18 Week RTT Clinical Review Process

Background:

Following the recent IST diagnostic and publication of their findings, the Trust has identified the need to look at the large number of patients who were waiting over 18 weeks as a result of recording the correct overall waiting time.
The Trust needed to ensure that patients waiting longer than 18 weeks had a clinical review to determine whether there is a risk of harm to a patient due to the length of wait for their procedure. The review primarily focussed on any patients who had waited due to unnecessary delay rather than due to clinical or social reasons for delay such as patient choice or planned procedures.

Methodology:

The Trust agreed two methods of review with the CSU/CCGs.

Internal Process:

Patients waiting over 52 weeks: The Trust completed root cause analysis of the length of the waiting time identifying key reasons for the delay in treatment as well as a clinical view on any potential harm due to the length of wait.

Patients waiting over 18 weeks: The Trust completed a clinical view of the patients that were currently waiting over 18 weeks for their procedure during September 2013. There was a two-step process.

Step 1: A retrospective review which identified patients who as of 1st September 2013 have waited longer than 18 weeks. Clinical Directors and Clinical leads were sent the patient level data by speciality and feedback was required on patients who required clinical expediency due to the length of time waiting for their procedure, patients who were routine and still require treatment but in line with current wait, and patients who didn't require treatment due to clinical/non-clinical reasons.

Step 2: The development of a prospective review which identifies patients that move past the 18 week target on a weekly basis. This process will allow the Trust to proactivity review the types of procedures that waiting beyond the 18 week target and appropriately prioritises the patient's procedure date. The data will be reviewed during at a weekly meeting involving the Medical Director, Director of Operations and/or Head of Performance and will involve Clinical Directors and Clinical leads as required. Start date w/c 30th September 2013.

Review of mortality rates whilst on the waiting list: The Trust reviewed the number of patients who were over 18 weeks whilst waiting for a procedure and were removed from the waiting list as a result of dying. It compared the current year to previous years to understand if there are any trends that require investigation. The primary causes for a patient's death across 2012/13 and 2013/14 were reviewed to see if this is related to the procedure they were waiting for.

The Trust invited an external Medical Consultant/Director to review/assess our current processes for clinical review. The aim was to provide assurance that the Trust has put in the place appropriate measures to ensure clinical review of long waiting patients.

External process:

The Trust agreed with the local CCGs, Brent and Harrow and the CSU that it would send patient level information to GPs across all CCGs. The data was in an agreed format and the patients will be live on the system and were currently waiting on the Trust's inpatient waiting list. The patient level detail was sent via post with the request for the GP to review their patient's that were currently waiting and contact the Trust if they wished to update us on the priority for their patients.

Results review process

The clinical review process will be reviewed by the Independent review panel which is planned to meet in January 2014. The panel will assess the level of scrutiny that the Trust has undertaken as well as the results from the internal and external process.

Once assessed the results will be shared with the Trust Board and wider LHE.

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Date: 13th January 2014.

Northwest London Hospitals Trust – Capacity

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 reported that it had 4400 patients on the admitted waiting list and this number needs to be nearer 2000 to reach a sustainable balance. The Trust also had 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, Opthalmology, 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. From the initial review of demand and capacity the Trust has planned to increase its own internal capacity with the majority of additional work being carried out at Central Middlesex Hospital. The provisional increase in capacity is identified in Appendix 1.

4.0 OutSource Process

To support the Trust, the CCGs have agreed to fund additional capacity through an outsourcing process. The providers were chosen with the support of the CSU and CCGs. These are:

- BMI Healthcare group (BMI)
- The Hillingdon Hospitals Trust (THH)
- The Royal National Throat Nose and Ear Hospital. (RNTNEH)

The process started in November 2013 and the outline of how this was set up is explained below:

4.1 Patient Selection

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

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

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

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) 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.

4.2 Patient Tracking

***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, ie. 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 2. 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.

4.3 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.

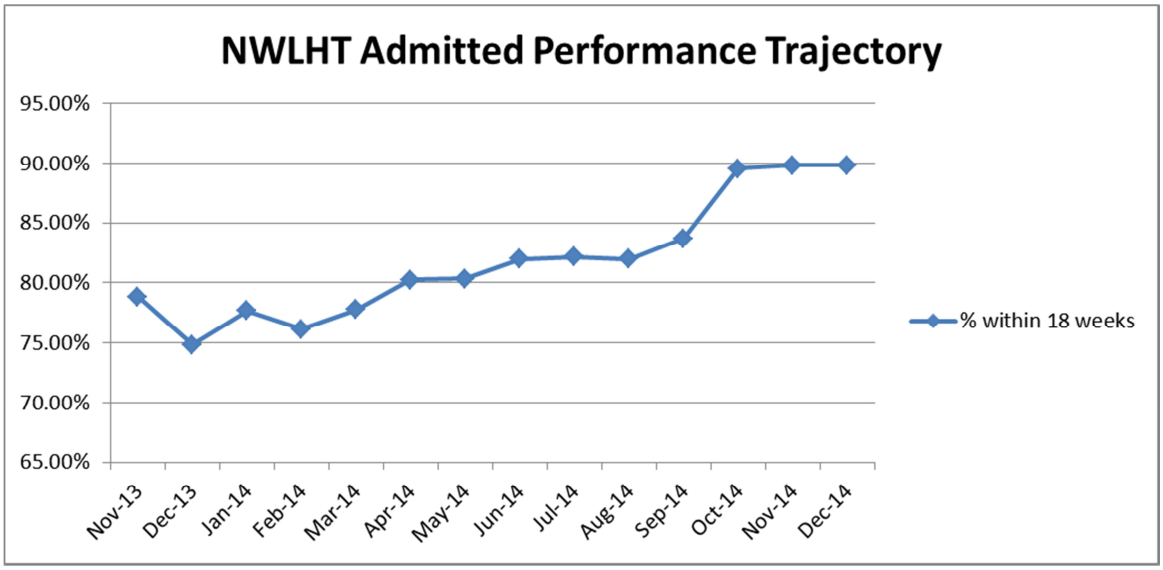
This paper proposes that the NWLHT reports the performance stats of all the outsourced patients to other providers. The CCGs, CSU and the Trust would need to ensure that both NWLHT and the providers manually update the same information so that the performance is removed from the external provider and is shown in the NWLHT UNIFY2 dataset.

5.0 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 3 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.

6.0 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. Where this is the case, the Trust and CCGs are working on further plans to deliver the required capacity. This will include further expansion of CMH capacity and a review of theatre capacity at NPH for those specialities which can only operate at that site.



7.0 Progress.

To date the Trust has identified and written to 985 patients through this process. Of which 819 patient details/records have currently been sent to the providers. The providers are now in the process of booking these patients into clinics, pre-assessment and offering treatment dates. The Trust and the CSU are currently collating data regarding further detail on the process.

The Trust currently has under 3800 patients on the waiting list with under 700 patients waiting over 18 weeks.

8.0 Capacity Demand Modelling

The Trust completed some initial modelling work across a small number of specialities using the Intensive Support Team's (IST) published model. This helped form some early views that led to the increase in capacity as already identified earlier in this document. The Trust is currently working in collaboration with the CCGs on a "flow through" model which joins up capacity/demand and activity modelling across the 18 week pathway. This will help provide summary data on the available capacity to see new out-patient appointments, follow-up appointments and for patients who need treatment on waiting lists.

This work is planned to achieve model outcomes across five key specialities Orthopaedics, ENT, Gastro, General Surgery and Urology by the end of February 2014.

9.0 Conclusions

The Trust is increasing the overall capacity for theatres to manage both emergency and elective pathways. Overall the Trust is planning to increase 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. Good

progress has been made to date with a small level of attrition resulting from contacting patients. However this is expected to increase as providers contact the patients.
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 its existing theatre schedules through booking the volume of work not outsourced on the waiting list. This is already starting to be evidenced in section 7 of the paper.

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13/1/14

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 in by Gen Surg and Urol up to end of November.
OMFS	3	9	Y
Ortho	8* * previously CEPOD and trauma	12	Y

Capacity to be delivered:

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	

Appendix 2

Patient letter template.pdf

Appendix 3

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 wont 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 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	The Trust will introduce a separate patient tracking list for outsourced patient which will track patients moving forward. It 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

Summary – Urology serious incident

Northwest London Hospitals Trust uses a "planned" waiting list as part of the processes used to manage patients waiting for procedures. This is in line with National guidance and rules for the 18 week referral to treatment (RTT) target. The planned list is used for patients who need procedures that cannot clinically be carried out until a period of time elapses or other processes are required to be done first. The planned list is often used to manage patients who require surveillance procedures which occur over years. Through validation of the RTT pathways for the Trust, personnel in the Access Centre confirmed that a number of patients under Urology had been booked onto a planned waiting list for a diagnostic/cystoscopy procedure, but that they had never been offered/given a date. Following a review of Urology patients on the planned waiting list in October 2013 there were a total of 196 patients identified as waiting over 10 weeks for a flexible cystoscopy appointment. This is the group of patients that were reviewed by clinicians in Urology for either urgent follow up in the department or update on PAS to reflect their correct clinical status.

Review process

An internal Consultant agreed to lead the review process supported by experienced Registrar level medical staff.

1. Clinical review lead – Mr Rajesh Kavia, Consultant Urology (Year 2)
   Clinical reviewer – Ms Hazel Ecclestone, Specialist Registrar Urology ST5
   Clinical reviewer – Mr Iqbal Sahibzada, Specialty Trust Doctor Urology (ST4 equivalent)
   Patient data provided by Ms Catherine Endeley-Brown, General Manager

2. Quality assurance checks were managed by Mr Rajesh Kavia who had oversight of the data files used to manage the clinical feedback for the patients identified through this process

3. The clinical reviewers cross-referenced the information from the data file to that of ICS PAS and the Generic ICS system. This enabled patients to be validated from the clinical data available on GCIS against the status held for them on PAS. Where this information was insufficient, there was a request to bring the patient back to an outpatient clinic for further clinical review. All patients were reviewed by the clinical team and any decisions taken regarding their outcomes was based on the clinical information available at the time of review.

Results

The Trust is currently collating the results of the review process and clinics that were set up to see the identified patients. These will be reviewed through the Independent panel to provide assurance that the clinical review was appropriate with a final report to the Trust Board.

CCG Position

Cllr Daly Question: How is this capacity issue going to tie in with changes and current under-utilisation of CMH and how can CMH best be used to address this?

Brent CCG Response: Brent CCG supports the development of an elective centre at CMH for Ealing and NWLHT surgery. In addition Brent CCG supports the development of an elective orthopaedic centre at CMH. Both initiatives will ensure theatres at CMH are used to

full capacity and protect elective activity from emergency pressures that can occur where an A and E is on site.

Cllr Daly Question: (with input from SaHF if needed): Can you explain why/how there will still be capacity once there have been an extra 900 hospital beds closed across NW London.

Brent CCG Response: The demand and capacity study for elective activity will help the CCG and Trust to appropriately plan for sufficient capacity to meet demand at NWLHT. The CCG is committed to commissioning sufficient capacity to meet demand. The Trust is establishing the right balance between outpatients, theatre and bed capacity. The planning for implementation of SAHF ensures that no changes take place without ensuring there is sufficient capacity across the health economy to where services will be relocated.