North West London Hospitals Trust

18 week RTT Outsourcing proposal

1.0 Background

The Trust is currently working through an improvement programme for 18 weeks, which started with an IST diagnostic review in June 2013. 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.

2.0 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 these specialities to achieve a compliant pathway. This work has informed the both the internal capacity plan increase and the Trust draft trajectories for 18 weeks. For the majority of specialities, this showed a mis-match in capacity against demand.

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

3.0 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).

4.0 Trajectory

The increase in capacity has been mapped which 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 in-balance across a number of specialities after the Trust has delivered additional activity. See Appendix 2.

Work continues to confirm the accuracy of the trajectory which will be reforecast after 4 weeks in order to provide better assurance to the Commissioners that the figures reported are becoming more reliable and to assess the impact of the outsourcing volumes.

5.0 Meeting the Residual Gap

In order to improve the timescales to achieve a waiting list sizes by speciality that are closer to their sustainable waiting list targets the Trust and CCGs are agreeing 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 treat and addition to the admitted patient waiting list.

6.0 Outsourcing Process

6.1 Patient Selection

The patient group will be selected from all specialities where there are RTT performance issues who have patients on the admitted waiting list. The following exclusion criteria should be applied:

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

The Clinical Directors will be consulted on the patients that are currently undated across their specialities to ensure any specific procedures that are clinically contra-indicated for outsource remain with the Trust.

The patient will be initially selected as 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). This will begin on 20 November 2013. The process will then continue on a weekly basis pulling forward 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.

6.2 Patient Tracking

Code change **-** Once selected the patients would be coded using the National guidelines code for provider to provider transfer. The Trust will have an "Outsource PTl" which will be reviewed weekly which will track the patients that have been identified as potential transfers. The patients will not show on the Trust's weekly PTL monitoring sheets, which will prevent any duplication of process in terms of appointments/booking. The Outsource PTL will identify this specific cohort of patients by using ICS free text boxes to identify them as well as the specific external providers used in the outsource process.

Letter to Patients **-** 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 be a positive response letter, i.e. If patients do not respond back to the Trust, the Trust would treat this as consent to transfer to another provider. The letter will also contain information regarding the consent to transfer of the patient's information to another provider. The Trust will have a dedicated team to monitor the trackers and receive phone calls from patients. The letter is shown in Appendix 3 PDF file. Any patients wishing to remain with the Trust will have the code changed back to an internal code and will remain on the waiting list not disadvantaged by this process.

Provider to provider **-** The patient tracker list will be sent to the external provider weekly in agreed formats which will be the same for all external providers. This will be updated by the external providers twice a week providing the Trust with up to date information of appointments and admission dates. The provider will contact the patient for their appointments to receive their treatment. Any patients who wish to return to the Trust or need to return for valid clinical reasons

will be identified on the tracker and the code will be changed and the patient returned to the Trust waiting list, not disadvantaged by this process.

The Trust will send the minimum data set and agree with external providers on the relevant medical information required by the external providers. Where possible the Trust will copy the relevant patient medical records and send by secure fax/courier. In exceptional circumstances the Trust will send the original copy of the notes. Relevant diagnostics will be shared on the inter Trust image exchange portal or direct on CD or to a secure fax.

Access Policy **–** The Trust's Access Policy has been revised and as soon as this has been agreed with CCGs will be shared with the providers and they will be expected to follow the same process that would happen in the Trust. This would ensure that the principles that patients should be fit, willing and able to receive their treatment are adhered to.

Admission criteria **–** If the external provider clinician feels that the treatment choice decided on by the Trust Consultant is not in the patients best interest at the time of the consultation at the external provider the patient should be discharged to the GP with the appropriate management plan. Where there are clinical exceptions the external provider Clinician should seek to contact the NWLHT Consultant.

6.3 Reporting

In normal circumstances the National rules concerning provider to provider allows for the 18 week pathway to be handed over the receiving Trust and that Trust counts the admission and corresponding performance. In exceptional circumstances and with commissioner support providers can agree to "manually" adjust the performance statistics sent to UNIFY2 to reflect that the performance was of the original Trust.

This paper proposes that the NWLHT reports the performance stats 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 in the NWLHT UNIFY2 dataset.

7.0 Outsourced inclusions

The outsourcing will include all elements of the patient pathway after decision to treat. This is not limited to but would include Out-patient (as appropriate) and pre-op attendances, Treatment, post-op follow up and any subsequent rehabilitation in the community if this is required. The contract will also include translation services, transport and any other associated support service required to treat the patient. The providers will ensure that any notes associated with the treatment are copied and returned to the Trust to insert back into the patient notes. Where patient's treatments are part of the PPWT or IFR process, the agreement for payment for these procedures is between the CCGs and other Providers involved in this process. The NWLHT will send the PPWT or IFR request to the NWLCSU team as normal.

8.0 Resources Required

The Trust will set up a dedicated area to manage this process. It will require the skills of senior staff internally from both information and the Access teams. The overall resource will be:

- 1 WTE Band 2 Medical records
- 1 WTE Band 3 Access Centre Support staff
- 1 WTE Band 3 Radiology records management.

This will be monitored and may need to increase as the complexity and numbers of providers increase.

The CCGs have agreed funding for a lead for this team to work within the Trust and a programme manager from the CSU to oversee the overall process, maximise appropriate uptake and take action as required, assuring the process and progress of the outsourcing scheme in delivering the anticipated benefits for patients and resultant reductions in waiting times.

9.0 Risks

A number of risks have been identified both to the success of this process and in the process itself. These have been identified in a table in Appendix 4 with the largest risk remaining with the volume of patients that are likely to be choose to be treated elsewhere, risk score 12. This was noticeable when the Trust last carried out this process in February 2012.

10.0 KPIs to be agreed with CSU

This section is to be finalised between the CCGs / CSU and providers.

The following key performance indicators have been identified to monitor progress:

Indicator	Target	Action for underperformance
Number of patients accepting another provider	70% (TBC)	CSU/NWLHT/Provider meeting. Review letters, review phone calls and tracker log for decline reasons. Action plans to mitigate
Number of patients once accepted receiving treatment	90% (TBC)	CSU/NWLHT/Provider meeting. Review tracker log. Action plans to mitigate.
Treatment within 4 weeks	60% (TBC)	CSU/Provider meeting
Treatment within 6 weeks	98% (TBC)	CSU / Provider meeting
Return time for referral back to Trust if clinically appropriate (max 2 weeks)	95% (TBC)	CSU / Provider/ NWLHT meeting. Exception report and action plan.

The CSU programme manager will monitor the KPI standards once agreed, raise underperformance with the providers, report back on requirements to NWLHT and to the CCGs and take forward actions to address shortfalls.

11.0 Conclusions

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 outsourcing allows the Trust to reduce the overall size 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 on the outsource process and the Trust will have maintained and maximised its existing theatre schedules through booking the volume of work not outsourced on the waiting list.

12.0 Recommendations

It is recommended that the out-sourcing process commences with the first list of patients on 20th November 2013.

It is recommended that the Trust 18-week steering group monitors progress and takes action within the Trust where required to ensure that it succeeds.

The overall scrutiny of the delivery and success of the programme will be maintained by the CCGs and the CSU.

Authors:

Sean McCloy, Head of Performance

NWLHT.

Liz McLean

Interim Account Director

CSU

14th November 2013.

Appendix 1 – Admitted Capacity Increase

October 21st 2013 **Location CMH.**	**Extra lists / 4 week month**	**Est. Increase in Patient per month**	**Achieved (Y/N)**
ENT	2	6	Capacity used by Gen Surgery and Urology up to end of November.
OMFS	3	9	Y
Ortho	8* * previously CEPOD and trauma	12	Y

Capacity to be delivered by Trust:

Plan start date 4th November 2013 **Location CMH**	**Extra lists / 4 week month**	**Est. Increase in Patient per month**	**Achieved (Y/N)**
Ophthalmology	8	32	Y
Plan start date 15th December 2013 **Location NPH**	**Extra lists / 4 week month**	**Est. Increase in Patient per month**	**Achieved (Y/N)**
Colorectal	4	10	N
Plan start date 31st January 2013 **Location CMH**	**Extra lists/ 4 week month**	**Est. Increase in Patient per month**	**Achieved (Y/N)**
ENT	10	30	
OMFS	4	12	
Ortho	26	52	
Gen Surg	8	24	
Vasc	2	6	
Urology	4	12	
Plan start date 15th March 2014 **Location NPH**	**Extra lists/ 4 week month**	**Est. Increase in Patient per month**	**Achieved (Y/N)**
OMFS	4	12	

Gen Surg	4	12	

Planned Outsourcing volumes:

Provider Name	Total Volumes (@08.09.13)	RNTNE	Chelwest	THH	BMI
GENERAL SURGERY	402		60	141	201
UROLOGY	264			132	132
OMFS	475		190	190	95
COLORECTAL SURGERY	355		142	142	71
VASCULAR SURGERY	131			79	52
TRAUMA & ORTHOPAEDICS	879		293	293	293
ENT	866	736			130
OPHTHALMOLOGY	245			49	196
GYNAECOLOGY	544		218		326
Totals by Provider	4161	736	903	1025	1496
Overall percentage split	100%	17%	21%	24%	35%

Outsourced costs and average prices:

Based on avg waiting list for NWL hospital

Specialty	Activity	Cost
Colorectal Surgery	130	£370,496
ENT	348	£568,549
General Surgery	148	£235,894
Gynaecology	205	£270,360
Ophthalmology	30	£26,481
Orthodontics & Maxillo-Facial Surgery	166	
Trauma & Orthopaedics	368	£1,154,046
Urology	65	£68,350
Vascular Surgery	40	£71,922
Total	**1500**	**£2,766,098**

Based on best waiting list position across NWL hospital

Specialty	Activity	Cost
Colorectal Surgery	173	£493,995
ENT	465	£758,065
General Surgery	197	£314,525
Gynaecology	273	£360,479
Ophthalmology	40	£35,308
Orthodondics & Maxillo-Facial Surgery	222	
Trauma & Orthopaedics	490	£1,538,728
Urology	87	£91,134
Vascular Surgery	53	£95,896
Total	**2000**	**£3,688,131**

Appendix 2

Trajectories	Orthopaedics	General Surgery	Colorectal	OMFS	ENT	Ophthalmology	Gynaecology	Vascular	Urology
Current Core	1392	580	616	671	986	603	898	415	712
Regular excess	176	431	412	319	240	263	357	32	151
Proposed actions	150	85	18	57	68	42	18	0	5
Sub-total	1718	1096	1046	1047	1294	908	1273	447	868
W/L as at 8th Sept	879	402	355	475	866	245	544	131	264
additions - usual	1456	1031	1153	1152	1335	971	1335	455	1001
additions from OP backlog	22	74	67	78	194	90	0	29	51
Validations	53	24	0	48	75	0	12	15	18
Sub-total	2304	1483	1575	1657	2320	1306	1867	600	1298
w/l as at 31st Mar									
all above actions	586	387	529	610	1026	398	594	153	430
core only	912	903	959	986	1334	703	969	185	586
core & excess	736	472	547	667	1094	440	612	153	435
Sustainable target	285	163	145	206	303	196	213	67	159
Distance from sustainable target as at 31st March									
all above actions	301	224	384	404	723	202	381	86	271
core only	627	740	814	780	1031	507	756	118	427
core & excess	451	309	402	461	791	244	399	86	276
Date target met with current actions	***Aug-14***	***Dec-14***	***Does not***	***Does not***	***Jan-19***	***Jan-16***	***Does not***	***Dec-17***	***Does not***

Appendix 3

Letter to patients.

Patient letter template.pdf

Appendix 4

Risk	Likelihood	Consequence	Score	Mitigation	Residual
Small numbers of patients will take up opportunity to transfer.	4	4	16	Utilisation of same Consultant at BMI Provider staff telephoning, Greater awareness of patient rights.	12
Patients will complain that their data has been shared with another provider.	3	4	12	Letter to contain information on intent to data share. Patient has to communicate in order to retract this.	6
Patients information will be lost from the Trust waiting list therefore patient won't be contacted by either provider delaying their care.	2	4	8	Pathway supports staff data entry, only trained staff to use Trust ICS system. Senior staff to oversee process.	2
The Trust will lose visibility of the patients once they are transferred to another provider risking that a patient could fall in a gap of communication delaying their treatment.	2	4	8	There will be a separate patient tracking list for outsourced patients which will track patients moving forward. List will identify the specific cohorts in this group using freetext to uniquely identify them. The Trust will also have a tracker with external providers tracking updates on patients.	2