APPENDIX 4

18 week Referral To Treatment

Sarah Tedford
Chief Operating Officer
Executive summary

• Since the RTT issue was identified, good progress has been made to reduce the admitted backlog and we have completed a major validation of the non-admitted waiting list.

• There is a very significant challenge to return to meeting the RTT standards in a sustainable manner that will involve undertaking around 5k operations and 93k outpatient appointments over an 18 month period.

• Even with material demand management, outsourcing and additional recruitment, the size of the programme means this work will take until March 2017 to clear (based upon aggressive assumptions).
Our approach

1. Frame – strategic context
2. Diagnosis – key issues
3. Forecast – position to be achieved
4. Options review
5. Prioritisation – chosen approach
6. Delivery – leadership, resource, risk management
7. Governance – management and assurance
8. RTT Update
• NHS Constitution
  – Patients legal right to start non-emergency NHS consultant-led treatment within a maximum of 18 weeks from referral

• CQC Quality Report 2 July 2015
  – Improve the service planning and capacity of outpatients by continuing to reduce the 18 week non-admitted backlog of patients as well as ensure no patients waiting for an appointment are coming to harm whilst they are delayed, reduce the did not attend, hospital cancellation and hospital changes rates and improve the 31 day cancer wait target.
Diagnosis – key issues

- Poor governance and oversight of RTT
- Insufficient physical capacity to deliver volume of activity
- Ineffective systems and processes
- Poor data quality and information systems
- Ongoing structural misalignment between demand and capacity
- Limited operational capability of waiting list management
- Insufficient and inexperienced operational managers
- Disempowerment of clinical body
We are proposing to deliver a sustainable performance against the RTT standard by:

- Clearing the current backlogs of admitted and non-admitted patients to sustainable levels;
- Reducing outpatient waiting times to sustainable levels, and;
- Putting in place capacity to address the structural gaps in demand and capacity to ensure the backlog does not arise again.

This section covers the additional activity that is required to achieve this and how we expect to deliver it.

The capacity to be created through additional substantive staff, temporary appointments, productivity, outsourcing and material demand management and transfer of follow up activity out of secondary care.

40% of the admitted activity is expected to be outsourced. 54% of the non-admitted activity will need to come from demand management, diversion to the independent sector and modernisation of pathways to reduce follow up in secondary care.

The increase in activity is very significant and although the programme will start ed in late Q3 of 15/16 it will not be completed until the end of March 2017, and this relies on all the assumptions regarding capacity being realised.

There will be imperfections in the analysis as a consequence of an only recently validated PTL, which remains significantly in excess of the expected size for a Trust size of BHRUT but it is unlikely to effect the overall magnitude of the scale of required recovery.
Summary of the additional activity required to deliver sustainable RTT performance, with the non-recurrent element taking place over 18 months.

Non admitted

Admitted

Demand

Backlog Reduction Structural gap Conversion from OP Wait

Total 8,980 19,721 7,923 762 794 3,190 4,746

Backlog 56,401 93,025

Follow up 8,980

Reduce to 6w 7,923

Structural gap 19,721

Total (nonadmit) 56,401

794 762
• The mix of capacity to deliver sustainable RTT performance is different for admitted and non-admitted.

• For non-admitted there is a significant requirement for demand management, transferring follow up activity out of secondary care, and directing new referrals into alternative settings.
There will be a material requirement for additional diagnostic capacity resulting from the additional non-admitted activity

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<th>CT</th>
<th>MRI</th>
<th>US</th>
<th>Endo</th>
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<tbody>
<tr>
<td>29/1,000 attends</td>
<td>30/1,000 attends</td>
<td>74/1,000 attends</td>
<td>18/1,000 attends</td>
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<td>2,698</td>
<td>2,804</td>
<td>6,908</td>
<td>1,608</td>
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Current demand per 1,000 attends for main modalities

Likely additional demand arising from outpatient waiting time reductions
The additional activity requires a very large scaling up in capacity

**Clinics**
- Trust (new): 6,800
- Trust (productivity): 3,400
- Demand Mgt: 2,700

**Lists**
- Trust (new): 2,100
- Trust (productivity): 600
- Outsource: 500

**2011**
- Permanent: 19
- Locum: 13

**Trust (productivity)**
- Clinic rooms: 10
- Theatres: 2
- Theatre: 1

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**Trust (productivity)**
- Clinic rooms: 10
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**2011**
- Permanent: 19
- Locum: 13
Prioritisation – chosen approach

Top 5 actions

1. Appoint to new posts and undertake additional activity
2. Productivity – Increase theatre and clinic utilisation; reduce DNA rate, N:FU ratios; virtual clinics
3. Outsourcing
4. Demand Management
5. ISTC
To address the challenges in the demand and capacity plan, the CCGs and Trust have:

- Established a joint Clinical Reference Group that have reviewed the capacity gap and devised a joint plan building on the existing demand management plans and look to accelerate current initiatives including:
  - Dermatology – remove 100% of non-cancer activity
  - Musculoskeletal – remove 20% of activity
  - Gastroenterology - remove 50% of activity
  - Rheumatology – remove 100% of activity
  - Cardiology – remove 10% of activity
- Plans to focus on alterative provision and referral and pathway education

Plan subject to review through RTT NHSE and NHSI assurance meetings and as part of Commissioning Intentions for 16/17
Delivery – leadership and resource

Leadership
- Chief Operating Officer executive lead
- Deputy COO – Elective Care

Resource
- External subject matter expertise
- Increase in clinical consultant body
- Enhanced operational management
Delivery – risk management

- **Patient choice**
  - MITIGATION – agree formal process
- **Capacity – people**
  - MITIGATION – recruitment
- **Capacity – physical resource**
  - MITIGATION – Productivity, ISTC and review of pathways
  - Diagnostic support
    - MITIGATION – recruitment
- **Capability**
  - MITIGATION – External expertise, enhanced operational management
- **Internal systems and processes**
  - MITIGATION – Training programme, admin and clerical review, SOPs
- **Lack of demand management**
  - MITIGATION – CCGs to establish demand management centre
- **Affordability**
  - MITIGATION – Jointly agree funding and timescales for resolution
Governance – management and assurance

Management
- Weekly programme board - reporting to Trust Executive Committee
- Access board – reporting to programme board - chaired by Chief Operating Officer

Assurance
- Fortnightly RTT Programme Board
- Monthly review by Trust Board
- Weekly NHSE/NHSI Assurance Group – chaired by NHSE
- Monthly mtg NHSI- chaired by NHSI
- System Resilience Group – multi-stakeholder membership – chaired by CCG
• **52 Week Trajectory:** The Trust has developed a trajectory for clearing the current backlog of patients >52 and all prospective 52 week waiters up to 30/09/16. The RTT Recovery Programme is well ahead of the planned trajectory

• The backlog has demonstrated a 26.03% reduction since 03/04/16. Work continues to focus on expediting treatment for this patient cohort

• **Clinical Harm Review:** A key element of the RTT Recovery Plan is the Clinical Harm Programme. The programme is designed to ensure risk to patients waiting longer than NHS Constitutional standards for their treatment are appropriately and efficiently managed.
  – Phase 1 focused on patients on the Admitted pathway. A clinical review process was initiated where the Trust assessed >900 patients. No moderate or severe harm was identified.
  – Phase 2 of the clinical harm review process focuses on patients on the Non Admitted pathway >52 and will review >800 patients
• **Recruitment:** The Trust have a recruitment plan in place to support the increase in overall capacity in the system to support the reduction long waits
  – 19 consultant posts have been approved and are in the process of recruitment with phased start dates from April 16
  – 5 additional leadership roles have been appointed, to support the management of the RTT Recovery Programme and drive the internal changes that will support the reduction in waiting times
  – 16 additional administrative staff have been sourced to support patient pathway management

• **Productivity:** The Trust have initiated a Theatre Productivity Programme to increase the number of operations for patients on the Admitted pathway.
• **Outsourcing:** The Trust has developed relationships with independent providers who can assist in referral to treatment for suitable cohorts of patients on the Admitted and Non Admitted pathway.

• The focus will be on >52 weeks, >18 weeks patients (and any other clinically suitable patients).

• **Validation:** Validation of the Non Admitted PTL has seen the waiting list reduce from 112,414 to approximately 58,000. Work continues on the validation of Non Admitted pathways.

• **Communication:** A system wide communications strategy has been developed which sets out a joint communication and engagement approach between commissioners and service providers in relation to improving waiting times for elective care in Barking, Havering and Redbridge for local people.