for further OT input. The AHP RTT clock stops on the day that the assessment and the recommendations report is completed i.e. the 10th July, as this was the date that the assessment and report was complete.

Scenario 18

Mr P is referred to an Art Psychotherapist via a short-term intervention team. The AHP RTT clock starts when the referral is received and an assessment appointment is offered. Following the assessment the following options are a possible outcome:

- a. Mr P is discharged back to the referrer if inappropriate for intervention and the clock stops;
- b. A further assessment is offered and the clock keeps ticking;
- c. Treatment is offered and the clock stops on the day the treatment begins.

- v. **The supply of a medical device, with the clock stopping on the date on which definitive fitting, or where appropriate trial fitting, begins and there is no undue delay in subsequent fitting sessions thereafter;**

Medical devices (See Glossary) must have a 'medical purpose'. AHPs frequently assess patients for the need of assistive technology products. This equipment is intended for the alleviation of, or compensation for disabilities, and may or may not be considered as a medical device. The determining factor will be whether or not there is a direct link between the corrective function of the equipment and the individual concerned and that there is a stated medical purpose⁴.

Scenario 19

Ms N is diabetic and due to recurrent foot ulceration is referred by her GP to an orthotist for footwear. She attends the first appointment and is assessed by the orthotist. A need for bespoke footwear is established, measurements are taken and Ms N is given an appointment to return in 2 weeks, on the 14th May. Ms N returns on that date for a fitting of the footwear. Minor adjustments are required to ensure a comfortable fit of the bespoke footwear. Ms N is given a further appointment for the following week, the 21st May to collect the footwear. At this appointment, the patient and the orthotist are happy with the fit of the footwear.

In this situation, the clock stops on the date of the first fit of the footwear i.e. the 14th May.

⁴ Medical and Healthcare products regulatory Agency (2009), Guidance Note 20. Borderlines with medical Devices. London

vi. The delivery of general equipment to the patient.

Scenario 20

Mr W has been referred to the wheelchair service for an assessment for a wheelchair and he decides to part fund the manual wheelchair, through the 'voucher scheme'. At this point, the wheelchair services provide Mr W with the voucher, which he takes to a retail wheelchair supplier, who will then provide him with an appropriate wheelchair as identified at his assessment.

In this situation, the AHP RTT clock will stop on the date that Mr W received the voucher. If he had decided not to use the voucher scheme, the manual wheelchair would be provided by the wheelchair service with the clock stopping when the manual wheelchair was provided to the patient.

Scenario 21

Mr X is referred by a GP to the Wheelchair services for an assessment for a wheelchair. The physiotherapist assesses Mr X on the 16th June and identifies the need for a standard wheelchair with a specialised pressure-relieving cushion.

The Wheelchair service contacts Mr X by telephone to arrange an appointment to visit him at home on the 21st June to deliver the wheelchair. An order has been placed for the specialised pressure-relieving cushion but the service is still awaiting delivery. The expected delivery date is the 20th July.

In this situation, the clock does not stop on the 21st June when Mr X receives the wheelchair as the full requirement to meet Mr X's assessed needs has not been met. To fit the cushion there will be a significant delay.

The Wheelchair service takes delivery of the cushion on the 19th July. The service contacts Mr X and they fit the cushion on the 20th July. The AHP RTT clock stops on the 20th July.

Scenario 22

Mr U was referred to an OT for an assessment for daily living aids i.e. a raised toilet seat. Following assessment for this piece of general equipment (See Glossary) the NHS community loan store delivers the equipment on an agreed date.

In this situation, the AHP RTT clock stops when the raised toilet seat is delivered, as the first definitive treatment is the delivery of the equipment, and the service is jointly funded by the NHS and Local Authority. If the Local Authority fully funded the Loan Store service, the AHP RTT clock would stop on the date that the OT sent the referral to the Local Authority service requesting the equipment.

Scenario 23

Miss G requires a wheelchair. The OT undertakes an assessment of the house to assess access to the premises and decides that a concrete ramp is required. The ramps are constructed by an external company and the work is funded by the Local Authority.

In this situation, the AHP RTT clock stops when the OT sends the recommendations report to the external non-NHS funded provider who will undertake the building of the ramp. Locally, the service should monitor the length of wait that the patient experiences for the work to be carried out to ensure this is done in a timely manner.

Scenario 24

Miss D is referred to a mental health multi-disciplinary team (MDT) by her GP. An OT works within the mental health team and as part of their role triages and co-ordinates the patient's care. An AHP RTT clock does not start at this time as the co-ordinating role is an administrative role that is not AHP specific.

Six months later a clinical need for OT is actually identified. On this date, identified either by the OT coordinator or another MDT member, an AHP RTT clock would start. The clock will stop:

- a) When the OT provides the assessment report and recommendations with no further need for OT input or
- b) OT completes first definitive treatment or
- c) OT ascertains the referral is inappropriate and referrer is informed.

AHP RTT clock stops for non-treatment

40. **Any one of the following reasons can stop an AHP clock for non-treatment when the patient/carer, and subsequently their GP and/or other referrer is informed that:**

i. A clinical decision is made not to treat the patient.

- > This can be decided by the patient/carer or the AHP. This would usually result in the patient being discharged from the service.
- > Where there is a decision made not to treat, but the AHP wishes to retain clinical responsibility for the patient, then it would be appropriate to record this as active monitoring which stops the AHP RTT clock.

ii. A clinical decision is made to start a period of active monitoring, initiated by either the patient or AHP.

- > 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 undergo any further treatment or other clinical intervention at that time. This could be decided by the patient/carer or the AHP.
- > When a decision to commence a period of active monitoring is made with the patient, this stops the AHP RTT clock (see Appendix B). Active monitoring may apply at any point prior to a clock stopping for first definitive treatment, but only after a decision on treatment has been made. The AHP RTT clock stop until the patient agrees to start treatment and a new clock would start (see Scenario 26).
- > It is not appropriate to use active monitoring for patients that wish to delay an appointment.

iii. A clinical decision is made to return the patient to their GP for a referral onto a consultant-led service in primary or secondary care.

- > On assessment, the AHP may decide that the patient requires treatment by a consultant and AHP treatment is not required, resulting in referral of the patient back to the GP for onward referral.

- iv. **The patient declines the treatment they have been offered.**
 - > An AHP RTT clock can be stopped when a patient declines the treatment they have been offered, though they may not be discharged from the service. This does not include situations where a patient wants to delay their treatment.

- v. **Patient dies before treatment.**
 - > The patient's referral would be closed and the patient discharged, which stops the AHP RTT clock.

- vi. **A patient DNAs their first appointment following the initial referral that started their clock and the patient is discharged. The provider needs to establish the reason why the patient did not attend the appointment.**
 - > When a patient DNA's their first appointment the clock should be stopped and the patient discharged in line with Local Access Policy. The provider needs to establish the reason why the patient DNA'd the appointment, using an appropriate communication methodology e.g. email, telephone, text, and letter.
 - > Where it is more appropriate not to discharge the patient, the service needs to offer the patient another appointment, then the AHP RTT clock can be nullified and a new AHP RTT clock would start on the date that the patient agrees the new appointment date (see Appendix C).

- vii. **A patient DNA's any other appointment prior to first definitive treatment and is subsequently discharged back to the care of their GP or other referrer, provided that;**
 - > The provider establishes the reason why the patient did not attend the appointment;
 - > Discharging the patient is not contrary to their best clinical interests;
 - > Discharging the patient is in line with a local, publicly agreed and available policy on DNA's i.e. Local Access Policy.

41. When a patient's AHP RTT clock has been stopped a new AHP RTT clock for that patient only starts when:

i. A patient is re-referred back into the service.

If a patient has been discharged from an NHS AHP service but requires re-referring back to the same service with a different condition or a repeat recurrence of the same problem, a new AHP RTT clock would start. It is possible that the patient may still be attending for follow-up care for a previous problem and they are re-referred with a separate condition.

ii. A date is arranged to treat following a period of active monitoring (see Appendix B).

A patient's AHP RTT clock will stop when commencing a period of active monitoring without clinical intervention at that stage. If subsequently at a follow-up appointment a decision is made to treat, a new clock starts from the date that the appointment is communicated to the patient.

Scenario 25

Miss F refers herself to the podiatry service on the 10th January (clock start). She attends for her first appointment with a painful big toenail on the 20th January (clock has been ticking 10 days), and an assessment indicates that nail surgery is an option for resolving the problem. However, at this time, Miss F decides she does not want to have treatment.

At this point, there is the option to discharge Miss F who can refer herself back to the service when she decides she wants the treatment (clock stop). Miss F contacts on the 3rd June requesting further treatment. A new clock starts on the 3rd June (see Appendix B).

However, if Miss F was a person in vulnerable circumstances i.e. has a mental health problem, and discharging her from the service is inappropriate, a period of active monitoring can be implemented. Miss F contacts on the 3rd June requesting further treatment. A new clock starts on the 3rd June (see Appendix B).

iii. When a patient rebooks their appointment following a first appointment DNA that stopped and nullified their earlier clock.

If a patient DNAs their first appointment the clock would be stopped and the patient discharged. However, if the provider decides that it is inappropriate to discharge the patient and contacts them to rebook the appointment, the AHP RTT clock is nullified i.e. the clock is stopped and deleted, as if the clock never started. A new AHP RTT clock should start

at day 0 from the date that a new appointment date is agreed and communicated to the patient (see Appendix C).

Scenario 26

Mr K is a vulnerable adult with learning disabilities and has an appointment to attend the orthoptist for the first time. Mr K has a carer, and the carer is unable to bring him to the appointment but forgets to ring to cancel the appointment. The orthoptist service contacts the carer on the 15th March to establish why Mr K DNA'd his appointment.

In this situation, the orthoptist service would nullify the AHP RTT clock. The patient/carers agree another appointment date, when contacted on the 15th March, and so the AHP RTT clock starts again at day 0 from the 15th March (see Appendix C).

Did Not Attends (DNA's) and cancellations.

42. A DNA of a follow up appointment, i.e. the patient attended the first appointment but is still awaiting first definitive treatment, does not stop an AHP RTT clock unless it is appropriate to discharge the patient back to the referrer. The provider needs to establish the reason why the patient DNA'd the appointment. When the provider considers it appropriate to continue to retain clinical responsibility for the patient, the AHP RTT clock should continue to tick. An AHP RTT clock can only be nullified for a patient who has DNA'd their first appointment and it is inappropriate to discharge them, in accordance with Local Access Policy.
43. If a patient cancels either their first appointment or any subsequent appointment, prior to receiving first definitive treatment, the AHP RTT clock continues to tick i.e. cancellations do not stop the AHP RTT clock
44. There may be patients who choose to delay attendance of their first appointment for example work commitments, wanting an appointment in the school holidays, religious reasons or extended holidays, and this will delay an AHP RTT clock stop. Beyond a certain point, patient-initiated delay like this makes it unreasonable or impossible for the NHS to provide treatment in a timely manner and will prevent AHP services meeting a local waiting time target where this exists. This will be reflected in AHP RTT performance reports. However, there are mechanisms available to flag some of these situations.

Scenario 27

Mr Q is referred by his GP to see a dietitian. He receives an appointment letter and contacts the service to say he will be unable to attend as going abroad for 4 months.

If Mr Q were to be away for a few weeks, the AHP RTT clock would continue to tick. However, the patient has chosen to delay the appointment for a long period of time.

In this situation, the following options could be used:

- Discuss with Mr Q the option of discharging him from the service and re-refer when he returns home, resulting in an AHP RTT clock stop.
- If discharge is inappropriate, locally an identification code of 'Earliest Reasonable Offer Date' can be collected. Although the AHP RTT clock does not stop, when analysing waiting times, patients who have delayed their treatment can be identified. This would need to be in line with an agreed Local Access Policy.

Active monitoring could not be used in this instance, as the patient has not yet been seen and a decision has not been made to treat.

Scenario 28

Mrs D has been referred by her GP to a rehabilitation team and a team member visits her at her own home but she felt she was too unwell to receive treatment.

If Mrs D felt she would be well enough for treatment within a short period of time the clock would continue to tick. However, if a long delay is required there are options available:

- Discuss with Mrs D the option of discharge back to the referrer until she feels well enough for treatment. This would stop the AHP RTT clock.
- If discharge is inappropriate, locally an identification code of 'Earliest Clinically Appropriate Date' can be recorded. Although the AHP RTT clock does not stop, when analysing waiting lists, patients who have delayed their treatment due to illness can be identified.

Q & A

The following section consists of a non-exhaustive list of questions and answers raised by stakeholders involved in the development of the AHP RTT guide.

Background

Q1. Which AHPs are required to collect RTT data?

A. The AHPs required to collect RTT data are:

- > Art Therapists
- > Drama Therapists
- > Music Therapists
- > Chiropodists/Podiatrists
- > Dietitians
- > Occupational Therapists
- > Orthoptists
- > Physiotherapists
- > Prosthetists
- > Orthotists
- > Radiographers – Diagnostic and Therapeutic
- > Speech and Language Therapists

Q2. Which AHPs are exempt from collecting RTT data for national reporting?

A. The following AHPs are exempt from collecting RTT:

- > Any of the above AHPs providing treatment that is not NHS funded
- > Paramedics, who operate to response times and are exempt from collecting RTT data as this would be clinically inappropriate

Q3. Psychologists are registered with the Health Profession Council (HPC). Do they collect AHP RTT data?

A. No, although psychologists and healthcare scientists are registered with the HPC they are not included in the group of professionals known as AHPs and so are not required to report AHP RTT data nationally.

Q4. Radiographers are required to collect AHP RTT data but don't provide treatment. When would the clock stop?

A. Radiographers undertaking diagnostic testing, where the referral is either self referral or from the patient's GP, would stop an AHP RTT clock on the date that the diagnostic report was sent to the referrer.

Q5. I am an AHP working in a mental health non-consultant led team. Does the collection of AHP RTT apply to me?

- A. Yes. AHP RTT data collection and reporting applies to AHPs working within mental health teams.

Q6. Why is AHP RTT data collection being introduced?

- A. Measuring waiting times is important for understanding how well NHS AHP services perform. If long waits exist, service improvements can be initiated to enable the delivery of productive, innovative, quality services. This is part of the journey to transforming services for patients to improve access to NHS AHP services and for commissioning of services. The national reporting of the data will allow patients to make a choice about where they would like to access services and for commissioners to decide which services to commission.

Q7. Which patients do I collect AHP RTT data for?

- A. AHP RTT data should be collected for:
- > Patients who self-refer to an NHS AHP service;
 - > Patients referred by any permitted health or social care professional to an NHS AHP for a condition that is not part of a consultant-led RTT waiting time pathway. **This includes referrals to AHPs working in mental health and learning disabilities services.**

AHP RTT Clock Starts

Q8. Which patients do not start an AHP RTT clock?

- A. An AHP RTT clock would not start for a patient who is referred for treatment that contributes to a consultant-led RTT waiting time pathway.

Q9. What is a consultant-led RTT waiting time pathway?

- A. A consultant-led RTT waiting time pathway in the context of this guide relates to medical consultants. A consultant AHP may be involved in the medical consultants RTT pathway. The medical consultant retains overall clinical responsibility for the service, team or treatment but will not necessarily be physically present for each of the patient's appointments. NHS AHPs will contribute to the AHP RTT data collection except when:

- > They are providing the first definitive treatment on a consultant-led RTT waiting time pathway
- > They provide an interface or referral management or assessment service and they can onward refer direct to a medical consultant-led service. If the onward referral has to be via the GP, the clock start/clock stop would be for AHP RTT data collection.

Q10. How will we know if the patient referred to us is part of a consultant-led RTT waiting time pathway?

- A.** If the patient is referred from an area outside of the organisation and is part of a consultant-led RTT waiting time pathway, an Inter Provider Transfer Administrative Minimum Data Set form (IPT) will be attached to the referral if the patient is referred to a different provider organisation. The IPT minimum data set is designed to support the transfer of administrative data, including the original referral date and how long the consultant-led RTT clock has been ticking, thus allowing the receiving provider to report on the patient pathway. By sharing information via the minimum data set for inter provider transfers all parties involved can be fully aware of the patient's pathway.

If the patient is receiving care as part of a medical consultant-led RTT pathway and is referred to an NHS AHP service in the same organisation, the referral will not have an IPT form attached. However, the referrer can provide the information regarding the patient's RTT status within the referral, in accordance with Local Access Policy.

Q11. Is there a target time for AHP RTT?

- A.** No. Nationally a maximum waiting time target has not been set for AHP RTT. However, commissioners or providers may set a locally agreed target.

Q12. Who can refer patients to an NHS AHP service?

- A.** Any health or social care professional can refer a patient to an NHS AHP service. This includes self-referral by a patient, their family or carer where commissioners and providers have locally agreed pathways that include self-referral.

Q13. When does an AHP RTT clock start?

- A.** An AHP RTT clock starts on the date that the referral is received by the NHS AHP service, irrespective of the location where treatment will be provided, and where the treatment does not contribute to a consultant-led RTT waiting time pathway. For referrals made through Choose and Book, the clock starts when the patient converts their unique booking reference number (UBRN).

Q14. Do referrals to an AHP in a referral management centre or intermediate service e.g. Community Assessment Treatment service, start an AHP RTT clock i.e. a service established to deliver primary care or community provided services outside of their traditional setting?

A. Yes, an AHP RTT clock starts on the date the referral is received if the service is an NHS AHP led service, or a service that consists of AHPs led by another care professional other than a medical consultant. If the service is medical consultant-led, the data collected would contribute to the consultant-led RTT waiting time pathway.

Q15. If a General Practitioner with Special Interests (GPwSI) refers a patient to an AHP within the GPwSI's team, does an AHP RTT clock start?

A. A referral to a GPwSI within a referral management centre or intermediate service starts a consultant-led RTT waiting time pathway; therefore, referral to an AHP as part of that interface service would be within consultant-led RTT waiting time scope and a consultant-led RTT clock would stop when definitive treatment was delivered by the in-house physiotherapy team if they are to provide the first definitive treatment.

Q16. I work in a community stroke team which consists of a nurse, OT and PT. The OT and PT do not deliver therapy and coordinate care only. Should AHP RTT waiting times be collected?

A. No. There would be no AHP RTT waiting time for the OT and PT as they are not providing any therapy treatment, and are undertaking an administrative co-ordinator role. This is similar situation as for the mental health therapy role set out in scenarios 24.

Q17. What happens if a referral is sent to the wrong AHP service by the referrer?

A. In such a situation, the referral is redirected to the correct service as soon as possible. The clock would start from the date that the first service received the referral.

Q18. Does an AHP RTT clock start if the AHP service provides private treatments for patients in an NHS setting?

A. No, an AHP RTT clock does not start for patients paying privately for treatment, as this is not NHS funded work, regardless of the setting where the treatment is provided. However, if the NHS funds an external private provider to deliver an AHP service, AHP RTT should be collected.

Q19. When does the clock start if a patient decides to transfer their care from a private provider to an NHS AHP service?

A. The clock starts on the date the patient referral is received by the NHS AHP service.

Q20. Does an AHP RTT clock start for patients referred for medical devices?

A. Yes, with the clock starting on the date the referral is received by the AHP service.

Q21. When does a clock start if a patient receives surgery from a neighbouring PCT and is then referred to their local PCT for NHS AHP treatment?

A. An AHP RTT clock would start on the date the referral is received, as this is a new referral to the NHS AHP service.

Q22. I am an AHP working in an Integrated Care Team that is funded by the Local Authority. Does an AHP RTT clock start?

A. No. If the service is fully funded by the Local Authority, an AHP RTT clock does not start, as there is no mandatory requirement to collect and report RTT data nationally for Local Authority AHP services. However, they may choose to adopt the AHP RTT rules and measure the referral to treatment data at a local level. If the service is jointly funded AHP RTT would be collected.

Q23. A hospital ward sends a referral to a community NHS AHP service, requesting a home visit for a patient who will not require treatment until they are discharged from the hospital. The patient is not expected to return home for 6 weeks. When does the clock start?

A. The clock would start on the date that the service received the referral, irrespective of the fact that the patient does not require access to the service for another 6 weeks. In this situation a local data input of Earliest Clinically Appropriate Date can be collected but the clock will not stop until the patient receives first definitive treatment from the NHS AHP service. This would be an opportunity for the service to identify why advance referrals occur. If the ward based AHP undertakes the home visit the activity would be part of the consultant-led pathway for which the RTT clock will have already been stopped.

Q24. When does the AHP RTT clock start if the NHS AHP service sends a letter to the patient asking them to contact the service to make their first appointment i.e. an 'opt-in' letter?

A. The clock will start on the day that the referral is received and not on the date that the patient contacts the service to make the appointment.

AHP RTT Clock Stops

Q25. What stops an NHS AHP RTT clock?

A. An NHS AHP RTT clock stops when first definitive treatment begins or when a clinical decision is made that treatment is not required.

Q26. What is first definitive treatment?

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

- > First definitive treatment provided;
- > Receipt of first definitive advice;
- > Assessment and recommendations given, and no further clinical intervention is required;
- > The fitting of a medical device, with the clock stopping on the date on which definitive fitting or trial fitting begins, and with no undue delay in subsequent fitting sessions thereafter;
- > The delivery of general equipment to the patient.

Q27. What does not stop an AHP RTT clock?

A. An AHP RTT clock does not stop at assessment if the patient is expected to return on another date for treatment. The clock would stop when the patient receives the first definitive treatment.

Q28. When is an AHP RTT clock nullified?

A. An AHP RTT clock is nullified when a patient DNAs their first appointment and it is inappropriate to discharge the patient in line with Local Access Policy. The clock is nullified on the date of the DNA'd appointment and a new AHP RTT clock starts on the date that a new appointment is agreed with the patient.

Q29. If a patient chooses to delay their first appointment, does the AHP RTT clock continue to tick?

A. Yes. The AHP RTT clock will continue to tick for patients who choose to delay their first appointment. Reasons for delay, for example, could be religious reasons, work commitments or extended holidays. However, it may be appropriate to discharge the patient back to the referrer with an explanation of why the patient has being discharged and in accordance with Local Access Policy. If discharge is inappropriate a local data input of 'Earliest Reasonable Offer Date' can be collected. This does not stop the clock but when services analyse

their waits they can identify those patients that have chosen to delay their treatment.

Q30. Does the AHP RTT clock stop if a patient does not attend a follow up appointment for first definitive treatment?

- A. If a patient DNAs the follow up appointment for first definitive treatment, the AHP RTT clock does not stop unless the patient is discharged, in accordance with Local Access Policy. Where discharge is inappropriate, the patient should be contacted to offer another appointment or discuss starting a period of active monitoring.

Q31. I work in a multi-disciplinary AHP team (MDT). Patients referred to this team may require treatment from three or four different AHPs for the same referring condition. When does the AHP RTT clock stop?

- A. The AHP RTT clock stops when the first AHP in the MDT provides the first definitive treatment. Therefore, the clock stops even though other AHP treatment from the team is yet to be initiated. Locally it would be important to collect and measure the waiting times for patients to receive treatment from each AHP as patients may wait for significantly different periods of time to be treated. Therefore it is important for the access to each AHP to be monitored, as this is an important component of patient experience. This will support providers of care to use the data to benchmark, identify potential areas for improvement and monitor the impact of any improvement or efficiency measures. However, currently there is no foreseeable need to report this level of information nationally

Q32. Would this mean that long waits for different professions within the MDT would not be reported nationally?

- A. Yes. The mechanisms by which capture, collection and reporting of data relating to waiting times is being investigated and various options are being considered to enable all of the waiting times for each profession within the MDT to be collected nationally. However, it is advisable that local data should be collected for each profession within the MDT so that managers can monitor each AHP profession within the team, and implement service improvement if long waits exist to improve access to services. This provides an opportunity to enrich the information that would result from data capture and submission to further support analysis activity and the care plan approach to care. The MDT approach to patient care and the development of care plans to best meet the needs of the individual patient is not in question, but in practice it is acknowledged that patients whose care plan involves clinical interventions from different MDT members may wait significantly different periods of time to be seen and treated.

Q33. Many AHPs work in MDT's, but work in a generic role e.g. as care co-ordinator's in mental health or stroke teams. As the AHP is not delivering AHP therapy does an AHP clock start purely because they are an AHP?

A. No. AHP RTT data is collected for AHPs where they are using their therapeutic skills to treat patients. If they are undertaking a generic role and these are skills unrelated to their AHP role in providing treatment then AHP RTT data does not need to be collected.

Q34. I work in a multi-disciplinary team that includes nurses and AHPs e.g. Cardiac Rehabilitation Team. If the nurse sees the patient first and provides first definitive AHP treatment, can a nurse stop the AHP RTT clock?

A. Yes, the AHP RTT clock would stop if the nurse provides the first definitive AHP treatment that the AHP would have provided. The nurse is a member of the MDT to which the patient is referred for a package of care. If the nurse assesses the patient and this is not first definitive treatment the clock would not stop until a member of the MDT provides the first definitive treatment.

Q35. When does the AHP RTT clock stop if the patient is too ill to attend their first appointment?

A. The AHP RTT clock keeps ticking if the patient is too ill to attend and cancels the appointment.

Where the period of sickness is likely to be prolonged, the patient may be referred back to the original referrer in accordance with your Local Access Policy.

If discharge is inappropriate, a local data input of 'Earliest Clinically Appropriate Date' can be collected. This does not stop the clock but when the service analyses their waits, they can identify those where the treatment has been delayed due to illness.

Q36. Does an AHP RTT clock stop if a patient chooses to delay an offered appointment as they prefer to wait longer and attend for treatment at a specific location?

A. No, the AHP RTT clock does not stop if the patient chooses to delay their treatment. If the delay is expected to be lengthy a local data input of 'Earliest Reasonable Offer Date' can be collected. This does not stop the clock but when the service analyses their waits, they can identify those where the patient has chosen to delay their treatment.

Q37. Does the AHP RTT clock stop if a patient requests ‘thinking time’ to decide which of the offered treatment options they wish to choose?

- A. The AHP RTT clock should continue to tick if the patient requires only a short period of ‘thinking time’ but if it is agreed that the patient requires a longer period to consider the options a period of active monitoring would be appropriate.

Q38. What is the NHS AHP RTT rules for patients who do not attend appointments?

- A. If a patient DNAs their first appointment i.e. the patient/carer/guardian does not give prior notice that the patient cannot attend the appointment the patient should be discharged back to the care of the referrer, in accordance with Local Access Policy. The provider needs to establish the reason why the patient did not attend the appointment.

If it is inappropriate to discharge the patient, the patient should be offered a new appointment and the clock should be nullified. A new AHP RTT clock would start on the date that the patient agrees the new appointment date.

If a patient DNAs a follow up appointment prior to first definitive treatment, the AHP RTT clock will not stop unless it is appropriate to discharge the patient. As the patient has already attended the first appointment, a period of active monitoring can be started following consultation with the patient.

When discharging a patient because they did not attend an appointment, the provider needs to ensure that:

- > They establish the reason why the patient did not attend the appointment
- > Discharging the patient is not contrary to their best interests;
- > Discharging the patient is carried out in accordance with Local Access Policy.

Q39. Does an AHP RTT clock stop if a patient cancels their first appointment?

- A. No, an AHP RTT clock does not stop if a patient cancels their first appointment.

Q40. Does active monitoring stop an AHP RTT clock?

- A. Yes, active monitoring stops an AHP RTT clock. A period of active monitoring starts when the AHP or patient decides that clinical intervention is not appropriate at that time. A new clock starts when an appointment is made for treatment to continue.

If there is a clinical reason why it is not appropriate to continue to treat the patient at that time this constitutes a decision not to treat. The patient is discharged with referral back to the GP for ongoing management, and the AHP RTT clock stops.

Q41. A patient is on a ward following surgery to a knee and the consultant-led RTT waiting time clock has stopped as surgery was the first definitive treatment. The patient has received physiotherapy on the ward for which an AHP RTT clock did not start as the treatment is part of the follow up care of the consultant-led RTT waiting time pathway. The patient is now ready to be discharged from the ward, but will still require physiotherapy treatment. The inpatient Physiotherapy team send a referral to the outpatient PT team. Does an AHP RTT clock start or is this still regarded as follow-up treatment as part of the consultant-led RTT waiting time?

A. The care that the PT in outpatients will provide is a continuation of the inpatient PT care and theoretically a new clock should not start. However, a new AHP RTT clock needs to start so that the length of wait the patient experiences can be measured and monitored.

Q42. A patient was referred to Wheelchair services and on the day the chair was supplied the clock was stopped. The patient was not at this point discharged from the service. 6 months later the patient contacts requiring a change to the special seating due to postural changes. Does a new clock start?

A. No, a new clock does not start. If the patient had been discharged they would have required a new referral to access the service and a new clock would have started. As they were not discharged, the adaptation is part of follow-up care and a new clock does not start.

Glossary

A Active monitoring	<p>Active monitoring commences when a decision is made (and agreed with the patient) that it is clinically appropriate to start a period of monitoring, possibly whilst the patient receives symptomatic support, but without any specific or significant clinical intervention at that stage. During Active Monitoring the patient remains under the care of an AHP although the referrer will be updated with the progress of their patient.</p> <p>Active Monitoring may be initiated by either a care professional or a patient.</p> <p>The start of Active Monitoring ends a referral to treatment period.</p> <p>If a decision to treat is made during active monitoring this will end the Active Monitoring and will start a new referral to treatment period.</p>
Allied Health Professional (AHP)	<p>Allied Health Professionals are autonomous practitioners. All AHPs have four common attributes:</p> <ul style="list-style-type: none">> They are, in the main, first contact practitioners;> They perform essential diagnostic and therapeutic roles;> They work across a wide range of locations and sectors within acute, primary and community care;> They perform functions of assessment, diagnosis, treatment and discharge throughout the care pathway, from primary prevention through to specialist disease management and rehabilitation.
Assistive technology products	<p>This equipment is intended for the alleviation of, or compensation for disabilities, and may or may not be considered as a medical device. The determining factor will be whether or not there is a direct link between the corrective function of the equipment and the individual concerned and that there is a stated medical purpose. The following products are considered to be medical devices as there is such a direct link:</p> <ul style="list-style-type: none">Walking/standing framesWalking sticks/crutchesMobility aids for the visually impairedPatient hoistsOrthopaedic footwearExternal limb prosthesis and accessoriesOrthoses - lower/upper limb, spinal, abdominal, neck, head

(MHRA, 2009 Guidance Note 20, Borderlines with Medical Devices.

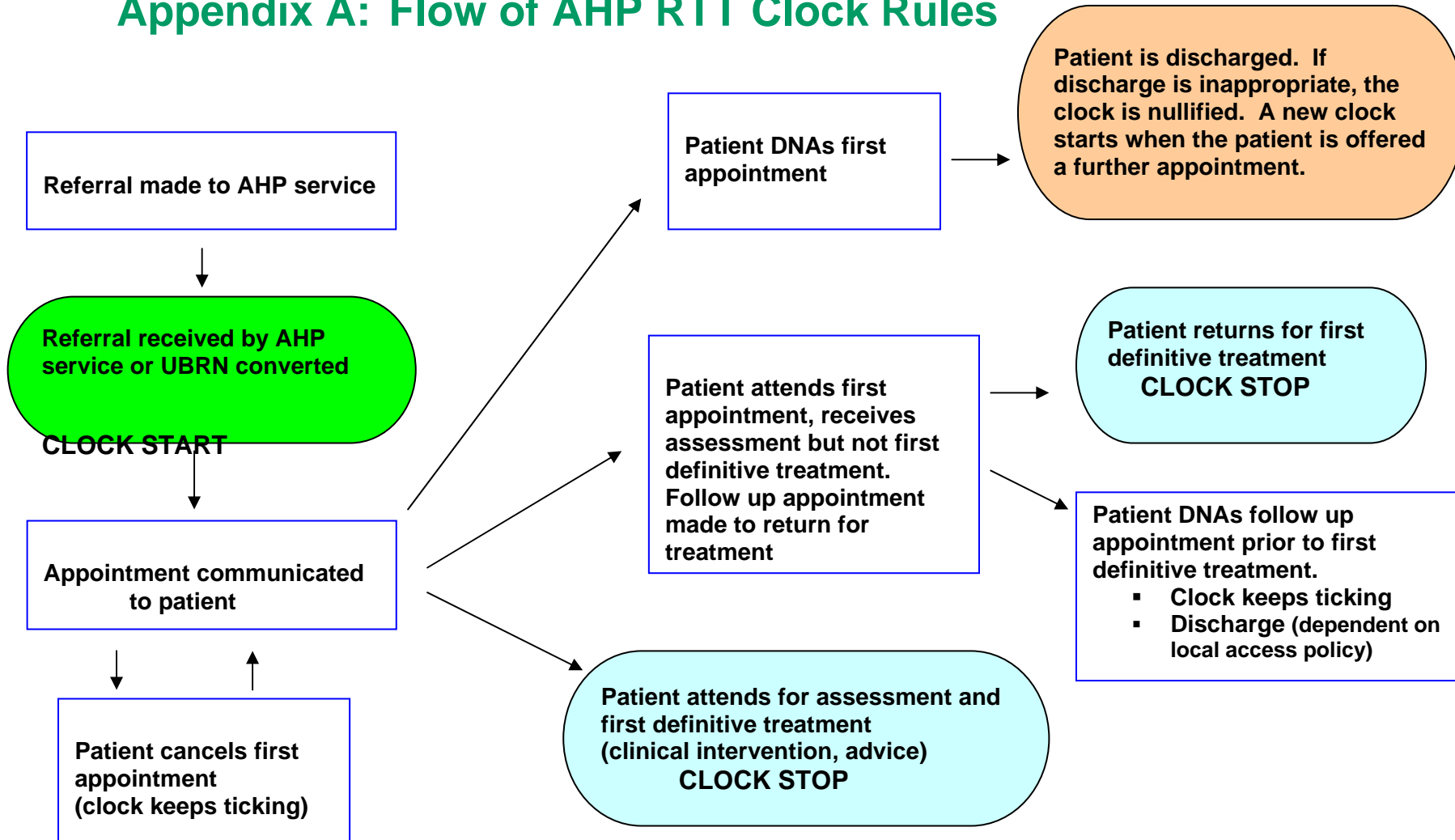
C	
Care Professional Choose and Book	<p>A person who has a professional registration with a professional registration body such as HPC, GMC, NMC.</p> <p>A national electronic referral service that gives patients a choice of place, date and time for their first appointment in a clinic.</p> <p>Choose and Book shows your GP which hospitals or clinics are available for your treatment. Your GP discusses with you the clinically appropriate options that are available for treating your medical condition.</p> <p>If you know where and when you would like to be seen, you may be able to book your appointment before you leave the surgery. You will be given confirmation of the place, date and time of your appointment.</p> <p>You may want more time to consider your choices. If so, you can take the Appointment Request letter away with you and book your appointment later. Your Appointment Request letter lists your unique booking reference number, your NHS number and a list of hospital or clinic options for you to choose from. Your GP practice will also give you a password with your Appointment Request letter.</p> <p>You can then decide how you wish to book your appointment; via the telephone, using the national number on the letter or via the internet.</p> <p>When an appointment is booked via Choose and Book, the unique booking reference number (UBRN) is requested and the referral is activated, and classed as converted.</p>
Clinical decision	A decision taken by a care professional, in consultation with the patient and recorded in the clinical records, with reference to local access policies and commissioning.
Consultant	A person contracted by a healthcare provider who has been appointed by a consultant appointment committee. They must be a member of a Royal College.
Consultant-led service	A consultant retains overall clinical responsibility for the service, team or treatment. They will not necessarily be present for each patient's appointment, but they take overall clinical responsibility for the patient's care.
D	
Did Not Attend (DNA)	Where a patient fails to attend an appointment without prior notice.
Decision to treat	Where a clinical decision is taken to treat the patient.
Earliest Clinically Appropriate Date	The earliest date that it was clinically appropriate for an AHP activity to take place. For example, this data item could be collected to identify early referrals for an inpatient for treatment in the community but the patient is not expected to be discharged from the ward for 6 weeks.

Earliest Reasonable Offer Date	The date of the earliest appointment offered to a patient. This data item is collected to identify when patients choose to delay appointments, prior to their first definitive treatment, where they wished to delay their appointment for a long period of time.
F First definitive advice	The first clinical intervention intended to manage a patient's disease, condition or injury and avoid further intervention. What constitutes first definitive treatment is decided by the AHP, in consultation with others as appropriate, including the patient.
First definitive treatment	
G General advice	Some equipment, considered as 'general equipment' may be used 'by all' rather than having a direct link with the individual concerned. Such products are usually considered as 'aids for daily living' and are not medical devices. For example: Special water taps Toilet equipment e.g. toilet seats, shower seats Grab rails e.g. at doorways and stairs Portable ramps Stair lifts
General equipment	
	(MHRA, 2009 Guidance Note 20, Borderlines with Medical Devices)
I Interface service	If a service is able to refer on to medical consultant care without transfer back to the referring clinician/GP first, then it is an interface service.
Inter Provider Transfer (IPT) Administrative Minimum Data Set form.	The IPT minimum data set 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. The form specifies the data necessary to permit the receiving provider to report the patient's progress along their RTT pathway (DH, 2007. DSCN 30/2007). By sharing information via the minimum data set for inter provider transfers all parties involved can be fully aware of the patient's pathway.
M Medical devices	'Medical device' means any instrument, apparatus, appliance, material or other article, whether used alone or in combination, including the software necessary for its proper application intended by the manufacturer to be used for human beings for the purpose of: diagnosis, prevention, monitoring, treatment or alleviation of disease, diagnosis, monitoring, treatment, alleviation of or compensation for an injury or handicap, investigation, replacement or modification of the anatomy or of a physiological process, and which does not achieve its principal intended action in or on the human body by pharmacological, immunological or metabolic means, but which may be assisted in its function by such means; (Directive 93/42/EEC, MHRA) (Also see Assistive Technology Products)

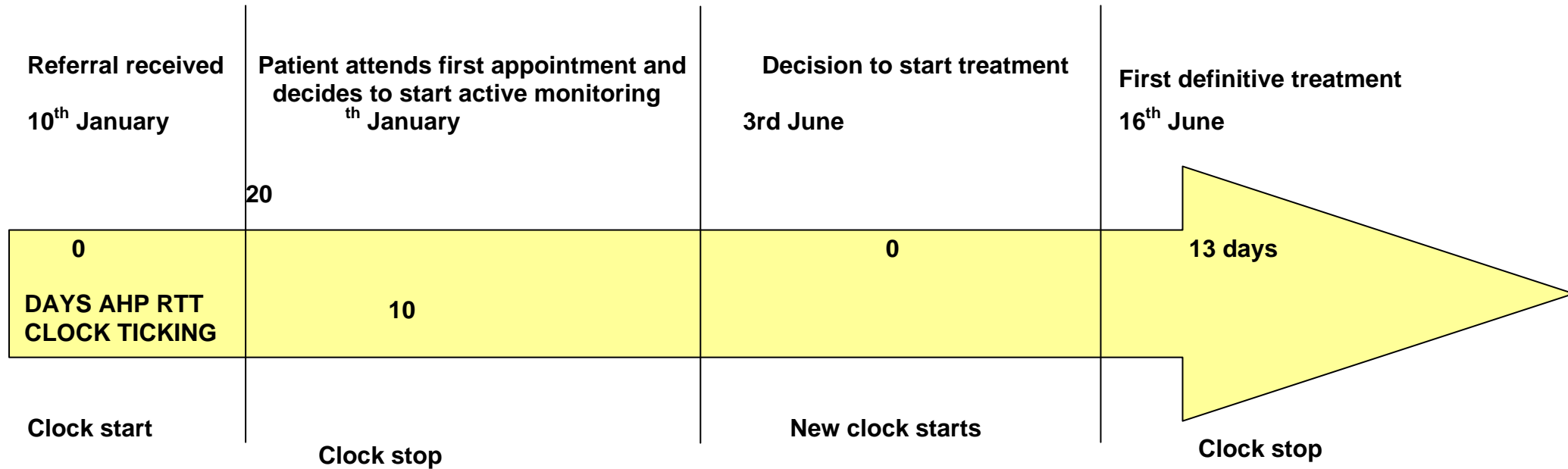
N NHS funded AHP services	<p>The AHP service may be fully or partially funded by the NHS.</p> <p>Only AHP services funded by the NHS are mandated to collect and report their RTT waiting times. This data should be collected locally from April 2011 and data will flow once the mechanisms to do so are available.</p>
Nullified clock	<p>If a person fails to attend their first appointment with an NHS AHP service, the clock can be nullified, i.e. as if the referral never existed. Where the provider decides that it is appropriate to contact the patient to rebook the appointment then a new waiting time clock should start from that date.</p>
O Outpatient therapy service	<p>Outpatient therapy services can be held in a variety of settings including:</p> <ul style="list-style-type: none"> Outpatient clinics in a hospital setting Patients own homes Care homes Local Health Centres GP surgeries Schools etc
P People in vulnerable circumstances	<p>A person aged 18 or over who:</p> <ul style="list-style-type: none"> • is living in residential accommodation, such as a care home or a residential special school; • is living in sheltered housing; • is receiving domiciliary care in his or her own home; • is receiving any form of health care; • is detained in a prison, remand centre, young offender institution, secure training centre or attendance centre or under the powers of the Immigration and Asylum Act 1999; • is in contact with probation services; • is receiving a welfare service of a description to be prescribed in regulations; • is receiving a service or participating in an activity which is specifically targeted at people with age-related needs, disabilities or prescribed physical or mental health conditions or expectant or nursing mothers living in residential care (age-related needs includes needs associated with frailty, illness, disability or mental capacity); • is receiving direct payments from a Local Authority/HSS body in lieu of social services; • requires assistance in the conduct of his or her own affairs. <p>In all the above settings and situations adults need to be able to trust the people caring for them, supporting them and/or providing them with services. (Safeguarding Vulnerable Groups Act 2006, DH)</p>

R Reasonable offer	An offer is considered reasonable where the offer is for a time and date three or more weeks from the time that the offer was made or the patient accepts the offer. (www.datadictionary.nhs.uk) If the patient declines the offer and decides to wait longer for treatment, a local data collection of Earliest Reasonable Offer Date can be recorded.
T Tolerances	Tolerances allow for patient-initiated delays and commissioners and providers should agree the percentage tolerance locally. The local data inputting of Earliest Reasonable Offer Date or Earliest Clinically Appropriate Date will provide services with the ability to monitor those with long waiting times that have been delayed by the patient.
Treatment	A care activity that involves a clinical intervention i.e. medical or surgical action that is performed on a patient. It can also involve an intervention within a psychsocial model of care.
U Unique Booking Reference Number (UBRN)	If Choose and Book is used by an organisation, the referrer will provide the patient with an appointment request letter that states the patient's UBRN and a password. The patient is required to contact the service who will ask for the UBRN and password. The service can then initiate the referral, which starts a clock.

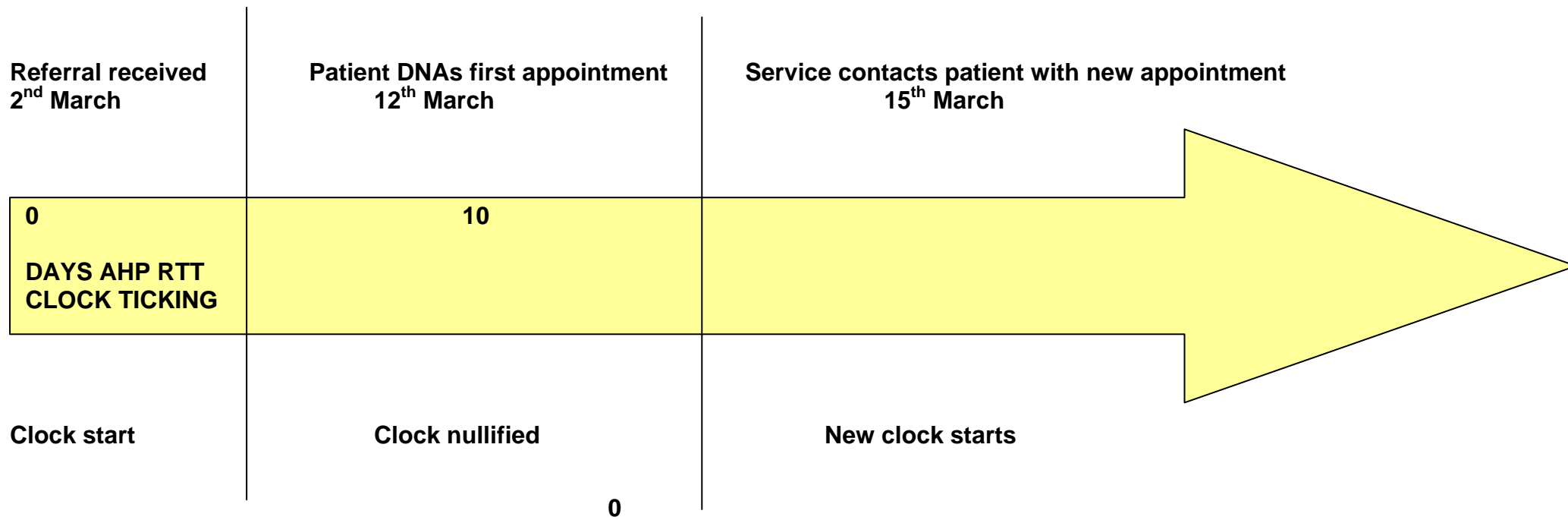
Appendix A: Flow of AHP RTT Clock Rules



Appendix B: Time line for a clock on active monitoring



Appendix C: Time line for a nullified clock



Appendix D: Participating Pilot Sites

Organisation	Strategic Health Authority
Bournemouth and Poole Community Health Services	South Central
East Lancashire Hospitals NHS Trust	North West
East Essex Hospitals NHS Trust	South East Coast
Lambeth Community Health	London
NHS Liverpool Community Health	North West
NHS Rotherham Community Health Services Barnsley Primary Care Trust	Yorkshire and Humber
North Tees and Hartlepool NHS Foundation Trust	North East
Oxleas NHS Foundation Trust	London
South Birmingham Community Health	West Midlands
South Devon Healthcare Foundation Trust	South West
Warwickshire Community Health	West Midlands

Appendix E: Summary of clock start and stops for AHPs as part of Consultant-led RTT Waiting Time Pathway

Scenario	Type of RTT Period	Clock start	Clock stop
Consultant refers patient to an AHP, who is delivering care as part of the consultant-led team, for 1 st definitive treatment to a condition and the consultant retains responsibility.	Consultant-led RTT waiting time	Consultant-led RTT waiting time clock starts on day consultant service received referral.	AHP treatment is activity that ends the RTT period as 1 st definitive treatment begins and the AHP will stop the consultant-led RTT waiting time clock.
Consultant refers patient to an AHP, who is delivering care as part of the consultant-led team, for treatment prior to 1 st definitive treatment by the consultant for a condition and the consultant retains responsibility.	Consultant-led RTT waiting time	Consultant-led RTT waiting time clock starts on day consultant service received referral.	AHP treatment is subsequent activity during a consultant-led RTT waiting time period. Consultant-led RTT waiting time clock continues to tick.
Consultant refers patient to an AHP, who is delivering care as part of a consultant-led team, for treatment to a condition following 1 st definitive treatment and the consultant retains responsibility.	None	Consultant-led RTT waiting time clock started on day consultant service received referral.	Consultant provided 1 st definitive treatment and stopped the clock. AHP treatment is activity that is a follow up to the consultant-led RTT waiting time clock and is not part of a RTT period.
Consultant refers patient to an AHP who is not part of a consultant-led team, for 1 st definitive treatment and the consultant retains responsibility	AHP RTT	AHP RTT clock starts on the day AHP service received referral.	Consultant-led RTT clock stops on the date the decision is made to refer to the non-consultant-led AHP service and is communicated to the patient.
Consultant refers patient to an AHP for treatment for a condition that they are not treating.	AHP RTT	AHP RTT clock starts on the day AHP service received referral.	AHP clock stops when 1 st definitive treatment provided.

Appendix F: Summary of clock start and stops for AHPs as part of AHP RTT

Scenario	Type of RTT Period	Clock Status	
		Clock start	Clock stop
Referral received by NHS AHP uni-professional service from agreed referrer	AHP RTT	AHP RTT clock starts on day referral received by service.	AHP clock stops when 1 st definitive treatment provided.
Referral received by multidisciplinary NHS AHP service from agreed referrer	AHP RTT	AHP RTT clock starts on day referral received by service.	AHP clock stops when 1 st definitive treatment provided.
Referral received by multidisciplinary NHS mental health service from agreed referrer	AHP RTT	AHP RTT clock starts on day need for AHP intervention identified	AHP clock stops when 1 st definitive treatment provided.
Referral received by Local Authority funded multidisciplinary service	None	For AHP services that are not NHS funded, there is no mandate to collect and report AHP RTT data therefore there will be no RTT period to collect.	
Referral to an interface service triaged and patient treated by an AHP who is an Advanced Practitioner	Consultant-led RTT waiting time	Consultant-led RTT clock starts on day referral received by service.	Consultant-led RTT clock stops when 1 st definitive treatment provided.