Elective and Diagnostic Restoration and Recovery

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Paper M

Purpose of report:

This paper is for:	Description	Select (X)
Decision	To formally receive a report and approve its recommendations OR a particular course of action	
Discussion	To discuss, in depth, a report noting its implications without formally approving a recommendation or action	X
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with treatment plan	X
Noting	For noting without the need for discussion	

Previous consideration:

Meeting	Date	Please clarify the purpose of the paper to that meeting using the categories above
OMG	Aug 21	
SOG	Aug 21 x 2	
Trust Board Committee (FRB)	Aug 21	
Trust Board	Sep 21	

Executive Summary

Context

This paper presents the UHL elective and diagnostic restoration and recovery plan to the Trust Board. It provides an update on achievements to date, actions taken in relation to the following areas.

- Elective Inpatient and Day case Surgery
- Outpatients
- Diagnostics

The paper outlines the ambitions and key milstones of delivery of the elective restoration and recovery strategy, the associated risks and the range of mitigations in place. This brief also describes the next stage of the restoration and recovery strategy (relating to patients waiting more than 104 weeks) in some detail to assure the Trust Board as to the robust nature of the plans.

Questions

1. Does the Trust Board support the actions the Trust is taking to track and improve restoration and recovery of elective and diagnostic services?

Conclusion

During July 2021 UHL has faced significant operational pressures due to the rising number of Covid patients and corresponding length of stay across intensive care and medical/respiratory beds. As a result, UHL has reported operational OPEL 4 levels on a regular basis but elective capacity has been maintained at 82% of 19/20 levels and 101% against plan.

LLR Elective activity sits 5% below the regional average of 87% for the 4 week period ending 18/07/2021 which is in part, representative of UHL's position of regional ECMO centre and the impact this has had on ITU capacity and consequential movement of theatre staff back into ward environments. UHL has a seen further reduction in the number of patients waiting 52+ weeks and has the largest percentage drop in 52+ waiters across the region's five largest providers. P2s have decreased by **253** within July. Trajectory is just 22 behind plan at the end of July, with only General Surgery and Urology left to recover the Feb 20 position.

A number of key steps are due to take to place to expedite recovery further for elective care within the organisation. An independent sector plan has been approved which will secure activity levels as H1 (April to September) in addition to further MSK work. Insourcing services to support elective activity (ENT & Max Fax) are being mobilised. Clinical and operational leadership forums are taking accountability for maximising use of Alliance theatres, we are securing support for Cardiac services through Park Hospital (BMI) and rolling out rapid expansion of Patient INtitiated Follow-up (PIFU) & switching off of Open Appointments and application of cost out efficiency modelling to all specialties.

The July 2021 performance reported in the DM01 (measures the current waiting times of patients still waiting for 15 key diagnostic tests or procedures) is 38.3%. Which is has stayed static against June's position with the waiting list 394 above trajectory. Overall LLR are in a positive position within the region with 102% for imagining against the average of 102% for the midlands and 113% for endoscopy against an average of 93%. The provisional Elective Recovery Fund (ERF) plan will identify further opportunities to improve diagnostics capacity.

Input Sought

The recommendation is that the Trust Board:

- Note the significant impact of Covid on UHL's elective and diagnostic performance and services
- Note the progress in recovery through innovation, the continuing hard work and commitment from UHL's clinical teams, and support from the wider system
- Note the risks associated with the restoration and recovery strategy and underpinning plans, including the potential impact of any future waves of Covid

For reference

This report relates to the following UHL quality and supporting priorities:

1. Quality priorities

Safe, surgery and procedures	[Yes ~~/No /Not applicable~~]
Improved Cancer pathways	[Yes /~~No /Not applicable~~]
Streamlined emergency care	~~[Yes /No~~ /Not applicable]
Better care pathways	[Yes ~~/No /Not applicable~~]
Ward accreditation	~~[Yes /No /~~Not applicable]

2. Supporting priorities:

People strategy implementation	~~[Yes /No /~~Not applicable]
Estate investment and reconfiguration	[~~Yes /No /~~Not applicable]
e-Hospital	~~[Yes /No~~ /Not applicable]
Embedded research, training and education	~~[Yes /No /~~Not applicable]
Embed innovation in recovery and renewal	[Yes /No /Not applicable]
Sustainable finances	[Yes /No /Not applicable]

3. Equality Impact Assessment and Patient and Public Involvement considerations:

- What was the outcome of your Equality Impact Assessment (EIA)?
  To be completed for each ERF programme of work
- Briefly describe the Patient and Public Involvement (PPI) activities undertaken in relation to this report, or confirm that none were required

  Patients are encouraged to participated in joint decisions making in terms of when and where they are treated.
- How did the outcome of the EIA influence your Patient and Public Involvement?
  Will be worked through with the advancement of each ERF programme
- If an EIA was not carried out, what was the rationale for this decision?

4. Risk and Assurance

Risk Reference:

Does this paper reference a risk event?	**Select (X)**	**Risk Description:**
Strategic: Does this link to a ***Principal Risk*** on the BAF?	X	Failure to deliver key performance targets
Organisational: Does this link to an ***Operational/Corporate Risk*** on Datix Register	X	
New Risk identified in paper: What ***type*** and ***description***?		
None		

5. Scheduled date for the **next paper** on this topic: November 2021

6. Executive Summaries should not exceed **5 sides**

Performance Update for Elective Care and Diagnostics

1. Purpose of the Paper

This paper presents the UHL elective and diagnostic restoration and recovery plan to the Trust Board. It provides an update on achievements to date, actions taken in relation to the following areas.

- Elective Inpatient and Day case Surgery
- Outpatients
- Diagnostics

The paper outlines the ambitions and key milestones of delivery of the elective restoration and recovery strategy, the associated risks and the range of mitigations in place. This brief also describes the next stage of the restoration and recovery strategy (relating to patients waiting more than 104 weeks) in some detail to assure the Trust Board as to the robust nature of the plans.

UHL currently has over 93,000 patients waiting for admitted and non-admitted care. There are approximately 7,000 additional patients waiting for care under the Alliance Pillar of UHL. Longer term perspectives of elective capacity and demand are being worked through with partner CMGs and organisations across LLR to ensure that post-recovery, the system has the appropriate capacity to support timely care for patients in the future.

In the immediate period however, LLR (and therefore UHL) is expected to be part of a proactive, timely and collaborative response to elective recovery. This paper outlines the current collaborative restoration and recovery plan, the overall strategy and the risks and mitigations of the same.

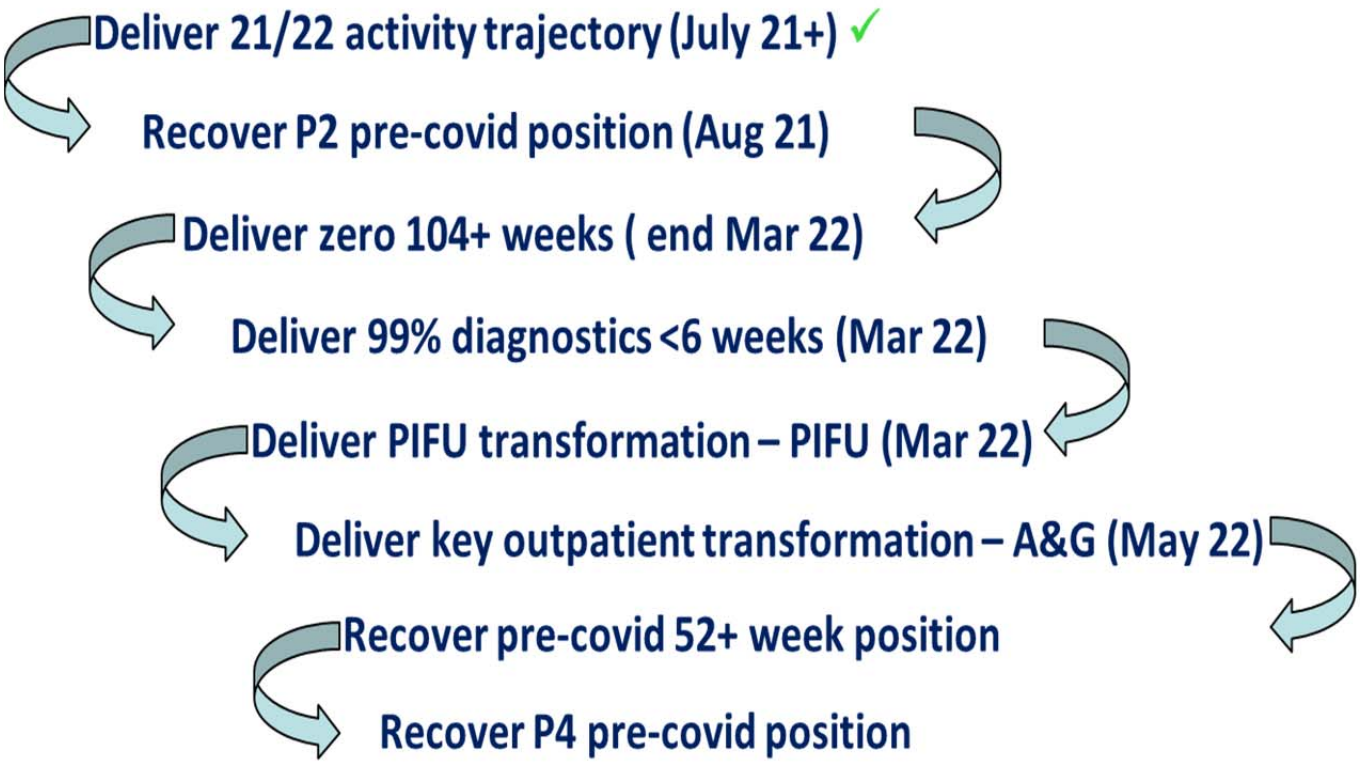
2. Elective and Diagnostic Restoration and Recovery

Recovery and restoration is complex and multifaceted. The first stage of the process is to deliver sustainable restoration in terms of pre-Covid elective activity. Delivery of this is mandatory in order for the system to access the Elective Recovery Fund (ERF) which is made available to systems to facilitate additional capacity for waiting list recovery. UHL is currently over achieving against its activity restoration plan.

The next steps which lead both the system and UHL to a pre-Covid waiting list position is a more complex pathway, driven by clinical prioritisation, the impact of long waits on patient complexity, well-being and outcomes, as well as the delivery of capacity to meet demand.

The LLR and UHL elective recovery pathway is demonstrated in the following roadmap:

The LLR and UHL Elective Recovery Pathway



Notes:
P2 – refers to one of the NHSE defined priority codes, urgent cases
PIFU – Patient initiated follow-up, an initiative to enable patients to decide when they need to access outpatient care as part of their ongoing clinical management
A&G – advice and guidance, a service which enables primary care clinicians to contact secondary care specialists for fast access to advice for individual patients as an alternative to a traditional referral
P4 – refers to one of the NHSE defined priority codes, routine cases

The next milestones for both system and Trust recovery are focussed on the recovery of the number of P2 patients waiting for treatment pre-Covid and the delivery of a zero position for patients waiting over 104 weeks for treatment.

3. UHL's Elective Recovery Journey To Date

The UHL waiting list (without the Alliance) currently stands at 93,537 in comparison to the 66,000 before Covid. Just under 1% of these patients have been waiting over 104 weeks.

Key Points:

- Since April 2021, UHL has delivered a significant increase in elective admissions with the initial focus being on treating P2s and cancer cases.

- Between April 2021 and August 2021, the total number of admitted patients waiting has reduced from 22,302 to 21,605, with the number waiting over 52 weeks reducing from 8750 to 7666 in the same 5 month period (a reduction of 12.4%)
- The reduction in 52 week waiters has been driven by several programmes including an increase in the number of patients transferred clinically appropriately to the Independent Sector as well as improvements in UHL theatre scheduling and utilisation
- Overall our number of P2 cases waiting has continued to decrease since the beginning of the financial year
- Trajectories for achieving zero patients waiting more than 104 weeks by the end of March 2022, supported by a number of recovery programmes (funded by the system ERF) have been developed in partnership with Clinical Management Groups (CMGs) and system partners including primary care providers of care

4. Elective Activity – Meeting our Trajectory and ERF Gateways

The restoration of UHL's elective activity is monitored in terms of planned performance against the actual activity of the same month in 2019 (i.e. pre-Covid). The following table demonstrates UHL's achievement against the NHSE target of activity in month, versus the same month in 2019.

Activity Type	Apr	May	Jun	Jul	Aug	Sep
Total Elective Activity (Actual or Forecast) 2021 compared with 2019	83.0%	83.4%	91.6%	92.5%	95.1%	94.6%
NHSE Target	70%	75%	80%	85%	85%	85%

Delivery of this will contribute to the system accessing its proportion of the national ERF (elective recovery fund). This is important so that we can continue to invest into elective care service recovery.

For this purpose, activity is measured in tariff financial value of activity undertaken. For example, UHL could undertake a lower number of procedures in 2021 compared with the same month in 2019, but of great complexity and still be able to achieve the target to access the ERF and continue to invest in services.

The ERF is a way of reimbursing systems for planned care activity above the national baseline in order to encourage recovery (funding dependent on delivery). Activity for elective inpatients, daycases, outpatient procedures & first and follow up outpatients all contribute to UHL's reportable ERF activity. As a system, LLR also have to meet five additional gateway criteria:

- addressing health inequalities
- transformation of outpatient services
- implementing system-led elective working
- tackling the longest waits and capacity generation
- supporting staff

UHL is working with system and NHSE colleagues to ensure LLR achieves the gateways and therefore access to the ERF available.

5. Clinical Priority (P2) Recovery

The number of P2s waiting has decreased by 1101 since 1 April 2021 and is forecast to recover to pre-Covid waiting list size during August 2021.

However, there are specialties of significant risk within this plan with a particular focus on Cardiac Surgery. The impact of an increasing pressure within ITU at the Glenfield, exacerbated by challenged staffing (7% sickness, 6% vacancy and 6% maternity) in addition to increasing regional demands for specialist ECMO delivery at the Glenfield site and increased Covid levels , has impacted heavily on the ability for Cardiac to deliver normal activity.

Measures have been put in place to re-restore activity for the most critically ill (P1B patients), however some alternative capacity must be sought for current Cardiac P2s. Collaborative solutions enabling partnership arrangements with both Nottingham hospitals and a high acuity independent provider will support UHL in solving this current challenge.

6. Patients Waiting Over 104 Weeks

Currently there are 731 patients waiting over 104 weeks for treatment. The majority sit within the following five specialties:

- General surgery
- Urology
- ENT (Inc. Paeds)
- Max Fax (Inc. Paeds)
- Orthopaedics

With the focus of substantive theatre and ITU activity on treating both cancer and P2 patients, 21/22 ERF focus is on the next phase of the recovery pathway, the treatment of all patients waiting over 104 weeks.

There are 6119 patients on the admitted waiting list, waiting over 65 weeks (i.e. those that will be waiting at least 104 weeks by the end of March 2022). A working assumption is that 2314 of these are inpatient that require treatment within UHL theatres and a selection of the 3805 patients requiring daycase treatment may be able to have their procedures either in UHL theatres or another of the system-based facilities, including operating theatres in community hospitals.

This system-based approach to resource management underpins the 104 week wait plans, ensuring access to services are expedited for all long wait patients. It is important to note that as patients have waited for increasing lengths of time, particularly through lockdown, that the presentation of patients has changed. Many are now more complex and this is translating into longer anaesthetic, operating and recovery times.

It is therefore vital that the ERF plans include the procurement of various data analysis and business intelligence tools which increasingly enable UHL clinicians to assess patients holistically, including changing co-morbidity and complexity intelligence gathered via primary care systems, to help ensure patients are treated in the right place, first time and to minimise the risk of introducing additional health inequalities into our waiting list management processes. An example of this is the NHSX supported Compass (C2-Ai) system which gives surgical staff an instant complication and morbidity risk assessment for patients being listed for surgery.

This more complete clinical picture enables the opportunity for patients to access relevant prehabilitation and enhanced pre-operative services, improving patient outcome post-operatively.

ERF plans have been developed to create both support for patients waiting for surgery and capacity to treat, both in and out of UHL. Additional capacity has also been factored in to ensure that patients waiting a long time for outpatients, can access any related inpatient or daycase treatment in a timely way.

There are a number of significant risks in delivering the 104 week plan:

- Further waves of COVID -19 which will directly and swiftly deplete ITU, theatre, anaesthetic and recovery staff capacity
- Availability of specialist-specific theatre, recovery and anaesthetic staffing to deliver the patient specific .capacity required
- Winter pressures (operational pressure to use elective wards to support emergency flow, increase frailty within the community during a winter)
- Availability of Independent Sector partners to deliver care for more complex patients
- Achievement of Elective Recovery Fund (required to fund additional capacity as part of mitigating action plan)
- Growth within urgent and cancer demand (working with primary care and other system partners to understand change early and proactively manage increases in demand

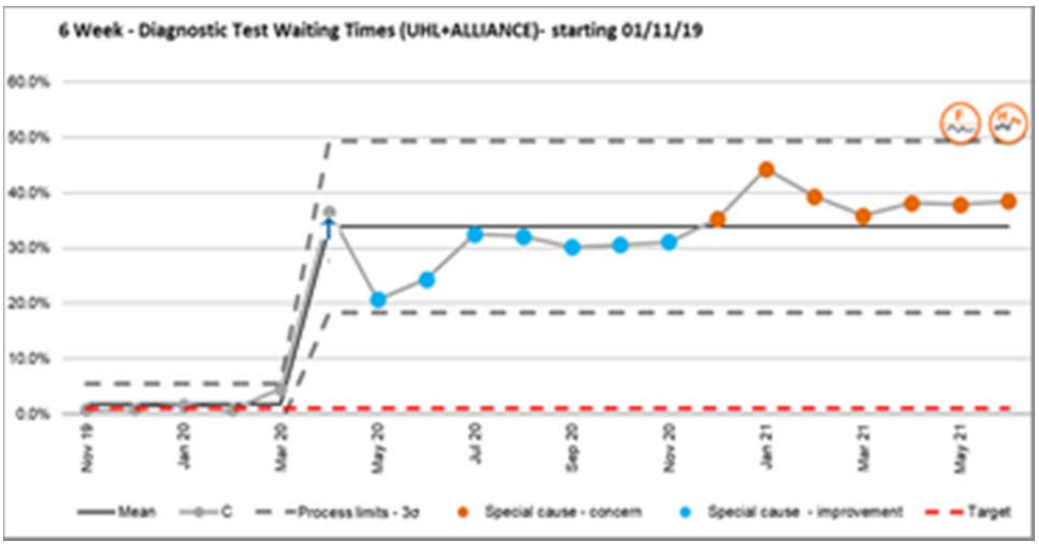
The mitigating ERF programmes include:

- Maximise use of all system theatre capacity across the system including the IS and LLR Alliance (focus on specific high volume, low complexity procedures)
- Insourcing of theatre, anaesthetic and surgical teams to work in partnership with our own teams
- Digital solutions to support new PIFU (patient initiated follow-up) pathways and to enable primary care co-morbidity data to better enable clinical priorisation
- Additional prehabilitation services to ensure patients undergoing complex procedures are as fit as they can be before theatre and that their outcomes are optimised
- Start-up of a patient support line which enables patients to consider accessing clinically suitable alternatives to elective treatment as part of shared decision making with patients. Linked to social prescribing in the community.
- Consideration of Vanguard theatre solution for specialties with a high proportion of Day Case P2s/104+ waits based at the Glenfield site
- New diagnostic at first outpatient pathways (e.g ENT), reducing the need for further appointments and waits
- Expedite programme to move services to a community setting/closer to home in partnership with optometrists, primary care providers, e.g. low risk glaucoma follow-up
- Creation of a patient support telephone line, linked to community-based alternative services whilst patients are waiting

7. Diagnostics

The overall DM01 (basket of 15 core diagnostics including CT, MRI and endoscopy), waiting times are forecast to be fully recovered by March 2022; that is, less than 1% of patients waiting for DM01 diagnostics will wait more than 6 weeks.

Currently, DM01 performance (measures the current waiting times of patients still waiting for 15 key diagnostic tests or procedures) is 38.5% (38.5% of patients are waiting more than 6 weeks).



The areas of significant pressure include CT, DEXA scans, Urodynamics, colonscopy, cystoscopy and gastroscopy.

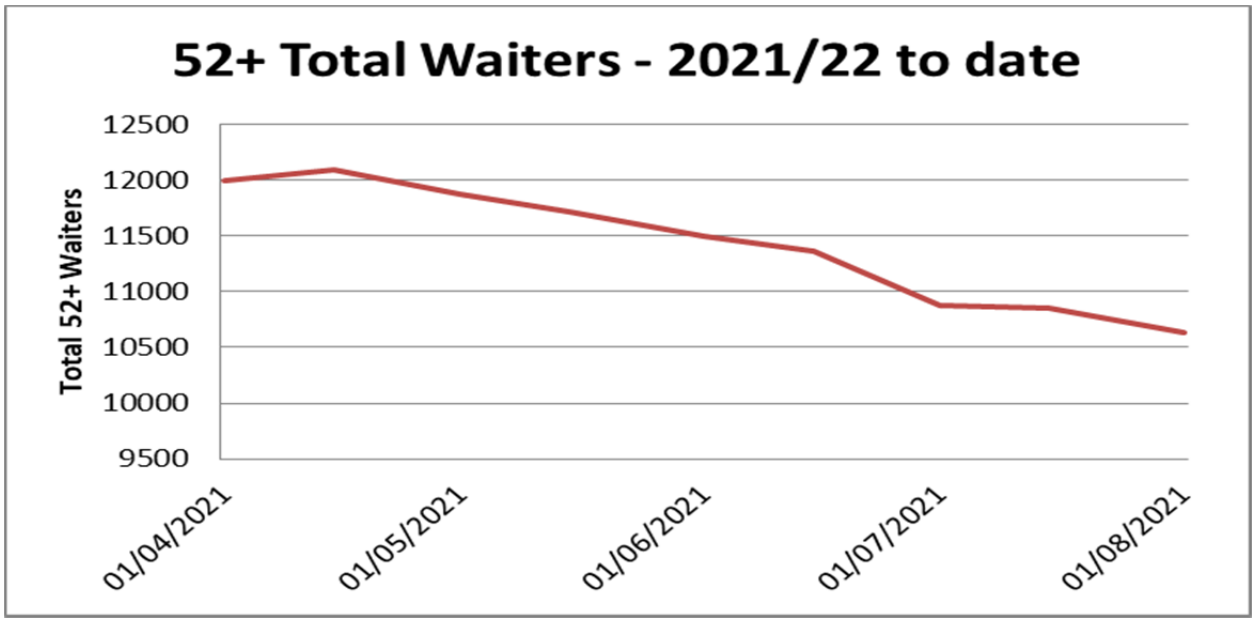
Next Steps

The following actions (supported by the ERF) are in place to deliver the forecast position for March 2022.

- UHL has had access to an additional CT van, been provided by NHSI/E
- MRI capacity is focussing on P2 pathways
- National diagnostic validation work continues, with a focus to prioritise services with largest number waiting 6+ week or more
- ECHO capacity extended in partnership with local primary care providers, and capacity increased to 200 per week
- The business case for the first system Community Diagnostic Hub has been submitted (led by the LLR Elective Care Design Group) and will be assessed before the beginning of September 2021
- The Vanguard endoscopy unit at the LGH remains in place and fully functional

8. Patients Waiting Over 52 weeks

The current number of patients waiting over 52 weeks (admitted & non-admitted) has reduced by over 1000 patients from April's position. There has been an increase of clock stops across both admitted and non-admitted activity resulting in a demonstrable steady reduction in 52 week waiters since the beginning of the financial year. The graph below shows this position for UHL patients.



Seven specialties are forecast to have not recovered their 52 week position before financial year end. The remainder of 21/22 will focus on retaining both activity and pre-Covid P2 positions, in addition to achieving a zero position of patients waiting over 104 weeks and the 99% DM01 diagnostics performance. The restoration and recovery priorities for 22/23 include the 52 week wait position across the Trust.

9. Outpatients

The early cut position for outpatients shows we have continued to increase outpatient activity which will be essential in reducing the growth with the non-admitted waiting list. It shows we are now delivering 109% against the 21/22 activity plan and 101% against June 2019 Levels.

		Jun 21 Actual as a % of Jun 21 Plan								
Activity Type	**Actual Management**	**Alliance**	**CHUGGS**	**CSI**	**ESM**	**ITAPS**	**MSS**	**RRCV**	**W&C**	**Grand Total**
OP	Outpatients (F2F & NF2F)	110%	133%	128%	120%	84%	126%	119%	110%	120%
	Outpatient Procedures	69%	85%	35%	40%	37%	48%	38%	52%	50%
	Admission Unit Attendances	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
OP Total		**105%**	**130%**	**100%**	**109%**	**78%**	**104%**	**118%**	**103%**	**109%**

		Jun 21 Actual as a % of Jun 19 Actual								
Activity Type	**Actual Management**	**Alliance**	**CHUGGS**	**CSI**	**ESM**	**ITAPS**	**MSS**	**RRCV**	**W&C**	**Total**
OP	Outpatients (F2F & NF2F)	98%	117%	74%	111%	82%	117%	121%	109%	112%
	Outpatient Procedures	54%	73%	39%	38%	62%	49%	n/a	47%	49%
	Admission Unit Attendances	n/a	n/a	n/a	0%	n/a	n/a	n/a	n/a	0%
OP Total		**91%**	**115%**	**68%**	**95%**	**81%**	**98%**	**121%**	**101%**	**101%**

This performance has been driven by a number of key actions:

- PIFU is now being offered in some Respiratory specialties; COPD, Allergy, and Asthma
- A number of cancer tumour sites are offering Personalised Stratified Follow-Up (which enables clinically suitable patients to decide when they require their next appointment)

- Other services are already offering open appointments but the information needs validating and patients either need to be discharged or transferred to a PIFU pathway with more robust processes and governance
- Formal recruitment of Outpatient Clinical Lead to enhance the clinical leadership across the outpatient transformation programme
- Development of action plans for utilisation improvement schemes within CMGs
- Trust agreed to use Attend Anywhere as its video consultation solution. Roll-out is going well and kit has been delivered to services for mobilisation.

Outpatient Transformation Priorities for the Remainder of 21/22

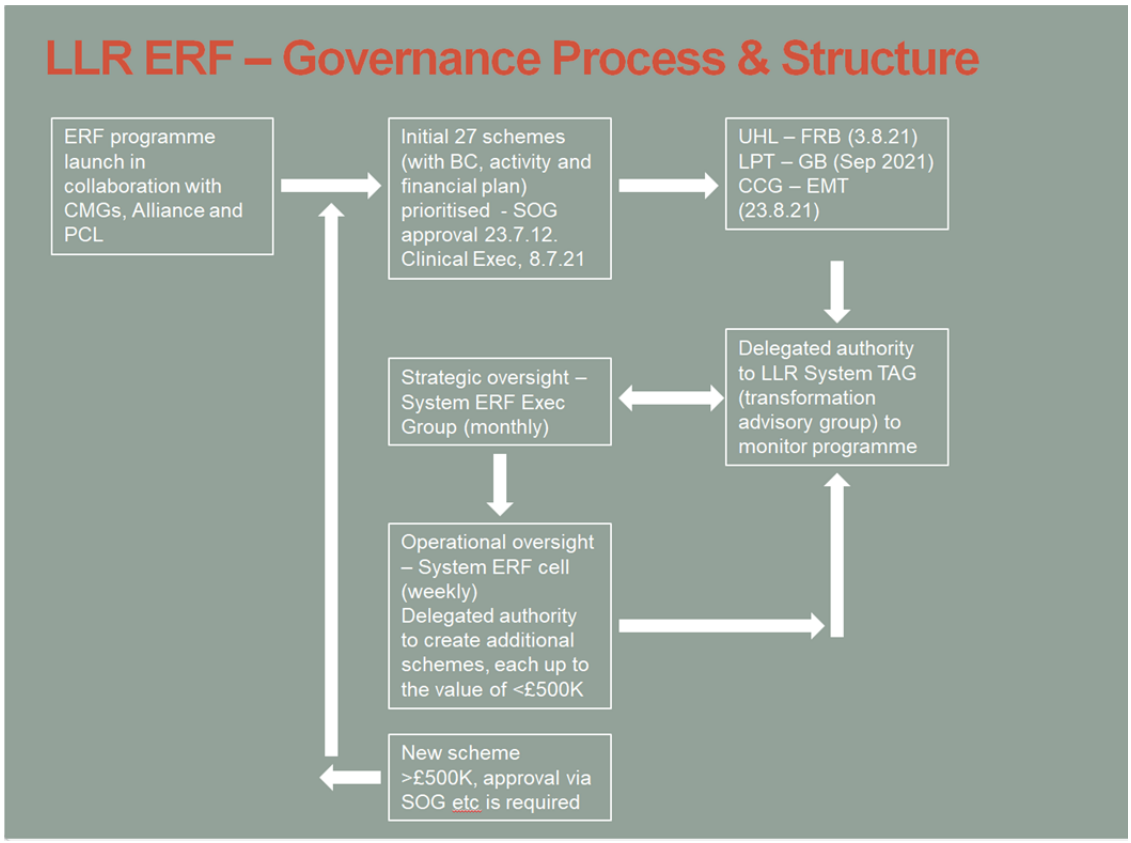
- Development of workshops for the creation of a full system Outpatients model
- Finalisation of a proposal on centralising of Outpatient services
- Roll out of PIFU within Respiratory
- Finalisation of Video Conferencing review within UHL
- Roll out of additional Video Conferencing equipment
- External Validation team to be identified to support the non-admitted waiting list.
- Implement Grommet OP clinic supper weekends
- Increase outpatients capacity within the Alliance to support Ophthalmology
- Scope the delivery of GPwSi-led service for Breast, avoiding need for secondary care

These additional transformation programmes will underpin the future of non-admitted patient care across UHL and the Alliance.

10. Governance Arrangements

The ERF plan, underpinning the next steps for elective restoration and recovery plan has been approved locally by the Operational Management Group and the Executive Finance and Performance Board (EFPB). System approval has been achieved via the LLR System Operational Group (SOG) and the LLR Clinical Executive.

For the ERF plan and mobilisation of the same, the governance process demonstrated below has been agreed by SOG, UHL's FRB and the CCGs' Executive Management Team.



From a reporting and project management perspective, each programme will have as a minimum:

- An outline business case or plan on a page
- An operationalisation risk assessment
- A QIA/EIA
- A monthly activity/work forecast
- A monthly financial forecast
- A monthly activity/work actuals report
- A monthly financial actuals report

Financial management for each scheme will be delegated to the relevant system organisation. The value per organisation for each scheme will be added to each organisation's current income (once approved/agreed) and that will follow with a contract variation to formalise the arrangement.

11. Recommendation

The recommendation is that the Trust Board:

- Notes the significant impact of Covid on UHL's elective and diagnostic performance and services
- Notes the progress in recovery through innovation, the continuing hard work and commitment from UHL's clinical teams, and support from the wider system
- Notes the risks associated with the restoration and recovery strategy and underpinning plans, including the potential impact of any future waves of Covid