18 week Referral to Treatment Target Board Update.

1. Purpose

The purpose of this paper is to describe the steps taken since the October report, to move the Trust towards an accurate reporting mechanism. The paper also explains the key actions achieved from the operational and technical action plan and highlights the next steps prior to the January board meeting.

2. Introduction

As reported in October the Trust had three key issues to address as a result of the IST report and are addressed in the action plans which have been circulated as part of previous board reports. These action plans are monitored fortnightly at the internal 18 week steering group.

A significant amount of work has taken place on systems and processes underlying the recording of 18 week RTT data. This includes the implementation of standard operating procedures at a local specialty level and a revised Trust wide access policy which has now been signed off by the Clinical Commissioning Groups.

Local training has occurred with an external 18 week project manager staff working on a day-to-day basis on the 18 week pathway. Additional training is being provided on 26 November by NHS IMAS for multidisciplinary staff groups, to ensure there is an understanding of the broader 18 week rules and the fit of this with the NHS constitution.

At recent staff open forums, David McVittie Chief Executive was clear that the culture of the organisation is to be patient safety and quality focused, ensuring that all staff feel able to do the right thing. The management team reiterate this message at local staff meetings.

The operational teams are not only working on the task focused action plans but also on the following three issues which work towards recovery of the 18 week RTT target:

1) Independent Review of Quality and Safety
2) Capacity and Outsourcing
3) Data Quality

3. Independent review panel

The Trust Board and NHS England London Region has authorised the External Review panel to undertake a review of the issues emerging from the backlog in patients on the 18 week wait non-admitted RTT pathway. In particular; the panel will ensure that no patient has experienced significant clinical harm as a result of delays, explore the causes for the incident and provide assurance that pathways have now been validated and causes rectified.

This is in the context that a Diagnostic review by the Intensive Support Team has looked at factors which caused and contributed to the backlog in patients on the 18 week wait non-admitted RTT pathway. Many of the recommendations and actions of this review have been undertaken as part of a comprehensive action plan.

3.1 Membership of the External Review Panel

- Susan Labrooy – Independent Medical Expert (Chair)
- Caroline Corby - Non Executive Director, NWLHT
- Chris Pocklington – Chief Operating Officer, NWLHT
- Tina Benson – Director of Operations, NWLHT
- Nigel Coomber – IST
- Bernard Quinn, CSU
- Kevin Connelly – Director of IT, NWLHT
- Sean McCloy – Head of Performance – NWLHT
- Carol Mattock, CCG
- Sarah German, CCG
- Catherine Thorne, Director of Governance NWLHT
- 2 x Medical Representatives (TBC)

3.2 Frequency

The group will meet monthly

3.3 Objectives and Aims

The review will also consider, but is not limited to:

1. The response to the discovery of a backlog within the 18ww pathway from all those involved.
2. The response to provide assurance around the 18ww pathway and other similar operational issues.
3. To gain assurance with regard to dealing with the backlog of patients and gaining an understanding of the current length of patient waits.
4. To provide assurance that the action plan developed in conjunction with the IST is fully implemented.
5. Make recommendations to further work from other matters considered by the panel e.g. cultural issues.

The Investigation will consider any lessons to be learned and make recommendations with respect to an action plan for improvement.

3.4 Reporting

The Report of the investigation will be presented to the Trust Board of North West London Hospitals NHS Trust at the end of January, and once accepted, will be made public to key external stakeholders including NHS England.

Pending the final report, any interim recommendations requiring urgent action will be published as soon as possible.

4. Capacity and Outsourcing

Part of the work carried out by the Trust and IST identified a significant mis-match in the number of patients that are currently waiting for treatment on the Trust waiting list and a sustainable waiting list size based on the demand coming through. The Trust has reported that is has had 4400 patients on the admitted waiting list and this number needs to be 2000 to reach a sustainable balance. The Trust also has 801 (189 undated as of 3/11/13) patients currently waiting over 18 weeks and a further 328 undated above 16 weeks.

4.1 Capacity Demand work

The Trust carried out some preliminary work in a number of key specialities[1] with technical support from the IST, to understand the capacity required in each of these specialities to achieve a compliant pathway. This work has informed both the internal capacity plan increase and the Trust's draft trajectories for 18 weeks. For the majority of specialities, this showed a mis-match in capacity against demand.

4.2 Trust Capacity Increase (Internal)

The Trust has historically carried out waiting list initiatives and continues to carry them out during 2013/14. Mindful of the capacity demand work the Trust is currently working toward increasing the capacity which is outlined in Appendix 1. The work has focussed on increasing elective capacity at CMH and emergency capacity at NPH (not included in this paper).

4.3 Trajectory

The increase in capacity has been mapped and has identified that for the majority of specialities who are currently failing the admitted performance target of 90%, a return to performance will either take a significant length of time or performance is not due to return into positive balance. The trajectories show a remaining imbalance across a number of specialities after the Trust has delivered additional activity. This means there is a residual gap in capacity which the Trust cannot meet on its own.

4.4 Meeting the Residual Gap

In order to improve the timescales to achieve waiting list sizes by speciality that are closer to their sustainable waiting list targets, the Trust and CCGs have agreed a process for outsourcing patients. There are many different methods for delivery however this paper will focus on the agreement to outsource at two points:

1. 16 weeks and above undated
2. At the point of decision to admit.

[1] General Surgery, Trauma Orthopaedics, OMFS, Ophthalmology, ENT.

4.5 Patient Selection for outsourcing

The patient group will be selected from all specialities that have patients on the admitted waiting list. The exclusion criteria are patients who are:

- cancer
- tertiary
- complex
- revision surgery
- already dated by the Trust
- clinically urgent (patients requiring treatment within 4 weeks)

The Clinical Directors have been consulted on the patient procedures that are currently undated across their specialities to ensure any specific procedures are clinically contra-indicated for outsource.

The patients have been selected as a one off large group to take into account the start of the process with a priority on the longest waiting patients (patients waiting >16 weeks). The process would then continue on a weekly basis looking at new patients added to the waiting list in the last week and those reaching 16 weeks without a date.

Patients sent from <12 weeks would expect to be treated before 18 weeks at the alternative provider.

Patients would only be selected from specialities where there are RTT performance issues.

The Trust will send an agreed letter to the patients identified. This will explain the process and ask the patients to contact the Trust on a dedicated phone line if they wish to keep their treatment at the Trust. The letter will also contain information regarding the consent to transfer of the patient's information to another provider. A patient tracker list will be shared between NWLHT, CSU and the alternative providers on a weekly basis to ensure all patient sent for outsourcing are receiving care in a timely manner.

4.6 Reporting

NWLHT will report the performance statistics of all the outsourced patients to other providers. The CCGs, CSU and the Trust would need to ensure that both NWLHT and the providers manually update the same information so that the performance is removed from the external provider and is shown

4.7 Outsourcing outcomes

The Trust is increasing the overall capacity for theatres to manage both emergency and elective pathways. Overall the Trust is increasing the elective capacity by 87 theatre lists per month by the end of March 2014; however this will not meet demand across a number of specialities.

The outsource proposal allows the Trust to reduce the overall sizes of the waiting lists across the specialities by utilising capacity at other centres. The Trust will report both the positive and negative performance results from this activity undertaken on its behalf.

There will be a positive reduction in the overall size of the waiting list which will depend on the success of the outsource process. The Trust will have maintained its existing theatre schedules through booking the volume of work not outsourced on the waiting list.

5. Data Quality

In order to provide additional assurance the Trust has asked KPMG, as part of the merger assurance work, to support a data quality audit at NWLH NHS Trust.

5.1 Scope of review

Indicators within scope:

- A&E 4 hour waits
- 18 week waits
- Cancer wait times

All these indicators involve administration processes and data primarily from the PAS.

5.2 Approach.

1) Initial high level look at the scope of people / technologies involved in producing metrics – focus the work on areas of perceived higher risk.
2) Understand the end to end process for producing the indicator.
    - Flowchart - Input / Process / Output / Control
3) Assess the level of risk within the process that could undermine the quality of the indicator. Consider key risk indicators such as:

    - Manual steps in process
    - Inconsistencies in the process & manual workarounds
    - Level of automated validation of source data
    - Completeness of data and confidence
    - Data ownership
    - Data reconciliation / controls
    - Use of MS Excel in process
    - Documentation and shared understanding of process

Potentially KPMG could run some data extraction tools to assess quality of existing data (Number of items with missing data fields etc.) they would need to agree the rules with the Trust.

5.3 Key considerations

A&E 4 hour waits

- Likely to be based on the least number of systems (could all be done through a single A&E PAS for example).

18 week waits

- Likely to involve many systems, people and processes.
- Consider whether scope can be narrowed to focus on key risk areas.

Cancer wait times

- Subset of the 18 week wait.
- Need to understand the breadth of people / systems involved.

5.3 Timeframe.

KPMG have been engaged to report in time for the January Trust board.

5.4 Outcomes of data quality review.

It is anticipated that further issues with the Trust data quality may be found through this process of examination, both driven internally by continued work in relation to the technical action plan and by the KPMG review.

An issue has already been identified internally with a subset of Urology patients and further investigation is underway across all areas of waiting lists to ensure that all issues are identified at the earliest possible opportunity.

6. Communications

The Trust communication plan including all stakeholders has been undertaken successfully and the Trust will continue on-going communications as needed.

7. Board assurance

All areas of service are working hard to complete all waiting list validations including those which fall outside 18 weeks and this work is expected to be complete in the next two weeks. Following on from this, increased assurance will be delivered with the outcome of the two external reviews described in this paper.

8. Conclusion

All investigations and reports will be available for the January board in full with a summary paper to pull the outcome of the reports together and support an action plan for full recovery and assurance where required.

Tina Benson
Director of Operations
November 2013.