North West Anglia NHS Foundation Trust

REPORT TO THE TRUST BOARD (PUBLIC)

TITLE	Referral Assessment System
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DATE OF MEETING	29 March 2021
PRESENTED FOR	Information

PURPOSE OF THE REPORT

The purpose of this paper is to outline the current position of the Trust's waiting lists for outpatients, and processes for adding patients to the RTT incomplete PTL. Highlighting key challenges and actions being taken.

EXECUTIVE SUMMARY

Outpatient waiting list management has been a priority area of focus for NWAngliaFT. Following implementation of Medway, the Trust ceased national reporting of our RTT incomplete position because of significant data quality concerns for a period of nine months.

During wave one of the COVID-19 pandemic; the Trust ceased all routine outpatient activity in line with national expectations. Cancellations commenced on 23rd March 20, in line with national lockdown, through to the end of June 20. As a result, we introduced RAS as a mechanism for patient referral. The rationale for this was to allow for timely triage of referrals given that pandemic delays were likely to be significant on outpatient and elective activity. Usual ERS referral routes (in place pre pandemic) would not have allowed for clinical and risk prioritisation of referrals, resulting in all clinicians requiring to undertake a 1st OPA before being able to determine an appropriate course of action.

There remain a number of outpatient data issues for us to address and this paper seeks to outline both immediate risks and actions, as well as provide an overview of the priority areas for action over the coming quarter.

COMMITTEES/SUBGROUP WHERE THIS ITEM HAS BEEN CONSIDERED

Performance and Estates Committee – 25th March 2021

RECOMMENDATIONS

1. For Trust Board to note the outpatient data issues and associated actions being taken over the next quarter.

STRATEGIC GOALS THIS REPORT SUPPORTS *(Check all that apply)*

Delivering outstanding care and experience	✓
Recruiting developing and retaining our workforce	☐
Improving and developing our services and infrastructure	☐
Working together with local health and social care providers	☐
Delivering financial sustainability	☐

RISKS RELEVANT TO THE PAPER

Risk ID	Risk Description
none	

OTHER IMPLICATIONS OF THE PAPER

Legal/ Regulatory Relevance:	NHS England – Referral to treatment time delivery
NHS Constitution Delivery	Access to planned care waiting services within 18 weeks from referral to treatment
Freedom of Information Release	The following sections of this report should not be released under the Freedom of Information Act 2000.

Equality and Diversity Implications *(Check all that apply)*								
Age	Gender	Ethnicity	Disability	Pregnancy/ Maternity	Marriage/ Civil Partnership	Religion/ Belief	Sexual Orientation	Gender Reassignment
☐	☐	☐	☐	☐	☐	☐	☐	☐
Additional comments								

1. Introduction of the RAS

1.1 During wave one we introduced RAS as a mechanism for patient referral. The rationale for this was to allow for timely triage of referrals given that pandemic delays were likely to be significant on outpatient and elective activity. Usual ERS referral routes (in place pre pandemic) would not have allowed for clinical and risk prioritisation of referrals, resulting in all clinicians requiring to undertake a 1st OPA before being able to determine an appropriate course of action. Given the scale of the cancellations expected during the first wave and likely ongoing implications of COVID on provision and capacity of NHS services, effective and timely clinical prioritisation of referrals was critical.

1.2 Following clinical engagement it was determined by introducing a RAS we could ensure that all referrals were clinically assessed within a reasonable period (<72 hours) and that patients could then be classified (2ww / Urgent / Routine) in order to support priority order of booking and patient management. This approach was introduced specialty by specialty; with all services live (with a small number of exceptions for clinical reasons) by early July.

1.3 One of the known issues with implementation of the RAS is lack of interoperability with our PAS system. IS have confirmed that there is not an automated way (without investment) in which we can merge the two together and the only approach is an individual patient by patient manual one. As such, patients are being managed across multiple waiting lists (including RAS) before being moved onto our PAS. When patients are booked their first appointment and transferred onto our incomplete WL, their clock start is moved across, ensuring that we are recording them accurately from their initial referral date. This will and does result in long waiters 'popping up' on our incomplete PTL.

2. Outpatients Current position

2.1 There are currently multiple separate waiting lists for outpatient appointments that have to be used by teams in order to book appointment slots. The lists comprise of:

- RAS Triage and booking WL
- ASI WL
- OPFU WL

2.2 Please see Appendix 1 for an outpatient process flowchart.

2.3 While patients now being referred via the RAS are triaged quickly (<72 hours) and assigned a priority for booking, patients referred prior to the pandemic and implementation of RAS have not had the same assessment and therefore prioritisation of appointments, across the multiple lists remains a considerable challenge for the booking teams. With the Trust not having returned to 100% of previous years' activity in 20/21, the size of the OP booking WL continues to grow as alongside large volume routine cancellations during wave one and wave two, we have an underlying capacity and demand deficit.

2.4 The table below shows the current position of the RAS WL. This WL captures only 1st OPA requirements following referral from primary care / other routes.

As at 20th March:

RAS WL	Awaiting triage	Awaiting booking	Current average wait weeks for 1st OPA
2WW	8	19	4
Urgent	111	212	14
Routine	561	8,022	24
TOTAL	580	8,253	

As at 6th April:

RAS WL	Awaiting triage	Awaiting booking
2WW	10	16
Urgent	115	272
Routine	1,276	9,800
TOTAL	1,401	10,088

2.5 There is also an ASI (Appointment Slot Issue) list. These patients have been referred, have been triaged via the RAS, have been taken from the RAS WL to book but are now awaiting an appointment date with no capacity available to book. The table below shows the current position of the ASI WL.

As at 20th March:

ASI WL	Awaiting OPA	Average wait weeks for 1st OPA
2WW	59	
Urgent	469	18
Routine	5,624	20
TOTAL	6,142	

As of 6th April:

ASI WL	Awaiting OPA	Average wait weeks for 1st OPA
2WW	120	
Urgent	170	10
Routine	3,877	12
TOTAL	4,167	

2.6 It is important to highlight that neither the patients in the RAS WL or ASI WL are included in the overall Incomplete WL. This is not dissimilar to processes pre COVID pandemic and the introduction of the RAS. Referrals previously would have sat within ERS and the ASI WL. The process both pre and post COVID, remains largely the same. Patients will remain on the ASI list until capacity can be found for the patients. Volumes on the ASI waiting list pre COVID are fairly static to those shown now.

2.7 When patients have their first OP appointment booked, they will then appear on our PAS and are therefore able to be included into our Incomplete PTL Waiting List. The referral is then backdated on Medway to reflect the original referral date. These patients will then appear on our RTT Incomplete PTL. When all of these patients are added, it changes the profile of our incomplete PTL as shown below.

2.8 To put it in to context, if all the patients from the RAS and ASI lists were included in our Incomplete PTL WL, the overall number waiting would increase by 46%. Although the majority (54%) of patients are at 16 weeks or less along their pathway linked to the drop in demand seen in wave one of the pandemic.

2.9 The patients who have appointments cancelled are included in the numbers for ASI, OP WL and follow up reports respectively on CXAir. These are not in addition to those figures but presented here to give context on drivers for the backlog of patients on the WL.

3. Outpatient immediate issues

3.1 NHS Digital (NHSD) have suggested that their systems are not good for managing patient referrals. This is demonstrated when patients reach 26weeks + on the E-Referral System (formerly Choose & Book), they drop off the worklist and are difficult to identify due to only receiving the UBRN (unique booking reference number) for each patient. The UBRN is included in the CXAir report. Patients are retained on our CXair internal ASI report for a period of 18 months, though patients also drop off our lists at this point.

3.2 We currently have >1,100 patients that have exceeded 26 weeks on our ASI list. We cannot at this point, assure ourselves that all of the patients currently on our ASI list require a further outpatient appointment; they may have been seen or transferred to other providers.

3.3 Specialties have to refer to multiple CXAir reports – RAS, ASI, OPWL and OPWL FU in order to know which patients need booking. Outpatient bookers are required to review **four** separate waiting lists held in different systems (CXAir reports, ERS worklist, Medway) in order to gain a single view of patients waiting for a first outpatient appointment. These need consolidating into one WL.

3.4 The pathway start date populated from ERS into Medway creates a discrepancy giving an incorrect pathway start date in Trust systems, requiring manual amendment by the booking team.

3.5 Some trusts have set up a CAS rather than a RAS with a 'ghost appointment', due to concerns that there would be a 'hidden' waiting list within the RAS. Patients are referred into the CAS, triaged, P-scored and placed onto one waiting list to be booked when the capacity is available dependent upon p-score (P1 to P4). There are a handful of ASI's when a patient tries to cancel their ghost appt in the CAS and rebook another. In these circumstances, the patient is contacted to explain and rebook.

4. Wider Outpatient Issues

There are wider discussions required regarding how we are managing patients through the multiple systems we have at the Trust. Whilst discussions have taken place, a larger programme of transformational work is required.

- The recording of outcomes in clinics and admin outcomes at the end of clinic by clinicians and administrative staff, requires more focused actions to clear the currently 14k+ outstanding outcomes.
- Information services have noted that the selections of outcomes available in PAS, are too wide and depending on what is chosen then patients follow up can fall into back holes (e.g. SECM – Secretary to manage).
- A team have been working within the DQ/IS department to validate the Outpatient Waiting List (OPWL). They have so far removed 17k follow up patients as well as

a further 3k new patients that were in the system but for various reasons should not have been. They have also removed 1k deceased patients. Medway does not bulk spine check so we constantly have deceased patients on our waiting lists that require manual input in order to remove.

- The validation team will continue to work with us through to early April to complete additional validation. However, the specialty teams will be required to have input for those that require a review.
- Business process changes were not identified at the time of implementing Medway. This leads to unclear roles and responsibilities on who should be managing the next step.
- We will have to prioritise patients on the OPWL (like we have for IPWL) and there is no clear way to do this and very poor data to work with.
- PAS does not handle follow-up review patients very well and allows for some odd recording that causes issues with WL (eTrack helps solve some of this).
- Both centralised and specialty based booking allows for gaps in patient journeys and different ways of working.
- No agreed KPIs in place yet for outpatient metrics for divisions and OP Management.
- New Ophthalmology referral system coming soon that will introduce another way of getting patients into our systems and waiting lists.
- Still get some paper referrals to deal with so a different process, ScanMan needs some fixes for MS Windows 10.
- ClinicMan although built is not yet rolled out (build, testing and Covid delays), this needs re-introduction and strong push on ways of working.
- Outpatient team have to download letters from ERS, print, scan and then destroy to make available on our systems.

5. Actions to be taken

5.1 Following a cross-divisional meeting on Outpatient data issues in March, we have agreed a number of immediate actions, as well as an approach to a longer-term improvement plan. An OP data task and finish group has been established, chaired by the COO to oversee this activity.

5.2 Short term actions to assure ourselves on the accurate size of the OPWL:

- Validation to remove patients seen by other providers from the RAS/ASI waiting lists to be implemented
- Cross checking of patients on the waiting lists to ensure they are 'real' by the divisions.
- To understand where the additional bookers that were recruited recently are being used.
- To ascertain from NHSD if they can provide more than the UBRN to help us identify the long wait patients.
- Provide clear guidance on how to ascertain patient details for those on the RAS & ASI WL for other divisions to follow.

5.3 Medium term actions agreed to progress with addressing wider OPWL and data issues:

- Identify additional resource to support ongoing validation of the waiting lists.
- Investigate if a process for booking RAS patients directly on to ghost clinics is possible understanding that this will need to be excluded from the OP utilisation report.
- Refine the report for identifying what the Outpatient utilisation is.

- Capacity & Demand to be undertaken to identify what is required going forward – what can be delivered virtual vs face to face.
- Improved IT system and information reporting.
- Review current OP Transformation projects vs more major transformation piece of work required across the Trust.

6. Recommendation

6.1 Trust Board are asked to note the challenges presenting with Outpatient data and the actions identified to make both immediate progress with an accurate waiting list and position and those actions

Appendix One – OP referral / appointment process