18 Weeks
Referral to Treatment (RTT) Standard
Recovery Planning and Assurance Framework

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Running order

What should a good plan comprise of?

• Understanding why the organisation is not delivering the standard
  – Capacity and demand
  – Maximum size of waiting lists
  – Pathway delivery

• Assurance for sustainable delivery (Internal and External)
  – Data quality
  – Operational delivery
  – Key performance indicators
Recovery Plan - the basics

What makes a good Recovery Plan?

• **Detailed** - Needs to contain an appropriate level of detail to explain how the problem will be addressed.

• **Regular (weekly) Review** - Recovery plans and trajectories need to be reviewed regularly (weekly) to ensure they are on track and can be delivered.

• **Recovery Trajectory** - Plans should relate to a Recovery Trajectory which defines numerically how the problem will be recovered. These need to be operationally realistic.

• **Quantitative** - Each action should quantify the effect that it will have on the problem.

• **Risk Assessment** - All actions should be assessed for risk of delivery. Contingency plans should be developed for any high risk actions.

• **Be Honest** - Present an honest picture. If the desired outcome can’t be delivered in a certain timeframe - say so!

• **Highlight Supporting Processes** – outline what changes to the current management, PTL meetings and booking processes are being made to help with the delivery of the trajectories.
Suggested sections for the recovery plan

• Governance, leadership and assurance
• Data Quality
• Eliminating lengthy waits
• Sustainable improvement - aligning capacity and demand, access policy and Standard Operating Procedures (SOPs) update, training
• Managing clinical risk
• Performance management
• Communications
• Risks and mitigations
Why is the Trust not delivering referral to treatment (RTT) in 18 weeks?

• Is capacity and demand in balance in all specialties (sub specialties)?

• Are the pathways deliverable in 18 weeks?

• Are the waiting lists a manageable size?
Supplementary Issues

Data quality issues;
- National reporting
- Priority Targeting Lists, RTT, diagnostic and planned
- Validation

Operational management and understanding
- Structure and governance
- Accountability
- Work streams not linked
How do we deliver consistent 18-week RTT performance?

A. Maintain capacity and demand balance

B. Pathway management to reduce journey times

C. Operational processes on patient pathways

D. Scheduling and booking

E. Tracking and validation

F. Performance management system

G. Leadership and focus

Level 1

Level 2

1. Balance underlying supply and demand (each stage)
2. Create pre-agreed flexible supply options
3. Define shape and size of waiting list and monitor both
4. Analyze and manage capacity/demand down to sub-specialty level
5. Root cause analysis of failing pathways
6. Systematically remove admin. delays and unnecessary steps
7. Staged wait reduction where bottlenecks occur
8. Agree ideal pathways and escalate at trigger points
9. Redesign of clinical care processes, order of activities
10. SOPs for referral triage and addition to waiting list
11. Widespread knowledge on clock stops
12. Decision to admit processes clear and documented
13. Frequent outpatient template review, clear clock stop process
14. Widespread training in scheduling and booking
15. Written rules on classification of ‘urgents’ and booking in turn
16. High quality access policy, regularly reviewed
17. Monitoring of “treat in turn” and “urgent levels”
18. Dedicated tracking and validation of resources linked to specialties
19. Use patient tracking list (PTL) at all stages: IP, OP and diagnostic
20. Focus on undated and dated to fail patients and minimize/eliminate
21. Track patients at staged triggers untreated breaches
22. Systematic maintenance of data quality reports
23. Measure adherence to access policy and adherence to rules
24. Publish the right measures and use measures at all levels
25. Good performance conversations with actions, feedback
26. Clarify and implement incentives and consequences
27. Senior input (Board and CEO) to performance conversations
28. Board and directorate-level reporting on predictive measures
29. Support for training, validation, and scheduling functions
30. Communication and coordination with commissioners
RTT Assurance

Some basic questions:

• What does the data look like?
• Is capacity and demand in balance?
• Is there a backlog?
• Is operational management/understanding good enough?
• Are any other (non RTT) patients waiting?

This is not about numbers, its about patients.

• Patients ought to be managed fairly – not via a quota
• The focus needs to be on those still waiting for treatment
• The focus needs to be on treating the patients not managing the target
Data Quality checks locally

Commissioners and Trusts should ask themselves:

• Is the data reasonable?
  – distribution of waiting times

• Is the data plausible?
  – does clock stop activity make sense when compared to incompletes pathways
  – RTT incompletes compared with inpatient and outpatient waits
  – elapsed time to decision to admit (DTA)
  – percentage of patients with a DTA date identical to RTT start date

• Does the data correlate with other available information?
  – e.g. complaints; discussions with clinicians, outpatient booking clerks etc.
Clearance times – rules of thumb

No scientific analysis to substantiate but experience tells us:

• A backlog of over half a week worth of clock stops lead to problems, e.g.
  – Specialty A has 400 clock stops per month. On average this is approximately 100 per week making half a weeks activity 50 clock stops. If the specialty grows a backlog of admitted patients greater than 50, it will struggle to sustain 90 per cent performance
  – This is a clearance time of half a week

• Clearance times for the entire waiting list should ideally be 10 to 12 weeks. E.g. Specialty A has a total incompletes PTL of 1200 patients. Assuming no more patients were added to that list, how long would it take to treat that 1200 patients?
  – If weekly activity is around 100 per week, then clearance time is 12 weeks
  – If weekly activity is 60 per week, clearance time is 20 weeks
Is capacity in balance with demand?

Ask the following questions of the data;

• Where is the imbalance? Which specialties or sub specialties?
• Where in the pathways? Outpatient, diagnostics, admitted?
• What has led to the imbalance?
• Aim is to reach an understanding of why. Can commissioners help?
• What demand and capacity modelling have Trusts done? Is it at the appropriate level?
  • Do they know ideal waiting list sizes?
  • Ideal capacity to match current demand
  • The size of any backlogs
Waiting list size

The size of the waiting list matters - more patients waiting means a longer waiting time, and if the number waiting is too large then the standard cannot be achieved.

There is a way of calculating how many patients a Trust can have on the waiting list (the ideal) and still meet (any) required standard.

The calculation is based on four components:

- Weekly demand
- Variation in demand
- Urgency profile
- Desired maximum waiting time

NHS IMAS Intensive Support Team (IST) models to do this via the website.
Pathways

For typical “groups” of conditions e.g. Hip replacements, cataracts, etc. providers should have a clear idea of what a typical pathway should look like. In simple terms this should set out what should happen to the patient and in what order.

There should also be clarity as to the timing of the following “events”:
- Earliest first outpatient appointment;
- Latest first outpatient appointment;
- Decision to admit;
- Earliest admission;
- Latest admission
Operational Delivery

• Assure patient safety in relation to long waiters
• Should focus on the patient, not the rules
• Should include clinicians
• Must be founded on a good understanding of the pathways (including diagnostic events)
• Should be based around prospective management of patients that are still waiting, not retrospective validation of patients who have already been treated
Operational Delivery (2)

Features of effective management of waiting times:

• Concise access policy supported by Standard Operating Procedures (SOPs) for key processes
• PTL meetings or similar to provide a focal point for internal performance management
• Senior managers know the names of the longest waiting patients – and what they are doing about them
• Key performance indicators (KPIs), e.g. list size, number of referrals, weekly admitted activity, are used to prospectively manage pathways
• At least as much emphasis on clinically important (not just cancer) patients as on RTT

Much of this is described in the NHS IMAS IST elective care guide
## Suggested non admitted KPIs

<table>
<thead>
<tr>
<th>Indicator:</th>
<th>Measure:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  Clearance of backlog</td>
<td>0 patients waiting over 52 weeks</td>
</tr>
<tr>
<td></td>
<td>Less than 8% patients waiting over 18 weeks</td>
</tr>
<tr>
<td></td>
<td>All patients over 18 weeks to have a ‘next event’</td>
</tr>
<tr>
<td>2  Outpatient capacity being fully utilised (four week forward look) against backlog clearance plans</td>
<td>100% of capacity booked against backlog clearance trajectories</td>
</tr>
<tr>
<td>3  First outpatient appointment booking gate reducing to a level commensurate with 18 week delivery</td>
<td>95% patients to have first outpatient appointment date within six weeks of referral for all surgical specialties</td>
</tr>
<tr>
<td>4  Improvements in data quality/ 18 week tracking</td>
<td>No more than 2% of Clinic Outcome Forms with unknown outcomes</td>
</tr>
<tr>
<td>5  Referral to DTA time commensurate with 18 week pathway</td>
<td>95% of patients to wait no longer than 12 weeks from referral to DTA for surgical pathways</td>
</tr>
<tr>
<td>6  Specialty level compliance with target</td>
<td>95% patients seen and treated within 18 weeks</td>
</tr>
<tr>
<td>7  Non 18 week follow up activity and capacity maintained</td>
<td>100% of non 18 week pathway patients to have an OP appointment date within four weeks of the date specified by clinician.</td>
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<td>2  Inpatient / day case capacity being fully utilised (six week forward</td>
<td>100% of capacity booked into against backlog clearance trajectories</td>
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<td>look) against backlog clearance plans</td>
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<td></td>
<td>Assessment of proportion of under/over 18 week patients booked into capacity against backlog size</td>
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<td>3  Overall reduction in waiting list size</td>
<td>Removals from the admitted PTL are to be greater than the additions</td>
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<tr>
<td>4  Monitoring of patient cancellations – impact on backlog clearance</td>
<td>Weekly report - numbers and reasons for patient cancellations – identification of hospital cancellations</td>
</tr>
<tr>
<td>trajectories</td>
<td></td>
</tr>
<tr>
<td>5  Specialty level compliance with target</td>
<td>90% patients seen and treated within 18 weeks</td>
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<tr>
<td>6  Planned waiting list activity and capacity maintained</td>
<td>100% of patients on the planned waiting list to have an admission date within four weeks of the date specified by clinician</td>
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And don’t forget ……non RTT waits

Planned admissions and regular follow up patients will (should) have future appointments at clinically determined intervals

• Does this happen?
  – How many patients have a review date and how many don’t?
  – Of those with a date how many have passed it?
  – By one month, six months, one year?

• Is capacity for planned and follow ups sufficient – are the numbers passed their expected date growing?

• How are these patients (actively) managed?
Contact details:

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NHS IMAS Elective Intensive Support Team models & Elective Care User Guide can be found at:

www.nhsimas.nhs.uk/ist

More information and guidance documentation can be found on the NHS England web page, at: