SUPPLEMENTARY 1 - PRESENTATIONS GIVEN AT THE MEETING

THE HEALTH AND WELLBEING BOARD

Tuesday, 26 April 2016

Agenda Item 4. **Draft Primary Care Transformation Strategy (Pages 1 - 14)**

Agenda Item 5. **Better Care Fund 2016/17 (Pages 15 - 23)**

Agenda Item 6. **Referral to Treatment (Pages 25 - 47)**

Agenda Item 8. **Care City Programme Update (Pages 49 - 58)**

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Clinical Commissioning Group

Primary Care Transformation

Health & Wellbeing Board

25 April 2016

What is the national and local policy context for Primary Care Transformation?

- **Policy at a national and regional level is focusing on ensuring a sustainable high quality primary care landscape**
  - NHSE Five Year Forward View
  - London Health Commission
  - Strategic Framework for Primary Care in London
  - Think tanks (Kings Fund, Nuffield Trust)
  - Care Quality Commission
- **Move funding from acute to primary care**
- **New incentives and models of care – networks**
- **Expand primary care workforce**
- **Ambitious quality standards**

Three areas of care form the basis of a vision for General Practice in London

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Patients and clinicians alike have told us about the importance of three areas of care; this forms the basis of the new patient offer (also called the specification)

Accessible Care

Better access primary care professionals, at a time and through a method that's convenient and with a professional of choice.

Coordinated Care

Greater continuity of care between NHS and other health services, named clinicians, and more time with patients who need it.

Proactive Care

More health prevention by working in partnerships to reduce morbidity, premature mortality, health inequalities, and the future burden of disease in the capital. Treating the causes, not just the symptoms.

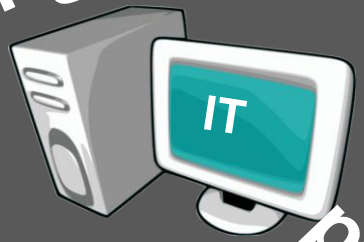
Local GPs and their teams have identified issues with primary care as it is now…..

Workload

Ageing & increasing population

Ageing workforc

Management of LTC & co-morbidities



Patient expectat

Improving patient experience

Variation

Assurance of QA

Patient access

Attracting & retaining staff

Funding

Practices have provided their perspective on these challenges based on feedback from locality discussions

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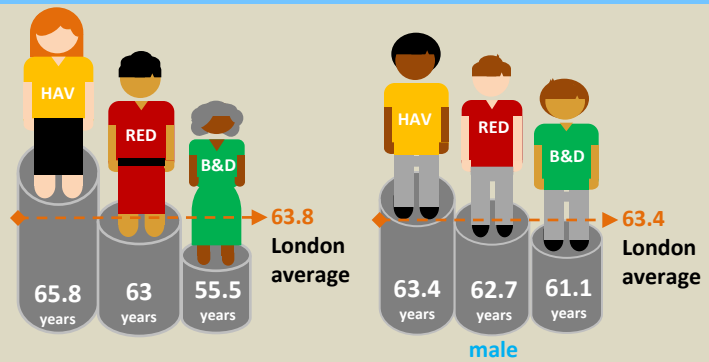
We are facing a crisis in recruitment and retention of GPs and nurses, with many people about to retire too

The current workload in general practice is unsustainable - GPs are seeing patients, coordinating care, chasing others for information and doing too much admin and not enough of the pro-active patient care that make being a GP rewarding

My practice isn't financially sustainable

I value my autonomy and the freedom to run my practice in a way that works for my patients and me.

What are the key challenges across BHR?



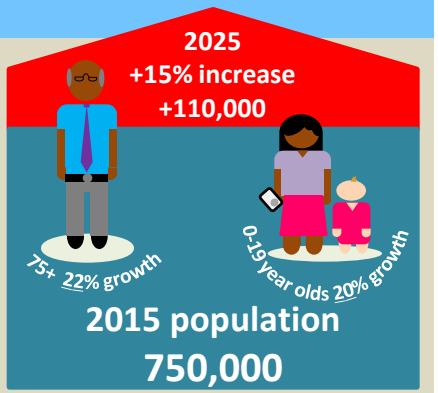
Deprivation

Ranked in order of most deprived in England

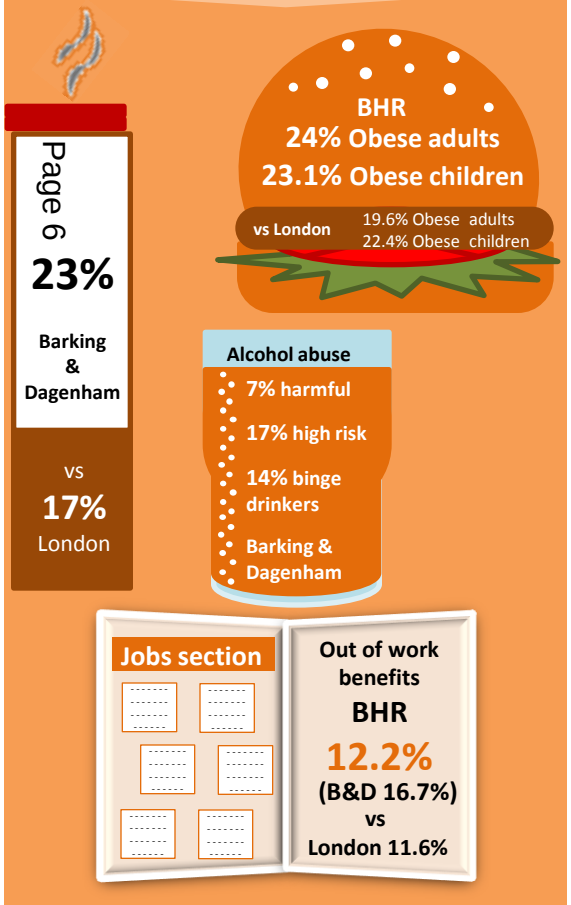
Barking & Dagenham
Child poverty 30.2% vs London 23.5%

Havering
Largest net inflow of Children in London

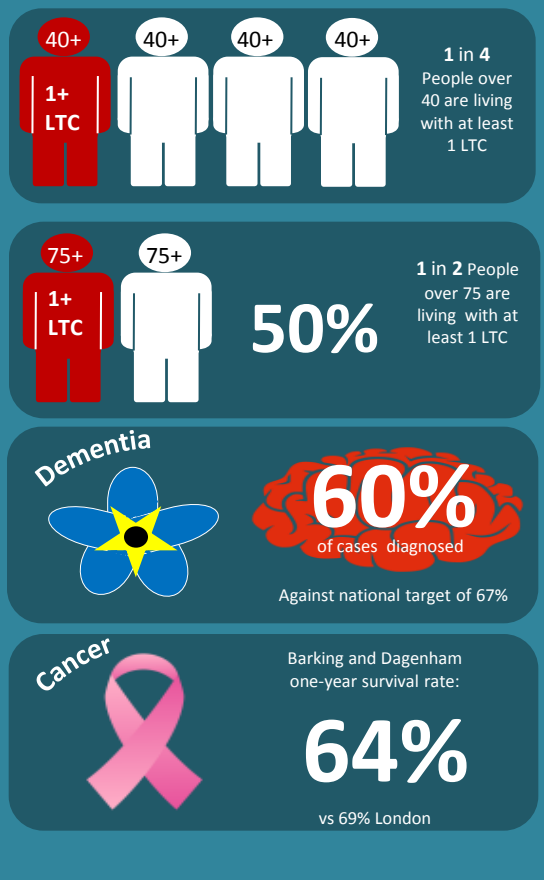
Redbridge
Highest rate of stillbirths in London



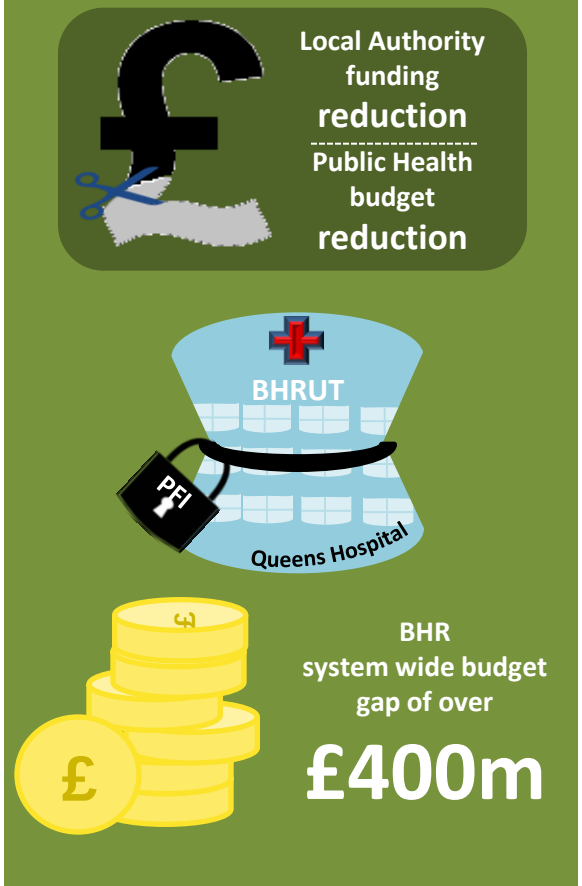
Health and wellbeing challenges



Care and quality challenges



Funding and efficiency challenges



In summary, we need to find a solution that addresses the following points

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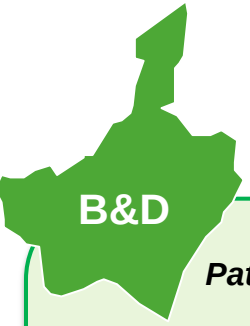
Patient experience	▪ Our patients can continue to benefit from a relationship with their local GP ▪ Our patients receive a joined-up cost-effective care service with unnecessary duplication avoided
Delivery	▪ We have the capacity and capability to meet the health and care needs of BHR's growing and ageing population ▪ We meet the health and care needs of our diverse local communities ▪ We contribute substantially to the improvement of health outcomes for our populations ▪ We meet, as a minimum, national and regional quality standards for primary care – care that is accessible, co-ordinated and proactive ▪ The skills and assets of local professionals and provider organisations are effectively harnessed and co-ordinated ▪ Our solution contributes significantly to the financial sustainability of the BHR care economy
General Practice	▪ Productive GP practices can retain their autonomy and have a financially sustainable future ▪ GPs have the time they need to provide quality patient care ▪ Minimise the time spent by GPs and practice colleagues on administration ▪ Respective roles and responsibilities of all local care providers in delivering care are clearly defined and consistently applied day-to-day by all parties
Infrastructure / enablers	▪ GPs and colleagues can rely on IT to present the information about their patients that they need to make the best decisions for patients at each point of care ▪ Care is delivered in premises that are fit for purpose in a way that makes the best use of existing assets
The GP & their teams	▪ Good career offer and working environment for GPs - retain existing GPs and attract new recruits

The emerging vision is primary care-led locality-based care, founded on strong practices



Patients

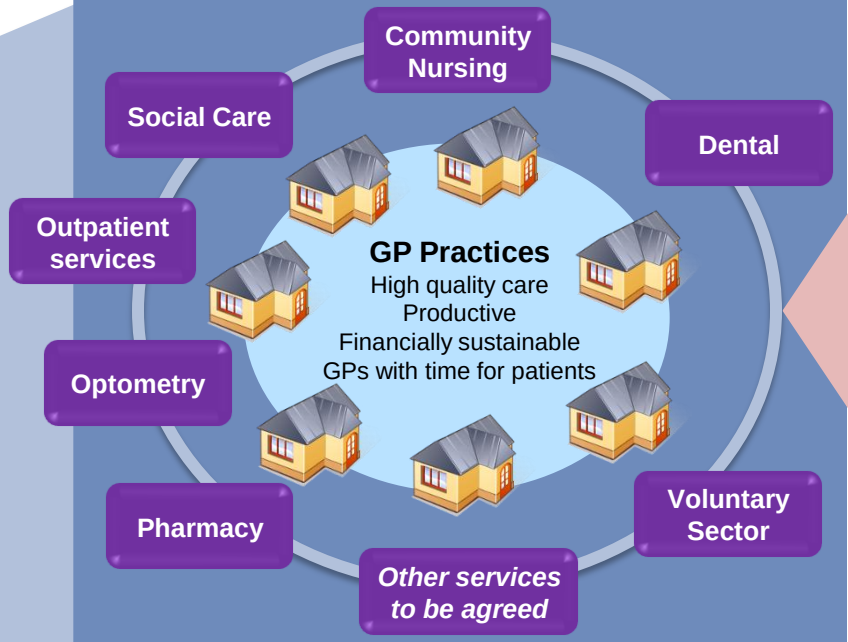
Co-producing their care

Registered with a local practice, with treatment, referral and care oversight from their GP

When needed, receiving personalised, joined-up care and support, mostly near home

Network arrangements

✓Care provision ✓Prevention ✓Administration



Workforce development, recruitment and retention

A team of around 100 professionals, with trusted relationships, working together to design and deliver a high quality locality care service that meets local needs cost-effectively

- Digitally-enabled scheduling and administration
- Patient-level information sharing at point of care
- Business intelligence: Ops management, Outcomes
- Smart use of available Locality estate

Locality-based care would be designed and delivered within a wider set of standards and priorities

SPG / Borough

SPG / Borough level plan and priorities – supporting implementation of BHR transitional programmes and CCG assurance measures

GP Network and extended team:

'Locality' development

OUTCOMES

Delivery Improvement

Primary care-led locality team forms and develops (framework in development)

Locality team sets outcomes and priorities to best meet local health needs

Locality team defines local pathways and division of workload across practices, practice networks and extended locality team

Individual GP practices

Delivery

Localities make sense for Place Based Care – Barking and Dagenham

Picture does not represent actual B&D localities

Locality level

50,000 – 70,000 per locality

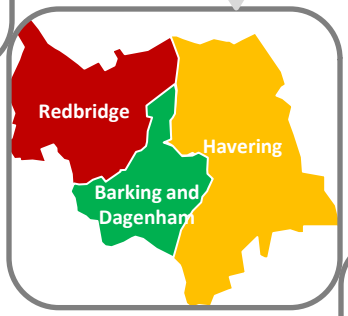
Provides integrated health and social care services through Local Accountable Care Organisations.
Includes the right level of service consolidation that maximises value for money

- HWB strategy and challenges
- HWBB leadership
- Local consultation and engagement

Borough level

B&D: 200,000

- Local plans to address local gaps and challenges
- Devolution test/ACO development
- Delivery via contracts (lead commissioner)
- Local enabler plans
- Local out of hospital plans



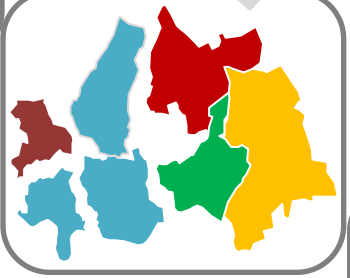
BHR Level

750,0000

- Overall Sustainability and Transformation plan strategy – clinical and financial sustainability
- Issues needing a plan

NEL approach:

1. Acute reconfiguration / pan NEL flows
2. Mental Health
3. Cancer
4. Urgent and Emergency Care (incl. LAS)
5. Maternity
6. Specialised
7. Estates and workforce coordination of enablers and interface with HEE/HLP etc.
8. Transformation funding



NEL Level

1,800,000

Interface with HLP on agreed plan
London initiatives

London Level

8,500,000

The commissioning and provider landscape in BHR can be layered into locality level, borough level, BHR level, North East London level and London level, allowing services to be commissioned for specific groups, achieving a degree of local autonomy at the same time as achieving economies of scale where appropriate.

Evidence advanced by the Kings Fund, drawing on examples from New Zealand, is that place-based care works best with a population of 50-70,000 people

Barking & Dagenham has a history of working in localities which contain populations of this size, and it is proposed that place-based care be established within these boundaries

The vision would have positive benefits for patients

- **Quality improvement** – an overall improvement in the quality of services provided and a reduction in variation in quality between GP practices
- Patients will experience a more **integrated** service that improves their health and wellbeing and ability to self-care
- Primary care will be **personalised**, responsive, timely and accessible and provided in a way that is patient centred and co-ordinated
- Practices will show **improvement in outcomes** for key cancer, COPD, diabetes, mental health and patient satisfaction indicators
- Patient access will be improved by providing **seven- day primary care** with integrated IT
- The locality model will provide the opportunity for more care to be provided **closer to home**

The vision would have positive benefits for practices

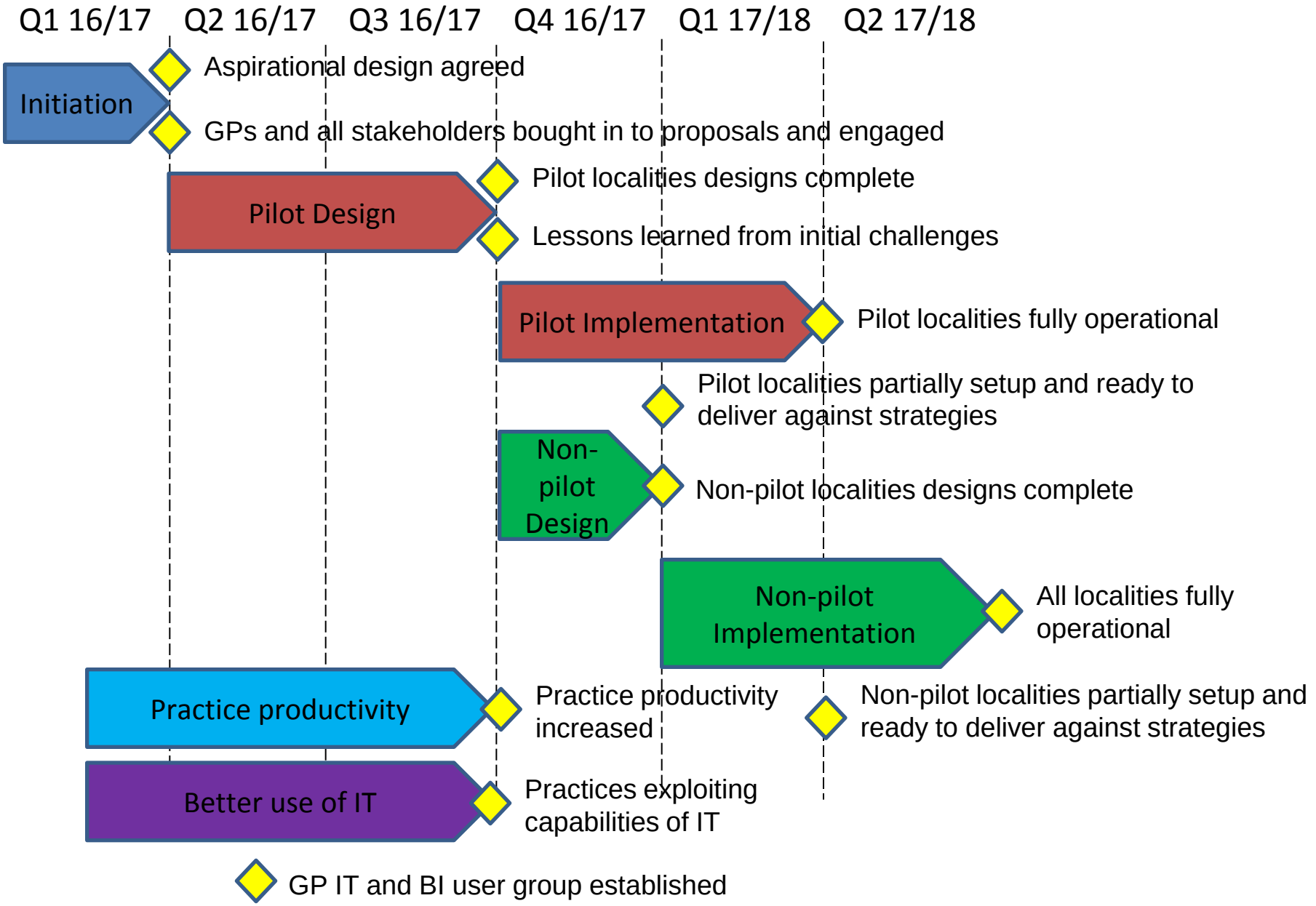
- **Retain autonomy** - allow step-by-step change with GPs leading
- Working together help to **ease financial pressures** - pooling resources to reduce costs and creating new opportunities to generate income
- **Partnership working** - GPs have confidence to devolve routine work to other members of the primary care team (e.g. repeat prescriptions) i.e. r**educe workload & free up GP time**
- **Integrated IT** will help **reduce duplication of work** in the wider primary care team, including chasing information
- **Integrated IT allows new ways of working that save time** (e.g. e-consultations or multi-disciplinary team meetings)
- **Attractive career offer to retain and recruit staff**:-
  - Model will allow for **more diverse job roles** within the extended primary care team
  - Enable **new ways of working**
  - **More rewarding work** focusing on patients
  - Create opportunities for **career development** for both clinical and non-clinical staff

Our Implementation Approach

King's Fund framework to develop place-based care

- **Define the population** served and the system boundaries.
- **Identify the partners and services** that need to be included.
- Create a **shared local vision and objectives**, based on local need and the priorities and preferences of the population.
- Develop an appropriate **governance structure** which must include patients and the public in decision-making.
- Identify the right **leaders** to manage the system, and develop a new form of system leadership.
- **Agree how conflicts will be managed and resolved**.
- Develop a **sustainable financial model** for the system across three levels:
  - the combined resources available to achieve the aims of the system
  - the way that these resources will flow down to providers
  - how these resources are allocated between providers and the way that costs, risks and rewards will be shared.
- Create a dedicated team to manage the work of the system.
- Develop ways to allow different members of the group to focus on different parts of the group's objectives.
- Develop a **single set of measures** to understand progress and use for improvement

What are the next steps?



One borough; one community; London's growth opportunity

Encouraging civic pride

Enabling social responsibility

Growing the borough

For more information visit
lbbd.gov.uk/visionandpriorities

London Borough of Barking & Dagenham
lbbd.gov.uk

Better Care Fund 2016/17

- Sharon Morrow, Chief Operating Officer, Barking and Dagenham CCG
- Andrew Hagger, Health and Social Care Integration Manager, London Borough of Barking and Dagenham

• Approving BCF 2016/17

- Report sets out plans for the BCF 2016/17
- Final template released by NHS England on 21 April
- Report and appendices are the information we will submit
- Format of information will change to fit the final template
- Submission to NHS England on 3 May 2016
- Section 75 agreement to be approved by 30 June 2016

• BCF Planning Process

- HWBB received updates on performance and planning for BCF in December 2015 and March 2016
- Plans developed by BCF Delivery Group and approved by Joint Executive Management Committee
- Plan looks at one year, vision and plan for further integration beyond 2016/17 being developed elsewhere
- Have engaged with other BHR BCF teams, especially re DTOC plans
- Tight and changing timescales from NHS England

• Meeting the national conditions

- 6 conditions for 2016/17 that were in 2015/16, which we met
- 2 new conditions for 2016/17:
  - Agreement to invest in NHS commissioned out-of-hospital services
  - Agreement on local action plan to reduce delayed transfers of care
- How we meet all conditions set out in detail in Appendix A

• Metrics

- BCF did not perform well on metrics in 2015/16, have looked more closely at metrics for 2016/17
- Non-elective admissions still key focus, though no performance penalty attached in 2016/17
- DTOC has increased in importance
- Analysis being carried out into admissions to residential/nursing care
- Re-ablement effectiveness – crude measure
- Local targets around GP user satisfaction and falls

• Changes to schemes

- Previous approach unwieldy and not targeted
- Amalgamated some of previous schemes and identified 3 crosscutting themes:
  - Avoiding Admission to Hospital
  - Integrated Support in the Community
  - Discharge from Hospital
- Identified individual projects which contribute directly to a theme and a metric
- Projects include:
  - Developing online resources for carers
  - Strengthening referral routes to the CTT
  - Reviewing the Richmond fellowship contract ariounf Mental Health

• Finances

- £20.7m fund for 2016/17, similar to the amount for 2015/16
- Local Authority contribution is £7.5m
- CCG is contribution is £13.2m
- No risk share agreement
- Finances governed by Section 75 agreement (to be approved by 30 June 2016)

• Approving BCF Plans

- HWBB sign-off and delegate authority
- Final sign off and submission by 3 May 2016
- Send to NHS England and NHS London for assurance
- Assurance provided by NHS London indicating one of 3 categories:
  - Not approved
  - Approved with support
  - Approved

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Barking, Havering and Redbridge University Hospitals NHS Trust

Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups

Referral to Treatment Times (RTT) Issues, high level plan and governance

26th April 2016

V 3 0 DRAFT

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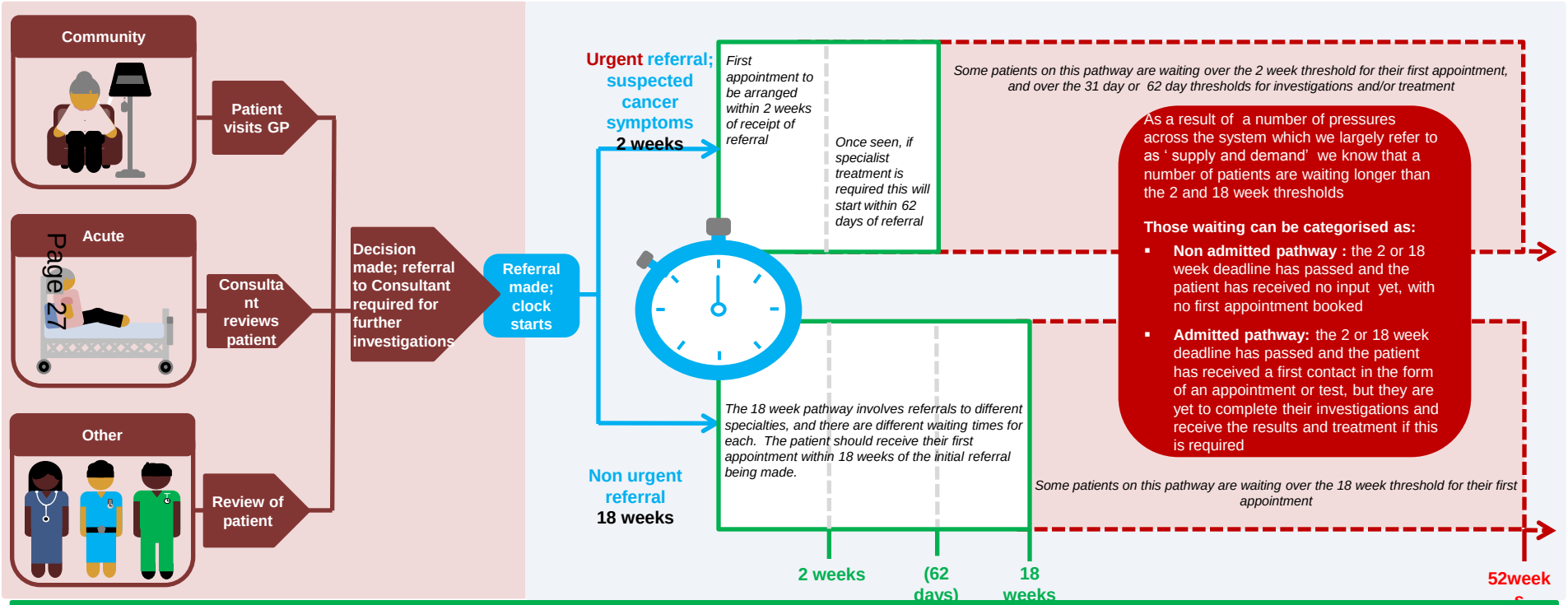
Contents

Barking and Dagenham, Havering and Redbridge: Referral to Treatment

Referral to treatment or 'RTT' refers to the target time from the point when a referral for further investigations is received by the hospital, to the point when the investigations are complete and the patient begins to receive treatment, or when feedback is given to the patient if no treatment is required.

For individuals who display possible cancer symptoms there is a different waiting time standard known as the 2 week Cancer wait. This means that those individuals should be seen within 2 weeks of their referral being received by the hospital. An additional standard that applies to Cancer is that once seen if specialist treatment is required then that will start within 62 days of referral. For those with less urgent symptoms, the referral to treatment time is 18 weeks. Due to a number of factors, Barking Havering and Redbridge University Hospitals NHS Trust (the trust who run Queens and King Georges Hospitals where most of the investigations take place) is experiencing delays in both pathways where for a number of patients the target waits are not being met.

The diagram below summarises this process and the current issues, and identifies key principles to address this going forward.



Key principles to address the delays and backlog going forward

We need to ensure that we return to adhering to the nationally set waiting times. This will require action not only to address the backlog that is in existence but also to ensure that this is maintained and does not build up again in the future.

There are some immediate actions we are taking;

1. **is to stop the flow of referral activity in high backlog areas into BHRUT and provide an alternative source of service for our population**
2. **is to identify through review of clinical pathways across our health and social care system how we can provide the services our population need in the future in a way that best meets their need and makes best use of all the services that they may access with a clear focus on providing quality care closer to home where possible**

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Background and Context

The Issue	The Response	The Delivery
RTT Performance	**The Recovery Plan**	**The RTT Programme**

- In December 2013 the Medway Patient Administration System (PAS) was upgraded.
- Following this upgrade a significant decline in RTT performance was recorded.
- In February 2014 the Trust stopped reporting and ran an investigation into the origin of its RTT problem.
- The following issues were identified:
  i. RTT performance was not calculated correctly;
  ii. The Trust's governance processes for reporting and oversight were weak;
  iii. There was limited operational capability of waiting list management;
  iv. Demand and capacity were not aligned;
  v. Data quality was poor; and,
  vi. Training and organisational awareness of RTT and its rules was limited.

- Following the investigation a recovery plan was developed to address the issues raised.
- The NHS Trust Development Authority (TDA) and Barking and Dagenham, Havering and Redbridge (BHR) Clinical Commissioning Groups supported the Trust in developing this Recovery Plan.
- It was recognised that recovery is dependent on the following being achieved:
  i. Maintenance of an activity level over and above business as usual (in order to meet demand);
  ii. An increase of internal capacity and productivity;
  iii. Implementation of demand management schemes; and
  iv. Outsourcing of demand to the independent sector.

- The RTT Programme is a system-wide programme set up across the BHR Health economy to:
  i. recover the RTT position; and
  ii. deliver the RTT constitutional standard by March 2017
- The Programme's aims and objectives are supported by a number of underlying initiatives identified across six individuals workstreams within BHRUT and BHR CCG
- The Programme is governed by a series of weekly meetings where the workstream initiatives are monitored carefully to assess the impact they are having on the waiting list positions and activity run rates
- The position is then reported back weekly to NHSE to provide assurance over the programme of work and demonstrate progress

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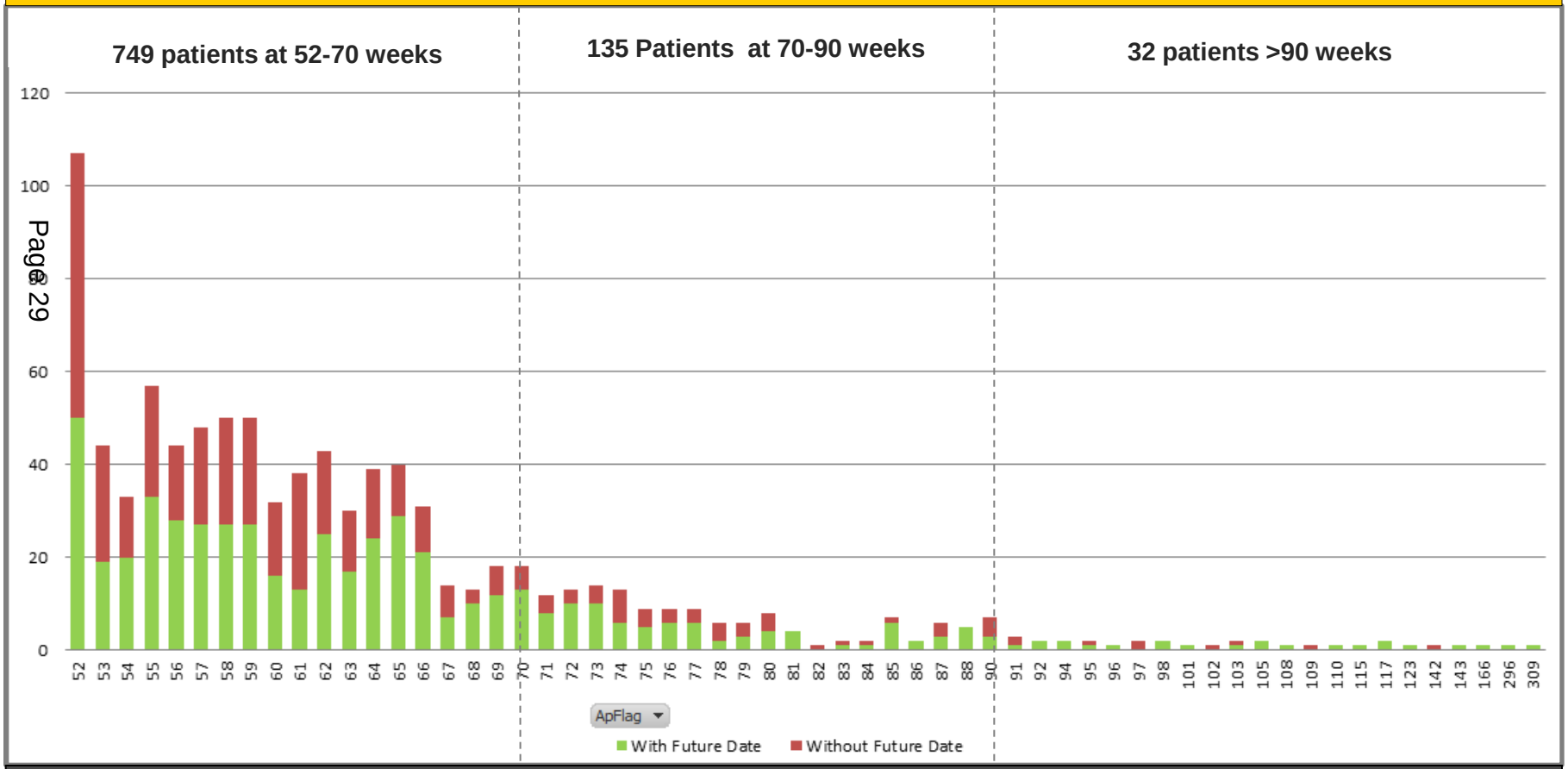
Understanding the Issue: Latest Headline Numbers

- The latest PTL position indicated over 58,000 patients waiting on the RTT pathway (including 975 patients over 52 weeks).
- Circa 16k of non admitted patients working 18-51 weeks.
- Circa 2.5k of admitted patient waiting 18 – 51 weeks.
- This is split into two reportable pathways – admitted and non admitted.

Non Admitted Patients (52+ weeks)



916 patients over 52 weeks

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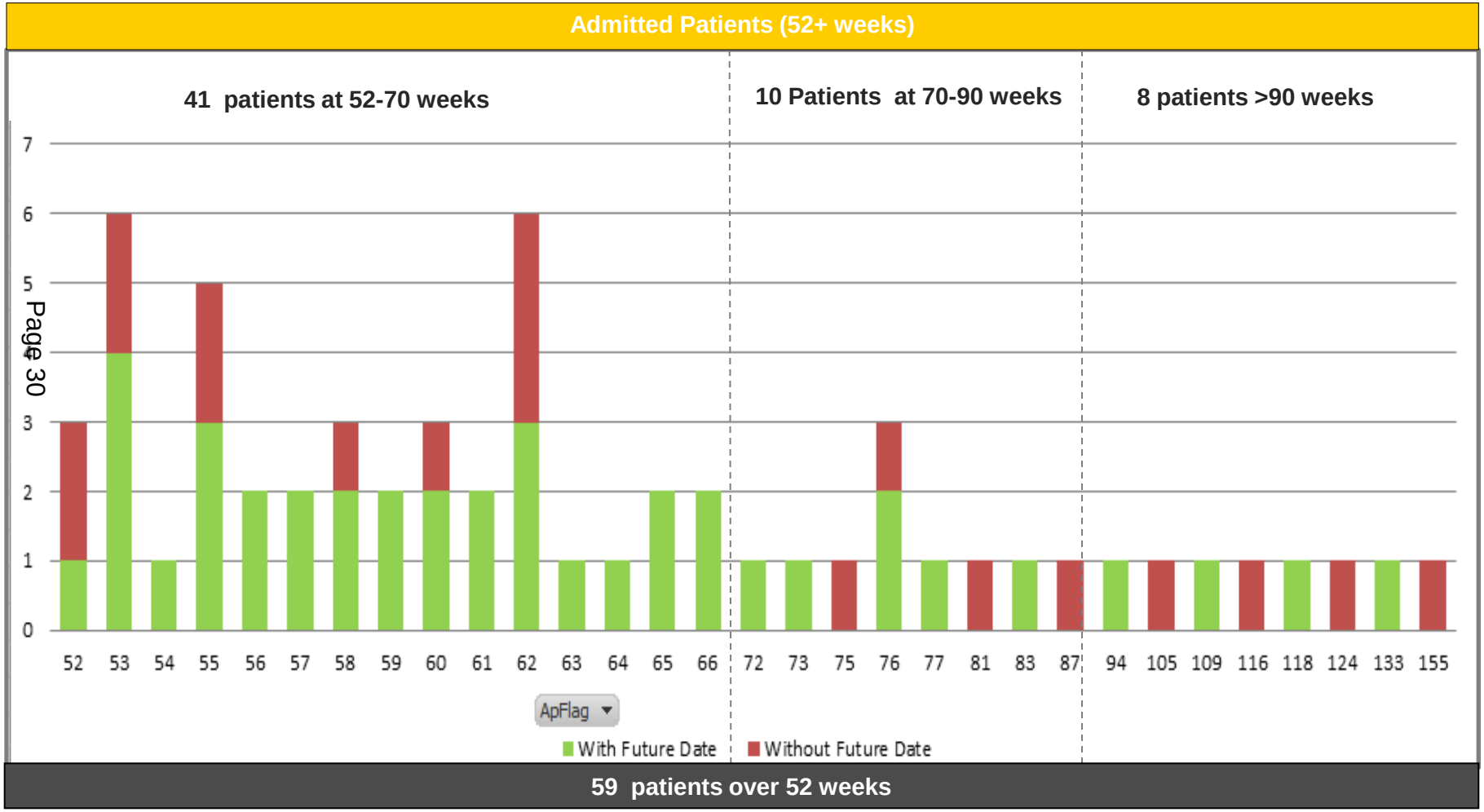
Understanding the Issue: Latest Headline Numbers (continued)



RTT Recovery Programme - Aim and Objectives

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Strategic

Tactical

Operational

Return to 18 week RTT Compliance by March 2017

PHASE THREE
Implement sustainable improvement

External Stakeholder Communication

PHASE ONE
Reduce number of patients waiting over 52 weeks to 8% in line with national standards by 30th September 2016

PHASE TWO
Reduce the number of patients waiting 18 – 52 weeks to zero by March 2017

Reduce over 90 week waiters to 0 by 14th April
Reduce 52 – 70 week waiters to 0 by 31st May
Reduce 70 – 90 week waiters to 0 by 30th September

Proactive management of 18-52 waiters
Data Quality issues rectified
Return to national reporting once all parties are in agreement

Outsourcing
- Review of theatre productivity opportunity identified by four eyes
- Project plan to realise the delivery of this opportunity
- Increased activity rates in theatres

Administration
- Recruitment of additional staff
- Additional capacity and activity delivery
- Virtual clinics
- Booking processes and validations processes

Validation
- Management of outsourcing team
- Identifying IS capacity
- Management of relationships with providers
- Increased throughput of outsourcing

Productivity
- Delivery of O/P RTT recovery initiatives identified

C&D
- Management of current validation process carried out by Cymbio
- Establishing in-house validation capability

DM
- Set up DM system to direct referrals to alternative providers
- Set operational intermediate services and procurement
- Manage delivery of RM initiatives

Referral and Demand Management

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In response to RTT performance, the BHR CCGs have set themselves a trajectory (shown below) to reduce the number of new outpatients referrals into the Trust by c30k. per year by March 2017

Number of referrals reduced	Apr	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
	457	1472	2609	2459	2751	2927	3177	3107	3628	3585	3832	30,565

In order to sustain this, each CCG has agreed to take up to three each of the following specialties to source alternative arrangements

Barking and Dagenham	Havering	Redbridge
Orthopaedics	Dermatology	Neurology
Gynaecology	Gastroenterology	ENT
General Surgery	Ophthalmology	Rheumatology

These will be developed by a GP clinical director , lead consultants and independent facilitation offered from University College London Partners (UCLP) and explore the following alternative arrangements:

- fundamental redesign of advice and guidance offered by Consultants to GPs;
- improving pathway to direct referrals in diagnostics;
- new pathway and methods of treatment in community including GPSIs, Consultant led community clinics etc;
- use of more home care provider; and
- use of technology and remote monitoring to manage long term conditions.

EY SCOPE OF SUPPORT

EY RTT Review – High level plan

EY RTT Workstream	w/c 11th April	w/c 18th April	w/c 25th April	w/c 1st May
(1) Clinical Harm	Documentation review			
	Review good practice elsewhere			
	Carry out interviews			
			Discuss emerging recommendations in workshop	Final report
(2) Governance	Carry out desk-based reviews of governance processes			
	Carry out interviews			
		Benchmarking exercise	Discuss emerging recommendations in workshop	Final report
(3) Demand and Capacity Modelling	Assess current work and strength and weaknesses of the current models		Model scoping workshops to produce joint solution	Final report
(4) PMO support	Establish role of EY PMO support and assess current state	Support introduction of effective PMO processes		Draw conclusions for the next phase of work

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Workstream Project Charter – (1) Clinical Harm

1. Objectives

- Provide clear analysis of current situation, contrasting BHRUT clinical harm practice against stated procedures and best practice elsewhere
- Make clear recommendations for improved management of clinical harm relating to RTT at BHRUT, supported by an action plan
- Develop support within CCGs, BHRUT and NHS London for proposals

2. Deliverables

- Workshop in week commencing 3rd May
- Final report that sets out:
  - Clear analysis of current situation, contrasting BHRUT clinical harm practice against stated procedures and best practice elsewhere
  - Clear recommendations for improved management of clinical harm relating to RTT at BHRUT, supported by an action plan

3. Workstream scope

In scope

- Assessment of Clinical Harm in RTT management across specialities in everyday working
- Assessment of Clinical Harm in RTT management across specialties in stated practices
- Reported complaints about clinical harm impact
- Any Board discussion of Clinical Harm management
- Best practice elsewhere
- Recommendations on management of Clinical Harm
- Stakeholders' perspectives; eg GPs

Out of scope

- Management of individual cases

4. Key Activities

Workstreams	Key tasks
(i) Assess current policies and procedures **Weeks 1-3**	► Meet Patient Bookings team ► Assess stated procedures and policies relating to management of clinical harm ► Review any Board papers ► Understand waiting lists by specialties ► Assess relative clinical harm by type of specialty; so how much harm done by waiting for particular conditions ► Review complaints and correspondence ► Meet Patient liaison team ► Interview Divisional Directors, Medical Director and NEDs ► Interview GPs
(ii) Review against best practice elsewhere **Weeks 1-3**	► Identify the acute trusts which are outstanding performers against RTT ► Interview them to draw out common themes
(iii) Develop recommendations for next steps **Weeks 3-4**	► Interim report drawing out key findings from initial work ► Workshop with key stakeholders to develop new proposals ► Develop final report with supporting action plan

5. Benefits

- Clear assessment of current situation and of how it can be improved in line with best practice
- Recommendations supported by action plan

6. Interdependencies (other workstreams / projects)

- PMO Programme
- Governance workstream

7. Resourcing

Trust

- Access team
- Divisional managers
- Medical Director and NEDs
- PMO Lead

Ernst & Young

- Owen Sloman and Sarah Tunkel
- Clinical Associates Paul Edwards and Helen Thomson

Workstream Project Charter – (2) System-wide Governance Review

1. Objectives

- Review governance over the system wide end to end RTT processes
- Identify areas for improvement in the governance and reporting on RTT

2. Deliverables

- Report documenting:
  - Existing governance processes over RTT
  - Findings in respect of gaps in controls and areas for improvement
  - Recommendations with reference to best practice and other comparable Trusts
- Workshop / Meeting to discuss findings and implementation of recommendations

3. Workstream scope

In scope

- Governance and oversight with reference to 4 Well Led Governance Framework questions as regards RTT processes in BHRUT
  - Are there clear roles and accountabilities in relation to RTT governance?
  - Are there clearly defined, well understood processes for escalating and resolving issues, and managing performance, particularly in relation to RTT?
  - Is appropriate information on organisational and operational performance being analysed and challenged?
  - Is the Board assured of the robustness of information?
- Contractual arrangements and oversight between Barking & Havering CCGs / NHSE and the Trust

Out of scope

- RTT PMO Governance

4. Key Activities

Workstream	Key tasks
(i) Desk top review **Weeks 1-2**	► Review key governance documentation including performance reports, risk assurance processes
(ii) Meetings **Weeks 1-3**	► Meet with senior officials and Board members identified in BHRUT, CCGs and NHSE
(iii) Benchmarkng **Week 2**	► Compare Trust processes with best practice and comparable Trusts (where information is available)
(iv) Reporting **Weeks 3-4**	► Flag issues as they emerge ► Workshop to provide initial feedback and agree on any changes required ► Draft report ► Report validation and factual accuracy check ► Workshop

5. Benefits

- Better understanding of best practice
- Identify recommendations for areas for improvement noted
- Identify areas for implementation in the short term

6. Interdependencies (other workstreams / projects)

- PMO Programme
- 18 week validation project

7. Resourcing

Trust

- PMO Lead
- Executive and Non Executive Team
- Divisional / Directorate Leads

Additional trust resource

- tbd

Ernst & Young

- Ross Tudor
- Olayemi Karim
- Agne Rimkute

NHS Havering Clinical Commissioning Group

Workstream Project Charter – (3) Demand and Capacity Modelling Review

1. Objectives

- Understand the extent to which current models at the Trust and CCG are appropriate for the use of developing a RTT recovery plan
- Propose options for future analytics and modelling support to support a recovery plan
- Produce a model specification that defines the inputs, calculations and outputs a new demand and capacity model, or modifications to existing tools where deemed fit for purpose

2. Deliverables

- **Summary Report** highlighting findings related to current Trust and CCG modelling and recommendations on whether they are fit for purpose
- **Model specification document** documenting the approach and design of a demand and capacity model suitable to supporting the recovery program, detailing inputs, calculations and initial outputs

3. Workstream scope

In scope

- High level review of existing Trust and CCG demand and capacity models relating to RTT
- Two model scoping workshops
- RTT pathway demand and capacity

Out of scope

- Model build
- Quality assurance of existing models
- Non-elective demand and capacity

4. Key Activities

Workstream	Key tasks
I. Review current modelling and assess suitability for developing recovery plan **Week 1-2**	► Establish RTT Modelling Steering Group ► Identify model specification working group and arrange scoping workshops ► Identify existing models and analysis ► Review purpose and use of existing work
II. Scope modelling requirements **Week 2-3**	► Meet with key stakeholders individually and two sample specialties to identify modelling requirements ► Hold initial scoping workshop to scope and design model specification ► Write draft model specification ► Hold second scoping workshop to present draft model specification and refine ► Review initial findings of data quality review and estimate impact on demand and capacity modelling
III. Document recommendations and write model specification **Week 4**	► Discuss recommendations to be include in summary report ► Issue final specification for comments and signoff ► Present specification at Weekly BHRUT RTT Meeting for comments and approval

5. Benefits

- Engaged scoping and design of bespoke solution
- No commitment to building new model
- Identification of operational issues concerning modelling and information

6. Interdependencies (other workstreams / projects)

- RTT PTL Data Quality Review (MBI)
- Governance review – understand any issues why previous information/reporting may not be currently used

7. Resourcing

Trust

- Sarah Tedford - COO Trust
- Steve Russell - Deputy CEO Trust (Information)
- Alan Steward - COO, BHR CCG
- Clare Burns - Deputy COO (DM)
- Kevin Pirie - RTT Trust lead
- X – Director of information
- Martin Pottle - Theatres project manager
- Maureen Blunden - Head of outpatients

Ernst & Young

- Ed Pennington – Modelling lead
- Thameesha Peiris – Modelling support
- Gareth Fitzgerald – RTT subject matter expertise

NHS Havering Clinical Commissioning Group

Workstream Project Charter – (4) RTT PMO Support

1. Objectives

- Establish rigorous programme management practices across the RTT system improvement programme
- Align key stakeholders to the programme's direction and establish clear lines of accountability
- Provide assurance to system wide stakeholders on RTT performance

2. Deliverables

- **Terms of Reference for RTT PMO function**
- **RTT Programme structure**
- Establish a **weekly PMO working group**
- Validate existing plans and collate into a **single plan**. This includes managing the development of: (i) Milestone plans for each workstream (ii) Detailed plans containing weekly activity
- **RTT governance structure**
- **RTT Programme dashboard**
- **Stakeholder management plan**
- **RAID management** - establish required logs and management of these
- **Summary Report**

3. Workstream scope

In scope

- Establishing and managing PMO documents/processes
- Validating/establishing governance and reporting arrangement
- Establishing monitoring practice against plan and KPIs
- Undertaking key stakeholder management
- Validating and managing development of plan(s)

Out of scope

- Direct RTT performance improvement i.e. performance optimisation of individual teams
- Wider system Governance review (picked up in workstream 2)

4. Key Activities

Workstream	Key tasks
(i) Establish scope and assess current state **Week 1**	► Establish role of EY PMO support ► Validate scope of work ► Start review of current PM practices ► Identify key stakeholders. Arrange individual interviews for wks 2 & 3 ► Identify which processes work (continue), which need to stop and which need to start
(ii) Support introduction of effective PMO processes – Develop PMO documents/ processes **Week 2**	► Develop key stakeholder management plan ► Establish role of RTT PMO ► Collate RTT system improvement plans - Undertake stratification of monitoring against plan and KPIs ► Develop and establish PMO processes and tools, including lines of responsibility/reporting protocol ► Hold meetings with key stakeholders
(iii) Support introduction of effective PMO processes – Establish PMO documents/ processes **Week 3**	► Align workstream leads/sponsors to Programme vision and proposed PMO processes ► Validate level of assurance received with senior stakeholders
(iv) Draw conclusions for the next phase of work **Week 4**	► Check progress against PMO plan/processes ► Produce summary report on PMO processes updated and next steps for each

5. Benefits

- Programme management rigour
- Key stakeholders are engaged and understand their accountability
- Timely assurance provided to senior stakeholders
- Clear governance in delivering and managing identified risks

6. Interdependencies (other workstreams / projects)

- System wide governance review –
- RTT PTL Data Quality Review (MBI)

7. Resourcing

Trust

- Faith Button – RTT Programme Director
- Sarah Tedford - COO Trust
- Steve Russell - Deputy CEO Trust (Information)
- Alan Steward - COO, BHR CCG
- Clare Burns - Deputy COO (DM)
- Kevin Pirie - RTT Trust lead

Additional trust resource

- Martin Pottle - Theatres project manager
- Maureen Blunden - Head of outpatients

Ernst & Young

- Basma Jeelani – RRT PMO Workstream lead
- Alice Chester- Masters – RTT PMO Support

ELECTIVE SERVICES FOR OUR PATIENTS

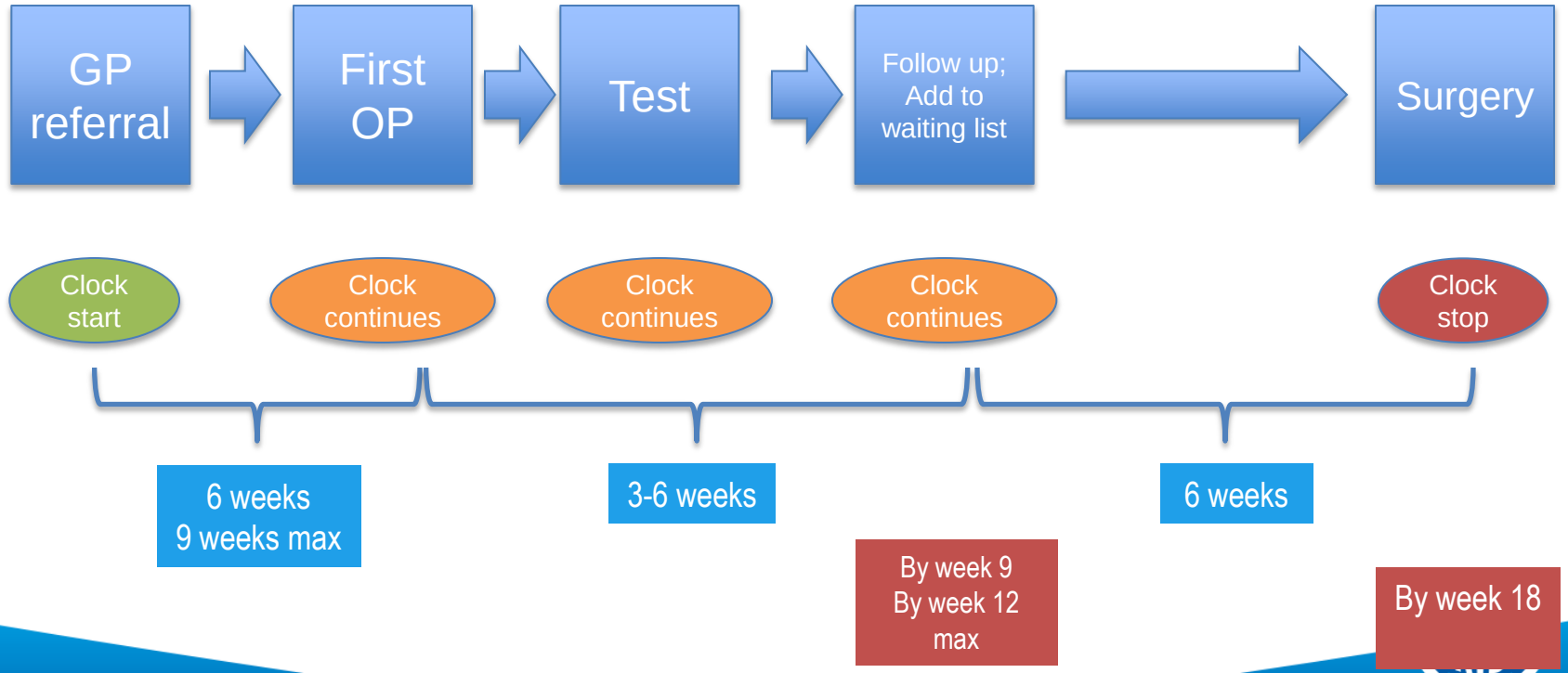
Matthew Hopkins
Sarah Tedford

TAKING PRIDE IN OUR CARE

Barking, Havering and Redbridge University Hospitals NHS Trust

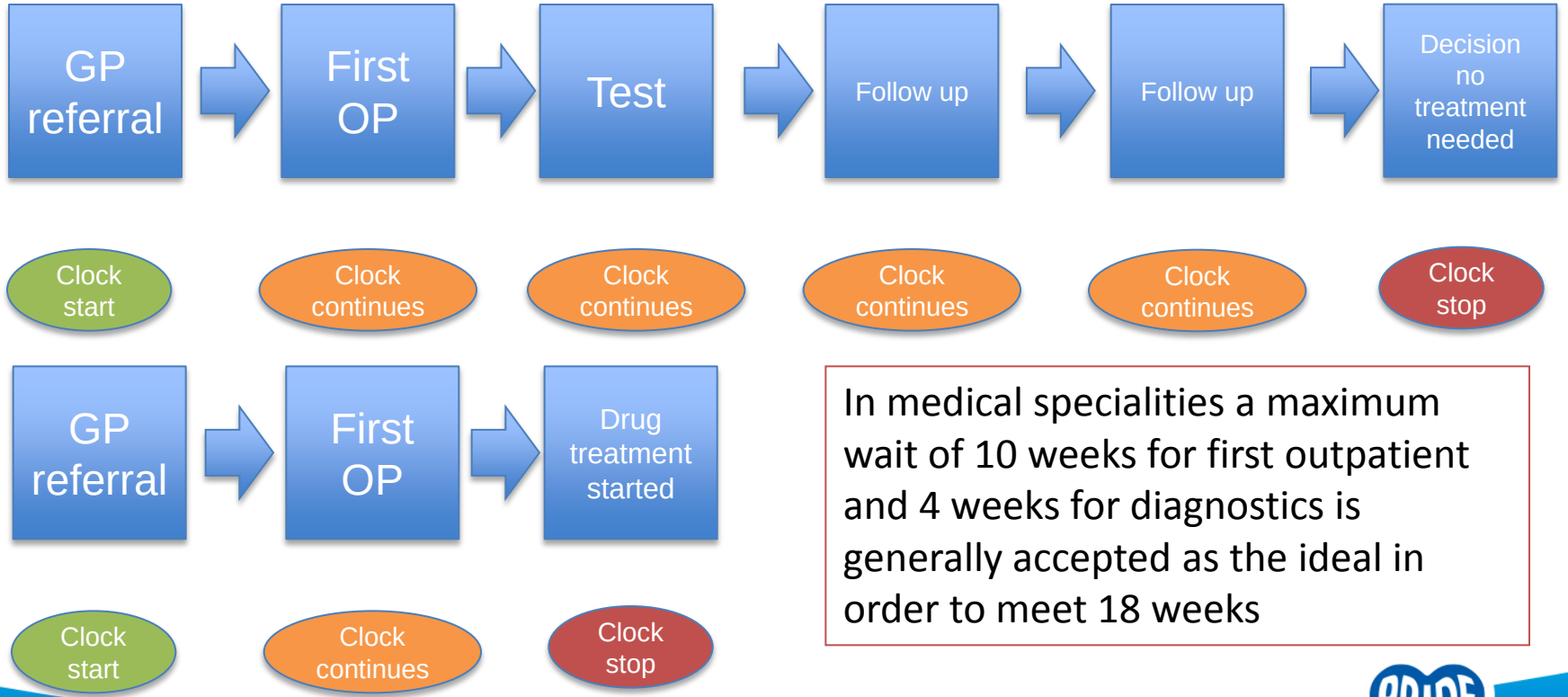
RTT PATHWAYS – BACKGROUND (1/2)

- Patients who are on an 'admitted' pathway have been referred to hospital and it has been decided that their condition needs to be treated with surgery. This is known as their definitive treatment. 92% of patients should be waiting under 18 weeks.
- An ideal pathway for a patient is shown below. For medical specialities it is possible to have a slightly longer wait for first outpatient appointment.



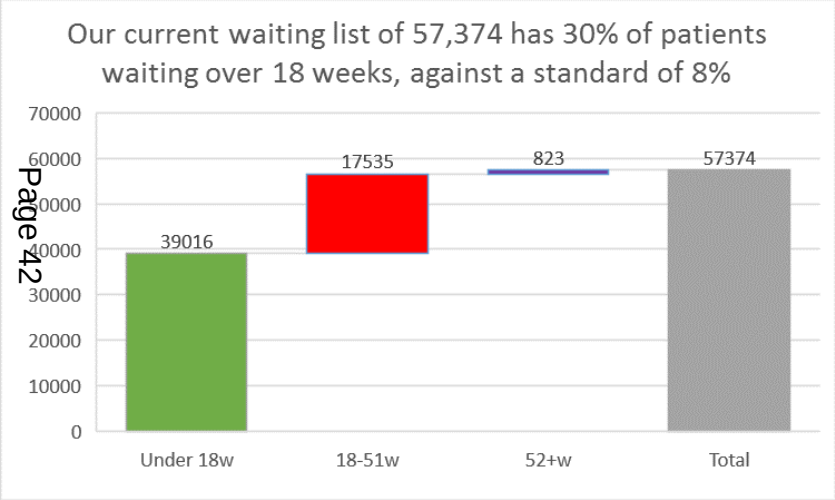
RTT PATHWAYS - BACKGROUND (2/2)

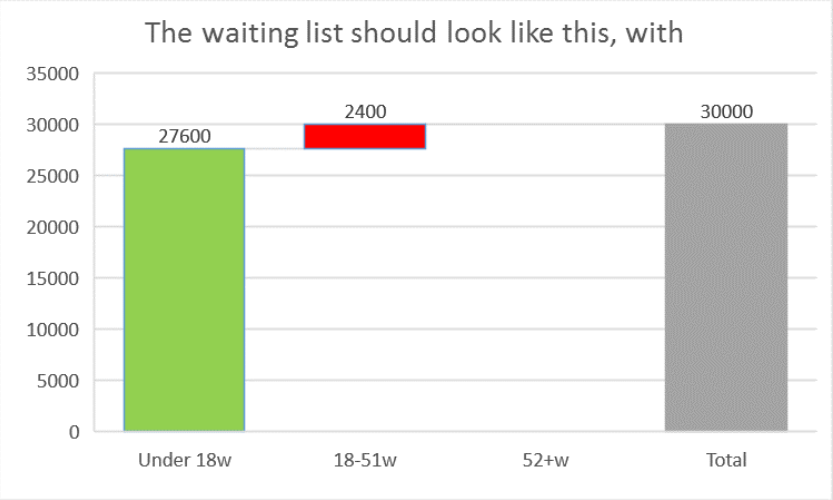
- For a patient on a non-admitted pathway, patients will be assessed i[redacted]ent settings, will have tests and their treatment may be medication, therapy or a decision will be made that no treatment is necessary. Unlike in an admitted pathway we cannot predict whether the next test or appointment will stop the clock, as simply seeing a patient does not mean definitive treatment has been given



In medical specialities a maximum wait of 10 weeks for first outpatient and 4 weeks for diagnostics is generally accepted as the ideal in order to meet 18 weeks

OUR CURRENT WAITING LIST HAS 57,000 PATIENTS WAITING FOR FIRST DEFINITIVE TREATMENT





OVERALL, GP REFERRALS ARE LOWER THAN IN THE PREVIOUS YEAR, BUT IN 7 OF THE KEY SPECIALITIES DEMAND HAS RISEN, ADDING TO THE STRUCTURAL GAP

- In addition to the change in demand, there has been an increase in the proportion of patients referred as urgent which pushes out routine capacity.

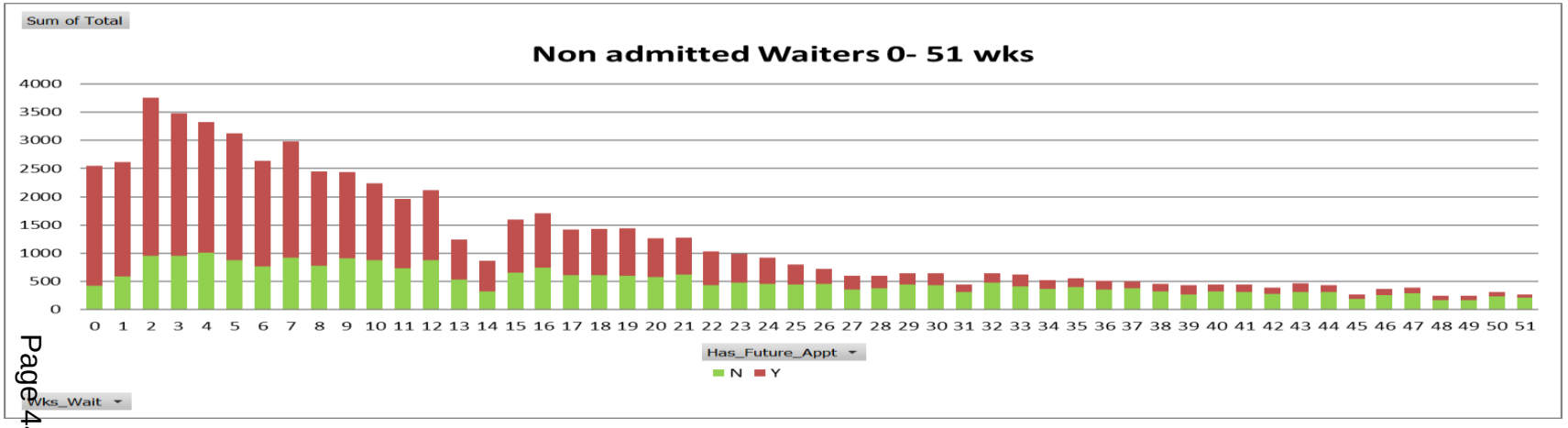
- 35% of patients were referred urgently by their GP at the beginning of the year, and this has risen to 43%

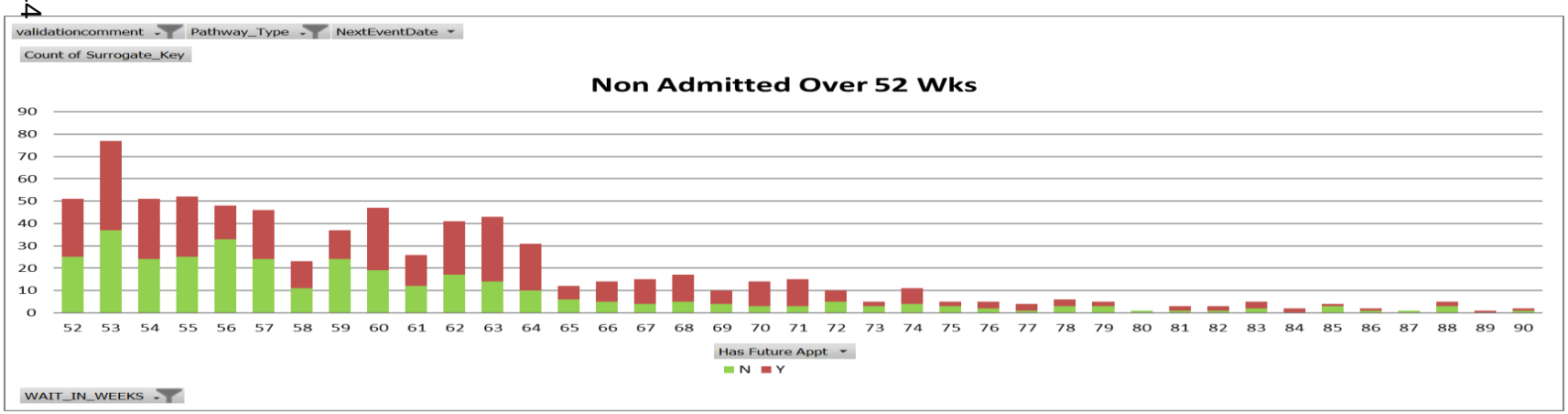
- Consultant to consultant referrals are at a much more significant level than in comparable Trusts, and compared to the contract

Specialty	Change YoY
General Surgery	+ 5.3% (815)
Urology	+ 5.8% (281)
ENT	+ 5.5% (462)
Gastroenterology	+ 5.8% (251)
Cardiology	+ 5.8% (755)
Gynaecology	+ 4.9% (331)

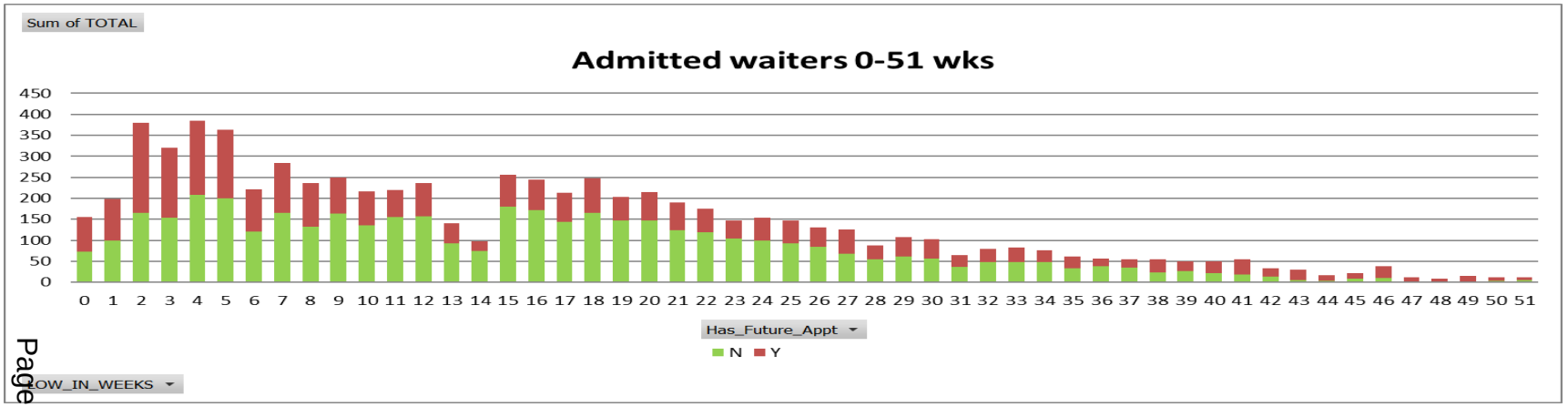
Specialty	Change YoY
T&O	- 14.7% (1135)
Ophthalmology	- 12.9% (892)
Pain	- 17.8% (347)
Dermatology	- 25.9% (2154)
Rheumatology	- 17.7% (700)

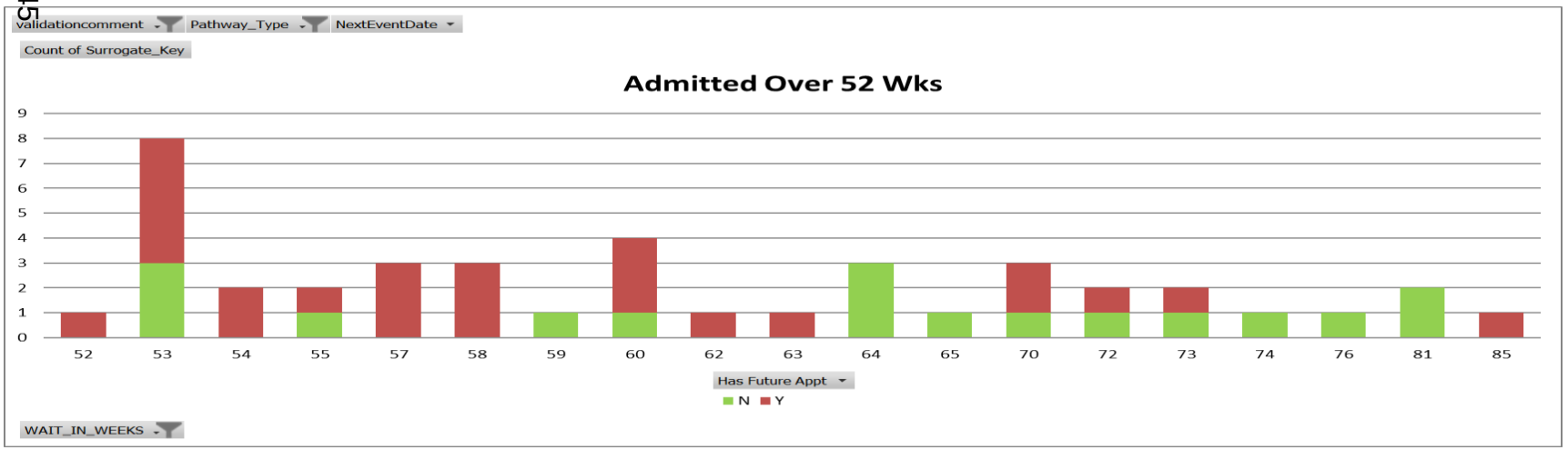
THE LONGEST WAIT ON THE NON-ADMITTED PTL IS 90 WEEKS, DOWN FROM 188 AND 312 WEEKS IN THE PREVIOUS TWO WEEKS





THE LONGEST WAIT ON THE ADMITTED PTL IS 85 WEEKS, DOWN FROM 296 AND 141 WEEKS IN THE PREVIOUS TWO WEEKS





OUTSOURCING

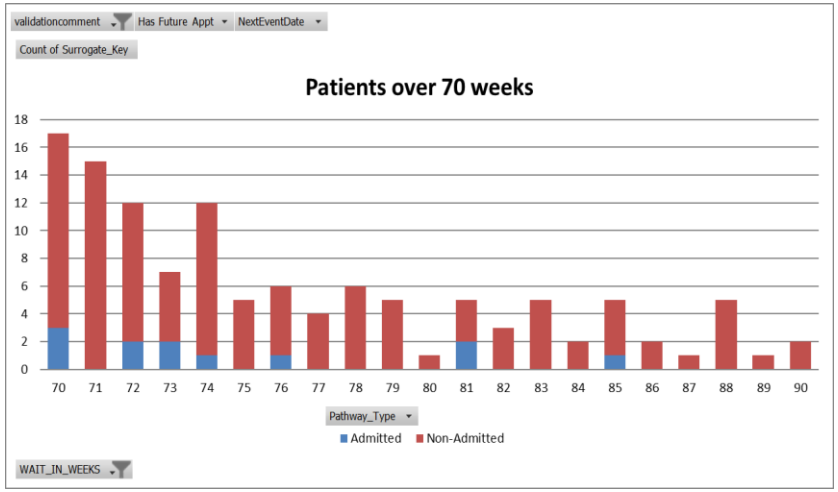
198 patients were referred to the independent sector during March 2016, with a further 55 offered outsourcing who declined (no clock reset)

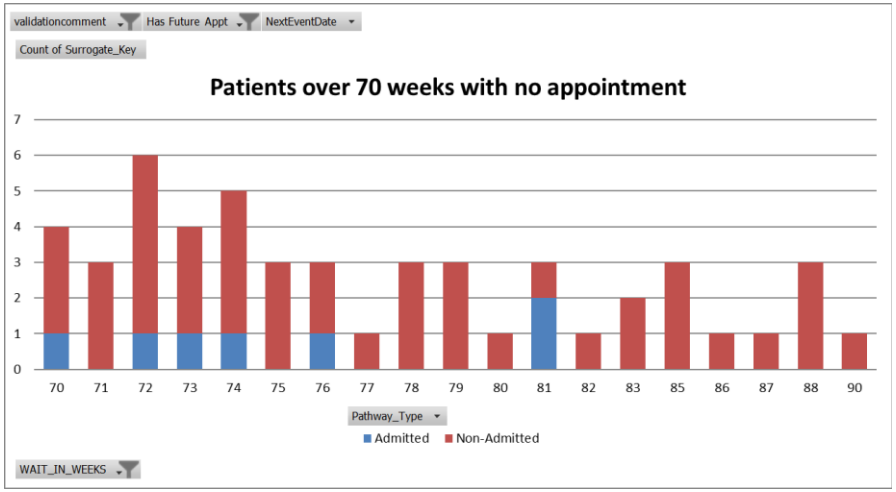
129 of the 198 patients are awaiting treatment, and a further 12 are waiting for treatment from previous months referrals.

	Referrals in the Month of March 2016						
	Number of Patients Declined	Number of Patients Transferred	Of which treated in month	Total treated in month	Number of Patients Returned	Number of Patients Waiting for Treatment	Total Number of Patients Waiting for Treatment
BMI	47	86	61	171	8	17	17
ISTC	0	0	0	9	0	0	1
Roding	0	0	0	0	0	0	0
Holly	8	99	0	0	0	99	99
Nuffield	0	0	0	0	0	0	0
Hartswood	0	5	0	2	0	5	11
Baddow	0	8	0	1	0	8	13

183 patients were treated in the month

THERE ARE 121 PATIENTS WAITING OVER 70 WEEKS OF WHICH 51 DO NOT HAVE A FUTURE APPOINTMENT





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Health and Wellbeing Board Programme Update

26 April 2016

Helen Oliver
Care City Managing Director

CARE CITY

VISION

To create a centre for innovation, research, and education to deliver a dual mission of measurable improvements in **healthy ageing** for our local population and to act as a catalyst for **regenerating** one of London's most deprived communities

COMMUNITY

INNOVATION

RESEARCH

WORKFORCE

Innovation

Aim: To stimulate continuous improvement and innovation across the local health and social care system:

Activity 1: Implement innovations through our local **TEST BED**

Care City is hosting London's Innovation Test bed. The **£1.8m** allocation from NHS England will create local evaluation and acceleration capabilities to overcome historic system barriers to scaling innovations.

https://vimeo.com/interlinkcomms/review/152409444/303f6e3ca5

Our 9 Innovations

AliveCor	A mobile ECG
Kinesis Health Technologies	A device which measures mobility and gait to identify risk of falling
HealthNavigator	Targeted Proactive Health Coaching
MyBrainBook	User led support plan and reminiscence tool
Join dementia research	Dementia Research register portal
HealthUnlocked	Peer network website
Canary	Home sensor monitoring and notification system
St Bernard Location Service	Geo tracking monitoring device
supportspace	Web portal to support recruitment of Personal Assistants

Innovation

Activity 2: Access and create new Innovations through an **INNOVATION EXCHANGE**

Care City is working with UCLPartners to establish a local ‘Innovation Exchange’ for our community and system to identify gaps where innovation will be beneficial and then conduct systematic call outs to workforce and innovators

Research

Aim: To advance the application of cutting-edge research into practice by bringing research to local people, and facilitating new models of research.

Activity 1: Research and Intelligence Hub

- Use existing **EVIDENCE** in decision making and service delivery
- Understand the impact local reform is having through robust **EVALUATION**
- Create new opportunities for **RESEARCH**
- Support **TRAINING and ACADEMIC PRESENCE** in the patch
- Instil a culture of continuous **LEARNING DISSEMINATION**

Education and Workforce

Aim: To increase resilience across the system's workforce by inspiring new entrants, facilitating life-long learning and generating future leaders

Activity 1: Local Skills Escalation through **LABOUR FORCE** Analysis and targeting unemployment

Activity 2: Facilitating cross organisation **QUALITY IMPROVEMENT**

Community

Aim: To support community engagement in Care City's work

Activity 1: Creating an **ASSET** based Community Engagement model

Activity 2: Providing system insight into **CARER** resilience

Health and Care Infrastructure

Activity 1: Barking Riverside Healthy New Town

https://www.youtube.com/watch?v=Da5UJ3tI5z4&feature=youtu.be

London's only Healthy and Age Friendly new town in partnership with NHS England enabling a new approach to integration within a legacy free community setting

Activity 2: Small Solutions

Health and Social Care Community Enterprise Growth

CARE CITY