Barking, Havering and Redbridge University Hospitals NHS Trust

DELAYED REFERRALS TO TREATMENT – HEALTHWATCH REPORT

BHRUT Response

TAKING PRIDE IN OUR CARE

INTRODUCTION

This document represents Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT/the Trust) formal response to the **Delayed Referrals to Treatment** report of the Joint Topic Group of the Havering Health Overview and Scrutiny Sub-Committee and Healthwatch Havering.

We are pleased to have the opportunity to respond to this report, and would like to place on record our thanks to the Joint Topic Group for their time spent on this issue.

We would also like to thank the Topic Group for the opportunity to review and input to the draft in advance.

In the main, we are pleased to be able to acknowledge this report as a good record of most of the issues and contributory factors.

Nevertheless, we do believe there are places where some additional context or amplification is helpful, to ensure that the right emphasis is placed on what we would consider to be the key elements. We feel it is important to ensure these are noted and acknowledged to provide assurance such a situation can not arise again in the future.

It is a happy circumstance that we are able to put forward this response in the same month that we were able to report nationally that the Trust has hit the 92% Referral To Treatment (RTT) incomplete standard for the first time in three years (June 2017), against a national picture of stagnating or declining performance.

This follows the success of the major recovery programme we have undertaken, delivered in partnership with local GP commissioners, which has seen us treat a huge number of patients. It therefore seems appropriate now to reflect a few of the key achievements:

- At beginning of 2014, waiting list included over 1,000 people waiting longer than 52 weeks – now down to a very small number
- Thousands of extra clinics and nearly 100,000 appointments delivered, with thousands of patients redirected by GPs
- June performance saw BHRUT exceed national average (90.3%)
- Less than 8% of patients waiting longer than 18 weeks for June

We would again like to thank our staff, patients and key partners, particularly our local GPs, who have delivered a remarkable turnaround in performance. We would also like to thank colleagues in local government and the Healthwatch groups across our community, who have helpfully supported and challenged us in a positive and constructive manner.

RESPONSE

We have responded specifically on a paragraph-by-paragraph basis for ease of reference.

Section 1

1.1

- We note and appreciate the Topic Group's acknowledgment of our openness.
- Line 5 – we would expect waiting lists of c.32,000 rather than 30,000 as published

1.4-1.7

- We do not recognise most of the numbers in this section, and would suggest that there may have been a misunderstanding (or failure on our part to successfully explain) these figures at the time.
- For example, the 9,000 extra appointments referred to in 1.4. We calculated (and have typically explained) that the additional work was equal to around 93,000 outpatient appointments, and 5,000 operations.
- Paragraph 1.6 We are not quite sure as to the origins of the assertion re: additional anaesthetists. It relates to surgery, not outpatients, as anaesthetists do not support our outpatient activity.
- The report is right to highlight the additional consultants – in total, 19 were targetted to deliver this workload.

Section 2

2.5

- A point of terminology re: "backlog" – this should read "total waiting list", as we would categorise everyone waiting 18 weeks or more as being a "backlog" – there would always be a waiting list.
- The 52,000 referenced is the total waiting list. They were awaiting treatment, not an appointment.

2.6

- While this is accurate, it is important to note that readmission is an issue largely related to ED – as the paragraph concludes, for elective patients, this is less of an issue.

Section 3

3.4

- We would echo and emphasise the importance of this point, which remains a challenge. We welcome the ongoing support for CCGs and other partners to continue to identify ways to progress this.

Section 6

6.4

- This was and remains true. We have dedicated significant time, resource and effort in conducting a Clinical Harm review. This has been run alongside the recovery plan, reviewing more than 4,000 patients, in particular those patients who had waited more than a year, and has indicated so far that no RTT patient has come to harm.

Conclusions

Overall, we believe an appropriate conclusion is that there was an absence of effective demand and capacity plans, which meant that as a Trust (and a system), we did not understand the gaps, or the ebbs and flows of demand across the specialties, and how best to manage the service and capacity appropriately.

We did not have the specialist expertise within the Trust to manage the waiting lists (a highly complex operation), and we were not consistent with our reporting, with our application of rules and processes, or with our patient classification.

The expertise and experience we have acquired in the past two years particularly means that we have taken a significant step to resolving this, and minimising the risk of any future relapse. Specifically, the processes, systems and procedures we have put in place mean that our entire operation is far more data-driven and robust.

C1

- While we recognise some of the points made within, we are concerned that this conclusion as currently phrased does not seem to tackle the main underlying issues, and we believe puts undue emphasis on the ICT factors.

- While we accept all the points of concern, we would want to be clear that the migration of the databases was not the root cause of the problem – rather it was this which actually uncovered the problem.

- We absolutely agree that the management was clearly inadequate prior to this.

- We believe that the reference to cybersecurity in this instance is somewhat tangential to the matter in hand. There were no cybersecurity issues relating to this circumstance.

- The suggestion made in the final paragraph, while an admirable ambition, represents a significant logistical challenge.

C2

- The “central point” of referrals does exist within BHRUT, however we absolutely recognise the potential for exploring this further as a system-wide solution, and are exploring this.

C3

- We would question whether GPs (who are already extremely busy, and working very hard) would realistically be in a position to chase every appointment or referral. We already work closely with our GPs via our GP Liaison Service, to help escalate issues and chase appointments. We send clinic letters following attendances as well as discharge records.

Recommendations

R1/2

- As per our above comments. We acknowledge and endorse the Topic Group's comments regarding the need for robust ICT governance and management, and this remains a top priority for the Trust. We also acknowledge the shortcomings here.

- We do believe it is important to note that in our view, it was not the "loss of data" which occasioned the delays. We believe that presenting this as an ICT or data transfer issue does not fully acknowledge the complexity of the problem, so would be keen to make sure this is understood.

R3

- We agree and support this recommendation. However, we would suggest that a more active verb than "modelling" – we believe that active management is required here.

- We believe that very strong progress has already been made, by us and our CCG partners to better understand the picture in our community. We now have far more information and a more accurate picture about the specific nature of the demand, in order to plan effectively to meet the need.

- We believe that tackling this is a top priority, as now we have established a reliable picture of the demand, thanks to the work we and CCG/GP colleagues have undertaken, it is showing how high these levels truly are. We are committed to playing a full role in supporting the work of partners, particularly the CCGs, in their efforts to continue to find ways to reduce this demand, and explore all solutions, whether in or out of our hospitals.

R4

- Work is already underway to address this issue with a joint system approach. We are working with the BHR CCGs to develop a business case for the establishment of a referral management system. This is being overseen at a senior level by the System Delivery and Performance Board of which which both commissioners and providers are members.