INFORMATION STANDARDS
GOVERNANCE PROCESS

INFORMATION STANDARD
REVIEW SUBMISSION

Referral To Treatment Waiting Times

November 2007
INFORMATION STANDARD REVIEW SUBMISSION
FOR NEW OR CHANGED (INCLUDING RETIRED) INFORMATION STANDARD

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REVIEW SUBMISSION” TEMPLATE

REVISION HISTORY
Date of this revision:

<table>
<thead>
<tr>
<th>Version no.</th>
<th>Revision date</th>
<th>Summary of Changes</th>
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SUBMITTED BY:

Document completed by: James Ross

Role & organisation: Performance and Improvement Manager, 2009 Access Team, Delivery & Support Unit.

FEEDBACK TO BE PROVIDED TO:
Feedback will be provided on the Review within 10 days of the WIGSB meeting. If the feedback is to be directed to another nominee please provide the name and contact details below.

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SUBMISSION PURPOSE
Proposal submitted for: Information / Draft Review / Formal Consideration

If this Review Submission is not for formal consideration then please state the specific aspects on which you would like more detailed comments.

Specific Areas for WIGSB to comment on when not submitting for formal consideration at the Review stage

Section 13 – Maintenance Process
Section 14 – Planned Review Dates
Section 18 – Review section
SECTION 1: BACKGROUND

1. Information Standards Reference Number [From Information Services Division]

TBC

2. Name of Information Standard

Referral to Treatment Reporting

3. Type of change

Formal approval of existing standard

4. Type of standard

Operational

5. Introduction

In March 2005 the First Minister and Minister for Health and Social Services announced that by December 2009 no patient in Wales would wait longer than 26 weeks from referral to treatment. The length of time people wait for NHS treatment is an important part of their experience of healthcare.

The 2009 Access project was established in September 2005 to ensure that health communities across Wales achieve a year on year reduction in waiting times culminating in achievement of the 26 week target by December 2009.

In December 2006, the Welsh Assembly Government issued its pathways guidance document “Delivering a 26 week Patient Pathway: an Implementation Framework” (WHC (2006) 081). This document identified the definitions and scope of the target, including where a reporting period begins and ends. This guidance has been updated in the light of subsequent experience, and in October 2007 the Welsh Assembly Government issued WHC (2007) 075 “Delivering the 26 week Target: Operational Guidelines for Applying the RTT Rules and Definitions” which provides final guidance in relation to the operational management of the target.

Following the publication of the 2006 guidance, a standard was developed for the reporting of the target, including the methodology of recording clinical events, and the frequency, content and timing of reporting required. This standard was brought to WIGSB in January 2007 for approval, in order to meet the government target for reporting against the target, and was given qualified approval, subject to further review after implementation. The requirements for organisations were published as WHC (2007) 014 “Access 2009 – Referral To Treatment Time Measurement” and DSCNs (2007) 01 “Referral To Treatment Times” and (2007) 08 “To Provide Guidance on the Reporting Structure for the Referral To Treatment Time Reporting Requirements”.

The outcome of the January approval included a request to review the implementation of the standard after six months. In August 2007 a short paper was submitted to WIGSB defining the scope of the review. This paper stated that the review would include;

- Patient Level Reporting
- Cross Border Reporting
- Data Quality and Completeness
- Further Development of Outcome Codes
- 6 Month Review of Trust RTT Experience

After reviewing the paper WIGSB asked that the scope of the review should also include;

- Uniqueness of the NPI
• Inclusion of LHB codes
• Further refinement of the specialties included in RTT monitoring

This document provides a review of the Referral To Treatment Waiting Times standard, and addresses the issues identified by WIGSB in January 2007 as requiring review. The review is detailed in section 18.

6. Sponsor

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8. Implementation Date


Implementation of revisions proposed in this review: 1st April 2008.
SECTION 2: BUSINESS JUSTIFICATION

9. Purpose

A Ministerial requirement to deliver a maximum 26 week referral to treatment time initiated an urgent need to develop a data collection to monitor compliance with the target.

The purpose of this data collection is to provide reporting against the 2009 Access target standard, of a maximum Referral to Treatment Time of 26 weeks.

10. Scope

This target refers to the treatment of all Welsh residents, whether treated in Wales or in England.

The target provides a measure which eliminates the current gaps into which a patient's pathway can fall, leading to long overall waits. The data collection is informed by the document “Delivering a 26 Week Patient Pathway - An Implementation Framework” published as WHC 081 (2006) and the further guidance “Delivering the 26 Week Target: Operational Guidelines for Applying the RTT Rules and Definitions” published as WHC (2007) 075.

This collection and publication is aimed at providing consistent referral to treatment times data to enable Trusts, LHBs, and Regional Offices to:

- Measure patient pathway lengths from referral to treatment.
- Identify which specialities have the greatest gap to meet in relation to the target, and therefore require the greatest focus of service redesign. This may be used internally by Trusts or externally by performance managers.
- As service redesign is implemented to achieve the total time from referral to treatment, the data collection will inform the success of this service redesign.
- Identify Regional variations to facilitate Regional planning.
- Provide defined data for performance management purposes.
- Facilitate benchmarking within each specialty – this is a longer term goal.

The data collection will also enable the Welsh Assembly to performance manage and monitor the implementation of the policy and to report publicly on progress toward the target.

The 26 week commitment will cover all referrals to secondary and tertiary care where locally agreed direct referral protocols exist. This may include referrals from:

- General Practitioners
- GPs with Special Interest (GPwSI)
- District Nurses
- Screening programmes
- Intermediate Services
- Referral Management Centres
- Dental Practitioners
- Optometrists and Orthoptists
- Consultant or Independent Nurses
- GUM clinics
- A Consultant in private practice
- A secondary/tertiary care Consultant
- Out of Hours Services (regardless of location)
- An emergency attendance referred onto an elective pathway
- Allied Health Professionals: (see WHC (2007) 075 for AHP inclusions)
Other events that start a 26 week clock may be:

- A new decision to treat made at any point on a long term pathway;
- A new decision to treat made at a follow up appointment;
- After a period of active monitoring;
- Diagnostic or Therapy services where a referral to a named Consultant is required; and
- Planned follow-up treatment, where the primary procedure has taken place.

The 26 week pathway does not replace other waiting times targets where these are shorter than 26 weeks, such as the current cancer and cardiac service targets.

**Elective Specialties Within the Scope of the 26 week Target**

A full list of specialties considered within the scope of the 26 week target has been developed and is shown at Appendix 1

**Paediatric Specialty**

Elective paediatric patient pathways are within the scope of the standard. Community paediatric services, however, are not within the scope of the standard, as these are services are essentially a Primary Care service frequently co-located in a Secondary Care setting.

**Welsh Residents Treated by English Providers**

Welsh resident patients treated on elective pathways by English provider organisations are within the scope of the standard

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### 11. Funding

There has been considerable financial allocation in relation to the 2009 Access Target by the Welsh Assembly Government through the sponsor. In 2005, an allocation of £80 million of revenue funding was made, in order to meet the service requirements in relation to the target. This funding was for three years, beginning in 2006/07. Of this funding, a total of £51 million was allocated recurrently for LDP capacity gaps, and £11 million was held centrally to support the achievement of the cardiac surgery access target. The recurrent funding has been directed at closing ongoing capacity gaps, and providing funds for modernising clinical services.

The remaining £18 million pounds of funding is a non-recurrent allocation, and is intended to be allocated to meet specific requirements.

In addition to the £80 million funding, a further financial allocation has been made to Trusts for the 2007/08 financial period. The Director of Performance and Operations wrote to Trust Chief Executives in December 2006 to announce the allocation of £50,000 per Trust to meet project and support costs associated with the delivery of the target. This total allocation of £650,000 is non recurrent.

Trusts have also had the opportunity to bid against a capital allocation of funding. This allocation has not been capped, but bidding projects are assessed on their merits and against agreed criteria. The allocation is specifically for capital investment to support delivery of the 2009 access target.

This very significant total funding indicates the importance of the target, and the high priority accorded to it by the Welsh Assembly Government, NHS Wales, and the Director of Delivery.

### 12. Support

The proposal is in response to the requirements of *Designed for Life*, under which programme users will be required to support the introduction and measurement of RTT times. This is a mandatory target, and end users of the information, including Regional Offices, the Assembly, and the DSU have been closely involved in the development of these proposals.
Users

Consultation has taken place with provider organisations, initially through the Early Adopter Health Communities and subsequently through close links with Organisational Project Executive Leads and Project Managers. The data collection is viewed as achievable, although highly challenging. To date there has been a positive response to the data collection and progress towards full compliance is well underway.

Stakeholders

Letters of support were attached to the January 2007 Submission from the following: DPO, Conwy & Denbighshire, North East Wales, Bro Morgannwg (The Project Early Adopter Trusts.)
SECTION 3: MAINTENANCE AND REVIEW

13. Maintenance Process

Inclusions in the Referral to Treatment 26 week pathway may over time change as Ministerial requirement and business needs develop. Alongside this IHC solutions are planned to be implemented post 2009, which may enable patient level reporting. Whilst this is not likely to be available by December 2009, the development of these solutions will fall within the time envelope of meeting the 26 week target by December 2009.

Therefore, reviews based on changing needs may be instigated over and above planned periodic reviews.

Access 2009 Intensive Support

Ongoing support to the implementation of the standard will be offered to organisations identified as being challenged through the LODA assessment or through the monitoring of RTT submissions. This will be in the form of an intensive support intervention, led by the 2009 Access team, and focussing on targeted development of systems to ensure full deployment of effective monitoring, measurement and reporting of the 26 week target.

RTT Scoring Systems

Each month, the RTT reports are scored on the basis of:

- Compliance with the reporting timetable as set out in WHC (2007) 014
- Data completeness
- Data Quality

This score is placed into a league table, and results fed back to CEOs. If scores are low, 2009 Access team intensive support may be triggered. It is expected that once data of publishable quality is achieved, RTT scoring will be discontinued.

14. Planned review dates

Review Process

A rolling six-month review process will be established to assess:

- Changing business needs
- Assessment of fitness for purpose
- Development of IT solutions
- Clinical developments which may impact on the specialties included

The results of this review will only be returned to WIGSB where a change in the standard is required.
SECTION 4: STANDARD REVIEW

15. Review undertaken by:

The review of the standard has been directed by the Access 2009 Informatics workstream, a multi-organisational group of information and service representatives. All review work has been specified and reported to this group.

Access 2009 Informatics Workstream Membership:

Christine Miles  Access 2009 Project Sponsor (Chair)
Andrew Sallows  Head of Information, DSU
Catherine Bridges  Head of Information Analysis, Corporate Analysis Team
Claudia Blair  Health Statistician, Health Statistics and Analysis Unit
Debbie Croft  Information Manager, Carmarthen NHS Trust
Eluned Cousins  Head of IM&T, Mid & West Region Business Service Centre
Gareth Lee  Head of Information Services, Swansea NHS Trust
Heidi Rosenberg  Information Services Manager, Health Solutions Wales
James Ross  Performance Improvement Manager, Access 2009, DSU
Jan Davies  Service Improvement Lead, Diagnostics and Therapies, DSU
Jayne Griffiths  Associate Director of Informatics, Gwent Healthcare NHS Trust
Pam Hall  Programme Director, Corporate Health Information Programme
Steve Ham  Director of Finance, Newport LHB
Sue Leake  Head of Health Statistics and Analysis, Welsh Assembly Government
Sue Rowe  Project Director, Access 2009, DSU
Thomas Manning  Implementation Lead, Access 2009, DSU

16. Implemented Solution

The solution is based on the concept of start clock and stop clock points which will occur along an individual patient’s pathway. These start and stop clock points are derived from the clinical management of the patient (e.g. referral and treatment). The exact nature of the measurement points will vary by specialty and by patient. There is extensive guidance as to the derivation of start and stop clock points in WHCG (2007) 075 “Delivering the 26 week Target: Operational Guidelines for Applying the RTT Rules and Definitions”.

Organisations are required to capture the start clock and stop clock points for each individual patient pathway in line with the definitions expressed in the guidelines. To capture these points organisations use existing data points for those start clock points occurring at the point of a new referral and for those stop clock points occurring at elective or planned admission. Organisations have expanded the outpatient clinic outcome data point to allow collection of start and stop clock points occurring in the outpatient clinic. Trusts are also capturing outcomes at each other patient interaction (e.g. Diagnostic, Consultant office decision). In addition, Trusts have created a unique pathway identifier (UPI) in order to effectively link start clock to stop clock points for each individual pathway, where multiple pathways may be in progress for individual patients at any given point in time.

A pathway is opened with each new referral and only closed when a patient is discharged. Within that pathway there may be a number of treatment clocks, designated by recorded start and stop clock outcomes. In the example below, a patient is referred, seen in OPD, added to the elective surgical list, admitted, treated and then discharged.
In the next example the patient has two treatments. The first is a medical treatment in outpatients, which is found at a later appointment to be unsatisfactory. At this point a decision is made to undertake a surgical intervention. This is successful and the patient is discharged at a subsequent follow up appointment.

In this example, there are multiple stop clock points at the end of the pathway (admission for surgery, discharge following surgery, and discharge from follow up outpatient). Organisations will need to look back on the pathway to discover the previous outcome. If this is a new clock start, then a pathway will be recorded. If, however, the previous outcome is also a stop clock, there is no active clock, and therefore no clock time to report.

This type of pathway may also occur for the patient with chronic disease, where a pathway may continue for years, with multiple treatment episodes during that time. Each treatment episode would have an associated clock, each with a 26 week maximum length.

Trusts are reporting two sets of monthly aggregate data. The first report shows the number of patients by specialty, who have reached stop clock points during the reporting period by length of wait in weeks. This completed clock report is further split by patients reaching a stop clock point due to admission and those reaching a different stop clock point. The second report, the continuing clock report, shows the number of patients by specialty, who at the end of the reporting period have not yet reached a stop clock point by length of current wait in weeks as at the end of the reporting period.

The solution is designed to be used for the measurement of referral to treatment times. Individual organisations may wish to further develop the solution to obtain management information to enable advanced management of the pathway length.

HSW are the central data point for this data collection. It is anticipated that the Health Statistics and Analysis Unit of the Welsh Assembly Government will publish the figures when the data flows have been established and the quality of the data is considered sufficiently robust.

### 17. Original Fitness for Purpose

#### Development and Testing

The methodology for this solution was developed through experience from the English 18 week project and through testing with the Early Adopter Health Communities within NHS Wales. The methodology met the requirements for fitness for purpose;

- System capable of delivering the required data
- Organisations able to collect the data as required
- Administrative and Clinical Burden assessed and within manageable limits
- National Patient Identifier developed to provide unique reference for linking components of the individual patient pathway where required
- Sufficient information contained within the report to allow assessment of data quality and acceptability for publication
Performance Characteristics

The following characteristics were identified as being indicative of a successful implementation:

All Trusts shall:

- Implement outcome reporting across all patient interactions within their organisation – Partially Achieved- In Progress toward full achievement. Assessed through RTT Scoring mechanism.
- Develop systems for recording outcomes electronically – Achieved – All organisations reporting RTT Times
- Develop systems for tracking patients across departmental and organisational boundaries – Achieved – Systems in place, further development in progress
- Supply valid datasets covering all relevant pathways on a monthly basis – Partially Achieved – Ongoing development of data quality. All organisations reporting against pathway types.

18. Review Findings

Review Programme

The standard has been reviewed constantly since implementation in April 2007, with regular formal and informal discussions with stakeholders in regard to progress and development. Results of formal reviews are described below, under each section reviewed. In total, ten specific areas have been reviewed, either in respect of further developments to the standard, or to ensure the standard as initially approved has met the requirements for which it was developed. The ten areas of review are;

- Patient level reporting
- Cross Border Reporting
- Data Quality and completeness
- Further development of outcome codes
- Stop clocks in other areas
- Review of six months’ experience of Trusts in collecting the data
- Involvement of the BSC’s
- National Pathway Identifier (NPI)
- LHB codes inclusion in the reporting system
- Transition from Current (GTGP) to Future (RTT) Waiting List Management Rules

The outcome of the review of each of these areas is described below.

Patient Level Reporting

Initial reporting of Referral To Treatment times has been via aggregated reports. These reports aggregate results by length of pathway in weeks, Trust, LHB and specialty. This method of reporting was selected due to the level of technical ability within reporting organisations. It is also the system of reporting used in England, making reporting consistent for all organisations when reporting across the border.

A full review of the process, involving CHiP, HSW, HSA, DSU, IHC and service representatives has demonstrated that a patient level RTT MDS is not required at present for RTT recording. The present aggregate data collection will be taken forward by the project team as the preferred level of data collection.

Cross Border Reporting

Data Collections

The English data collection is split into three separate forms held by each Trust, and these are

- Completed Pathways - Admitted Patients
- Completed Pathways - Non-Admitted Patients
- Incomplete Pathways - All Patients
The Welsh data collection is submitted in one format with all record types being submitted centrally in one file.

In comparison between the two data collections, the Welsh files are considerably larger and hold additional information. There are additional specialties included and these will be matched to LHB codes for the Trusts, the weeks time bands follow a greater range picking up patients waiting up to 105 weeks where as England stop at 52 weeks. In Wales Mental Health, Cardiology and Cancer are excluded but in England Cardiology is included.

**Future Data Collection Changes**

Monthly reporting will continue in both jurisdictions. England is to mandate weekly Patient Targeting List (PTL) reporting from January 2008, Wales intend introduce PTLs from April 2008. English patient level data will be available for access by commissioning services via the Secondary Uses Service from April 2008, but reporting to the central teams and publication of data in England will remain in aggregate form.

**Definitional Differences**

A full examination of definitional differences was conducted with English organisations on 14th September 2007. Differences identified are:

**Policy Differences**

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<th>England</th>
<th>Wales</th>
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<tr>
<td>18 Weeks</td>
<td>26 Weeks</td>
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<tr>
<td>Commissioner Target</td>
<td>Commissioner / Provider Target</td>
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<tr>
<td>Patient GP registration</td>
<td>Welsh Residents</td>
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**Operational Differences**

<table>
<thead>
<tr>
<th>England</th>
<th>Wales</th>
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<tr>
<td>Mental Health &lt;18 weeks</td>
<td>Mental Health excluded</td>
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<tr>
<td>Dentistry to “case start”</td>
<td>Orthodontics &amp; Restorative dentistry to 1st OP</td>
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<tr>
<td>C2C referral for same condition continues clock</td>
<td>C2C referral stops/starts clock except in pooled environment</td>
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<tr>
<td>Tertiary referral continues clock</td>
<td>Tertiary referral stops/starts clock</td>
</tr>
<tr>
<td>Referral to RMC / Intermediate care starts clock</td>
<td>RMC/Intermediate onward referral starts clock</td>
</tr>
<tr>
<td>Clinical Transfer MDS to be mandated</td>
<td>Clinical transfer MDS to be locally defined</td>
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All of the operational differences will act to lengthen the allowable clock period under the Welsh definitions. Therefore any patient achieving an RTT time of less than 26 weeks under English definitions will also achieve the target under Welsh definitions. Therefore the different definitions need only be applied to patients apparently breaching the Welsh target under English rules. This can be undertaken between provider and commissioner as part of the breach review on an individual patient basis, before the breach is formally reported.

**Welsh usage of English Data Flows**

The English data flows provide the information required centrally for the Welsh target, and therefore the reporting systems used by English organisations can be used for Welsh data returns.

The split by commissioning organisation within Unify 2 is to “non-English commissioners” which will include a wider patient group than Welsh residents. English Trusts are able to split out Welsh commissioned patients (by postcode) but Unify 2 does not provide for this submission. Therefore submissions will have to be manual in the first instance. The project team are actively pursuing the option of developing a Welsh domain on Unify 2 allowing Welsh data to be submitted via this route.

**Timetable for Data Flows**

English Trusts have been requested to submit RTT data for all Welsh resident patients (using English definitions) from November 2007, via the BSC. This submission will be according to English RTT
definitions, and will follow the same timetable as the English submissions. This submission will be monitored for the top 15 English Trusts by the Access 2009 team.

A letter has been sent to all Welsh commissioners setting out the reporting requirements and requiring them to request reporting from all English organisations with whom they have an LTA or with whom they agree individual funding requests. A similar letter has been sent to all English Trusts treating more than 50 Welsh elective patients per year outlining reporting requirements and data flows.

The Access 2009 team and HSA will monitor data returns from English organisations, and will seek to add an English data report to the Welsh data report by March 2008 to meet the timetable for publishing RTT data.

**English Resident Patients with Welsh GPs**

There is an outstanding issue at national level in regard to the group of patients who are resident in England, but have a Welsh GP. Targets in Wales relate specifically to Welsh residents, while English Targets relate to those patients registered with an English GP and therefore commissioned by English PCTs. As such, English Resident Welsh Registered patients fall outside the scope of either target. This is a problem for all performance targets in Wales, and is currently under consideration as part of the cross border commissioning process in the Welsh Assembly Government. When guidelines are published, the RTT data collection will need to comply with those national guidelines in respect of these patients.

**Data Quality and Completeness**

Following the beginning of RTT reporting in April 2007, it is necessary to move to the second stage of reporting; developing the data quality and completeness. The aim is to provide data of publishable standard by the end of March 2008. In order to achieve this, there will need to be a number of data quality and completeness indicators introduced. The indicators have been developed by the 2009 Access Team, HSW and HSA, and these indicators have been shared and discussed with trusts in both the 2009 Access project leaders meetings and Secondary Care Information Steering Group. These will be monitored using a Web based submission tool currently under development by HSW. In the meantime, these processes are being undertaken by HSW after the data has been submitted.

**Structure of Indicators**

Three types of indicator have been identified; Validity Standards, Consistency Indicators and Benchmarking Indicators. This approach is linked to the CHIP approach to data quality (see diagram).

**RTT Validity Standards**

These are indicators which are assessed at the point of submission. They address the timeliness and validity aspects of the data quality jigsaw. They include ensuring that all necessary fields are completed on the report, and that fields match the required format. These indicators have been developed by Health Solutions Wales, and are implemented into the NHS Wales Switching Service. This ensures that all submitted data is accepted by the system, and can be analysed correctly.

**RTT Consistency Indicators**

These indicators are comparators between existing data sets and the new data submissions. These comparators will address the completeness and consistency elements of the data quality jigsaw. Exact matches will not be expected for these indicators, and a tolerance will be developed for each. The following comparators are proposed:

*Closed pathway due to admission (Data reference = CA).* These are the referral to treatment times that end due to the patient being admitted for treatment. The number of patients reported in the RTT data should be close to the number of records for elective admissions submitted to PEDW. The match will not be exact because:

- Some patients will be admitted for a diagnostic procedure (if the result of the diagnostic is that the patient needs to be treated, this will not stop the clock)
- Some patients may be admitted but have no treatment.
Comparisons are made with average annual PEDW elective admissions by Specialty for specialties with a large number of patients e.g. T&O, Gen Surgery, Urology, ENT and Oral Surgery, plus a total for all specialties. Specialties with small numbers will be subject to too much variation to make any meaningful comparisons.

**Consistency Indicators:**
- Data recorded against all specialties where there is PEDW elective activity reported.
- RTT data count is within 10% of average annual PEDW count.
- RTT data count is within 30% of average annual PEDW count.

**Closed pathway for reasons other than admission (Data reference = CO).** Currently, there is no data source suitable for cross-referencing this data against. Data recorded here will include closed pathways in the outpatients, therapies, and diagnostics areas. When the ‘outcome code’ in the Outpatient MDS (OPMDS) is used to record RTT clock status this may be used. The quality of the OPMDS and this field is will be assessed in 2007/08.

**Open Pathways (Data Reference = PO).** Anyone who is on a current waiting list (outpatient, inpatient, day case, diagnostic and therapies) will be on an open pathway. Additionally, patients on an open pathway will include those waiting for an outpatient follow up appointment, those waiting for a diagnostic test or therapies other than those specified for the waiting times data collection.

The total count on the open pathway should be at least the count of the waiting times data supplied information but will not exactly match. An assessment of the expected number of people on an open pathway for a specialty and Trust based on the OP, IP and DC waiting times will be made and the number reported on the open pathway will be compared with this. Using information on first outpatient attendances and follow up ratios, we can estimate the total number of open patient pathways.

Comparisons should be made with the average waiting times by Specialty for specialties with a large number of patients e.g. T&O, Gen Surgery, Urology, ENT and Oral Surgery, plus a total for all specialties. The diagnostic and therapies can only be included for the all specialties comparison since these are not available by specialty.

**Consistency Indicators:**
- RTT PO data count is not less than the waiting times expected number
- RTT PO data count is within 10% of the waiting times plus first out patient appointments expected number

**Trend checks**
The data must follow a logical pattern. Patients can only be added to the clock at week 0, and will be closed in a sequential order. Therefore a number of checks can be made, based on Trend patterns.

Open Pathways: The time pattern should be a downward trend. There will inevitably be variation at a week on week basis but in 4 weekly time bands the pattern should be more apparent.

**Consistency Indicator:**
- total count for weeks n+4 to n+7 should be less than n to n+3 of the previous month (n=0,4,8,12 etc).

All Pathway Types: Monthly trends of activity for the larger specialties should be reasonably consistent. Therefore in any given month, a similar number of submissions would be expected for each specialty. Where the number of pathways for a given specialty in a given category changes by month by more than 10%, an explanation should be sought.

**Consistency Indicator:**
- Total count by category (CO,CA,PO) for Month n should be no more than 10% variance from total count by category for Month n-1.
The Validity standards and consistency indicators will form a validation at source (VAS) module to be developed by HSW and implemented by April 2008.

**Benchmarking Indicators**
These are indicators which can be used to compare the use of the definitions across organisations, identifying consistency of application. These indicators address the consistency element of the data quality jigsaw.

There are a number of areas within the definitions where clinical interpretation is to be applied. This relates most specifically to the clinical intention at the time of a particular intervention, and therefore the recorded outcome – for example, if a medication change is given, is this treatment (and therefore a stop clock), or is this to manage the condition until surgery can be performed (and therefore a continuation). To ensure that the definitions are being applied consistently across Wales, FAQs are being issued to address specific queries. There is a need to validate the application of these decisions, however. This can be done by benchmarking across organisations at a specialty level, as the proportion of clock stops caused by one particular intervention should be relatively consistent within any given specialty across the country.

It is recognised that valid reasons may apply in certain Trusts for variations and outlier positions in this benchmarking (e.g. Tertiary services). Any outliers in a benchmarking comparison would trigger the need for further investigation at a more detailed level, to ensure that definitions are being correctly applied. The five areas of comparison identified below represent the major stop clock reasons, and therefore comparison of these areas will assure the consistency of application.

**Benchmarking indicators:**
- Percentage of clocks stopped by:
  - Admission
  - Commencement of Active Monitoring
  - Consultant to consultant referral
  - Treatment commenced in outpatient clinic
  - Discharge

These benchmarking indicators will be used as spot check comparators in the assurance process. The benchmarking checks will be undertaken initially as part of the Intensive Support process, enabling organisations to understand where errors in the interpretation of definitions may be occurring. After April 2008, a regular three monthly audit process will be instigated by the Project Team, including the benchmarking indicators, to provide ongoing evidence of the validity of application of the definitions.

**Further Development of Outcome Codes**
Views from the service and other stakeholders on the potential development of closed pathway outcome codes to identify other clock stop areas, generated a request from WIGSB and the 2009 Access Informatics Workstream, to establish a business justification, prior to proceeding to a new development.

A short questionnaire was circulated widely, to business users centrally and within the service, on 8th August 2007 with a return date of 24th August. The questionnaire asked for detail on any outcome sub-codes to the existing “Closed by Admission” and “Closed by Other” codes currently in use. Stakeholders were asked to specify sub-code requirements and describe the business application if they were to become part of the centrally collected data.

One Trust responded that it may be useful to distinguish between inpatient and daycases “Closed by Admission” pathways, however, the comments below from one Trust reflects the consensus of opinion expressed by other respondents,

> “Having discussed the merits or otherwise of introducing closed pathway sub-codes at our RTT Measurement Task Group Meeting, we feel that it is too early in the RTT reporting process to start monitoring in any further detail. Most .......would be reluctant to add another tier into what is already a complicated process. “

Similarly, the 2009 Access project does not require subdivision of the codes to monitor the 26 week target.
The conclusion is therefore that there is no business justification for developing closed pathway sub-
codes at this point in time.

**Stop clocks in other areas**

WHC (2007) 014 specified reporting to begin using Stop Clocks which occur in outpatients and consultant
offices, and on admission. It also specified that in February, stop clocks occurring in all other areas
should be included. The Project have utilised a number of approaches to discover what other areas are
relevant, and how stop clocks in those areas can be recorded, with a specific focus on whether a new
data collection system is needed for these areas.

As part of the Access 2009 project Integrated Implementation and Delivery plan, all NHS Wales
organisations were requested to provide feedback against a number of specific areas of the plan. One of
these areas was where Stop Clocks occurred and would need measurement outside of the previously
identified areas.

In addition to this process, information regarding stop clock occurrences was also sought from England,
both from the 18 week project and from the Early Achiever sites.

Access 2009 Project Managers were also asked to review their individual organisations to identify if any
further areas of practice may deliver stop clock points.

The outcome of this extensive exercise was to conclude that the only area where stop clocks are not
reported under the existing requirements is for Ward Attender appointments. Several responses to the
feedback process commented that this can be recorded using existing methodology, either through
outcome forms or through capture of the clinical pathway management at the point of recording of clinical
decisions.

It is therefore concluded that there is no requirement for new systems and processes to capture
information flows from stop clocks in other areas.

**Review of six months’ experience of Trusts in collecting the data**

A full review and impact assessment has been undertaken, after Trusts had been collecting data for 6
months. The assessment tool was divided into 5 sections; Systems, Processes, Resources, People and
Consultation. Each section examined specific questions, and offered a space for comment. The impact
assessment tool was sent to all Trusts. 11 of 13 trusts returned the impact assessment. The results are
shown below.

**IT Systems**

All organisations identified that IT system development has not been completed for the standard. Most
have undertaken internal development of systems to deliver the requirements, although three have also
used external development. Only one trust was already recording
the required information before the implementation of the standard, and all have incurred direct costs in making the required
changes. These costs are further examined in the resources
section. Overall impact on IT systems was assessed as per the
attached table.

<table>
<thead>
<tr>
<th>Impact Level on IT Systems</th>
<th>Number of Trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some</td>
<td>3</td>
</tr>
<tr>
<td>Significant</td>
<td>8</td>
</tr>
</tbody>
</table>

**Business Processes**

Organisations across NHS Wales have not completed the business process changes required by the
standard. On average organisations consider they have completed 75% of the process changes
required. The planned timetable for the remaining changes shows completion by March 2008. Two organisations identify
longer timescales, based upon PAS replacement plans. Only
4 of 11 trusts have developed processes to manage as well as
measure the target. Overall impact on business processes
was assessed as per the attached table.

<table>
<thead>
<tr>
<th>Impact Level on Business Processes</th>
<th>Number of Trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited</td>
<td>1</td>
</tr>
<tr>
<td>Some</td>
<td>3</td>
</tr>
<tr>
<td>Significant</td>
<td>7</td>
</tr>
</tbody>
</table>
Resources

Estimated monthly costs of achieving the data collection varied from £4,000 to £24,000. The average estimated cost was £10,000. Several Trusts commented that this cost was very difficult to estimate, however. Estimations of outstanding costs to completion of the development also varied considerably, from 3 trusts who stated that there were no outstanding costs, to one Trust who identified an outstanding cost of £308,000. Where outstanding costs were higher, this was mostly appropriated to bringing diagnostics and therapies into the PAS system. Timescales were identified as similar to those for IT system development.

People

Six Trusts have completed training for all staff. Other Trusts identify considerable progress in completing training, but identify ongoing needs. For these Trusts, the major groups requiring further training are departmental and clinical staff groups. Nine of eleven trusts have extended engagement to all staff groups. The other two trusts have not yet extended engagement beyond managers and IT professionals.

Consultation

All Trusts had consulted with project teams, and executive managers. Eight trusts had also consulted clinical staff, medical, nursing and AHPs in the completion of the impact assessment. Five trusts had signed off the consultation with their Project Boards. Others commented that the timescales for completion did not allow for this, but that the assessment would be taken to the next project board.

Additional Comments

There was an opportunity within the impact assessment for organisations to comment on each area of the assessment. The table below identifies the comments made and the response made or to be addressed by the 2009 Access project team.

<table>
<thead>
<tr>
<th>Themes</th>
<th>Action to date</th>
<th>Action required</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Systems –</td>
<td>• Requirement of reporting Diagnostic and therapies was flagged to organisations in WHC 014</td>
<td>• Ongoing support in system development</td>
</tr>
<tr>
<td></td>
<td>• Support is being offered to challenged organisations</td>
<td>• Sharing of best practice</td>
</tr>
<tr>
<td></td>
<td>• Sharing best practice at project managers meetings in manual solutions</td>
<td>• Evaluation of commercial tools e.g. Ardentia and No Delays Achiever</td>
</tr>
<tr>
<td></td>
<td>• Working with IHC to support new PAS implementation (including funding)</td>
<td></td>
</tr>
<tr>
<td>2. Processes –</td>
<td>• Mixed response in the completeness of changes to operational processes but all respondents bar one planning to make the necessary changes by March 08.</td>
<td>• March 2008 date identified for the achievement of data of publishable quality</td>
</tr>
<tr>
<td></td>
<td>• Majority of organisations felt that RTT has a significant impact on organisational processes with the majority developing these processes only for measurement of the target and not to help with the management.</td>
<td>• Support to develop data quality and operational processes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Sharing of best practice in management of RTT pathways</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Evaluation of commercial tools to assist in management of RTT pathways</td>
</tr>
</tbody>
</table>
### Themes

<table>
<thead>
<tr>
<th>Themes</th>
<th>Action to date</th>
<th>Action required</th>
</tr>
</thead>
</table>
| • Several respondents are reliant on procurement and development of IT systems before training can be put in place and rolling out operational processes and therefore finding existing systems difficult.  
• It was acknowledged that RTT would have an impact on administration processes and change to job roles especially when collection becomes electronic.  
• As clinical pathways develop this may have an impact on commissioning and LTA processes. | • Working with IHC to support new PAS implementation (including funding)  
• Evaluation of workforce impact of RTT project | • Advice to the development of commissioning frameworks and LTA processes |

### 3. Resources –

<table>
<thead>
<tr>
<th>Resources</th>
<th>Action to date</th>
<th>Action required</th>
</tr>
</thead>
</table>
| • Out of the eight that replied seven reported that RTT information had not been reported before and has cost the organisation to implement a system to report.  
• Varied response to the additional costs of the project with all respondents giving estimated costs in the areas requested.  
• In some trusts there was requirement for additional funding for posts and resources to put in place processes such as clinics outcome forms or to provide ongoing project management until the project is fully operational.  
• Most agreed it would take 6-12 months to complete although one trust felt it would take longer than 12 months | • Funding provided as under resources above | |

### 4. People –

<table>
<thead>
<tr>
<th>People</th>
<th>Action to date</th>
<th>Action required</th>
</tr>
</thead>
</table>
| • All respondents bar one (who have just appointed trainers) stated that the minimal training and engagement has been carried out specifically for management and the organisation. Some trusts had higher numbers to train increasing the burden of training  
• Further detailed training has been tailored to specific specialities groups when carrying out pathway re-design. Some trusts have progressed to training clinical staff but again only those specialities that are focusing on changing services.  
• It was recognised by all respondents that training will be an ongoing requirement and should be in line with service changes, guidance released and new staff starting as well as to ensure data quality and assurance. | • Support given to training programmes  
• Training resources provided on website  
• National and regional meetings planned to share best practice and identify and resolve any national issues. | • Currently undertaking a clinical stakeholder survey and project plans to build on this with an engagement workshop at the start of 2008  
• Training and awareness through varied routes e.g. LMCs and Clinical Advisory Groups |
5. Other comments –
- Actual impact of the target on resources had not been understood prior to commencement.
- It was also recognised the need to devise the mechanisms for recording decisions and redesigning clinical pathways as fundamental to moving forward with RTT.
- Guidance has been published for the systems required for recording decisions
- Redesigning pathways remains a high priority
- Ongoing support to organisations in recording pathway lengths and redesigning pathways

Involvement of the Business Service Centre

Meetings have been held with the BSC to examine their role in the collection and reporting of RTT times. The BSC has a key role in providing information support to LHBs, and therefore will be in receipt of RTT information from HSW in order to provide this information out to the LHBs. In addition, as identified above, the BSC will receive information from English Trusts in relation to RTT, and will act as a forwarding service in the initial phase to HSW. It is intended that this role will be short term, as the collection mechanism for England is subject to further development.

National Pathway Identifier (NPI)

A concern has been raised in relation to the National Pathway Indicator (NPI) regarding the possibility of this not being a unique number, as it is formed from an amalgamation of four data items; the NHS Number, Specialty code, Trust Code and date of Referral. If two referrals are made on the same day to the same specialty, this number will not be unique. This would be a rare occurrence, but could happen, if, for instance, a patient was referred by their GP for an endoscopy to investigate rectal bleeding and for a hernia repair on the same day.

This will only be an issue for pathways where patients are transferred between pathways and remain on the same pathway clock. A solution for this issue will be discussed with relevant organisations and a proposal developed for the January submission.

LHB Codes

LHB codes were made optional for submission in the initial data collection, as concerns were raised that organisations would find it difficult to include the LHB information in the data submission. However, in practice, this has not proved to be a difficulty. In the August report, of 448,301 submitted records, only 414 did not have an identified LHB. It is therefore proposed that from April 2008 this field will be mandatory for completion.

Transition from Current (GTGP) to Future (RTT) Waiting List Management Rules

The NHS in Wales is currently utilising waiting list management rules outlined in “A Guide to Good Practice” (GTGP) published in 2005 by the National Leadership and Innovation Agency for Healthcare. These rules include guidance on how to treat patient suspensions, and situations where patients fail to attend for an appointment. Under the 26 week target, these rules will change. The details of the rule changes and the rationale for these are expounded within WHC (2007) 075 “Delivering the 26 week Target: Operational Guidelines for Applying the RTT Rules and Definitions”. This section outlines the transition from the GTGP rules to the RTT rules, and identifies how this transition will be achieved. The specific rule changes are:
- DNA / CNA rule changes: Rules regarding the management of DNAs/CNAs have been tightened.
- Medical Suspensions: There will no longer be the facility to suspend from the waiting list for medical reasons.
- Social Suspensions: Where a patient was previously suspended for social reasons, the new guidance allows for an adjustment to be made to the 26 week patient pathway.

Adjustment for Social Reasons
The principle behind allowing for an adjustment of RTT time for social reasons is that of disadvantage. Where a patient makes themselves unavailable for a period of less than two weeks, the NHS provider should be able to absorb this within the pathway. Where the period is more than six weeks, the patient cannot remain on an active list, and therefore should be removed. However, where the period of unavailability is between two and six weeks, neither the patient nor the Trust should be disadvantaged.

To achieve this, the patient must remain on the active waiting list until treated, showing the accurate (unadjusted) waiting time. The patient will then be treated in the appropriate timeslot, and therefore will not be disadvantaged. However, when the pathway is closed, if the patient is in breach of the target, the treating organisation will be able to apply the adjustment, bringing the patient back to a non breach position. This system has a number of advantages over the suspension system. All patients remain on an active waiting list, and therefore patients will not be lost or hidden. In addition, real waiting times are shown across Wales, including all periods of waiting, whether generated by the treating organisation or the patient. Organisations will, however, avoid penalties when the only reason for breach is outside their control (patient initiated).

**Impact of Rule Changes**

There are three areas of significant impact to consider in relation to the transition between rules; the effect on currently reported component waits, the effect on reported RTT waits, and the organisational burden of making the transition. An options appraisal was carried out examining potential methods of introducing the new rules. On the basis of this assessment, the maintenance of ongoing accuracy in both data collections with the lowest level of organisational burden will be best assured by undertaking the rapid implementation of the new RTT waiting list management rules. If this is undertaken through a planned transition process, the integrity of all data collections can be maintained.

The effect of these changes on the ongoing integrity of the component wait data collections is being explored with HSA. The view has been taken that there will be some effect on the shape of the waiting list, with some patients being removed earlier than before (when they would have been medically suspended) and then, on reinstatement to the list, showing a shorter wait than previously noted. Some patient level data has been requested from the BSC to attempt to quantify this effect. HSA intend to append notes to the published data to explain the changes from April 2008, and to provide quantification of the effect after full implementation has been completed.

**Organisational Capability**

An assessment of organisational ability to record a cumulative adjustment period whilst a patient remains on the active waiting list was undertaken by the Access 2009 team with information managers and project managers from each Trust and Powys LHB. This ability will be required for adjustments caused by patient induced delays to the waiting time. The assessment demonstrated that all organisations were able to implement this change, using existing fields used for suspensions to record the adjustments.

**Transition Times**

For each area of rule change, a transition time is required. These are outlined below.

- **DNA / CNA rule changes:** These changes can be introduced at a single point in time – there is no requirement of a transition period.
- **Medical Suspensions (Patients currently suspended):** Organisations will need to validate all suspended patients and either remove them from the waiting list through referral elsewhere (e.g. back to GP, to another specialty) or reinstate them onto the active waiting list. This process of validation will take some time, and it is suggested that a period of not less than six months be allowed for the removal of all medical suspensions. At a point two months before the end of the removal period, no further patients should be medically suspended. This work should proceed in conjunction with the recommendations for each Trust from the Welsh Audit Office Spot Check Reports.
- **Medical Suspensions (Patients reinstated to the active waiting list):** All patients reinstated to the active waiting list following medical suspension (whether as part of the above validation or not) will have an adjusted waiting time (WLD) as a result of that suspension which is allowed under GTGP rules but which will not be allowed under RTT rules. It is proposed that the change on waiting time is allowed for a maximum of 22 weeks after the cessation of the ability to suspend for Medical reasons for the component waiting data return only. This will allow Trusts to treat patients coming off suspension in turn, according to current plans, and would maintain the integrity of the component wait data return, whilst promoting the accuracy of the RTT data return.
• Social Suspensions (Patients currently suspended): As for medical suspensions, organisations would need to validate all suspended patients and either remove them from the waiting list if the period of unavailability is greater than six weeks, or reinstate to the active waiting list and generate a cumulative adjustment period to be applied to both data collections (see below). This process should be completed within four months.

• Social Suspensions (Patients reinstated to the active waiting list): All patients reinstated to the active waiting list following social suspension will have a cumulative adjustment applied for the period of the validated social suspension. These periods should be calculated and recorded at the time of reinstatement, and will apply to both component and RTT waits from the transition date.

**Recommended Timescale for Implementation**

The transition date should be the 1st June 2008. The assessment of Trust ability to record adjustment times and the policy decisions will need to be completed by 1st December 2007, and the six month validation period will be from 1st December 2007 – 2nd June 2008. The 22 week allowance period for including adjustments for appropriate medical suspensions from before 2nd June would therefore end on 3rd November 2008. The full timetable of actions required is shown below (Completed actions greyed out).

<table>
<thead>
<tr>
<th>Action</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proposals to 2009 Board</td>
<td>27th September 2007</td>
</tr>
<tr>
<td>Impact &amp; Ability Assessment of organisational systems</td>
<td>October 2007</td>
</tr>
<tr>
<td>Policy changes agreed</td>
<td>October 2007</td>
</tr>
<tr>
<td>Communication of new rules and transition period to NHS organisations</td>
<td>November 2007</td>
</tr>
<tr>
<td>WIGSB Approval</td>
<td>January 2008</td>
</tr>
<tr>
<td>Validation Period</td>
<td>1st December 2007 – 1st June 2008</td>
</tr>
<tr>
<td>No new suspensions allowed from</td>
<td>1st April 2008</td>
</tr>
<tr>
<td>New Rules Apply</td>
<td>2nd June 2008</td>
</tr>
<tr>
<td>End of allowance period for medical suspensions incurred before 2nd June 2008</td>
<td>3rd November 2008</td>
</tr>
</tbody>
</table>

19. Lessons Learned

Most lessons learned have been covered in the review section, but a summary is provided here.

• Patient level reporting
  o There is no requirement for patient level reporting

• Cross Border Reporting
  o Reporting is possible on the Welsh target from English Trusts using the English definitions
  o Submission from English Trusts should follow the Welsh format

• Data Quality and completeness
  o A number of validations can be applied to the data to provide assurance of data quality
  o Significant ongoing work is required in this area to ensure data is of publishable quality

• Further development of outcome codes
  o There is no business requirement for additional outcome codes

• Stop clocks in other areas
  o There is no requirement for new systems and processes to capture information flows from stop clocks in other areas.

• Review of six months’ experience of Trusts in collecting the data
  o The process of beginning to report RTT pathway times has been highly challenging for all organisations, and the impact continues as training and systems are rolled out.

• Involvement of the BSC
  o The role of the BSC is now clear in the data flows

• National Pathway Identifier (NPI)
  o Further work is required in development of the NPI to ensure it is unique
• LHB codes inclusion in the reporting system
  o LHB codes should be a mandatory inclusion in the reporting system
• Transition from Current (GTGP) to Future (RTT) Waiting List Management Rules
  o The transition is challenging but should be undertaken in the earliest possible timeframe
  o There is an impact upon component waiting times data collections which must be quantified once the transition has been made.

20. Recommendations

It is recommended that the Referral To Treatment Times Data Standard is approved, and proceeds as outlined above.
Appendix 1

Specialties that are used for RTT reporting by Trust

General Surgery  
Urology  
Trauma and Orthopaedic  
Ear, Nose and Throat  
Audiological Medicine  
Ophthalmology  
Oral Surgery  
Restorative Dentistry  
Orthodontics  
Neurology  
Neurosurgery  
Pain Management  
General Medicine  
Gastroenterology  
Endocrinology  
Occupational Medicine  
Rheumatology  
Rehabilitation  
Dermatology  
Thoracic Medicine  
Nephrology  
Paediatric Surgery  
Paediatric Dentistry  
Paediatrics  
Paediatric Neurology  
Geriatric Medicine  
Gynaecology  
Burns and Plastic Surgery  
Haematology (clinical)  
Dental Medicine

Query RTT reporting specialties*

*Final determination is being made against these specialties, and a final list will be appended to the January submission

Clinical Genetics  
Anaesthetics  
Clinical Physiology  
Radiology