West Hertfordshire Hospitals NHS
NHS Trust

Trust Board - 28 November 2013

Title of the Paper:	18 weeks Referral to Treatment (RTT) Recover Plan
Agenda item:	**TB Item 88/13**
Author:	Bernadette Bluhm. Interim Chief Operating Officer and Deputy Chief Executive.
Trust Objective:	Achieve continuous improvement in the quality of patient care that we provide and the delivery of service performance across all areas

Purpose
To inform the Board of the current position of the 4 underperforming specialities (Orthopaedics, Ophthalmology, ENT and Pain)
To provide the Board with assurance that the capacity and demand model will enable the Trust to effectively manage the 18 week RTT and develop recovery plans that are developed with the support of accurate data at speciality level.
To inform the Board of the recommendations made by the national 18 week Intensive Support Team (IST) following a diagnostic review of 18 week reporting and recording processes carried out in September 2013. The diagnostic visit was commissioned by the Chief executive Samantha Jones.

Previously Discussed And Date For Further Review (list relevant committees)
Trust Leadership and Executive Committee

Benefits To Patients And Patient Safety Implications
Failure to treat patient's within 18 weeks poses potential risks to patient outcomes.

Risk Implications for the Trust (*including any clinical and financial consequences):*	**Mitigating Actions** *(Controls):*
Inability to see and treat patients within the required times frames for both admitted and non-admitted pathways. Financial penalties for failure to see and treat within the required time frames. Risk of financial penalties for patients who may have to wait for longer than 52 weeks.	Weekly PTL meeting now is place. Weekly speciality reviews now in place. Capacity and demand modelling being completed for all specialities. IST assignments to the trust to support the delivery of 18 weeks.

Links to Board Assurance Framework, CQC Outcomes, Statutory Requirements
The delivery of the NHS constitution and the national 18 week RTT operational standards (90% admitted, 95%non-admitted and 92% incomplete)

Legal Implications: (if applicable)
N/A

Financial Implications (if applicable)
These will be identified subject to discussions with the Herts Valleys Clinical Commissioning Group

Communications Plan (if applicable)
N/A

Recommendations

The Board is asked to:

- note the IST report on 18 week RTT information and reporting systems.
- support the process for speciality back log clearance that will treat patients in chronological order, noting that this will mean that performance for these specialities will remain below the operational standard and may worsen before recovery is achieved.
- support the proposal that subject to CCG approval and full financial costing, the Trust will deliver a recovery program that requires significant outsourcing to approved third party providers.

West Hertfordshire Hospitals NHS
NHS Trust

Agenda Item: 88/13

Trust Board 28 *November* 2013

Referral to Treatment (RTT) demand and capacity modelling/recovery plan

Presented by: Bernie Bluhm, Interim Chief Operating Officer

1. Purpose

1.1 To outline to the Trust Board the recent work on 18 weeks and support from NHS Interim Management and Support (IMAS) with developing speciality level demand and capacity models.

1.2 To brief and provide detail on the draft recovery plans for delivering the 18 weeks standards.

1.3 To make the Board aware of the risks, timelines and potential costs to these recovery plans.

2. Background

2.1 Over the last year, the Trust's speciality level Referral to treatment (RTT) performance has varied, with mainly the same four surgical specialities struggling to deliver the RTT operational standards (90% admitted, 95% non-admitted and 92% incomplete performance) – see appendix 1. During this time, due to the weekly capacity gaps (which have been verified by the Interim Management and Support (IMAS) work, the total waiting list sizes for these specialities have continued to grow.

2.2 Over the last few months the Trust had identified a number of issues and concerns relating to RTT and the delivery of the operational standards:

2.2.1 Poor information and reporting systems to support RTT delivery.

2.2.2 Raising of a serious incident concerning 6,000 patients "missing" from waiting lists.

2.2.3 Poor speciality performance against the three operational standards (admitted, non-admitted and incomplete).

2.2.4 No detailed demand and capacity analysis previously conducted at speciality level

2.2.5 Variation in the implementation of operational processes on patients pathways.

2.2.6 Variation in knowledge of the national RTT rules and local interpretation through the access policy (management of Did Not Attend (DNA)s and cancellations).

2.2.7 Variation in validation resources and use of the RTT patient tracking list (PTL).
2.2.8 Loose performance management systems in place at speciality level.
2.2.9 Little or no clinical engagement concerning leadership and understanding of RTT pathways and performance.

2.3 NHS IMAS was asked to support the Trust with detailed demand and capacity analysis for four surgical specialities which are currently failing the RTT operational standards. This was for both outpatients (first appointment) and admitted pathways. The aim of the work was not only to provide the services with an overview of their weekly demand and capacity, but also to start constructing recovery plans based on the information from the analysis.

2.4 The Trust requested IMAS to carry out a review of the RTT information and reporting systems and has since utilised their IMAS support with the implementation of the recommendations following the review.

2.5 The Trust has recruited an IMAS member on a longer term assignment, as Planned Care Programme Lead, to carry out a specific and detailed programme of work designed to address the rest of the issues and concerns raised by the Trust.

2.6 The draft recovery plans have been developed following IMAS' support and using the IMAS tools. See appendix two for summary information and trajectories.

2.7 The recovery plans are part of a wider 18 weeks RTT programme underway at the Trust and also in line with recent TDA guidance covering:

2.7.1 Demand and capacity analysis to reduce waits and maintain balance within services.
2.7.2 Pathway management to reduce journey times.
2.7.3 Operational processes to improve patient pathways.
2.7.4 Improving scheduling and booking processes/RTT rules training.
2.7.5 Tracking and validation of patients.
2.7.6 Performance management.
2.7.7 Leadership and focus.

2.8 Doing nothing about the situation will not guarantee delivery of the RTT operational standards at speciality level across the Trust and will result in waiting lists continuing to either plateau through the use of ad hoc extra capacity or increase – see appendix two.

2.9 The second solution is for the Trust to continue with the internal extra capacity plans for the specialities, however in some specialities this will not provide enough capacity to reduce the waiting lists in line with sustaining 18 weeks in the long term. All patients will be treated by urgency and then in chronological order.

2.10 The optimal solution is to continue with increasing the internal extra capacity to treat patients and to approach / seek approval from the CCG on a programme to outsource patients. This is subject to CCG approval and returning to the Board plus CCG with indicative costs and volumes of patients, plus any other initiatives. Through outsourcing, the Trust will endeavour to treat the clinically urgent first and then in chronological order.

2.11 Currently, the recovery plans involve a combination of; internal extra outpatient and surgical lists, and using existing outsourcing arrangements to treat the backlogs of patients in line with delivering 18 week RTT operational standards. There are projected cost implications of the current internal plans over the next 12 months in the region of £1.5 million with contributions coming back to the Trust in the region of £1 million. Further plans to outsource patients to be developed (subject to full costings).

2.12 There are some cross functional impacts of the additional work to be carried include;

2.13 The current pressure on beds (dependant on casemix).
2.14 Winter pressures.
2.15 The physical limitations at the Trust (both outpatient clinics and inpatients).
2.16 The potential increase in diagnostic demand as a result of the extra clinic activity.

3. Analysis/Discussion

2.17 The key challenges with recovering and sustaining 18 week Referral To Treatment (RTT) performance is initially with the volumes of patients for the challenged specialities that require treatment to reduce waits in line with the desired milestones. In some cases, the waiting lists need to be halved. For first appointments, the total backlog to be seen is approximately 3000 patients. The admitted backlog to be eventually cleared could be in the region of 1400 patients – this is taking into account possible additional conversions for surgery from the extra outpatient activity.

2.18 There were issues with obtaining key data for the demand and capacity analysis but this was mainly to do with staff availability/sickness, which led to 2-3 weeks delay with the work.

2.19 IMAS have stressed throughout the process that the models are only theoretical and dependent on the quality of the data used. The data has been scrutinised and validated by IMAS and in addition by the services. IMAS have outlined the models do not give precise timelines or identify precisely when 18 weeks will be delivered but they can be used to outline significant milestones in recovery. It is anticipated before the end of the backlog clearance programme, 18 weeks will be delivered at speciality level for the three operational standards.

2.20 At this stage, many of the recovery plans have used assumptions and forecasts on potential extra capacity to contribute from late November 2014 onwards.

2.21 There is also the uncertainty of the timing when any additional extra clinic activity will impact on the admitted waiting list through conversions for surgery. The specialities have been asked to consider this when deciding how long to implement extra capacity both at follow-up and for admissions.

2.22 Where possible outpatient and theatre efficiencies have been considered, but the lead in times for these are not clear and therefore the impact over the course of the recovery plans are currently not included.

4. Risks

a. The main risk is the capacity that has been outlined not materialising either in a timely manner, which leads to slippage in progress or not at all, which will cause the Trust not to deliver on the 18 week RTT operational standards.

b. It is also important that the Board is aware that despite the specialities outlining extra capacity options, some of the plans are currently insufficient to deliver the desired milestones and 18 weeks. This is where the current weekly shortfall in capacity has been so significant, that despite outlining a number of extra capacity options, there has not been enough activity to bridge this weekly gap and start to clear the backlog of patients waiting. This is also where significant outsourcing of patients will need to take place.

c. The type of risks for recovery to consider are;

i. Bed capacity.
ii. Providing enough theatre and bed capacity for the complex surgical cases.
iii. Winter pressures leading to an increase in A&E/Trauma activity.
iv. Unsuccessful outsource patients.
v. Internally not being able to provide the required number of clinics or theatre lists.
vi. The impact on support services, such as diagnostics has also not yet been finalised.

d. To try to mitigate some of the risks, the Trust is looking to cover the following:

i. Establish a robust programme for outsourcing patients with clinical leadership and engagement from the Trust to ensure patients are treated in a secure and clinically safe manner.
ii. Outsource patients at source of referral to relieve pressure on clinics and beds.
iii. Review potential HDU resources or expertise at SACH to reduce the acute pressures caused by complex cases post operatively.

iv. To utilise Access meetings to closely monitor and manage recovery plans on a weekly basis using key performance indicators in the IMAS models.

e. Impact on diagnostics will be developed with the help of IMAS as part of their diagnostic review in November 2013. The impact of extra first appointment clinics on follow-up resources has been outlined but it is difficult to predict at this stage at what stage this extra demand will filter through. The ADMs have all been asked to consider this as part of their recovery plans.

f. The current solutions to bridge the weekly underlying capacity gaps for some specialities are not sustainable in the long term because they are based on additional (unfunded) capacity. If this risk is ignored then the waiting list pressures will return once the extra capacity is removed.

5. Recommendation

5.1 A number of surgical specialities have undertaken detailed demand and capacity modelling with the support of IMAS to ascertain the current waiting list positions concerning the delivery of the national RTT operational standards. The work has been used to support the first draft of RTT recovery plans for the Trust Board to consider.

5.2 The Trust Board is asked to note the three options available following the recent modelling exercise and to support **option 3** as the Trusts preferred option moving forward.

5.2.1 Do nothing – this will lead to the Trust not delivering 18 weeks RTT at speciality level and to some waiting lists increasing over time.

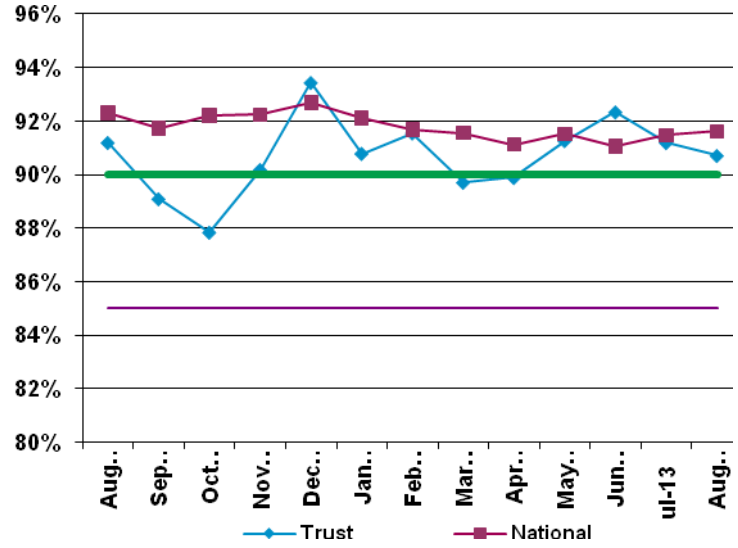
5.2.2 Continue with the current internal extra capacity options and using existing outsourcing arrangements. In some specialities this is not enough capacity to deliver 18 weeks RTT so speciality-level compliance will not be achieved.

5.2.3 Approach the Clinical Commissioning Groups (CCGs) to secure their support and approval to undertake a recovery programme to outsource patients to external third parties. Subject to Cost and volume being presented to the board in January 2014.

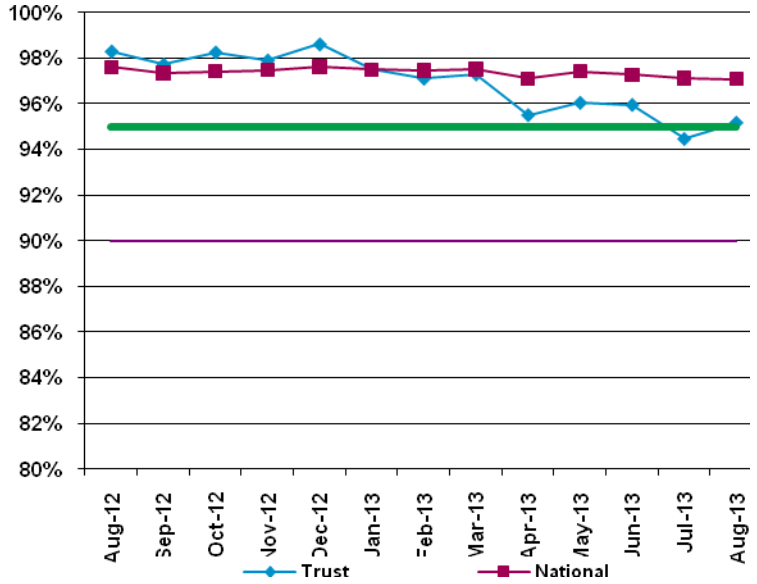
Bernie Bluhm
Interim Chief Operating Officer and Deputy Chief Executive.
November 2013

Appendix One - West Hertfordshire Hospitals NHS Trust Monthly RTT Published Performance

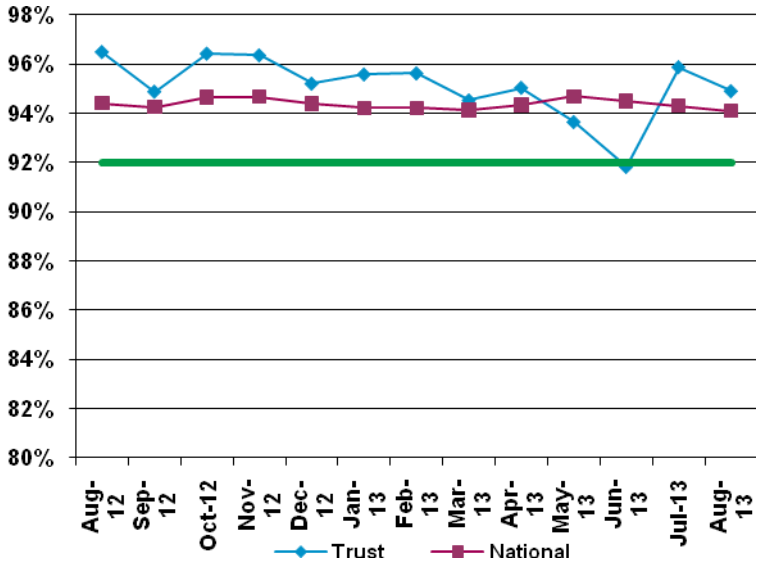
Admitted Compliance



Non-Admitted Compliance

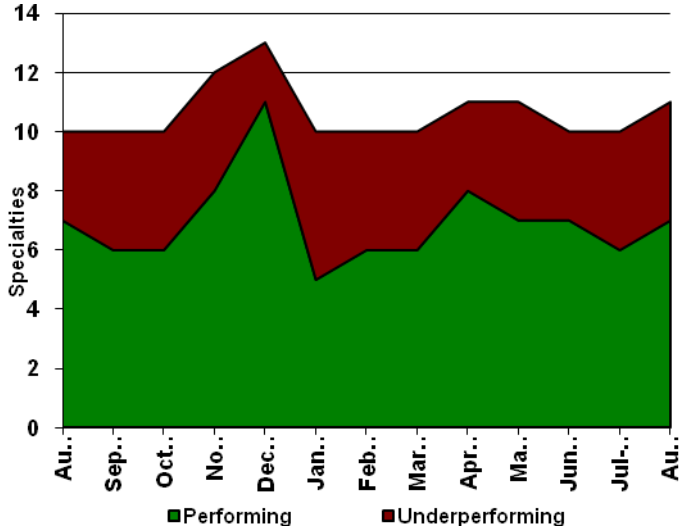


Incomplete Performance

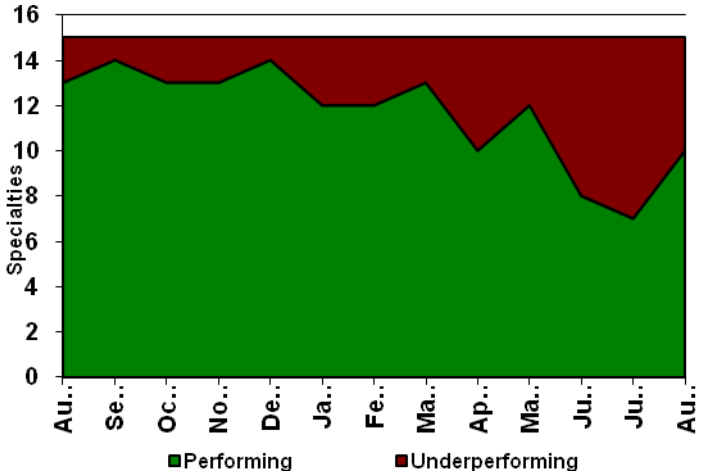


Appendix One - West Hertfordshire Hospitals NHS Trust Monthly RTT Published Performance

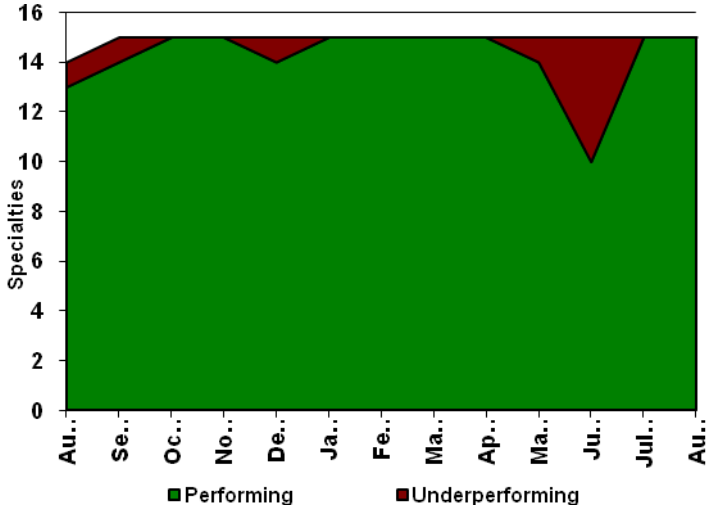
Admitted speciality performance



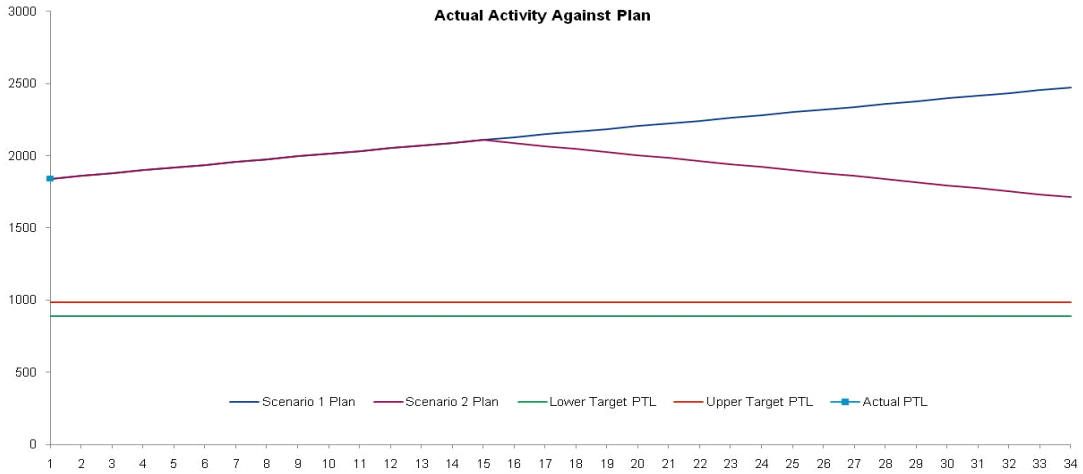
Non-admitted speciality performance

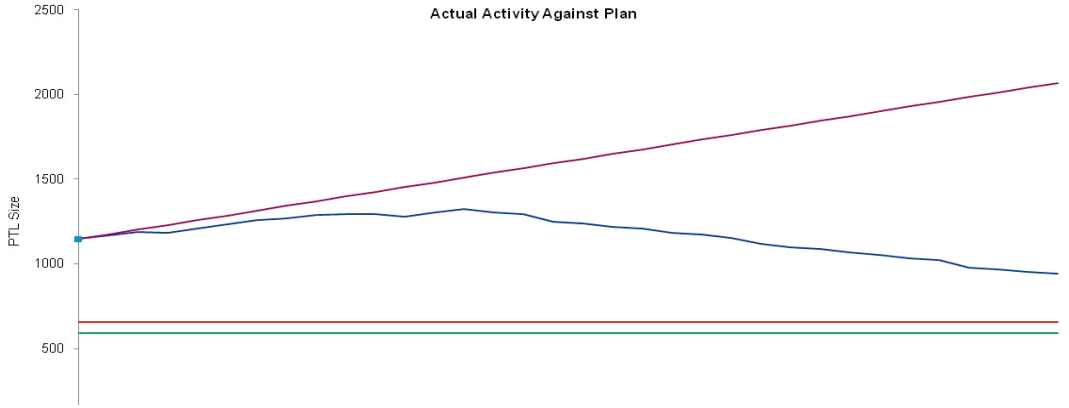


Incomplete speciality performance



Appendix Two - T&O recovery plan trajectories





First Appointment Analysis

Speciality	1st Appointment starting WL size	Target 1st Appt waiting list for 18 weeks	Backlog to be reduced		Current Anticipated completion date	RAG rating
Orthopaedics	1842	890-984	858	952	Dec-14	

Weekly Capacity Gap

Speciality	Mean Refs per week	65th percentile	85th percentile	DNAs rebooked	Mean Capacity per week	Net waiting list change
Orthopaedics	206	241	256	19.5	209	17

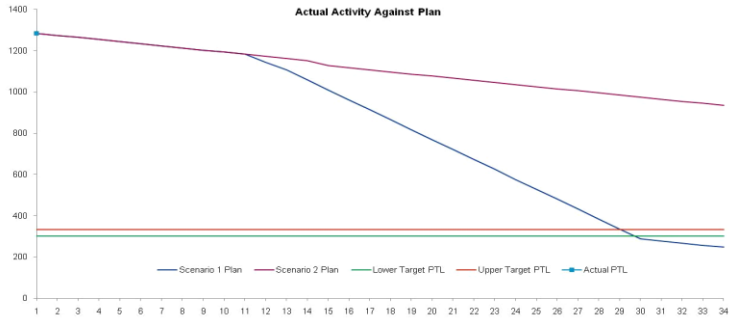
Admitted backlog analysis

Speciality	Admitted starting WL size	Target admitted WL size for 18 weeks	Backlog to be cleared		Current Anticipated completion date	RAG rating
Orthopaedics	1146	593 - 655	491	553	01/12/2014 (500 cases potential outsourced)	

Weekly Capacity Gap

Speciality	Mean decisions to admit per week	Weekly ROTT rate	65th percentile - ROTT	85th percentile - ROTT	Mean Admissions per week	Mean Net waiting list change
Orthopaedics	116	6	115	134	82	27

Appendix Two - Ophthalmology recovery plan trajectories



First Appointment Analysis

Speciality	1st Appointment starting WL size	Target 1st Appt waiting list for 18 weeks	Backlog to be reduced		Current Anticipated completion date	RAG rating
Ophthalmology	1284	300 - 332	952	984	Dec-14	

Weekly Capacity Gap

Speciality	Mean Refs per week	65th percentile	85th percentile	DNAs rebooked	Mean Capacity per week	Net waiting list change
Ophthalmology	76	85	92	0.8	87	-10

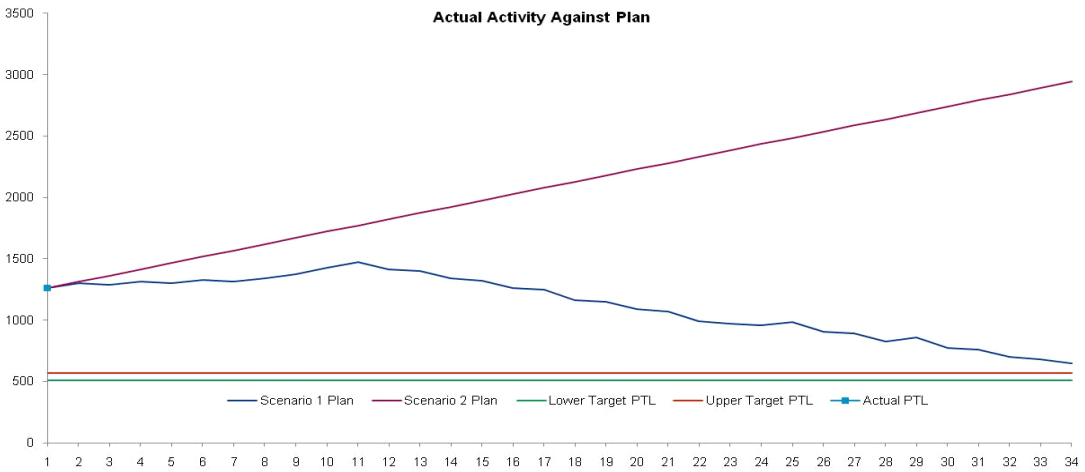
Admitted backlog analysis

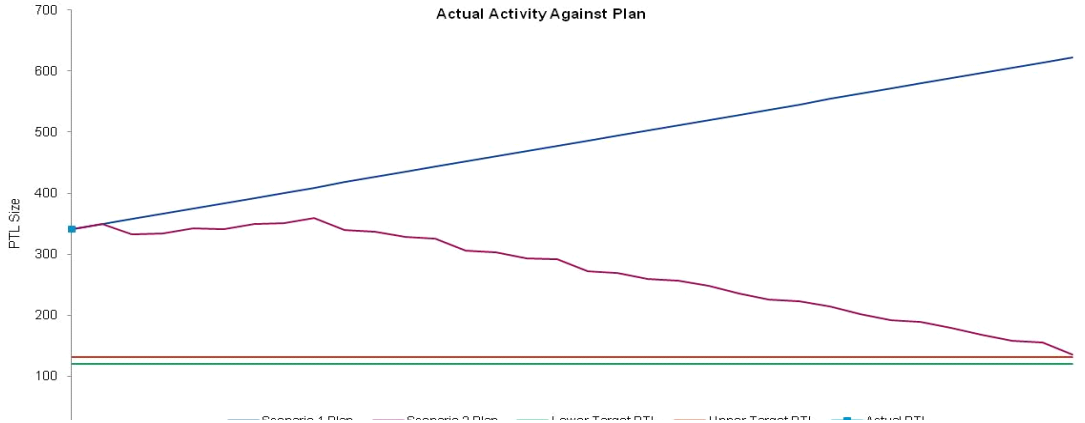
Speciality	Admitted starting WL size	Target admitted WL size for 18 weeks	Backlog to be cleared		Current Anticipated completion date	RAG rating
Ophthalmology	292	211 - 233	59	81	Apr-13	

Weekly Capacity Gap

Speciality	Mean decisions to admit per week	Weekly ROTT rate	65th percentile - ROTT	85th percentile - ROTT	Mean Admissions per week	Mean Net waiting list change
Ophthalmology	37	0	40	47	34	3

Appendix Two - ENT recovery plan trajectories





First Appointment Analysis

Speciality	1st Appointment starting WL size	Target 1st Appt waiting list for 18 weeks	Backlog to be reduced		Current Anticipated completion date	RAG rating
ENT	1262	512 - 566	696	750	Sep-14	

Weekly Capacity Gap

Speciality	Mean Refs per week	65th percentile	85th percentile	DNAs rebooked	Mean Capacity per week	Net waiting list change
ENT	134	145	156	1	84	50

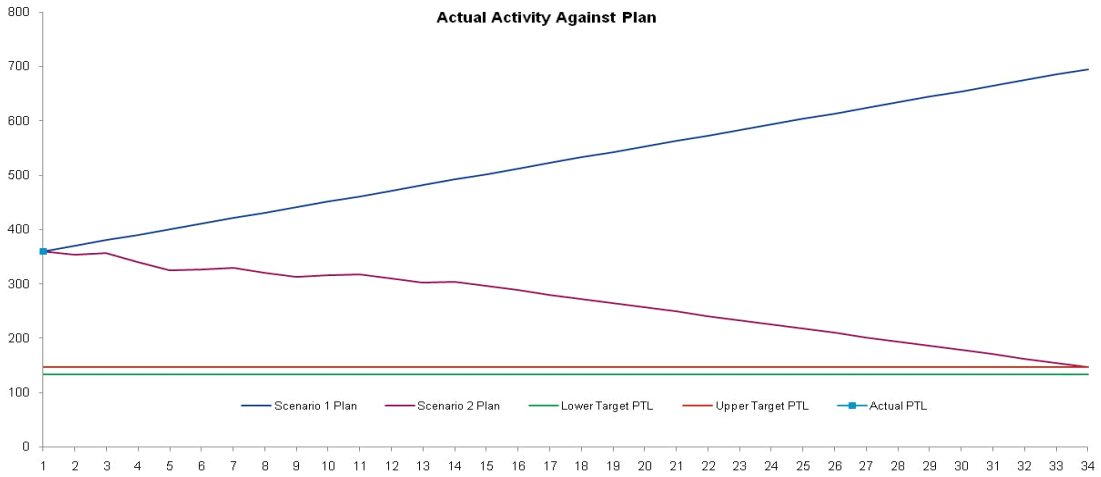
Admitted backlog analysis

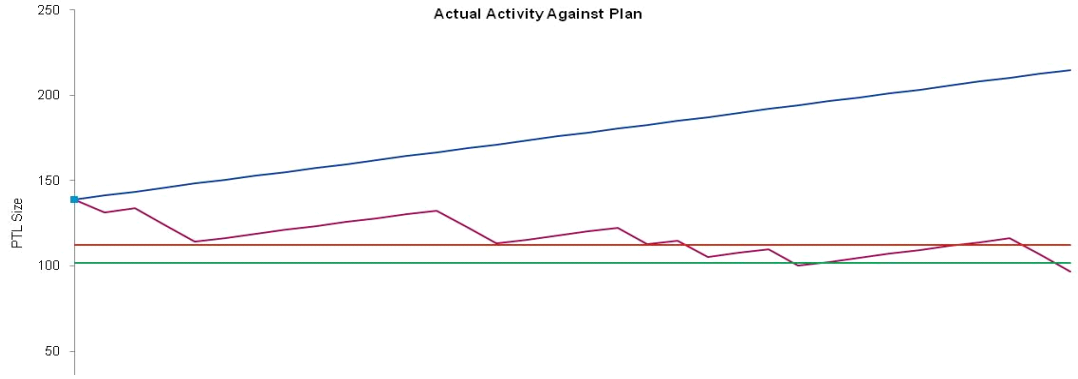
Speciality	Admitted starting WL size	Target admitted WL size for 18 weeks	Backlog to be cleared		Current Anticipated completion date	RAG rating
ENT	341	120-132	209	221	June 2014 (200 cases potentially outsourced)	

Weekly Capacity Gap

Speciality	Mean decisions to admit per week	Weekly ROTT rate	65th percentile - ROTT	85th percentile - ROTT	Mean Admissions per week	Mean Net waiting list change
ENT	28	5	24	29	15	8

Appendix Two - Pain recovery plan trajectories





First Appointment Analysis

Speciality	1st Appointment starting WL size	Target 1st Appt waiting list for 18 weeks	Backlog to be reduced		Current Anticipated completion date	RAG rating
Pain	360	133 - 147	213	227	Jul-14	

Weekly Capacity Gap

Speciality	Mean Refs per week	65th percentile	85th percentile	DNAs rebooked	Mean Capacity per week	Net waiting list change
Pain	24	30	44	2.6	17	10

Admitted backlog analysis

Speciality	Admitted starting WL size	Target admitted WL size for 18 weeks	Backlog to be cleared		Current Anticipated completion date	RAG rating
Pain	139	102- 112	27	37	Dec-13	

Weekly Capacity Gap

Speciality	Mean decisions to admit per week	Weekly ROTT rate	65th percentile - ROTT	85th percentile - ROTT	Mean Admissions per week	Mean Net waiting list change
Pain	18	3	16	21	13	2

West Hertfordshire Hospitals NHS Trust
RTT Information Review

September 2013

Introduction and Scope

The Intensive Support Team (IST) were asked by the Trust to carry out a detailed review of referral to treatment (RTT) information, data quality and reporting following concerns raised internally regarding data quality (DQ) and PTL reports. The review consisted of two brief meetings with staff involved with the monthly external Unify report and validation process; there was a subsequent WebEx with an independent contractor responsible for internal reports and RTT data; and a further telephone call with the Head of Information and Performance Analysis to cover specific DQ concerns. It should be borne in mind that the contents and conclusions of this report are wholly contingent on the completeness of information shared with the IST during the course of the visit and subsequent information requests.

Executive Summary

There are two parallel methods used within the Trust to calculate RTT waits which is very basic practice. The method used to report externally is not understood, there is inadequate technical documentation and the Trust has no assurance of the accuracy of the figures provided. Complete reliance on PAS RTT codes combined with questions over the functionality of PAS, a lack of user training and inadequate data quality checks again leave the Trust with little assurance over RTT data. The audit process of the recently-identified 6,000 'missing' patients appears to lack robustness and adequate documentation was not provided at the time of writing.

RTT Process

Within the Trust there are effectively two parallel systems for calculating and reporting RTT waiting times for patients still awaiting treatment: one is the online 'IReporter' system used for internal operational reports, the other a Microsoft Access-based system used to calculate the final monthly reports and as the basis for a weekly and monthly validation cycle. The two systems are not aligned and produce different numbers. This is extremely bad practice and the IST recommends that the two systems be brought into line as soon as is practicable.

The CSC Patientcentre PAS used in the Trust supports RTT pathways and allows users to select an RTT status for each stage of a patient pathway; to input a unique ID number for each pathway; and input start and stop dates. This RTT information is stored within PAS and output into the Trust data warehouse as an overall pathways table, with one record per patient pathway, and as an events table which allows links to be made to outpatient and other activity.

IReporter Process

The IReporter system uses the RTT information generated by PAS in a largely straightforward way. When a user creates a new referral on PAS the choice must be made as to whether it should be an RTT or non-RTT pathway; the default is RTT. This automatically populates the start date on the pathway and IReporter counts all pathways with a start date but without an end date to be open. There are currently no filters or checks within the IReporter system to check that, where users have selected that a pathway should be RTT or not, this is consistent with other PAS

information. Examples of checks which might be used could be whether the referral is from A&E, whether the patient has come through fracture clinic, whether the patient has been referred to obstetrics etc.

As subsequent activity is added to a pathway the overall status of the pathway and the clock dates should be populated automatically by PAS. When a clock stop event is recorded, for example that the patient has received a first definitive treatment (RTT status code 30), PAS should automatically populate the end date in the RTT information and thus the patient would no longer be recorded as waiting on the IReporter system. During a demonstration of this functionality on PAS it was clear that this does not always work as expected, resulting in clock stop outcomes without a corresponding clock stop date. It is furthermore clear that only a select group of users have the right to then rectify this error when it occurs. This raises significant questions about the robustness of the assumption behind the IReporter methodology of relying on clock stop dates. This is somewhat mitigated through an existing DQ report but, at present, there is not a member of staff in post to run and check this report..

Patient pauses on an admitted pathway are not supported by PAS in the version with which the Trust has chosen to use and are taken from a version of InfoFlex used within the Trust as a clinical information system. These pauses are linked to the patient pathway using the pathway ID and there is a built-in check to prevent a pause from starting prior to the RTT start date of the pathway. There is nothing in place to prevent pauses from running beyond the end of an RTT pathway; there is nothing in place to ensure that pauses cannot start before the patient is added to the admitted waiting list; there is nothing in place to ensure that pauses are not added to non-admitted pathways, although there is a flag within Infoflex which could be used for this purpose; there is nothing in place to ensure that pauses are only added for reasons of patient choice; there is nothing in place to check that reasonable notice and a choice of two appointments if offered; and there is nothing in place to ensure that pauses are not added to patients awaiting diagnostic procedures. This is not a robust system and the IST recommends that it is tightened significantly to address the above concerns.

Recommendations:

- *Review the functionality of PAS with respect to generating automatic clock stop dates and update either PAS configuration or IReporter calculations accordingly; and*
- *Review and improve the current pause system to ensure consistency with RTT rules.*

Access Process

The MS Access system used as the basis for validation and for Unify reporting has been in place for many years and all of those staff involved in its creation have since left the Trust. Whilst current staff are happy to follow clear procedure notes on which reports/queries to run at what time, there is not currently anybody in post who has a clear understanding of how the reports/queries currently work and the decisions underpinning them as to how waiting times and patient numbers are calculated. This is a significant vulnerability for the Trust and, given that this system returns different patient numbers and waiting times to the IReporter system, the Trust cannot be confident that figures reported nationally are accurate.
Whilst the IST did not go into the detail of the weekly/monthly validation process it appears that it involves extracting RTT data from PAS and then sending individual Excel documents out to operational staff for validation via the validation team. This is then passed back to the validation team, whereby changes are noted on the Excel spread sheet and should also be made on PAS. The final Unify report, however, appears to be based on the contents of this master spread sheet rather than on the underlying PAS data i.e. data submitted to Unify does not necessarily match

that which is held on PAS. This is very bad practice and the Trust should change this system to ensure that changes are made at source and the reports are taken directly from PAS data.

Recommendations:

- *Urgently review and better understand the mechanics of the current Unify reporting system;*
- *Review the current validation process with a view to simplifying it; and*
- *Cease the practice of reporting data changed manually in Excel rather than from PAS.*

Data Quality

Both of the above RTT data systems are totally reliant on the quality of RTT information entered on PAS and, thus on users understanding both of how to use PAS and the RTT rules. Whilst there was specific PAS/RTT training in 2009 it is unclear the extent to which this has continued, if at all. As detailed above, even in a simple demonstration of the RTT functionality given to the IST the system did not work as expected and very few users have the privileges to deal with these issues once they arise. On the basis of anecdotal evidence given to IST that users are not adequately trained on either the RTT functionality of PAS nor on the RTT rules, and that the system does not appear to work as expected, the Trust cannot regard the current RTT PTL as robust or accurate. The IST has not, however, had sight of current RTT training tools but the Trust is aware that these are out of date and there are plans to update them.

Where RTT information is relied upon exclusively as within the Trust, it is important to have a comprehensive suite of DQ reports in order to address any apparent inaccuracies or contradictions in the data. There are currently several reports available which, until recently, were reviewed on a weekly basis by a 0.5WTE member of the IT team. The Trust is aware of the recent changes in validation resources and plans to review the current 18 week roles across the organisation as a result. One of these reports does indeed identify the issue raised above where an RTT status code may contradict the clock stop date. Considering the importance of DQ to the organisation with respect to gaining assurance about RTT data, anecdotal evidence from staff is that this staff member is unable to review all DQ reports every week and that not all errors are corrected. The extent of this shortfall has not been quantified to the IST but it would not be difficult to estimate. The 18 week validation team concentrate on patients with long/breaching waiting times. Although through this work some DQ errors are inevitably picked up, there is no structured approach within the 18 week team to target specific DQ errors.

Recommendations:

- *Review the current provision of RTT/PAS training;*
- *Review the current provision of RTT training to those deciding on RTT status codes i.e. consultants; and*
- *Review the current reliance on a single part-time individual to maintain routine RTT data quality.*

Reports and PTLs

Under RTT rules, patients should only be considered to be on an admitted pathway when they are awaiting a procedure where the intention is therapeutic rather than diagnostic. The present IReporter system does not follow this rule and instead reports patients awaiting a diagnostic procedure on the admitted PTL. This has implications for patient experience as it may well result in patients having their diagnostic procedure booked with an 18 week target date whereas, in fact, they are likely to require it significantly sooner in order to potentially receive a subsequent treatment within 18 weeks. The Trust does not currently appear to have a diagnostic waiting list featuring RTT information and it is unclear how the Trust currently monitors diagnostic waits.

The current reports available on the IReporter system provide a standard view of RTT open pathways. This offers several 'waiter types' to allow the report to be filtered. Whilst the default is to show all pathways, the other options are KH07 (the old waiting list stage of treatment report, discontinued in early 2010) and QM08 (the old first outpatient stage of treatment report, also discontinued in early 2010). In addition to having been operationally irrelevant for over three years, the focus on these groups of patients has led to the effective exclusion from operational monitoring of any patient neither waiting for a first outpatient appointment (having been referred from a GP) nor waiting for an inpatient procedure.

The Trust reports that there were originally around 6,400 patients in this group. These patients were always reported externally (subject to the reservations expressed above regarding data quality) but the issue is that they have not been actively tracked until such time as they were either added to the waiting list or passed 18 weeks (and would then presumably have been flagged for validation). Since uncovering this operational issue, the Trust report that all 6,400 patients have been validated in the space of two weeks. This is an extremely short time to go through 6,400 individual patient records thoroughly and the IST has not seen details or documentation of the process behind this.

The IST has seen evidence of the results of 856 of those patients who had waited over 18 weeks, and approximately 25% of those pathways were still open i.e. over 230 patients are still awaiting treatment, who are not on any waiting list and who are not being tracked. This is cause for concern and the Trust must ensure that adequate arrangements are in place to see and treat these patients as soon as possible. The Trust has not, at the time of writing, provided evidence of the corresponding figures for those circa 5,500 patients waiting under 18 weeks.

Recommendations:

- *Report only patients awaiting a therapeutic procedure on the admitted waiting list;*
- *Review the current reports and process for monitoring diagnostic waiting times;*
- *Remove the QM08 and KH07 filters from the RTT PTL and replace with more relevant categories;*
- *Include training on how the updated IReporter system should be used in new RTT training as recommended above;*
- *Provide assurance documentation of the large-scale patient-level validation undertaken by the Trust;*
- *Ensure that treatment plans are in place for the above cohort of patients still awaiting diagnostics and/or treatment; and*
- *Provide analysis of the output of the validation of the ~5,500 other patients validated.*

Potential for IST Support

The IST would be pleased to offer support to the Trust in the following areas:

- Review of the current RTT data calculation processes.
- Review and re-launch of the current RTT PTLs and other elective care reports.
- Review of the current validation process.

The IST will be happy to discuss this report in more detail and help the Trust address these issues where appropriate.

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West Hertfordshire Hospitals NHS Trust comments and response on the draft report:

The Trust acknowledges that there are a number of areas regarding RTT reporting and more importantly data quality which we need to focus on and we welcome the recommendations made by the IST. The Trust will put in place resources and staff to work with the IST to rectify the areas raised in the report over the next couple of weeks as we are keen to rectify any problems as soon as possible.

With regards to the issue of the 6,400 pathways the Trust had concerns were “missing” from the RTT reports, we appreciate that not all of the relevant information, in particular patient level detail has been made available to the IST. This has obviously led to the IST commenting it feels the steps taken by the Trust appear to lack robustness and adequate documentation. The Trust will ensure the IST has the patient level detail along with a narration of the steps taken to investigate/validate these pathways. It is important the IST has this information so that they can complete this part of this work and the Trust hopes they will then revise this part of the report accordingly. Unfortunately at the time the IST commenced their diagnostic visits at the Trust, key personnel who led the internal audit of the 6,400 pathways were not available and only telephone conference calls were available to the IST.

The Trust has on an IMAS assignment a Planned Care Programme Lead who will be tasked with working closely with the IST to implement a number of the recommendations highlighted in the report. This includes improving the overall training and education of staff at the Trust on RTT rules in order to improve the quality of the underlining data the Trust uses to manage pathways. The IMAS assignment will also look at how to incorporate the recommendations in the current outpatient productivity programme and the plans to centralise a number of the outpatient services/processes.

Addendum

Subsequent to the original visit the IST has been provided with more detail on the validation of those ~6,000 patients which were subject to a SI alert within the Trust. These patients were not missing and were always reported both internally and externally within the total number of RTT pathways. The issue was that, due to the operational emphasis on the first outpatient and admitted waiting lists, patients who fell between the two had insufficient focus both managerially and with respect to validation.

When the issue came to light, the Trust embarked upon a programme of patient-level validation. This consisted of the central 18 week validation team reviewing the PAS records of affected patients manually, updating their RTT information on PAS as deemed appropriate and noting in pen. Due to the manual nature of this process, any analysis of the outputs beyond that produced by the Trust (in Report Appendix 1) is not possible.

The process itself appears to have been thorough: all patients were checked and any changes noted, and those where clear information could not be found on PAS and other electronic sources were sent out to the divisions for clinical validation. There is, however, insufficient documentation regarding the steps followed by the validation team and especially by the divisional staff – given current concerns about the level of understanding of RTT rules within the wider Trust this remains a concern, which the Trust is beginning to address with the current review of RTT training and the implementation of new Standard Operating Procedures.

Report Appendix 1

Validation outputs as reported by Trust as of 17th September 2013:

Total number of patients validated **6471**

164 Patients pathway closed after 18 weeks (Breached)

2,674 Patient pathways closed before 18 weeks

299 Patients on incorrect/duplicate pathways have been removed

3,334 Patients on an open pathway

Out of the **3,334** patients on an open pathway **2,478** are under 18 weeks leaving **856** patients over 18 weeks on an open pathway.

Since those figures were circulated the **856** patients that were on the RTT open pathway over 18 weeks have now been re-validated by their Divisions.

840 of those patients were on the Non-Admitted pathway

426 Patient pathways closed before 18 weeks

164 Patient pathways closed after 18 weeks (Breached)

232 Patients STILL on an open pathway over 18 weeks

14 Patients on incorrect pathways, pathways have now been removed

1 Patient has been transferred to another Trust

3 Patients RIP before being treated

The remaining 16 patients were on the Admitted pathway

8 Patient pathways closed before 18 weeks

6 Patient pathways closed after 18 weeks (Breached)

2 Patients STILL on an open pathway over 18 weeks