Delayed Referrals to Treatment

Barking, Havering and Redbridge University Hospitals Trust

January 2016 to March 2017

Trust Headquarters,
Queen's Hospital, RM7 0AG

Revised report of a Review by a Joint Topic Group of the Havering Health Overview & Scrutiny Sub-Committee and Healthwatch Havering

Including responses of Barking, Havering and Redbridge University Hospitals Trust and NHS Improvement

Joint Foreword

Councillor Michael White
Chairman
Health Overview & Scrutiny Sub-Committee

Anne-Marie Dean
Chairman
Healthwatch Havering

The Joint Topic Group was formed to enable Healthwatch volunteer members and Councillors the opportunity to explore the issues, regarding the very significant delays in the care of patient at Queen's Hospital and King George Hospital.

A joint review seemed a sensible way forward, given that the two organisations have complementary statutory powers – Healthwatch has the power to enter and view hospital premises[1], while the Overview and Scrutiny Sub-Committee has the power to hold NHS officials to account[2]. In the event, recourse to those powers was not necessary as all relevant NHS and other agencies co-operated fully in the Review.

Using the values of the NHS as the basis for the review the Joint Topic Group asked a series of individuals and organisations to meet with the Group and respond to the questions and concerns.

The NHS values of

- Accountability – everything done by those who work in the NHS must be able to stand the test of public judgements
- Probity – there should be an absolute standard of honesty in dealing with the assets of the NHS: integrity should be the hallmark

[1] s225, Local Government and Public Involvement in Health Act, 2007, as amended by s182 of the Health and Social Care Act 2012
[2] s21, Local Government Act 2000, as amended by s244 of the NHS Act 2006

of all personal conduct in decisions affecting patients, staff and suppliers, and in the use of information acquired during NHS duties.

- Openness – there should be sufficient transparency about NHS activities to promote confidence between the NHS organisation and its staff, patients and the public.

The problem became apparent in December 2013 when BHRUT migrated data from one computer data base to another and this exposed a discrepancy. In February 2014, BHRUT undertook a major investigation to identify the cause of the problem and the number of patients affected. In June 2016, legal directions were issued by NHS England to Havering CCG (lead CCG for BHRUT contract) to develop a robust and credible recovery plan; these legal directions were lifted in February 2017.

In autumn 2015, it became apparent that delays had occurred for a significant number of patients in receiving treatment at Queen's Hospital, Romford and King George Hospital, Chadwell Heath, both run by the Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT).

Healthwatch Havering and members of the London Borough of Havering's Health Overview and Scrutiny Sub-Committee became greatly concerned at this and agreed to carry out a joint review of the circumstances that had led to the delays.

The delays breached the NHS Constitution rights of the affected patients – to treatment within 18 weeks of referral – in some case to a considerable degree; delays more than 12 months were not uncommon.

It was acknowledged that the delays had arisen under previous management of the two hospitals but the current managers bore the responsibility of both eliminating (so far as possible) the backlog of treatments and ensuring that current and recent referrals were not themselves delayed by the clearing of that backlog.

The purpose of the review, and of the consequent report, was not to seek to apportion blame for the delays but to examine why they occurred, to be satisfied that adequate steps had been taken both to ameliorate their effects and to ensure that, so far as possible and practicable, appropriate steps had been taken to avoid their recurrence.

The good news is that BHRUT is now expected to be able to deliver the RTT national standard by the end of September 2017. By the end of March 2017, local GPs had redirected a total of 26,000 patients into alternative services, helping ease pressure on BHRUT waiting lists. The Topic Group is generally supportive of the work undertaken by BHRUT and the CCG to resolve this issue and is also pleased at the enhanced monitoring that has been put in place with, for example, the issue of delayed Referrals to Treatment now being a standing item on the agenda at meetings of the Council's Health and Wellbeing Board.

But the concerns remain that the initial cause of the delay – which could well have been devastating for some of the individuals affected – could recur if a migration of data from one ICT system to another went awry and the contract was not robustly monitored both for performance and quality.

Although it happened long after the issues under examination in this report and when most of them had been resolved satisfactorily, the ransomware attack that affected many NHS and other organisations in mid-May 2017 graphically illustrated the need for robust governance of the use of ICT within health service organisations. It is not just a question of care when migrating data but of ensuring that all risks are identified and addressed robustly and in a timely fashion, that security and other inadvertent vulnerabilities are not allowed to develop to be exploited by those with malicious intent, that all software is kept as up to date as possible and that software and system upgrades are applied without avoidable delay.

Acknowledgements

The Topic Group would like to record its appreciation of the assistance of a wide range of senior NHS staff, as well as Council staff, in response to the review.

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TOPIC GROUP MEMBERS

London Borough of Havering

Councillor Michael White, Chairman, Health Overview and Scrutiny Sub-Committee (from May 2016)

Councillor Dilip Patel, Vice-Chair, Health Overview and Scrutiny Sub-Committee

Councillor June Alexander

Councillor Nic Dodin (until May 2016 – Chairman of Health OSSC)

Councillor Jason Frost (until May 2016)

Councillor Linda Hawthorn

Councillor Linda Van den Hende

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Anne-Marie Dean, Chairman and Executive Director

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Volunteer Members:

Mary Bell

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Jenny Gregory

Emma Lexton

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Dianne Old

Valerie Perry

Jennifer Smith

WITNESSES WHO APPEARED BEFORE THE TOPIC GROUP

Maureen Blunden, Head of Patient Administration, BHRUT

Niki Eves, Communications Manager, BHRUT

Andrew Hines, Regional Chief Operation Officer, NHSI

Faisal Mangera, Improvement Team, NHSI

Hazel Melnick, Associate Director Communications and Marketing, BHRUT

Louise Mitchell, Senior Responsible Officer – Planned Care, CCGs

Barbara Nicholls, Director of Adult Services, London Borough of Havering

Steve Russell, Deputy Chief Executive, BHRUT

Sarah Tedford, Chief Operating Officer, BHRUT

Carol White, Integrated Care Director – Havering, NELFT

GLOSSARY OF TERMS AND ACRONYMS

BHR -	The area comprising the London Boroughs of Barking & Dagenham, Havering and Redbridge
BHRUT -	Barking, Havering and Redbridge University Hospitals NHS Trust
CCG(s) –	Clinical Commissioning Group(s)
GP -	General Medical Practitioner (Family Doctor)
ISTC -	Independent Sector Treatment Centre[3]
ICT -	Information and Communications Technology
NELFT –	NELFT NHS Foundation Trust (formerly North East London NHS FT)
NHSI -	NHS Improvement
PAS -	Patient Administration System
RTT -	Referral(s) To Treatment
TDA -	NHS Trust Development Authority

[3] A facility that is part of the NHS but is provided by an independent contractor

FINDINGS

Meeting 1: 6 April 2016, BHRUT

1.1 The Topic Group was pleased at the openness displayed by officers from BHRUT – the NHS Trust responsible for running Queen's and King George Hospitals - when discussing these issues. It was openly admitted that a hospital the size of Queen's would expect a waiting list in the region of 30,000 but this had at one point reached 120,000 (based on unaudited data). By the time of the meeting, this figure had reduced to around 57,000 but BHRUT officers accepted that this was still too high.

1.2 The implementation of a new computerised Patient Administration System (PAS) at BHRUT had taken place in December 2013. BHRUT officers felt that, with hindsight, the implementation had been undertaken too rapidly. The new PAS system had shown 110,000 – 115,000 patients on the waiting list compared to the 28,000 that had been reported previously. This had led BHRUT to take the decision, with the approval of NHS England and the former NHS Trust Development Authority (now NHSI), to cease reporting figures for referral to treatment to allow time to investigate fully the issues.

1.3 BHRUT officers accepted that there had previously been insufficient governance and oversight of the RTT issue. They told the Topic Group that, in hindsight, decisions around the issue taken by the previous management appeared to be counter-intuitive. The Topic Group accepted that many of the problems had occurred under previous management and the current BHRUT management advised that the management culture had now changed, with dialogue encouraged between management and frontline staff.

1.4 The BHRUT officers confirmed to the Topic Group that BHRUT was now using the ISTC at King George Hospital, as well as other private sector facilities. Indeed, some 49% of the additional activity required to clear the backlog was likely to be outsourced to the private sector. A total of around 9,000 extra appointments would be needed to clear the backlog with a further 20,000 to cope with the additional demand on BHRUT's services. A further 8,000 appointments would reduce the time to first outpatient appointment to six weeks and 56,000 additional slots would be needed for follow up appointments.

1.5 An additional 760 operations would reduce the backlog while around a further 800 would be needed to cope with additional demand. A further 3,000 operations would arise from patients currently awaiting outpatient appointments. It was not likely that these figures would be impacted by a rise in activity at A & E as other beds were normally ring fenced for emergency admissions from A & E.

1.6 It was noted that, if additional anaesthetists could be recruited to support the extra consultants, this would allow an extra 27,000 slots. Better productivity could produce a further 8,000 slots and more use of clinical nurse specialists a further 5,000.

1.7 The recruitment of the extra consultants would allow 2,000 more operations to be performed and better theatre productivity a further 1,400. Waiting list initiatives such as more weekend use of theatres would also allow 700 more operations to be carried out. Most theatre maintenance was carried out in August and December when demand was lower and other maintenance periods could normally be worked around. Trust officers accepted that recruiting enough consultants to facilitate these

changes remained a challenge. Recruitment initiatives included recruiting from overseas, joint appointments and the establishing of academic consultant posts.

1.8 Trust data on waits for treatment had been reviewed by NHS Intensive Support Team and was also considered weekly by a programme board with representatives from across the local health economy. Monthly updates were also given to a system resilience group. BHRUT officers accepted that, as at April 2016, based on publicly reported data, BHRUT had the most long-waiting patients in the country, with around 850 patients waiting in excess of 52 weeks for treatment.

Meeting 2: BHRUT, 22 July 2016

2.1 BHRUT had changed to a new computerised patient administration system in December 2013. BHRUT officers clarified that the new ICT system had not itself caused the delays to treatment but had made pre-existing delays (not previously known of) visible to BHRUT. Trust officers felt that, as a result of the lessons learned through the present delays, any future change to a new ICT system would be managed better than in 2013.

2.2 There was a dedicated, central team in BHRUT to receive referrals to hospital consultants but many referrals were sent directly by GPs to consultants. BHRUT officers felt it would be far more efficient if all referrals could be sent via the central team. It was suggested that the Health and Wellbeing Board could look at this issue.

2.3 At the meeting, BHRUT officers accepted that BHRUT was not at that point meeting the 18-week target for the time between GP referral and the start of treatment.

2.4 All consultants were required to give six weeks' notice of annual leave. The service manager would then discuss with the consultant which appointments could be booked to the next clinic and which needed to be referred to another consultant.

2.5 At the time of the meeting, the backlog of patients waiting had reduced by around 50% although this still meant that approximately 52,000 people were awaiting an appointment. This was, however, being reduced by approximately 500 patients per week. Extra clinics were being undertaken by BHRUT, and the BHR CCGs were commissioning alternative providers and redirecting patients.

2.6 Readmission rates at BHRUT were at 9% after 30 days compared to a national average of 12%. The readmission rate of patients undergoing elective treatment was only 1%.

2.7 Members of the Topic Group felt that the local health economy lagged behind on some digital systems. In Islington for example, a patient record could be shared, with the patient's consent, between the Hospital Trust, Council and CCG whereas, in Havering, not only was electronic file sharing between GPs and the Hospital difficult, there were different ICT systems operating within the Hospital that made in-house information sharing difficult.

Meeting 3: 5 September 2016, BHR CCGs

3.1 In addition to providing overseeing primary care medical services, the local CCGs commissioned the majority of services provided by BHRUT and hence had the responsibility of overseeing BHRUT's reduction in their backlog of appointments and accounted to NHS England on a weekly basis for this. Legal directions had been issued by NHS England to Havering CCG as the lead commissioner

for BHRUT, requiring the CCG to submit a plan for recovery of the RTT position by September 2016. A demand management programme had therefore been carried out which sought to slow the number of referrals going into BHRUT. The longest waits for treatment were in areas such as gastroenterology, dermatology, urology and general surgery.

3.2 The CCG officer was supportive of any measures that could streamline the process for patients, including all referrals being sent to the appropriate central team at BHRUT rather than to individual consultants. Referral activity from GPs to BHRUT was tracked by the CCG, although incidents of referrals that were not appropriate were not specifically monitored.

3.3 It was felt that a pathway redesign programme being worked on by both GPs and BHRUT clinicians would serve, in due course, to reduce delays to hospital treatment. Whilst there were no known cases of patients coming to clinical harm as a result of delays in receiving treatment, there had been a significant financial impact on the CCGs due to the need to fund additional activity to reduce the backlog of appointments.

3.4 It was agreed that the appropriateness of GP referrals was an important part of the redesign work and the Topic Group noted there had been enhanced engagement from the CCGs on this.

Meeting 4: 31 October 2016, London Borough of Havering Adult Services

4.1 The Council's Director for Adult Social Care confirmed that there was some anecdotal evidence from social care officers of people waiting lengthy periods for treatment. This could result in a danger of deconditioning for the individuals concerned, which could lead to a referral to social care for care at home. There

was, however, no direct evidence that the delayed treatments had actually resulted in this.

4.2 It was assumed that the delays in receiving appropriate treatment could only lead to poor long term health outcomes for patients concerned, and therefore Adult Social Care had been supportive of onward referral to other NHS Hospitals and private sector facilities to ensure appropriate treatment received.

Meeting 5: 23 January 2017, NELFT

5.1 NELFT provided a range of healthcare services in the community as well as being the principal provider of mental health services for the Outer North East London area. The NELFT officer was not aware of any patients who had come to harm specifically due to delays in their receiving treatment at BHRUT. NELFT were unaware of any direct correlation between instances of delay in transferring care (commonly called "bed blocking") and RTT delays.

5.2 A range of treatments were offered by NELFT for people waiting lengthy periods for hospital treatment. These included cardiac nurses, diabetes services, podiatry and audiology. NELFT were unaware of any cases where patients had come to clinical harm due to delays in receiving treatment. It was possible for some conditions to introduce pathways that did not include referral to a consultant but GPs were often not in favour of this approach.

5.3 NELFT monitored referral to treatment times at monthly performance meetings and, at the time of the meeting with the Topic Group, the 18-week target had been breached only rarely.

Meeting 6: 23 January 2017, NHSI

6.1 NHSI provided strategic leadership to hospitals and covered areas such as waiting times, finance, service quality and leadership. NHSI also worked with partners such as the local CCGs and NHS England to work with BHRUT on these issues.

6.2 NHSI and its predecessor – the NHS Trust Development Authority (TDA) - had worked closely with BHRUT on referrals to treatment since September 2015. A support team had been set up and specialist external companies had been brought in to help BHRUT manage its waiting lists. Reporting on waiting lists had been resumed by BHRUT from November 2016.

6.3 The measures of success that NHSI considered key for BHRUT were that BHRUT continued to report on waiting times, cleared the backlog of longest waiting patients and was expected to reach the target of 92% of patients waiting less than 18 weeks for treatment by September 2017. It was felt that the resumption by BHRUT of reporting on waiting times had been a key milestone.

6.4 BHRUT now had more robust processes in place to review patient outcomes and NHSI had seen no evidence of moderate or severe harm to patients resulting from any cases of delayed treatment. Summary data on waiting times was provided by BHRUT to NHSI and NHS England on a weekly and monthly basis.

The formal responses from BHR CCGs, BHRUT and NHSI to the following Conclusions and Recommendations begin on page 18.

CONCLUSIONS

C1 As explained at the outset, the Topic Group fully accept that the root cause of the delayed treatments occurred before the management changes that led to the present management team taking charge of BHRUT. It is a matter of concern, however, that no one appears to have noticed that things were going awry until a very late stage. It is clear that the Information Technology Governance arrangements under which the patient data was migrated from the old system to the new were inadequate; indeed, the governance arrangements prior to then may well have been equally inadequate, given that the delays had not previously been "visible" (see paragraph 2.1 above).

Current (and future) management of BHRUT must satisfy themselves that, in any future change of ICT systems, governance is sufficiently robust to ensure, so far as possible, that patient data is properly migrated. Subsequent events in May 2017 amply demonstrated the need for robust governance to ensure that ICT systems are kept at the highest possible level of cybersecurity.

The Trust should also consider what measures need to be taken to ensure that all ICT systems in use within BHRUT's hospitals are capable of exchanging full details about individual patients, both internally and externally with key partners, such as not only individual GPs but also Polyclinics and Walk-in Centres that may refer patients on for treatment, or to which patients may be referred.

C2 Whilst it is understandable that GPs should prefer to refer their patients to specialists whom they know and have confidence in,

it is apparent that their doing so is not the most efficient way of proceeding and can, inadvertently, lead to delays for individuals. GPs cannot know how consultants' workloads stand and direct referral introduces the risk that those workloads, already varied, will be further distorted by acceptance of direct referrals. It is clearly better for all GP referrals to be directed to a central point, from which they can then be allocated to whichever provider or consultant is best placed (in terms of both workload and relevant skill) to deal with that patient.

C3 Topic Group members were surprised to learn that there was no formal follow up process by GPs to find out whether patients had seen a consultant to whom they had been referred, and what had been the outcome. It appeared that, unless a patient returned to the GP to follow up an apparent failure to be offered an appointment, the whole process worked on a "fire and forget" basis: the GP made a referral but did not subsequently seek to discover its outcome.

RECOMMENDATIONS

R1 That BHRUT review its Information Technology Governance arrangements to ensure that, in any future migration of patients' data from one ICT system to another, robust steps are taken to ensure that the "loss" of data that occasioned the delays that have been the subject of this review are so far as possible avoided.

R2 That BHRUT and partners review their ICT systems to ensure that they are sufficiently compatible with each other to permit the free, secure exchange of patient data between them, and (so far as appropriate) to facilitate the secure exchange of patient data with GPs and other points of referral such as Polyclinics and Walk-in Centres

R3 That the CCGs review options in partnership with BHRUT to determine how demand, and in turn capacity, for elective referral activity is best modelled to optimise patient access and experience.

R4 That the CCGs work with GPs to develop procedures whereby, when a referral is made, it is followed up in a timely fashion to ensure that the patient is actually seen by the most relevant health care professional and treatment appropriate to their condition is arranged.

RESPONSES

Barking, Havering and Redbridge Clinical Commissioning Groups

This is the formal response of the Barking, Havering and Redbridge Clinical Commissioning Groups (BHR CCGs) to two of the four overarching recommendations of the report from P17, which it is hoped will provide some assurance.

Recommendation R3:

We have a formal contractual mechanism in place, as commissioner with BHRUT. One of our key priorities is to oversee and monitor demand and capacity modelling for elective activity which we do on a monthly basis.

Recommendation R4:

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

Barking, Havering and Redbridge University Hospitals Trust

This is the formal response of the Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT/the Trust) 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.

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.

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 targeted 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

C1 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.

- While we recognise some of the points made within C1, 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 comments on the Conclusions. 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 both commissioners and providers are members.

NHS Improvement

NHS Improvement is responsible for overseeing foundation trusts, NHS trusts and independent providers. We offer the support these providers need to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable.

The report highlights lessons learnt in the management of patient referrals and provision of high quality patient care. In particular it highlights the significant number of improvements that have been delivered at the trust, whilst recognising that there remain potential risks that could, if not adequately addressed, result in a future recurrence of the issues that led to the system delays in patient treatment.

NHS Improvement has noted that BHRUT has developed and implemented a recovery plan which has seen it make significant progress against the Referral to Treatment (RTT) national standard including reporting compliance against the standard in June 2017 - three months ahead of plan and for the first time in three years. The trust has also made significant progress in strengthening organisational oversight and governance systems and processes.

We note the conclusions and recommendations in your report. NHS Improvement will continue to monitor the trust's performance against the national standard to ensure the improvements delivered are sustained and to secure the necessary level of assurance that the trust is continuing to deliver timely care for patients.

BACKGROUND PAPERS

Presentations given at, and notes of, meetings of the Topic Group:

6 April 2016

27 April 2016

26 May 2016

22 July 2016

5 September 2016

31 October 2016

23 January 2017

APPENDIX – MEETINGS HELD

Meeting no.	Date	Witnesses
1	06/04/16	Niki Eves, Communications Manager, BHRUT Hazel Melnick, Associate Director, Communications and Marketing, BHRUT Steve Russell, Deputy Chief Executive, BHRUT Sarah Tedford, Chief Operating Officer, BHRUT
1A	27/04/16	None – planning meeting only.
1B	26/05/16	None – planning meeting only.
2	22/07/16	Maureen Blunden, Head of Patient Administration, BHRUT Steve Russell, Deputy Chief Executive, BHRUT
3	05/09/16	Louise Mitchell, Senior Responsible Officer – Planned Care, BHR CCGs
4	31/10/16	Barbara Nicholls, Director of Adult Services, London Borough of Havering
5	23/01/17	Carol White, Integrated Care Director, NELFT
6	23/01/17	Andrew Hines, Regional Chief Operating Officer, NHSI Faisal Mangera, NHSI