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

26th April 2016

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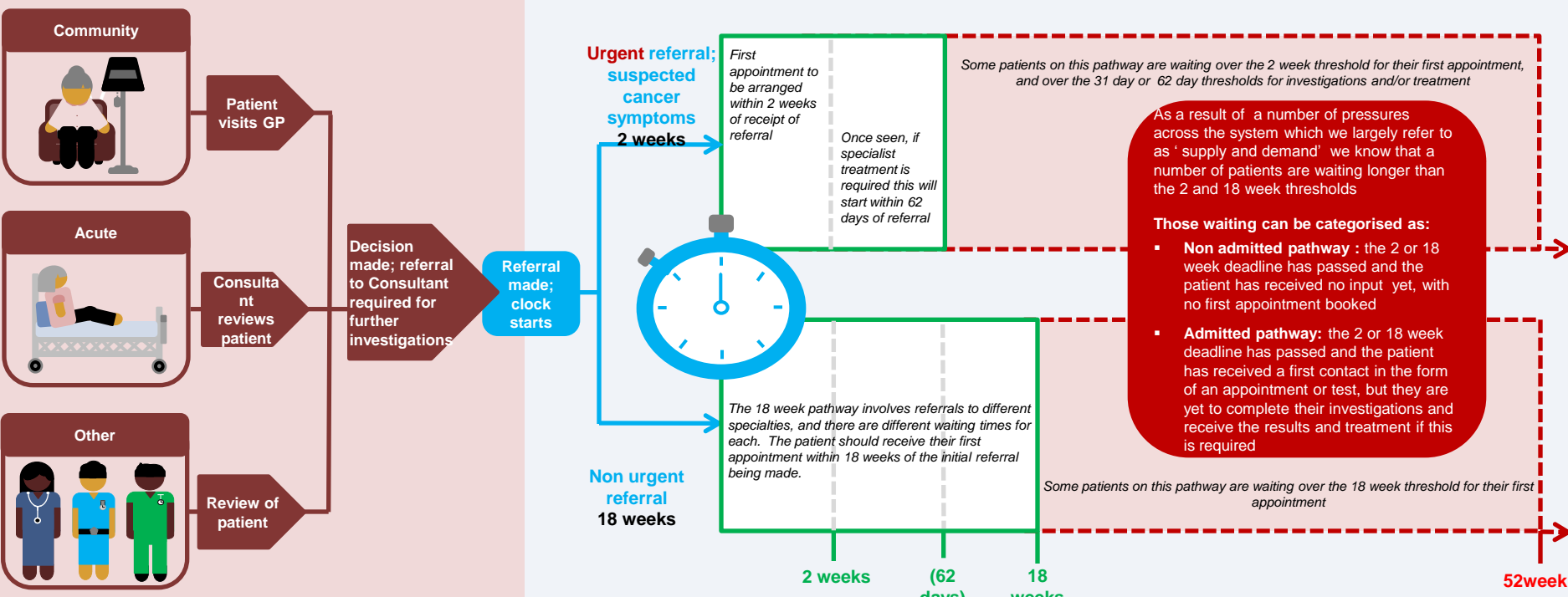
Contents

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.

Community

Patient visits GP

Acute

Consultant reviews patient

Other

Review of patient

Decision made; referral to Consultant required for further investigations

Referral made; clock starts

Urgent referral; suspected cancer symptoms
2 weeks

First appointment to be arranged within 2 weeks of receipt of referral

Once seen, if specialist treatment is required this will start within 62 days of referral

Non urgent referral
18 weeks

The 18 week pathway involves referrals to different specialties, and there are different waiting times for each. The patient should receive their first appointment within 18 weeks of the initial referral being made.

Some patients on this pathway are waiting over the 2 week threshold for their first appointment, and over the 31 day or 62 day thresholds for investigations and/or treatment

As a result of a number of pressures across the system which we largely refer to as 'supply and demand' we know that a number of patients are waiting longer than the 2 and 18 week thresholds

Those waiting can be categorised as:
- **Non admitted pathway :** the 2 or 18 week deadline has passed and the patient has received no input yet, with no first appointment booked
- **Admitted pathway:** the 2 or 18 week deadline has passed and the patient has received a first contact in the form of an appointment or test, but they are yet to complete their investigations and receive the results and treatment if this is required

Some patients on this pathway are waiting over the 18 week threshold for their first appointment

2 weeks   **(62 days)**   **18 weeks**   **52weeks**

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**

Background and Context

NHS

**Barking and Dagenham
Clinical Commissioning Group**

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

The Issue — RTT Performance

► 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.

The Response — The Recovery Plan

► 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
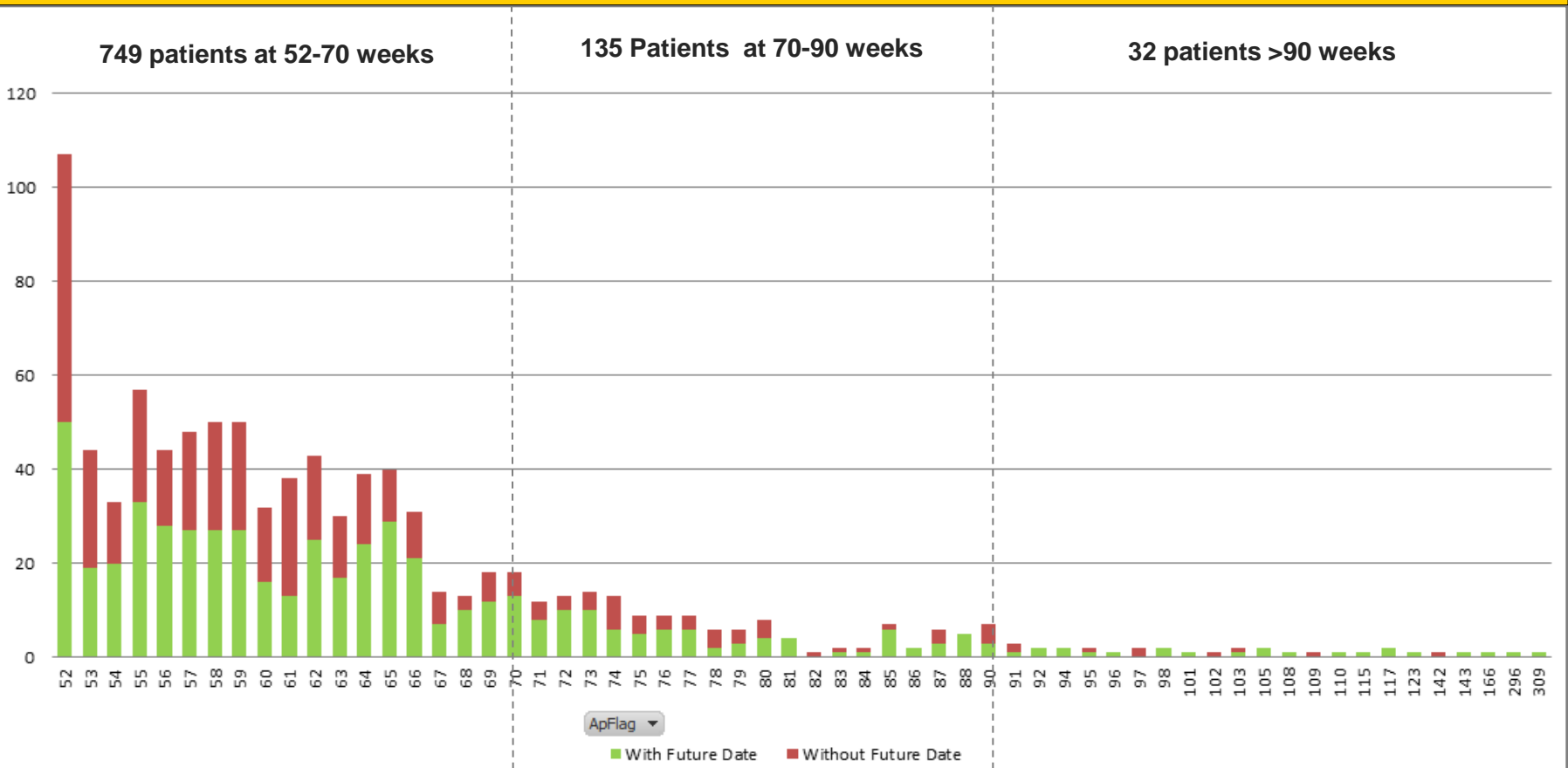iv. Outsourcing of demand to the independent sector.

The Delivery — The RTT Programme

► 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

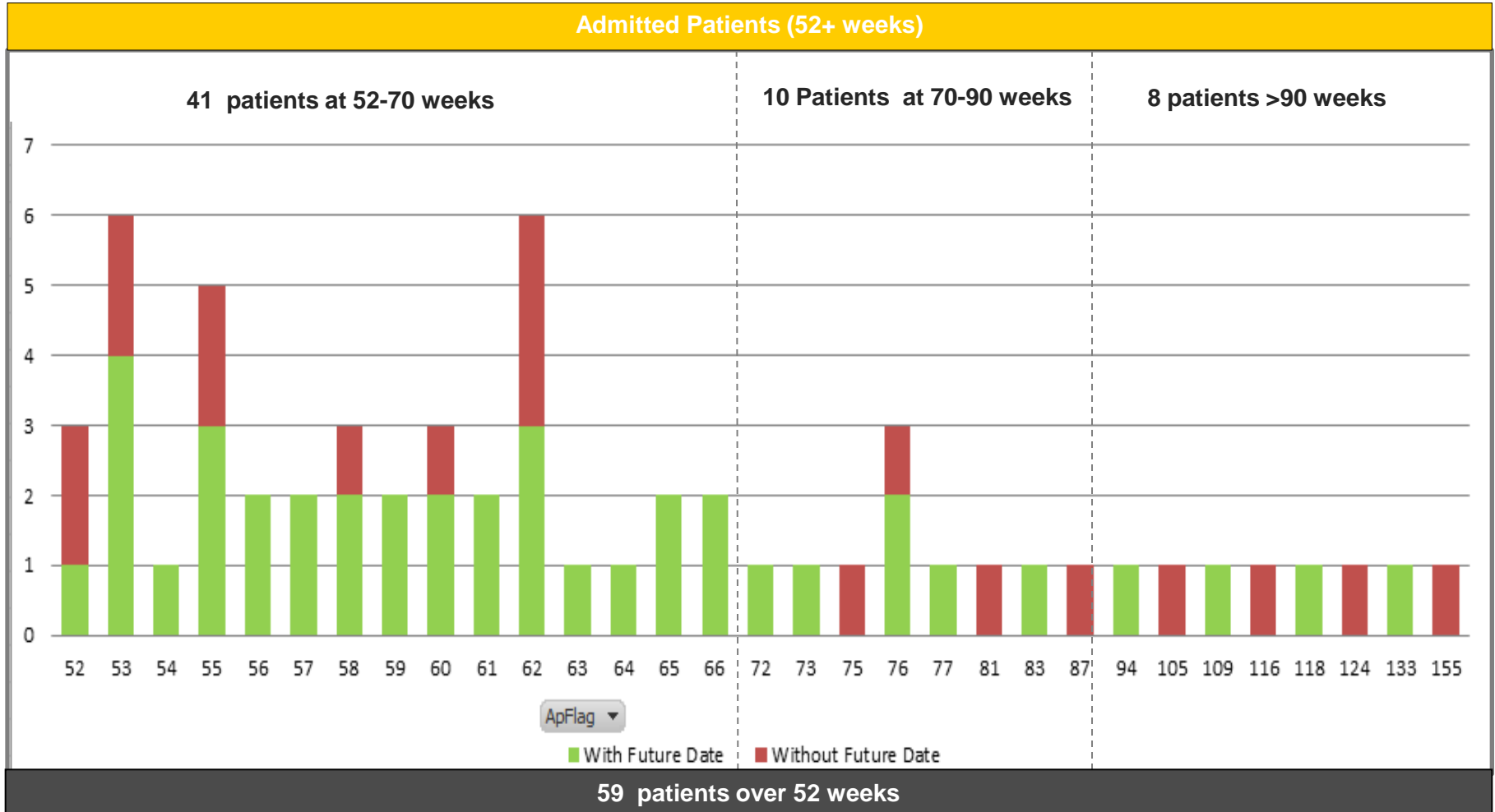# Understanding the Issue: Latest Headline Numbers

► 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.
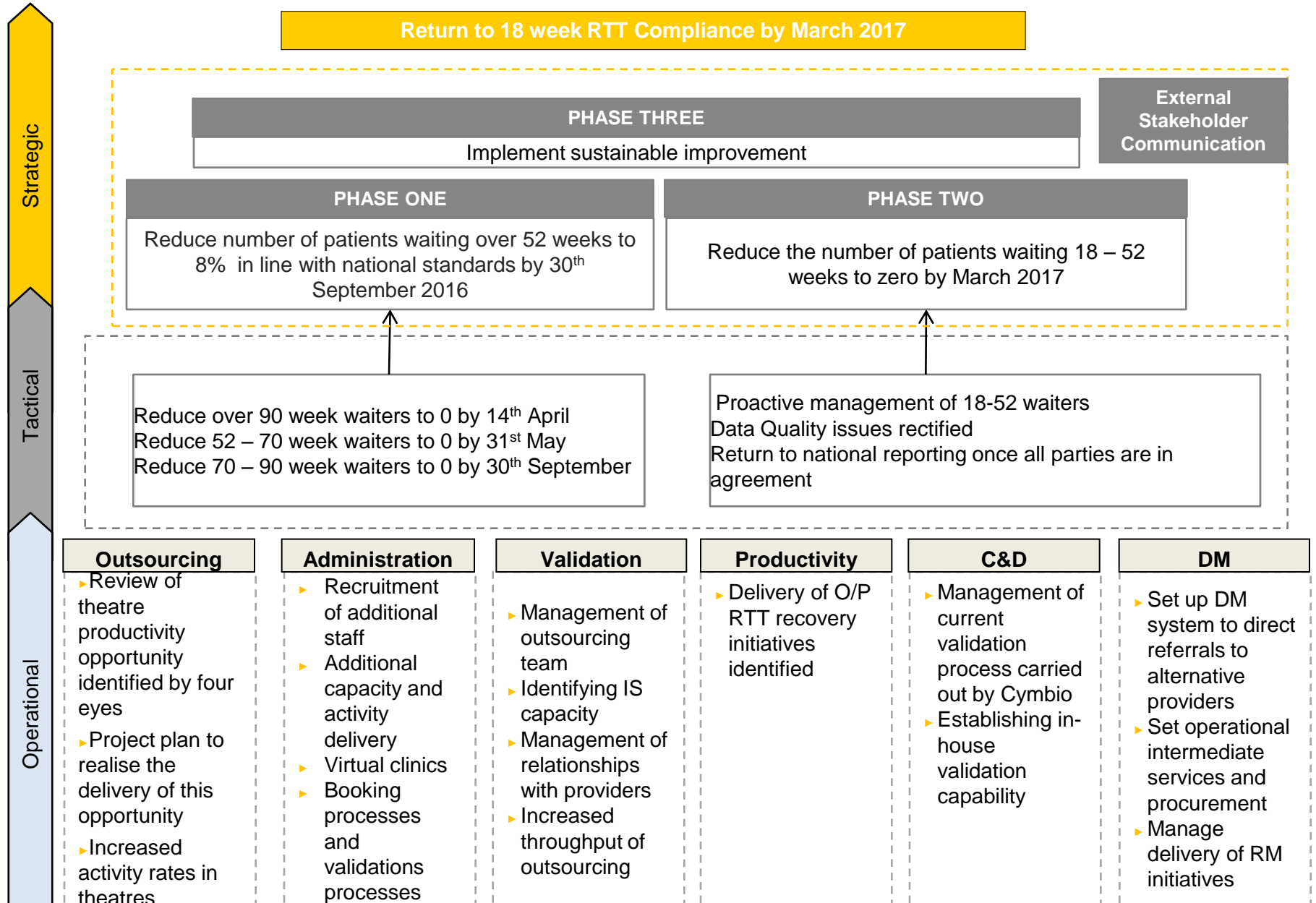
Non Admitted Patients (52+ weeks)

749 patients at 52-70 weeks   **135 Patients at 70-90 weeks**   **32 patients >90 weeks**

ApFlag ▼

■ With Future Date   ■ Without Future Date

916 patients over 52 weeks

Understanding the Issue: Latest Headline Numbers (continued)

Admitted Patients (52+ weeks)

41 patients at 52-70 weeks | 10 Patients at 70-90 weeks | 8 patients >90 weeks

With Future Date | Without Future Date

59 patients over 52 weeks

RTT Recovery Programme - Aim and Objectives

Return to 18 week RTT Compliance by March 2017

Strategic

PHASE THREE
Implement sustainable improvement

External Stakeholder Communication

PHASE ONE	PHASE TWO
Reduce number of patients waiting over 52 weeks to 8% in line with national standards by 30th September 2016	Reduce the number of patients waiting 18 – 52 weeks to zero by March 2017

Tactical

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

Operational

Outsourcing	Administration	Validation	Productivity	C&D	DM
▸Review of theatre productivity opportunity identified by four eyes ▸Project plan to realise the delivery of this opportunity ▸Increased activity rates in theatres	▸ Recruitment of additional staff ▸ Additional capacity and activity delivery ▸ Virtual clinics ▸ Booking processes and validations processes	▸Management of outsourcing team ▸Identifying IS capacity ▸Management of relationships with providers ▸Increased throughput of outsourcing	▸Delivery of O/P RTT recovery initiatives identified	▸Management of current validation process carried out by Cymbio ▸Establishing in-house validation capability	▸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

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

NHS
Havering
Clinical Commissioning Group

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

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

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

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**

► S**takeholder 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