RTT Assurance Paper

1. Introduction

The purpose of this paper is to provide assurance to Trust Board in relation to the robust management of waiting lists and timely delivery of elective patient care within the Royal United Hospital Bath.

2. Background

The National Audit Office undertook a review of NHS waiting times 2012-13, publishing their findings on 23rd January 2014 (Appendix I). It noted that all NHS patients have the right to receive elective pre-planned consultant-led care within 18 weeks of being referred for treatment (usually by their GP), unless they choose to wait longer or it is clinically appropriate to do so. NHS England and Clinical Commissioning Groups (CCGs) are responsible for upholding patients’ rights and NHS England holds CCGs to account for meeting the standards. In turn, CCGs agree contracts with the providers of services which face financial penalties if the standards are not met.

Accurate waiting time information is important to allow patients and GPs to make choices about their care, and is a “key measure used by NHS England, the Department of Health, public and Parliament use for assurance about the NHS’s performance at a time of financial pressure and growing demand” (NAO HC 964 Session 2013-14 23 Jan 2014, page 5).

The Trust Development Authority subsequently issued a letter to all NHS Trust Chief Executives on 25th March 2014, asking for assurance in relation to the effective management and delivery of referral to treatment pathways.

3. Waiting List Management for Elective Care

A further key document, “Operational Resilience and Capacity Planning for 2014/15” prepared by NHS England, the NHS TDA, Monitor and the Association of Directors of Adult Social Services was published in June 2014. A section of this paper (Appendix II) outlines the principles and guidelines for delivering efficient elective care pathways as developed by the NHS Elective Care Intensive Support Team. These principles are outlined below with assurance of full compliance in relation to the application of these within the Royal United Hospital.

a. Planning

Patient Access Policy

The patient access policy has been reviewed and revised by the Head of Performance and is publically available on the Trust website. This policy includes reference to cancer and other urgent patients in line with national recommendations.
Referral to Treatment Training Programme

100% of staff involved in RTT processes and procedures are trained and updated annually in relation to rules application and local procedures. Any new administrative staff receive generic training in relation to Cerner Millennium followed by local training in relation to their specific role within the RTT process.

Any discrepancy identified in the waiting list management process through validation is reported back to specialty managers, lead secretaries and the individual concerned. The Cerner training team provide adhoc support sessions as required to ensure that staff are made aware of any errors made and re-trained if required.

Clinical staff are trained locally at the beginning of any rotation and preference folders are set up for ease of use in each specialty or sub-specialty. Specialty specific outcome forms are in place to ensure accurate capture of outcome, onward management plan and any procedure performed.

Annual Analysis of Demand & Capacity

The annual review of demand and capacity for elective care is undertaken at specialty and subspecialty level and is completed as part of the business planning and contract setting process each autumn.

b. Building on Existing Work

Seasonal fluctuations are recognised to have significant impact on non-elective activity and subsequently put elective work at risk. A winter plan is outlined each year to ensure mitigating actions are identified and robust processes in place to be able to flex activity up if beds are available, but increase collaboration with other providers if required. Investment in the urgent care services during 2013/14 allowed the organisation to proactively manage these pressures and reduced the impact on elective care.

Extensive bed modelling is underway to assess the capacity required for elective work and to identify further mitigations within existing resources to maximise productivity within the bed base. This includes focussed work on length of stay, the shift from inpatient to day case to outpatient and innovation to deliver new ways of working / embrace technology.

c. Pathway Design

Expected RTT 'Timeline' for common referrals

A number of common referrals have expected treatment timelines. These are influenced to some degree by the likely nature of the treatment e.g. the majority of medical patients will receive initial treatment in the outpatient setting and their wait time may be longer to first appointment. The majority of surgical specialties, with the exception of Pain Services and Ophthalmology, are likely to have a higher proportion of surgical interventions as their first treatment. For these patients, the wait to first appointment needs to be low enough to allow access to the inpatient pathway within the 18 week timeline. These nuances are well understood by the clinical teams and their capacity is regularly flexed up or down between
theatre and outpatient capacity to address any shortfalls. Each specialty receives a monthly “Steady State" report which indicates the level of activity required to control the waiting list reviewed against 1 month, 3 month and 6 month data.

Clinical triage is undertaken at the point of referral and with patients subsequently listed as a two week wait (suspected cancer or rapid access chest pain), urgent or routine.

All patients waiting for assessment or treatment carry a degree of risk. To help manage the risk, urgent and two week wait patients are prioritised in all specialities; where demand exceeds capacity, this may mean that the waiting time for patients triaged as routine goes out at the expense of urgent patients.

For example, Cardiology has seen an increase in demand for all outpatient services – general, rapid access chest pain and diagnostic. Although the waiting time for new routine patients has increased, the waiting time for urgent and rapid access chest pain patients has been reduced, despite an increase in activity:

<table>
<thead>
<tr>
<th>RACP and urgent appointments</th>
<th>2011/2012</th>
<th>2012/2013</th>
<th>2013/2014 to end of M9</th>
<th>2013/14 projected activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity</td>
<td>468</td>
<td>868</td>
<td>777</td>
<td>1,036</td>
</tr>
<tr>
<td>Average waiting time</td>
<td>3.3</td>
<td>4.1</td>
<td>1.7</td>
<td>1.3</td>
</tr>
</tbody>
</table>

Table 1: RACP and urgent activity in cardiology, 2011/12 – 2013/14

Patients are also risk assessed at the point of addition to the waiting list as either urgent (including cancer) or routine, with urgent patients booked as a priority.

The outpatient and elective booking teams meet regularly with each Speciality Manager, and also attend the weekly Patient Tracking List (PTL) meeting – both are channels at which concerns about the waiting time for individual or groups of patients can be raised and addressed.

There are occasions when bed pressures across the hospital mean that elective patients are cancelled on the day of their procedure. Patients having treatment for confirmed or suspected cancer are prioritised, as are patients undergoing urgent procedures, for example interventional cardiology. Speciality Managers also discuss all patients who are at risk of cancellation with the clinical team in advance of the cancellation.

**Communication of Patient Choice and Patient Rights**

‘Choose and Book’ provides patients and GPs with information about existing services at the RUH and Community Clinics, and provides the patient with a choice of booking slots. This has now been rolled out to the majority of specialties with work on-going to embed it within remaining teams. Due to the nature of some outpatient services it is not always appropriate to open up capacity to patient choice e.g. Cardiology and Gastro, as clinical priority needs to be taken into consideration. Once waiting times in these specialties are reduced, these too will be made available to direct patient booking.

Both outpatient and inpatient booking teams within the RUH follow guidance in relation to patient choice including the provision of a choice of attendance dates and may, if appropriate offer access to other clinicians or partner organisations if treatment cannot be offered within the 18 week pathway at the RUH.

Patients are made aware of their rights and the teams are trained to provide accurate RTT information.
Work is underway to improve communication of these rights to patients, but also to outline our expectations of the patient or their carer in relation to these rights. This includes their responsibility to be available within the 18 week pathway and requires them to be fit to undergo the elective care planned. This is particularly targeted at patients with low risk procedures who frequently cancel or do not attend their appointments. 109 patients currently on open pathways have cancelled more than twice via Choose and Book.

The Trust DNA rate is currently 6.5% with work streams underway to improve communication to patients and text reminder services. A pilot completed in 2013/14 indicated that DNA rates could be improved by 2% across the Trust as a result of this system.

**Right size waiting lists in line with demand profile**

Many patients undergo complex pathways which need to be completed within the timelines for diagnostics and any subsequent treatment. It is essential that these procedures are completed and reported in a timely manner to minimise the delay and maximise the opportunity to administer treatment.

Effective working relationships have been established across all clinical divisions and services to take a holistic approach to each patient group and to prioritise those most at risk of delay. This includes cancer work, but also complex elective work which may be less clinically urgent.

The cancer coordinator meets with key specialties each week to ensure that patients on complex pathways have their attendances / likely treatment plans shadow booked in advance. A patient likely to have surgery who is yet to be seen in clinic will have a provisional date set so that the cancer targets are met. This has been particularly relevant for colorectal and urology patients.

Radiology have agreed to reporting timelines to support complex pathways. All cancer patients will undergo diagnostic examination and have their report completed within 2 weeks of referral. Complex orthopaedic patients will be seen and reported within 4 weeks of referral. These improved processes have dramatically reduced the number of patients being listed for surgery after their 18 week date.

**d. Measurement**

**Local Application of Rules against National Guidance**

A thorough review of RTT processes, in particular clock starts and pauses, has been completed across all elective specialties following the National Audit Office report published in January 2014. The Cerner team have undertaken refresher training to all key staff and the data quality team report any issues via PTL to ensure any concerns are acted upon swiftly.

**RTT Data Quality**

The audit of RTT data is continuous within the Trust. This includes the following specific data reports which undergo weekly scrutiny by the PTL team in addition to generic validation:
- Open pathway validation at 12, 18 and 30 weeks
- 31+ week patients by specialty
- Planned list by specialty
- Patients identified as likely to breach 18 week date
- Any late additions to the waiting list
- ROTT rate (Removals other than Treatment)

**Performance Management**

Further work is undertaken to continually review capacity and fluctuations in demand. A formal Patient Tracker List meeting (PTL) is held weekly with all elective specialties for a full review of a range of factors which influence RTT.

A further RTT meeting is chaired fortnightly, or weekly if required, by the Chief Operating Officer. This provides a forum for the divisional management teams to escalate any issues of particular concern which cannot be resolved within the specialty, or need to be considered within the wider strategic context. These meetings follow a 12 week cycle with actions tracked and successes noted at the end of each cycle.

RTT is further monitored as part of the monthly formal divisional performance meetings with the executive team and reported in to Management and Trust Boards via the operational report and integrated balanced scorecard.

**KPIs**

A wide range of KPIs are monitored weekly or monthly to ensure delivery of RTT is on track, or early intervention is in place to address any concerns. These include all generic targets but also some local trigger points to assist with performance management. Each specialty has backlog triggers in line with their activity levels and anticipated cohort of patients unlikely to be fit for surgery. This identifies whether each service is working easily to the 90% inpatient target or if mitigating actions are required.

e. **Governance**

This assurance paper is being submitted in line with the Governance expectations of the report. An internal audit of RTT systems is planned for August 2014. Most recently an audit was undertaken regarding cancer waiting list management in response to the Colchester investigation.

**4. RTT Performance June 2014**

It is recognised that the spring period has seen the RUH, and indeed the wider NHS, face a significant rise in non-elective activity. Furthermore, demand continues to rise for elective care across all specialties. In the surgical division alone, the elective waiting list has grown by 10.2% in the last two years.

Endoscopy and Cardiology are also facing significant growth of their elective work.

Performance in relation to key measures is shown below:
Patients waiting over 52 weeks

Significant work has been completed over the past year to identify patients on open pathways and to ensure robust treatment plans are in place. This work has led to the identification of specific loopholes in the waiting list management process.

A general surgery patient was identified in April 2013 who had been listed for a “planned procedure” in error when they should have been added to the inpatient waiting list. Further to this incident, a process to regularly review the planned list was implemented so that any patients added in error are identified early in their pathway. No further long waiters have occurred.

In November 2013 a gynae patient was identified who had been seen in outpatients and commenced a medical treatment for her condition. This was not successful and surgery was indicated by the registrar. Unfortunately he did not list her correctly and this led to a delay in her subsequent date for surgery. Further to this episode, a full review of patients was undertaken who had an outcome of “add to inpatient waiting list” from clinic, but had not actually had an inpatient episode. This lead to the discovery of two ENT patients early this year who had been missed for similar reasons. A weekly report is now generated which identifies any patients who may not have been added correctly to the inpatient waiting list and no further episodes of this nature have been found.

In April 2014 a general surgery patient was identified who had been seen by the colo-rectal team and referred on for Endoscopy and tertiary review in Bristol. The diagnostic episode stopped the clock and her referral back from Bristol was not picked up as a follow up appointment required. Having contacted the Trust, she was seen within a week, but had just exceeded the 52 week wait. No treatment was indicated and she was placed on active monitoring. This particular patient condition is susceptible to delays due to the current need to refer to the tertiary centre for investigations. However, work is underway to establish this service at the RUH as an improvement to the patient pathway, patient experience and timely treatment planning.

None of the patients identified above suffered any harm as a result of the delay and robust actions have been implemented in relation to each root cause to ensure these have been adequately addressed.
4.2 Failing Specialties

Since March 2014 a revised priority booking system has been trialled which picks up the long waiters across all specialties rather than focussing on the performance of individual specialties. This has led to the failure across the 3 RTT measures, but ensured that the longest waiters are treated in order which supports patient experience and equitable access to care for routine patients.

4.1 Open Pathway Performance (Target ‘2’)

The target of 92% achievement against open pathways ensures that waiting lists are managed in their entirety without building up a backlog of untreated patients. It captures those that have not had a clock stop on their pathway within 18 weeks. A number of these will be on complex pathways requiring extensive investigation prior to treatment. Others may have chosen to wait for their surgery due to their employment particularly those who are self-employed.

The graph above indicates that those waiting over 18 weeks on an open pathway is coming down, with improved performance against the 92% target.
4.4 Admitted Performance (Target ‘1a’)

The graph above demonstrates the planned failure against the inpatient target in July 2013 with sustained performance since then. Monitoring is completed daily by BIU and senior management team, weekly at PTL and RTT Steering Group meeting. Escalation of any concerns is to formal Performance meetings and Management Board.

4.5 Non-admitted Performance (Target ‘1b’)

The Trust has seen a significant rise in outpatient activity across the majority of specialties over the past year. Performance has been sustained at Trust level with local action plans in place to address specific specialty pressures e.g. Gastro.

A further validation exercise is underway to ensure follow up waiting list is up to date.

4.6 Size of Waiting List and Number > 18 weeks

Further to increased referrals the Trust waiting list for inpatients is growing. It was possible to hold the Trust performance in relation to the backlog over the winter months, but the unusually high non-elective activity in Spring 2014 has made this challenging. Collaborative working arrangements with alternative providers have enabled the Trust to maintain a positive patient experience by referring patients on to other organisations. This has allowed the backlog to be controlled and patient wait times kept to an acceptable level.
As the non-elective pressures ease over the summer, the Trust will seek to increase elective activity and reduce the size of the waiting list.

For the medium and long term, a full demand and capacity review will be undertaken to establish the services required as part of the annual planning process. However, it is clear that for Head & Neck pressures are already exceeding capacity. Business cases are in development to support these specialties.

5. Summary

In summary, the Trust is in a good position in relation to RTT performance with robust management structures in place. Teams are well trained and well-informed in relation to booking practice and waiting list management.

An external independent audit is scheduled for the summer and any actions identified will be managed.