Restoration and Recovery of Clinical Services

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Trust Board paper F

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	X
Discussion	To discuss, in depth, a report noting its implications without formally approving a recommendation or action	
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with treatment plan	
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
CMG Board (specify which CMG)		
Executive Board		
Trust Board Committee		
Trust Board		

Executive Summary

Context

Throughout 2020/21 the NHS has responded to two waves of COVID-19. Leicester was further impacted and remained in lockdown because of continued levels of transmission. Responding to COVID-19 has resulted in unprecedented pressures on all NHS Trusts. In order to respond to the number of patients requiring hospital care for COVID-19, the volume of elective treatment (planned operations) delivered was significantly reduced as resource was realigned to treat those with COVID-19. The result has been a significant growth in the both the waiting time and the number of patients waiting to have their treatment.

Following the first wave (June and July 2020), cross health economy planning took place to support a rapid restoration and recovery of elective activity. The strong & effective command and control structure (utilised to manage the organisations response to COVID-19) was redirected to ensure those waiting for urgent and cancer surgery could be treated. By September 2020, UHL had recovered the position to pre COVID-19 levels (for both urgent & cancer patients) although routine waiting lists continued to grow. The second wave was more significant in both length and impact and has resulted in significant backlogs for diagnostic and elective surgery.

This paper describes the process of restoring/recovering the services that were reduced during the pandemic of COVID-19. These include:-

- Urgent elective surgery
- Cancer
- Diagnostics
- Routine surgery

Questions

1. Does the Trust Board support the actions being taken to address elective waiting list?
2. Are there any further actions that need to be incorporated into our plans?

Conclusion

This paper has described the significant amount of work being undertaken to restore our elective services. As an organisation we have unprecedented challenges to address the number of patients on the waiting lists that have built up during the pandemic. The clinical and operational teams are focused on addressing this backlog and in doing so the key next steps are as follows:

- Working with Regional colleagues to ensure equity for Urgent Surgery, seeking mutual aid where appropriate.
- Filling all available capacity with Independent Sector (private hospital) providers.
- Ensuring we focus on the Wellbeing of our staff.
- Expanding our Intensive Care Unit capacity.
- Booking additional patients for phase 3 of our recovery.
- Restoring all of our theatres sessions to pre-COVID-19 levels.
- Activity modelling trajectory for elective recovery for Inpatients and Day Cases.
- Refreshing our governance arrangements to support business as usual.
- Planning for Half 2 – when the detailed planning guidance is released for the second half of our financial year (October to the end of March).
- Developing the winter plan to minimise impact on elective surgery.

Input Sought

We would welcome the Trust Board's input:

- To note the trajectory regarding Priority 1 & 2 patients (urgent cancer and non-cancer surgery).
- To note the trajectory for reducing the number of patients waiting surgery beyond 52 weeks.
- To support / provide further guidance in relation to the recovery of long waiting patients.
- To note actions taken for the restoration and recovery of outpatients and diagnostics.
- Acknowledge the risks relating to delivery.

For Reference:

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

1. Quality priorities

Safe, surgery and procedures	Yes
Improved Cancer pathways	Yes
Streamlined emergency care	No
Better care pathways	Yes
Ward accreditation	No

2. Supporting priorities:

People strategy implementation	Yes
Investment in sustainable Estate and reconfiguration	No
e-Hospital	No
Embedded research, training and education	No
Embed innovation in recovery and renewal	Yes
Sustainable finances	Yes

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

- What was the outcome of your Equality Impact Assessment (EIA)?
- Briefly describe the Patient and Public Involvement (PPI) activities undertaken in relation to this report, or confirm that none were required
- How did the outcome of the EIA influence your Patient and Public Involvement?
- 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	Operational Performance (PR2)
Organisational: Does this link to an ***Operational/Corporate Risk*** on Datix Register		
New Risk identified in paper: What ***type*** and ***description***?		
None		

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

6. Executive Summaries should not exceed **5 sides** My paper does not comply

Restoring and Recovering Elective Services

1.0 Introduction

Throughout 2020/21 the NHS has responded to two waves of COVID-19. Leicester was further impacted and remained in lockdown because of continued levels of transmission. Responding to COVID-19 has resulted in unprecedented pressures on all NHS Trusts. In order to respond to the number of patients requiring hospital care for COVID-19, the volume of elective treatment (planned operations) delivered was significantly reduced as resource was realigned to treat those with COVID-19. The result has been a significant growth in the both the waiting time and the number of patients waiting to have their treatment.

Following the first wave (June and July 2020), cross health economy planning took place to support a rapid restoration and recovery of elective activity. The strong & effective command and control structure (utilised to manage the organisations response to COVID-19) was redirected to ensure those waiting for urgent and cancer surgery could be treated. By September 2020, UHL had recovered the position to pre COVID-19 levels (for both urgent & cancer patients) although routine waiting lists continued to grow. The second wave was more significant in both length and impact and has resulted in significant backlogs for diagnostic and elective surgery.

This paper describes the process of restoring/recovering the services that were reduced during the pandemic of COVID-19. These include:-

- Urgent elective surgery
- Cancer
- Diagnostics
- Routine surgery

1.1 COVID-19 Second Wave

During the second wave, the number of COVID-19 patients admitted to our hospitals was double that seen in the first wave (reached a peak of 500 inpatients). Consequently, the impact on elective treatment was more significant than that experienced in the first wave as an increased amount of resource was diverted to treat our un-well population.

COVID-19 activity reduced throughout March & April 2021 and in light of this, a staged restoration and recovery programme has taken place. The stages include:-

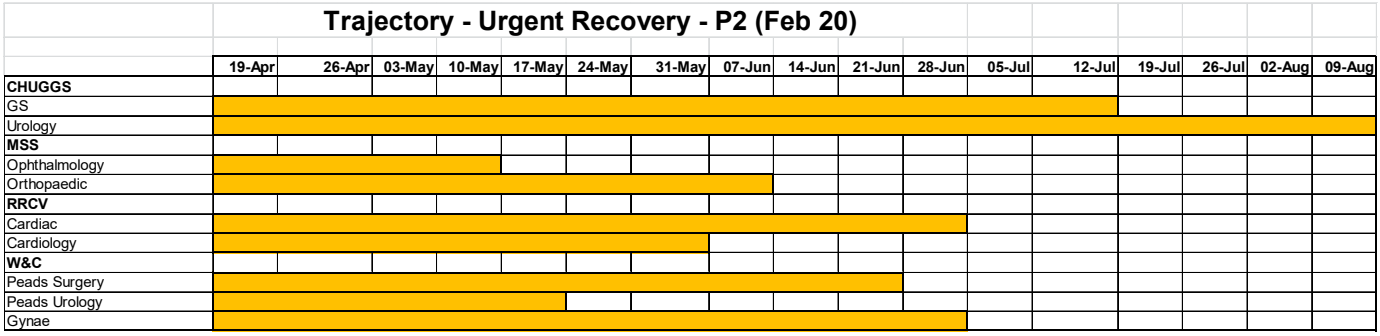
1) A 2 week wellbeing recovery period for Intensive Care Unit staff.
2) All specialties returning to their original wards.
3) A phased approach to restoring theatre sessions, starting from 50% of pre COVID-19 levels in April to 100% in May 2021.
4) A phased approach to Outpatient activity (utilising where clinically appropriate, virtual technologies, for example telephone/video appointments), ranging from 90% in April to 95% in June 2021.

A guiding principle of the restoration/recovery process is the adherence to key infection prevention & social distancing measures (to protect staff and patients).

2.0 Urgent Elective Surgery Recovery

The National Planning Guidance released in March 2021 stated that the key priority for Acute Hospitals is to ensure continued focus on Cancer and Urgent Elective Surgery patients. The Trust has developed a recovery plan for the number and waiting times of Urgent Elective Surgery patients to return to February 2020 levels (which would be 2,148 patients waiting in these categories). All specialties are predicted to achieve this by June 2021 with the exception of General Surgery and Urology as these services have larger backlogs. Further work is required for these 2 services for speed up recovery and we are working with NHSE/I seeking mutual aide.

The table below outlines the specific timelines by specialty that have seen the biggest increase in urgent patients waiting (these are categorised as P2s – priority 2s) across the last year.



2.1 Urgent Surgery Recovery Next Steps

- Continuous clinical validation of Urgent Elective Surgery patients.
- Identify any Urgent Elective Surgery patients who can be treated in the independent sector.
- Ensure all theatre capacity is fully utilised.
- Allocate theatre sessions based upon need using operationally led Session Allocation Scheduling (SAS) meetings.

Elements of the P2 patients are cancer patients, trajectories are being developed for each Tumour site. To ensure we follow planning guidance it is essential we are focusing on these two clinical priorities. This means that we will not see significant recovery within the first quarter for the non-urgent (routine) long waiters.

2.3 Theatre Recovery

UHL theatres and ICU teams have seen significant pressures throughout the COVID-19 second wave. COVID-19 activity reduced throughout March and April and in-light of this, a staged Restoration and Recovery programme has taken place. There has been a significant increase in the elective theatre sessions taking place between March and April but activity is still below 2019 levels:

KPI	Apr-19		Feb-21	Mar-21	Apr-21
Theatre Sessions	1720		567	728	1100
% compared to same period in 2019			32.9%	39.4%	64.0%

As of the 19th April Theatres restored to 75% of theatre lists and on 19th May increased to 100%.

To ensure we are able to restore and recover there is a key focus on ensuring theatres are fully utilised. A new Theatre Productivity and Assurance Board has been established chaired by the Medical Director to give oversight of theatre productivity and the delivery of Quality Improvement in line with the Trust's Quality Strategy and Transformation Efficiency Programme.
The Board will receive updates on the following KPI's by each surgical CMG.

1. Theatre utilisation
2. Average Case per list (ACPL)
3. Theatre start times
4. Cancellations on the day (with reasons)
5. Financial impact (cost avoidance/ out) via Transformation CIP tracker

Improvements in these five key performance indicators will be achieved through a number of forums to support the Governance arrangements including

- **Theatre Prioritisation and Productivity meeting (formally SAS)** this is a clinical meeting that meets weekly to review the clinical prioritisation of theatre capacity and theatre productivity. This group will be the clinical oversight to the Transformation projects that will be implemented by each Clinical Management Group (CMG) and cross CMG projects. This meeting is Chaired by the Deputy Medical Director and attended by nominated CMG clinical representation.
- **Theatre Cell** – Weekly meeting with CMG Heads of Operations to escalate concerns and issues raised at the weekly scheduling meeting and allocate any available theatre sessions that have been identified in the 642 process

2.4 Independent Sector

The overall strategy for 2021/22 is to continue to utilise the Independent Sector (IS) capacity in order to support system elective recovery. It is important to note that the working arrangements with the IS for 2020/21 during the pandemic has changed as of April 2021. UHL will transfer patients form our waiting lists directly on to the Independent Sector provider's waiting lists.

A Clinical Prioritisation Framework has been developed across LLR. This framework sets out a consistent STP approach to outpatient, diagnostic and surgical pathways, enabling the most urgent patients to be treated first and maintaining essential services in UHL including critical time surgery and vital cancer services. This should result in an approach that will ensure patients are able to access any treatment they require in as short a time as possible, based on their clinical priority first and waiting time second.

3.0 Cancer Recovery

3.1 March 2021 Cancer Performance (Fig 1)

In March 2021, UHL achieved 6 of cancer standards (as shown below). A non-validated view of April is also presented (this is subject to change throughout May 2021).

Figure 1– March 2021 Cancer Performance

Standard	Target	Mar Position	Pts treated in target	Pt treated after target	YTD performance	April Provisional As of 10.05.21 Not validated
2WW	**93%**	**96.0%**	3,781	158	**92.3%**	**89.1**
2WW Breast	**93%**	**94.9%**	187	10	**95.4%**	**76.8**
31 Day 1st Treatments	**96%**	**85.2%**	316	55	**91.1%**	**81.8**
31 Day SUB Surgery	**94%**	**56.9%**	58	44	**71.7%**	**49.6**
31 Day DRUGS	**98%**	**100%**	79	0	**99.6%**	**98.7**
31 Day Radiotherapy	**94%**	**96.8%**	149	5	**93.4%**	**88.4**
62 Day	**85%**	**58.6%**	133	94	**68.5%**	**71.4**
62 Day Screening	**90%**	**51.7%**	15	14	**63.9%**	**43.8**
28 Day FDS 2WW	**75%**	**86.5%**	3,151	492		**83.8**
28 Day FDS Breast 2WW	**75%**	**94.9%**	186	10		**97.7**
28 Day FDS Screening	**75%**	**66.3%**	175	89		**65.8**
Consultant upgrade	**No National target**	**73.3%**	44	16	**80.5%**	**68.3**

3.2 Cancer Activity – Growth

Cancer two week wait referrals received by UHL are currently significantly higher than this time last year (figure 2). This will have major impact on pathways over the following months if the conversion rate (the % of patients referred as potential cancers actually having cancer) continues to increase (figure 3).

Figure 2 – Cancer Referrals

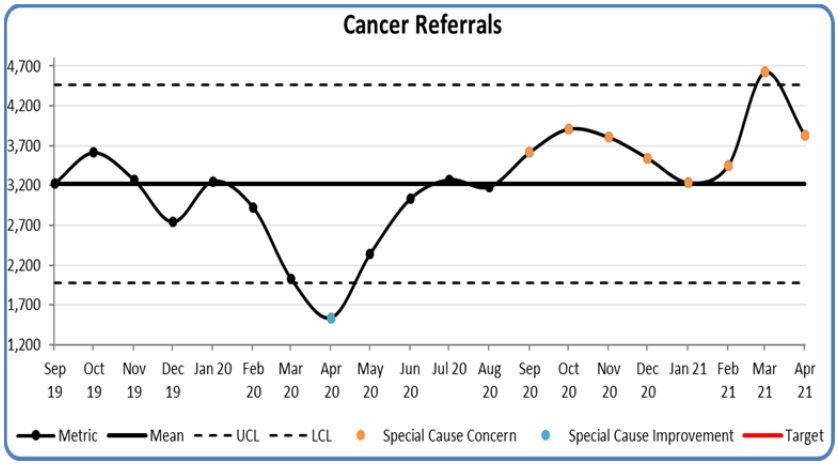
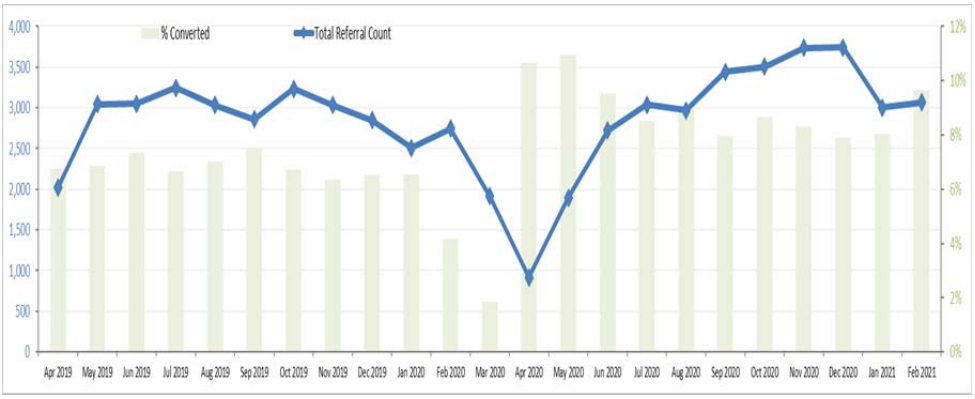


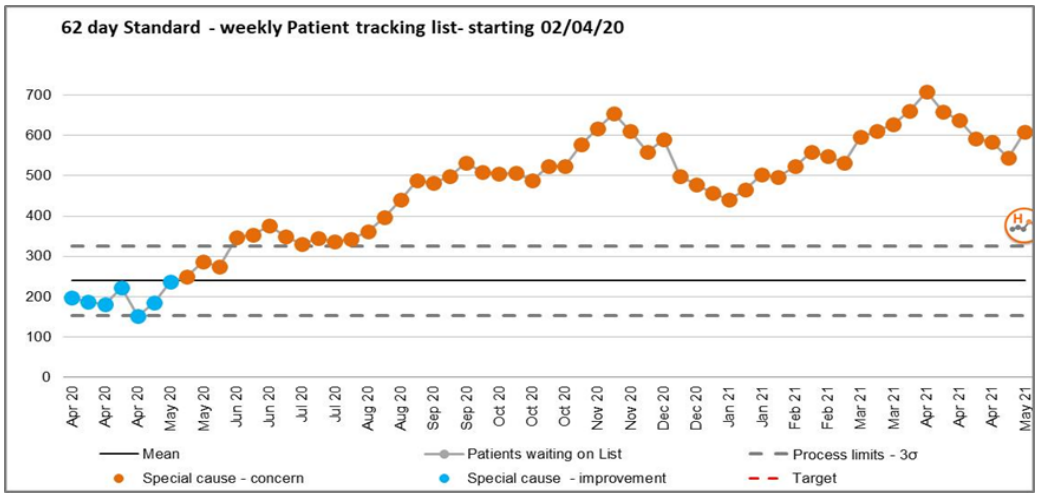
Figure 3 – Conversion from Referral to Cancer



3.3 Two Week Wait-Breast (Fig 4)

We have seen higher demand than pre-COVID; combined with reduced treatments due to decreased surgical capacity and IP restrictions resulting in an increase in the number of patients waiting.

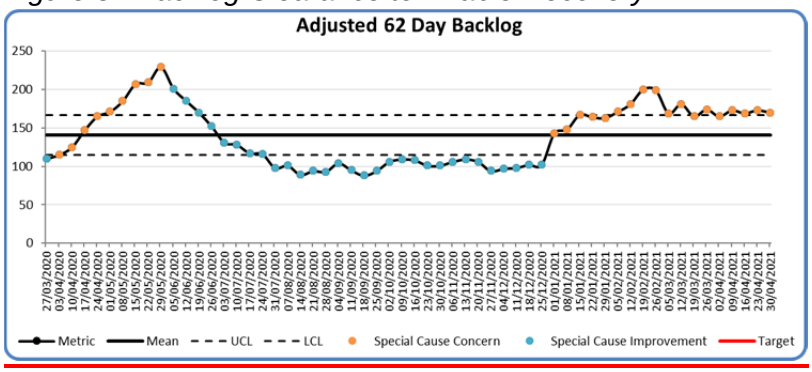
Figure 4 – Referrals on the Breast Patient Tracking List



3.4 62 Day Cancer Backlog (Figure 5)

62 day backlog (the number of patients waiting more than 62 days from referral and who have not had their first definitive treatment) has begun to stabilise following a significant increase in January and February. On a weekly basis, all 62 day breaches are reviewed by the tumour sites and analysed with the Cancer Centre, mapping out all pathway delays in accordance with Next Steps. Where a pathway is in excess of 62 days, a breach map is carried out to elicit themes and situations where inefficiencies in the process have occurred once the patient has been treated.

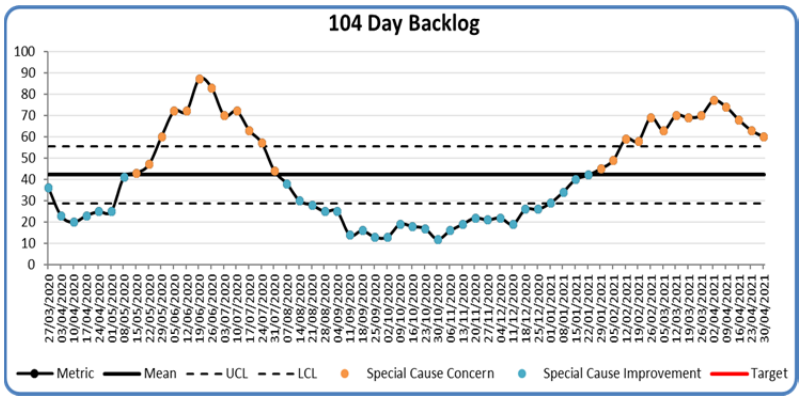
Figure 5– Backlog Clearance to Enable Recovery



3.5 104 Days (Figure 6)

The 104 day backlog numbers have started to decrease.

Figure 6 – 104+ days



3.6 Cancer Recovery

We continue to ensure that patients are prioritised; are clinically reviewed and harm forms are completed where indicated. In March we saw the first decrease in the 62 day backlog since wave 2, and a decrease in 104 day backlog since April. We have seen a spike in urgent two week wait referrals in March 2021; depending on conversion rate to confirmed cancer, this may impact performance recovery. Surgical waits continue to grow but we will see this decrease with the progression of the theatre recovery plan. A number of other actions are also underway:

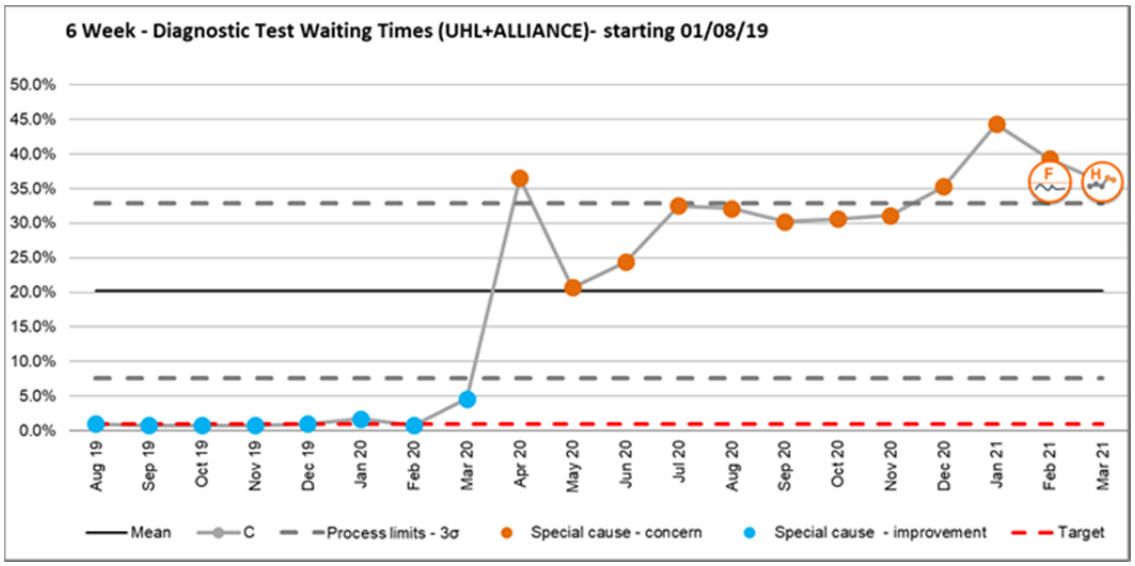
- We are working with our clinical teams to develop recovery action plans to ensure we make the most of the capacity available; these are being actively tracked to ensure progression and any blockers are addressed.

- We are having discussions with Northampton General/Kettering General Hospitals about supporting diagnostic procedures (in urology) to free up more capacity for surgical procedures.
- Work is underway on recovery trajectories, aligned to the elective plan so we can determine the length of time recovery will take. These will be available by the end of June.
- We are also starting the cancer Health inequalities work to ensure we are addressing equality of health care.

4.0 Diagnostic Restoration and Recovery

The diagnostic operational standard is less than 1% of patients should wait 6 weeks or more for a diagnostic test. The latest performance reported in the DM01 (measures the current waiting times of patients still waiting for 15 key diagnostic tests or procedures) is 35.9%.

Pre COVID-19 this standard was routinely achieved, this report details the actions that have been taken by our Clinical Management Groups (CMG's) to recover the waiting times back to pre COVID-19 performance.



4.1 Outline of Modality Action Plan

The overall DM01 diagnostic waiting times are expected to be recovered by March 22. The detail of recovery times by test are show below along with actions taken to recover the waiting times.

Modality	Actions
Magnetic Resonance Imaging (MRI) - 6+ week recovery to be achieved by March 2022	• 2 mobile MRI vans are in operation and these will be extended until March 2022. • 2 full days support from Nuffield. • Exploring potential changes to social distancing to increase capacity.
Computed Tomography (CT) - Revised 6+ week recovery to be achieved by March 2022	• Procurement plans for additional mobile vans now complete – awaiting funding approval. • Additional mobile van has been provided by NHSI/E with a June start date.

Non-obstetric ultrasound - Revised 6+ week recovery to be achieved by September 2021	• Additional agency staff appointed to combat high turnover of staff which is hampering progress.
DEXA Scan - Revised 6+ week recovery to be achieved by September 2021	• Service has been transferred to LGH and clinics are up and running. • Setting up new service at National Centre for Sports and Exercise Medicine at Loughborough.
Audiology Balance - 6+ week recovery to be achieved by March 2022	• Service resumed February 2021 • Increased capacity and investment in equipment allowing 2 clinics to run in parallel. • Increased capacity due to expansion of clinic and Waiting List Initiatives (WLI's). • Vacancy to be appointed to.
Audiological Testing - 6+ week recovery to be achieved by August 2021	• Service resumed March 2021. • Increase capacity utilising all LLR capacity and WLI's. • Source extra venue at Burbage Health Centre. Still in progress. • Vacancy to be appointed to.
Cardiology – echocardiography - 6+ week recovery to be achieved by September 2022	• PCL (Provider Company Ltd) contract has been renewed until end of June 21 (outsourcing between 100 and 125 patients a week). • Plan to extend the PCL contract beyond June 21. • Looking at additional options to outsource work to other providers • Infection Prevention) requested to review current working processes to identify opportunities to increase capacity. Action plan to be implemented post review.
Neurophysiology - peripheral neurophysiology - 6+ week recovery achieved	• Continued service provision throughout the COVID-19 pandemic has ensured no increase in wait times for clinical investigations. • Paediatric Video-telemetry is now operational
Adult Respiratory physiology - sleep studies - 6+ week recovery achieved	• Continued service provision throughout the COVID-19 pandemic has ensured no increase in wait times for clinical investigations.
Urodynamics - pressures & flows - 6+ week recovery achieved	• New consultant appointed will review this group of patients putting patient level management plans in place.
Adult Gastroenterology - 6+ week recovery to be achieved by December 2021	• Mobile endoscopy unit (Vanguard) has been extended with a contract for 12 months with a clause for early release after 9 months or a further extension if required. • Ventilation work in the endoscopy units at all 3 hospital sites have been completed which has facilitated increased patient throughput.

Cystoscopy - 6+ week recovery to be achieved by December 2021	• Following agreement at the CMG Performance Review Meeting the service is changing the use of Bay 2 on Ward 29 at the LGH to be an extended waiting room for Cystoscopy patients. This will increase capacity by up to 24 patients a week.
Paediatric Respiratory physiology - sleep studies - Revised 6+ week recovery to be achieved by June 2021	• The purchase of a 3rd sleep diagnostic device will allow the service to have a greater flexibility to conduct investigations • Review of staff resources is being under take to assess if more diagnostic sleep studies can be carried out each week.
Paediatric Gastroenterology - 6+ week recovery to be achieved by April 2021	• Service achieving the 6 week standard

5. Routine Elective Recovery

Routine waiting list numbers have continued to grow and in April 2021 the number increased to 91,088 (from 64,688 in March 2020). This is an overall growth increase of 50.66% since the start of COVID-19. There are now currently 12,369 patients waiting longer than a year for their surgery. UHL have not seen any further growth to this position within April, this is mainly due to the reduction in referrals we experienced in April 2020 and transferring some long waiting patients to the Independent Sector for treatment.

			Within 18 Weeks	18+ weeks	Sum:
Apr 21	**Incompletes**	Within 52 Weeks	45482	33237	78719
Apr 21	**Incompletes**	52+ weeks	N/A	12369	12369
		Sum:	45482	45606	91088

5.1 52+ Week Recovery

As detailed above, at the end of April 2021 there are 12,342 patients waiting longer than a year (admitted & non-admitted). 86% of the breaches are attributed to 10 specialities set out below:

Speciality	**52 + Breaches (30th April)**
Ear, Nose & Throat (Inc. Paediatrics Ear, Nose & Throat)	1935
Gastroenterology	725
General Surgery (Inc. Hepato-Biliary)	1126
Gynaecology	1263
Maxillofacial Surgery (Inc. Paediatrics Maxillofacial)	1016
Ophthalmology	690
Orthopaedics (Inc. Spinal and Sports Med)	2359
Paediatric Surgery (Inc. Paediatrics Trauma & Urology)	255
Plastic Surgery	391
Urology	804
Total	10564

Through the Weekly Access Meeting the specialties have been developing 52 week recovery trajectories for 2021/22 performance. This will be supported through utilising the Independent Sector, with activity plans agreed for H1 (April – September) and the increased utilisation of our existing capacity.

Each specialty is expecting to see a reduction in 52 Weeks waits except Urology due to demand being higher than capacity. Urology has a significant demand for both cancer and urgent patients which reduce the capacity to treat long waiting patients, further plans are being developed including seeking mutual aid from other hospitals to help address the Urology backlog.

There are a number of potential risks in delivering activity as outlined below:

- Further waves of COVID-19.
- Staffing levels to be able to deliver 100% theatre sessions.
- Winter pressures (utilisation of elective wards to support emergency activity).
- Funding for the Independent Sector for H2 (October – March)
- Growth in demand for urgent and cancer necessitating in moving resource away from routine recovery.
- Premium pay changes
- H2 planning guidance (as yet unknown).
- Achievement of Elective Recovery Fund

5.2 Next Steps

Below is the projected **best case** scenario for the March 2022 admitted 52+ week position:

Speciality	Admitted Position April 21	Admitted Position March 22	Reduction
Ear, Nose & Throat (Inc. Paediatrics Ear, Nose & Throat)	1539	1089	450
Gastroenterology	287	0	287
General Surgery (Inc. Hepato-Biliary)	1066	484	582
Gynaecology	623	216	407
Maxillofacial Surgery (Inc. Paediatrics Maxillofacial)	603	427	176
Ophthalmology	530	0	530
Orthopaedics (Inc. Spinal and Sports Med)	2115	429	1686
Paediatric Surgery (Inc. Paediatrics Trauma & Urology)	254	140	114
Plastic Surgery	389	0	389
Urology	742	742	0
Total	8148	3527	4621

This is an overall reduction by March 2022 of 4621 (57%) patients who are waiting more than 52 weeks for surgery. Previously in March 2020 a number of services were challenged in managing their 52+ week position in particular ENT, General Surgery and Urology.

With the current constraints on throughput including the necessary Infection Prevention and Control guidance it will be very challenging to address the current waiting list and the above is therefore noted as a stretch target. The expectation of each speciality is that there will be no patients waiting over 104+ weeks by **November 2021** and the aim to have no patients waiting above 78+ weeks by **March 2022.**

Trajectories will be managed through the Weekly Access Meeting and reported into the monthly Planned Care Board.

5.0 Risks

As detailed in the paper we have a significant challenge in addressing our waiting lists backlogs. The following bullet points highlight the key risk associated with our plans:

- Further waves of COVID -19
- Staffing levels to be able to deliver 100% theatre sessions
- Winter pressures (utilisation of elective wards to support emergency flow)
- Funding for independent sector for 2021/22 Half 2 (October-March 2021/22)
- Growth within urgent and cancer demand
- Premium pay changes
- 2021/22 6 month planning guidance (October-March 2021/22)
- Achievement of Elective Recovery Fund

6.0 Wellbeing of our staff

During the restoration and recovery of our services we need to ensure the wellbeing of our staff remains at the forefront of our plans, we are therefore focusing on the following key elements

- UHL Wellbeing Board continues and clinically led by Deputy Medical Director.
- The UHL Health and Wellbeing group priority - human/psychological/emotional input into the operational recovery from COVID.
- High levels of anticipatory anxiety, exhaustion and distress are prevalent with staff becoming concerned that additional pressure will be applied before they are ready to deliver it.
- Plans and activities in place to support and tailor made to support CMGs.

7.0 Conclusions

This paper has described the significant amount of work being undertaken to restore our elective services. As an organisation we have unprecedented challenges to address the number of patients on the waiting lists that have built up during the pandemic. The clinical and operational teams are focused on addressing this backlog and in doing so the key next steps are as follows:

- Working with Regional colleagues to ensure equity for Urgent Surgery, seeking mutual aid where appropriate.
- Filling all available capacity with Independent Sector (private hospital) providers.
- Ensuring we focus on the Wellbeing of our staff.
- Expanding our Intensive Care Unit capacity.
- Booking additional patients for phase 3 of our recovery.
- Restoring all of our theatres sessions to pre-COVID-19 levels.
- Activity modelling trajectory for elective recovery for Inpatients and Day Cases.
- Refreshing our governance arrangements to support business as usual.
- Planning for Half 2 – when the detailed planning guidance is released for the second half of our financial year (October to the end of March).
- Developing the winter plan to minimise impact on elective surgery.