

# NHS Intensive Support Team

## Information Sheet (G-24)

### MANAGING PATIENTS WITH UNCERTAIN RTT STATUS

#### Overview

The following document outlines a suggested approach to reviewing and managing patients that are recorded as having an 'incomplete' pathway.

Situations may arise, for example following a PAS upgrade, when large volumes of pathways appear as incomplete or open. In these situations it is necessary to apply logical tests to the data which are then audited and tested for compliance. Such a process is recommended when a provider organisation prepares to resume RTT reporting following a period of reporting suspension, see document Suspension of Mandatory Reporting:



#### RESUMING MANDATORY DATA REPORTING OF RTT WAITING TIMES

#### Excluded Pathways

In the first instance, a provider needs to ensure that the following have been excluded, in line with the RTT rules which can be found on:



#### WWW.ENGLAND.NHS.UK/STATISTICS /RTT-WAITING-TIMES/RTT-GUIDANCE/

- Obstetrics and midwifery pathways – treatment function codes 501, 560;
- Planned patients – admission method 13;
- Referrals to services which are not consultant-led;
- Non-English commissioners – usually small numbers;
- GUM – this is no longer commissioned by the NHS and must be excluded; and
- Clinics which are similar in structure to fracture clinics in that they take emergency pathway patients (see DH Frequently Asked Questions Q90 for further clarification if required). Patients

waiting for 1st attendances (and in some cases follow up attendances) at such emergency clinics are not on RTT pathways. Some Trusts have identified that RTT pathways were created for those clinics, but were then not closed and were included in the incomplete list. Obviously some patients who attend such clinics can then go onto RTT pathways but if they're shown to be waiting for a 1st appointment they should not be included on the RTT incompletes.

#### Stratification of Open Pathways

The table below lists some suggested criteria which can be used by information teams to stratify the pathways that remain open. By applying these criteria Trusts ought to be able to break the open pathways into levels of risk and then validate and audit accordingly.

The list is a starting point and is in no way a set of queries to be applied to pathways in order to close them. It should be used to identify which patients may still be waiting for 1st definitive treatment, the highest risk category, and also those that have a high chance of having had a clock stop event that has not been recorded or picked up.

#### Refinement with Clinical Input

With clinicians' help the criteria can be refined but pathways identified by any rule will need auditing. We suggest that:

1. The information team apply the rule to the running clocks (the incompletes) and identify a cohort of patients;
2. The information team then *randomly* pick 10% (or 25 whichever is the larger) of that cohort and send the list to the specialty so the accuracy of the rule can be checked;
3. An electronic pro forma is produced that can be used to record the circumstances of each of the

<p>10% sample. This will then be an auditable document. For the rule to be applicable it needs to be correctly identifying clock stops in 95% of cases. Below this level and the rule will need refinement to be more accurate;</p>		
<p>4. If the rule is found to be accurate in 95% or more cases then the entire cohort of patients identified by the rule can have their pathway closed down (following board approval) as a one-off group – not as part of an on-going ‘business rule.’</p>		
<p>IST strongly advise that each of the criteria listed need testing to first quantify the volume of patients it identifies and then audits are undertaken to ensure the criteria is not too wide and has identified inappropriate patients. Patients identified by these actions are not to be automatically removed from the PAS or the care of the consultants. However, the patients could be removed from the PTL if the evidence available convinces the Trust this is</p>		
	<p>identifier and same clinical specialty - duplicates</p>	<p>matched accurately to be able to identify the patients correct status on an RTT pathway</p>
<p><b>Next Priority</b></p> <p>Patients last seen 12 months ago* with no future activity on PAS for that clinical specialty</p> <p>Patient had treatment code/description recorded at last out patient appointment**</p> <p>Patients with three or more consecutive follow ups for the same clinical specialty</p> <p>Patients with more than 6 months* between last two appointments***/or gap of 6 months between last and next appointment*** recorded on PAS</p>	<p>Likelihood is that the patient has been discharged back to primary care</p> <p>Probability that the patient was treated at last outpatient appointment (see and treat clinics, one-stop clinics etc.)</p> <p>Probability that patient is on active monitoring</p> <p>Probability that patient is on active monitoring</p>	

## Translating themes into practice

It is essential that where systematic problems are identified, i.e. specific clinics not stopping clock for treatments, that this is fed back and staff trained to avoid further problems. Using these criteria to address the backlog will have little effect if the Trust simply rebuilds the problem day by day.

## Remaining pathways

Suggested criteria which can be used to stratify the pathways that remain open:

## Highest Priority

All those patients/pathways who are not identified by any of the processes suggested below

These are the patients who are at highest risk of waiting for first definitive treatment (for example suspected cancer, rapid access, and clinically urgent patient cohorts)

Patients with same identifier  
and same clinical specialty as  
on admitted PTL

The non-admitted pathway has failed to link to the admitted part of the pathway or the TCI – validation will link these correctly or remove multiple entries (this also validates those pathways on the admitted PTL)

Patients with multiple non-admitted pathways – same

The multiple entries need to be cleared and pathway

- \* Clinical and operational teams to consider the timings suggested which may vary between specialties.
  - \*\* Procedures to be agreed by the clinical teams
  - \*\*\* This is appointments and not attendances – ensure that cancellations/DNAs are not excluded from the count

## Clinical Checking and Audit

The rules need to be locally refined, clinically checked and audited before being applied. Processes then need to be put in place to stop the errors that created the open pathways reoccurring.