ADULTS AND HEALTH SCRUTINY COMMITTEE	AGENDA ITEM No. 6
18 JULY 2022	PUBLIC REPORT

Report of:	NHS Cambridgeshire & Peterborough ICB	
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ELECTIVE WAITS AND RECOVERY

RECOMMENDATIONS
It is recommended that Adults and Health Scrutiny Committee: 1. Consider the information contained within this report relating to current elective waits and recovery plans.

1. ORIGIN OF REPORT

1.1 This report is submitted to the Adults and Health Scrutiny Committee following a request from the committee for a report on the elective waiting list, particularly in the North Accountable Business Unit and the catchment area of North West Anglia NHS Foundation Trust hospitals.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to provide an update on current elective waiting lists, encompassing both surgical and outpatient pathways, and the strategy for recovery following the increasing waiting times for patients post the COVID-19 pandemic.

The report will include background information; highlighting the key issues, current position, particularly for the North West Anglia NHS Foundation Trust (NWAngliaFT), as well as actions taken to date and future plans to support recovery across the Integrated Care System (ICS).

2.2 This report is for the Health Scrutiny Committee to consider under its Terms of Reference Part 3, Section 4 - Overview Scrutiny Functions, paragraph No. 2.1 Functions determined by Council:

3. Scrutiny of the NHS and NHS providers.

4. BACKGROUND AND KEY ISSUES

4.1 Background

4.1.1 Following the COVID 19 Pandemic elective waiting lists have grown to unprecedented levels across the country. Patients are currently waiting for up to 2 years across Cambridgeshire and Peterborough for treatment, although these long waits have been reducing during 2021/22 with a target to eliminate them by end all by the end of July 2022.

The increase in waiting lists and length of waits is due to elective activity being reduced during each wave of the pandemic to enable redeployment of staff to critical care, and respiratory wards to manage unwell COVID patients as well as covering other staffing gaps due to the impact that COVID was having on the workforce. During each pandemic wave only cancer, and urgent

patients were treated impacting on routine procedure wait times. Post each wave, standing up elective services was a priority across the system, but other factors continued to impact the ability to return to pre-pandemic levels of available capacity. This included infection control measures within outpatient areas, theatres, and diagnostics; impacting on the number of patients that could be brought into the hospital and reducing patient flow through areas. New services were introduced to try to limit the impact and manage the new infection control risk for example, pre-procedure swabbing services, consultant triage of all referrals and virtual and telephone appointments.

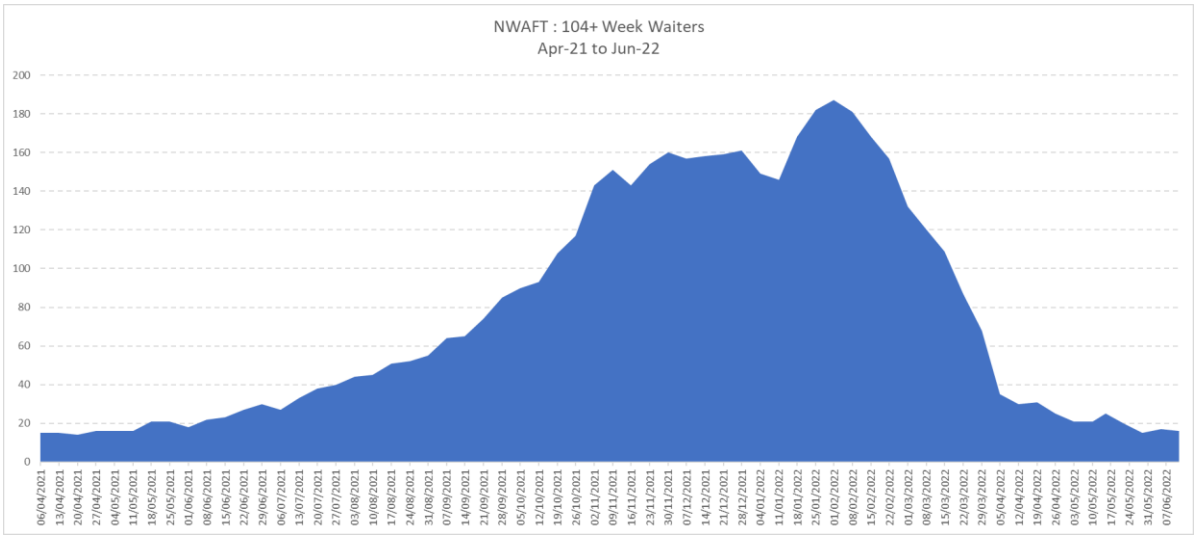
Cambridgeshire and Peterborough Integrated Care System (C&P ICS) is committed to reducing the overall waiting list; eliminating 104 week waits and reducing the number of patients waiting over 1 year for treatment. As of April 2022 the overall waiting list was 123,349 with 99 patients waiting over 2 years for treatment and 6618 patients waiting over 1 year.

To support this ambition, an elective recovery programme has been compiled with input from partners across the system. This is built up of key transformational schemes across elective services and outpatients as well as ongoing service improvement and business as usual processes. The key aims and objectives are to:

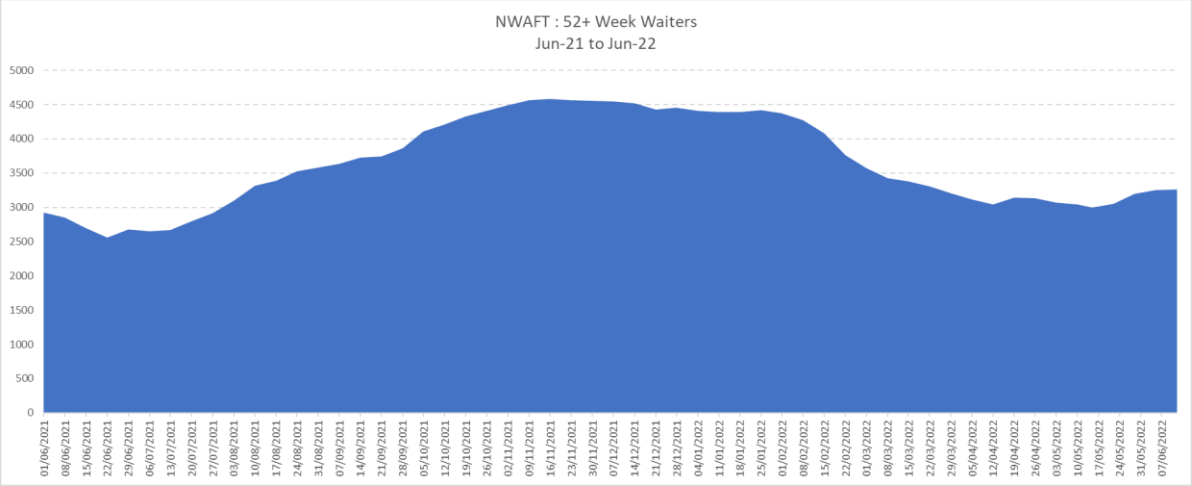
1. Improve access to outpatient and specialist advice
2. Improve patient outcomes and experience across the system
3. To reduce waiting lists
4. To increase capacity through being more productive and efficient

4.1.2 Waiting list position in North Accountable Business Unit (North West Anglia NHS Foundation Trust)

In September 2021 the Referral To Treatment (RTT) waiting list at NWAngliaFT was 59,548 and as of May 2022 has risen by approx. 8.6% to 64,647. From the information below you can see those patients waiting over 104 weeks peaked in February 2022 and have been steadily treated throughout 2022. As of the end of June 2022, NWAngliaFT will have a maximum of 10 patients waiting for treatment over 2 years, of which 6 are capacity related and the remainder are either clinical or patient choice delays. The Trust are forecasting that all 104 week waiting patients will have been seen and/or treated by the end of July 2022.



In addition to focusing on the very long waiting patients NWAngliaFT has continued to put plans in place to reduce the overall waiting times. The following graph shows how patients waiting over 52 weeks has been reducing since peaking in November 2021. Whilst plateauing now this remains a key focus for NWAngliaFT and the system.



The waiting times for treatment are variable according to specialties with some experiencing longer delays then others. The most challenged specialities for NWAngliaFT are Ear, Nose and Throat (ENT), Urology, and Ophthalmology. A combination of issues have impacted on these specialties including workforce, infection control measures and increases in demand, both in routine and cancer referrals for Urology and ENT. Ophthalmology and Urology were also in a challenged position pre-pandemic so the reduction in activity during each wave has compounded the issue. Ophthalmology has a high volume of patients that need to be seen for regular surveillance appointments which continues to grow as more patients access the service. Work is ongoing at NWAngliaFT to address these challenges. This has included additional clinics, one stop services, utilisation of virtual diagnostic tests, reviews of clinic templates, and staffing models. They have also had insourcing companies in to provide additional capacity in each of these specialties.

Other specialties including General Surgery, Plastic Surgery, Trauma and Orthopaedics and Gastroenterology also have long waits but lower volumes of patients over 52 weeks. All specialties have patients waiting between 26 and 52 weeks.

The current average wait time for each specialty is shown below (12th July 2022)

	Median Wait Time (weeks)	Average of waiting time (weeks)
General Surgery	14.29	18.10
Urology	20.57	25.56
Trauma and Orthopaedics	14.71	18.94
ENT	17.86	24.94
Ophthalmology	15.86	22.41
Oral Surgery	15.43	17.10
Plastic Surgery	18.57	23.21
General Medicine	20.00	17.67
Gastroenterology	14.14	17.72
Cardiology	13.86	15.96
Dermatology	12.43	15.60
Thoracic Medicine	8.86	11.31
Neurology	9.57	10.39
Rheumatology	12.57	15.59
Geriatric Medicine	13.43	16.50
Gynaecology	9.71	12.37

4.2 Elective Recovery Programme

The ICS elective recovery programme contains business as usual processes, service improvement and transformation schemes both at provider and system level. A number of these elements have been in place for some time within providers to ensure that elective services resumed activity and managed the potential clinical risk within the waiting lists.

Across providers a number of actions have been taken to return to elective activity, strengthening pre-pandemic procedures, and communicating with patients regarding wait times.

Some of the actions taken by NWAngliaFT have been:

- All patients waiting for an admitted procedure have been clinically prioritised to ensure that clinical need and risk is considered when treating patients
- Strengthened procedures to manage the waiting list
- Theatre timetables and scheduling meetings re-established to meet the demands of current service provision
- Specialty reviews undertaken with specific actions to increase or maximise capacity

Further service improvement work continues within specialties which includes clinic template reviews, introducing one stop clinic opportunities, utilising virtual options, and assessing whether some care can be provided by different clinical disciplines to create more capacity.

In addition to the above several other steps have been taken to address clinical risk, capacity and long waits across the system:

- Harm reviews - Providers, alongside prioritising patients, have been completing harm reviews for all long waiting patients and have embedded processes to ensure risk is assessed.
- System view - A system wide waiting list overview has been established which enables oversight of wait times, size of waiting list and building issues. This is monitored at system level and has instigated mutual aid discussions and support across the system.
- Mutual Aid – Orthopaedics across NWAngliaFT and Cambridge University Hospitals NHS FT (CUHFT) have worked together to move patients from the South to the North to ensure that they had their treatment as quickly as possible. This has reduced the waits and provided more equitable access. NWAngliaFT were in a position to support this due to a large-scale change project that they undertook post the first wave of the pandemic to support elective recovery within Orthopaedics. The graphs in Appendix 1 show the orthopaedic waiting list and how this has equalised for very long waiters. Currently there are no further patients transferring within orthopaedics. Opportunities for further mutual aid in other specialties are being explored.
- Independent sector – utilising capacity within the independent sector across the system. This has been beneficial in a number of areas but particularly with SpaMedica and long waiting patients for cataracts in the North. Opportunities continue to be explored across providers specifically at specialty level. There is also a potential for expanding provision with the establishment of a new private hospital in Peterborough – The Hampton's Hospital. This will be contingent on the provider's application to the Increasing Capacity Framework (ICF) being approved by NHS England, in addition to the providers successful Care Quality Commission (CQC) registration. Relationships are being established with the provider to understand the opportunities to establish services to support elective recovery.
- Insourcing – in addition, Providers have been accessing insourcing companies to increase capacity. NWAngliaFT have insourced for Dermatology, Plastics, ENT, Ophthalmology, Urology and Endoscopy.
- Additional short-term capacity with 'Super Saturdays' or additional clinics have been put on by providers in different specialties.

- My planned Care – In addition to individual providers contacting patients directly with communications on wait times and their treatment, a national system has been launched called My Planned Care NHS. Local providers are providing information to ensure their wait times are on this website for patients to access as well as useful information that will support them during their waits.

Alongside the steps mentioned above, a series of transformation projects have been identified to support elective recovery and sustain capacity and effectiveness of services for the future. NWAngliaFT has plans that sit under each of these workstreams and is engaged with the wider system work and initiatives. These are split across outpatients and elective procedures:

Outpatients

- Patient Initiated Follow Ups (PIFU)- Introduction of PIFU pathways across specialties within secondary care allows patients the option to access a further follow up within secondary care without having to go via primary care. Patients are discharged on this pathway with an option to access services if required. The aim is to reduce unnecessary follow ups but allowing patients an easier route back into secondary care. It will also support improved shared decision making and improved self-management. For example, if a patient has been seen by their gynaecologist and the treatment plan is complete, they may be able to refer themselves straight back to the specialist if the same symptoms return, rather than having to go through their GP practice for a referral.

  PIFU is already being rolled out across 14 specialties at NWAngliaFT.

  PIFU are part of the outpatient transformation requirements laid out in the 2022/23 Operational Planning Guidance.

- Virtual Consultations- To increase the number of first and follow up outpatient appointments that are offered via telephone, or a virtual platform. The aim of this is to improve access to outpatient services, reducing the number of patients accessing hospital sites. This should reduce time spent in clinic; improving productivity and improving patient experience by making it more accessible, reducing the time spent in attending services whilst still accessing clinical support. Face to face options will still be offered to those who have difficulties accessing telephone and online appointments.

- Pathway redesign - A number of pathways require redesign to support outpatient pathways. Two pathways have been agreed at a regional level for focus – Musculoskeletal Services (MSK) and Eyecare. Dermatology has also been identified within the system as requiring review and redesign. Work is in its infancy for some of these areas so will need to be assessed as the plans develop further.

  MSK – Initial focus within the delivery group is assessing the front door of the pathway into MSK services. Scoping of this has begun building on historic work that was completed pre-pandemic. The benefits expected from this redesign are:
  - Easier access to services
  - Reduced referrals into secondary care with patients being seen in community services closer to home

  Eyecare – The initial focus is the delivery of an electronic referral management and image sharing into secondary ophthalmology services. This is allowing Optometrists to refer electronically directly into secondary care instead of referring via the GP or via a paper referral system. The benefits expected from this are:
  - Improved quality and speed of triaging; reducing serious patient harm
  - Real time advice and guidance to support care closer to home
  - Access to the same patient health record which supports more appropriate allocation to specific specialist clinics reducing unnecessary outpatient and diagnostic appointments

- Supporting a user-journey led service
- Reduce reliance on face-to-face appointments

Dermatology – This is in initial scoping stage but is likely to include Teledermatology and a review of community provision and opportunities. The expected benefits are:

- Easier access to services
- Reduced referrals into secondary care with patients being seen in community services closer to home

PIFU, Virtual consultations and pathway redesign are all key areas of focus in the Delivery plan for tackling the COVID-19 backlog of elective care Feb 2022

Elective procedures

- High Volume Low Complexity (HVLC) procedures - This programme will deliver the recommended *Getting it Right First Time* (GIRFT) HVLC programme across Orthopaedics, Gynaecology, ENT, Ophthalmology, Urology and General Surgery. This programme provides clear guidance for HVLC procedures stating expected numbers that should be achieved within theatre sessions etc. This will ensure a greater volume of patients receive their surgery for procedures that may otherwise continue to have long waits. The key benefits are that a higher volume of patients will receive their procedures within our current capacity and within a reduced waiting time.

- Day case optimisation - By converting all clinically suitable elective inpatient procedures into day cases there will be a reduction in the reliance on inpatient beds. This will reduce the risk of cancellations on the day or day before surgery due to the impact Urgent & Emergency Care (UEC) pressures can have on surgical beds across secondary care providers. Long term this will also reduce elective Length of Stay (LOS) and the number of inpatient elective beds required. It will improve patient experience by supporting patients to return home as soon as possible post procedure and potentially improve outcomes. It will support elective winter programmes. This programme builds on the day case elements within the HVLC programme and the British Association of Day Surgery (BADS) recommendations.

- Theatre utilisation - There are opportunities at all providers to improve processes and pathways within theatre departments to improve efficiencies and gain productivity opportunities, again building on the recommendations from GIRFT. The key benefits from this will be an increase in procedures within current resources and a reduction in procedure cancellations; ultimately reducing the overall waiting list. This will also improve patient experience.

- Perioperative pathway transformation - Good perioperative care can optimise pathways, improve patient experience of care, and improve outcomes from surgical treatment. The perioperative pathway starts from the moment surgery is contemplated until full recovery. Parts of this pathway sit within the workstreams described above. Other projects that will sit within this workstream but are still being scoped at provider level are:
  - Review of Pre-operative assessments and optimisation
  - Supporting patients to Drink, Eat and Mobilise after surgery
  - Shared decision making
  - Enhanced care

  The benefits from the above are varied but include: reduction in face-to-face assessments where digital options can replace, reduced complications for patients and improved outcomes, supporting patients to make the right decision for them about treatment plans, and reducing cancellations due to limited availability of critical care beds.

- Waiting well - Patients are waiting longer for treatment post-pandemic which can mean conditions deteriorate and can impact on wider aspects of their health or life. It is

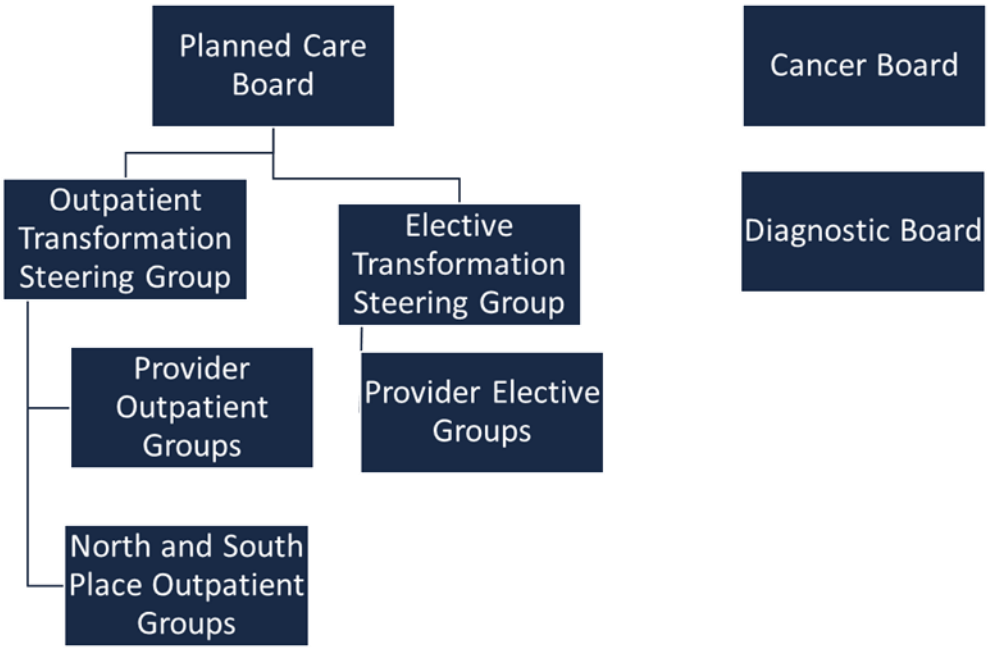
important that we provide information on waiting times, how to access services if deteriorating but also to support them whilst waiting by providing holistic support. This can be, for example, weight management, smoking cessation or accessing community or voluntary sector groups/services or social prescribing to improve their overall wellbeing. A pilot has been running by Meridian Primary Care Network called Worthwhile Wait. This workstream will work with system partners to build on this work and look at how we can roll this out to more patients on our system waiting lists. Expected benefits from this work are improved patient experience, outcomes, reduced complications, and informed decision making about accessing surgical procedures.

The Elective recovery plan is subject to a Health and Inequalities Impact Assessment (HIIA). This HIIA will be kept under ongoing review as our detailed recovery plans develop and deliver, to ensure it remains accurate. A new patient tracking list is also being developed to give providers and the ICS as a whole wider insight beyond existing waiting list data to include referrals and levels of pathway attrition split by IMD and BAME group.

Alongside the elective recovery plan there are separate ICS plans to support diagnostic and cancer recovery which all have interdependencies.

4.3 Governance

Governance and monitoring arrangements of progress are through the ICS Planned Care Board and sub structure (see below). The Planned care board will report into two Integrated Care Board (ICB) sub-board committees – Quality, Performance & Finance and Improvement & Reform.



A single system waiting list overview has been developed to support monitoring of the current waiting list, long waits, demographics of our patients and breakdowns of admitted and non-admitted pathways. This will enable us to ensure we continue to make progress on reducing the waiting lists and overall wait times. This is in addition to monitoring of key performance indicators within each transformation programme and other performance metrics to ensure we are delivering what we have set out to achieve.

5. ANTICIPATED OUTCOMES OR IMPACT

5.1 Through the combination of actions being taken by providers and the wider system we expect to:

- Improve access to outpatient and elective services
- Improve patient experience and outcomes

- Reduce the waiting times for patients and the size of the overall waiting list
- Ensure we are utilising all our services and resources across the system to provide equitable access
- Improve productivity and efficiencies to support the increasing demand into our hospital services

6. REASON FOR THE RECOMMENDATION

6.1 This paper is to provide an overview of the current position for our elective services and wait times across the system, particularly in the North Accountable Business Unit, and our plans to address them.

7. IMPLICATIONS

Equalities Implications

7.1 A high-level Equality and Health Impact Assessment (EHIA) has been undertaken on the whole programme which highlights how key protected characterised groups and groups who face health inequalities may be impacted by the programme. As it is a very varied programme it has been decided that EHIAs will be completed for each transformation project so that we can ensure we are addressing the needs of our whole population.

8. BACKGROUND DOCUMENTS

Used to prepare this report, in accordance with the Local Government (Access to Information) Act 1985

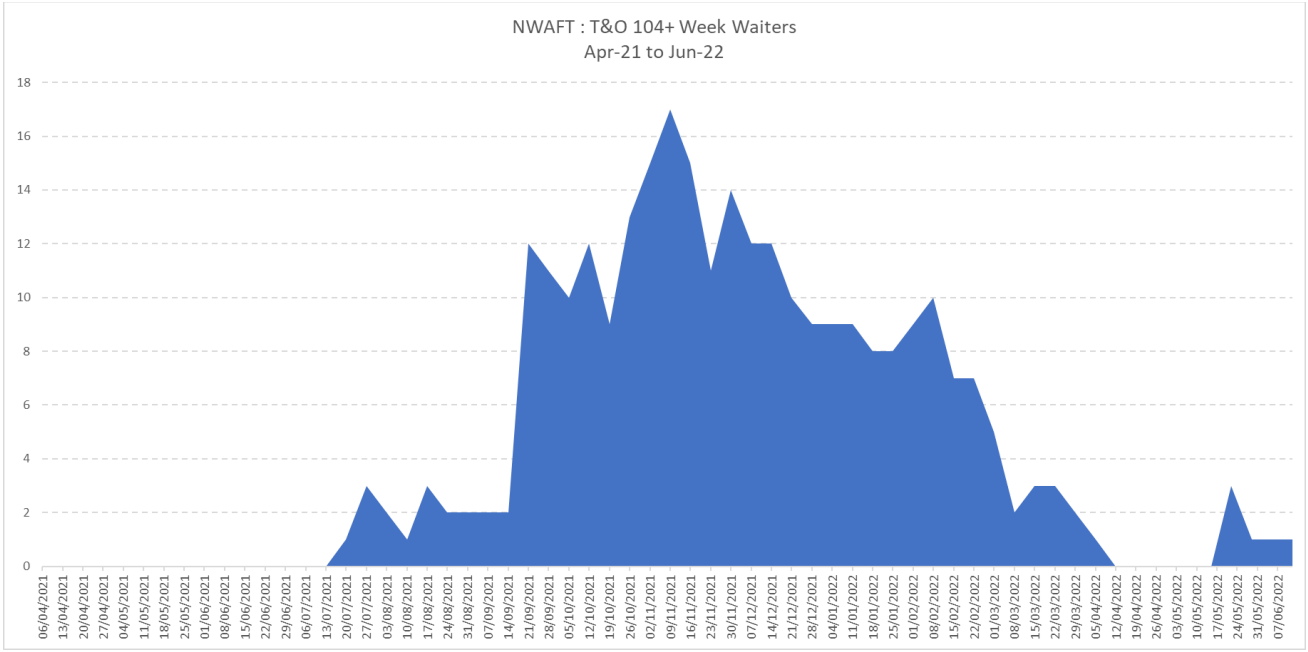
8.1 The following national guidance were used to compile the report and Elective Recovery Programme:
NHS England and NHS Improvement, "Delivery plan for tackling the COVID-19 backlog of elective care", February 2022
NHS England and NHS Improvement, "2022/23 priorities and operational planning guidance", V3, February 2022
NHS GIRFT, "Elective Recovery High Volume Low Complexity (HVLC) guide for systems", 2nd edition, November 2021

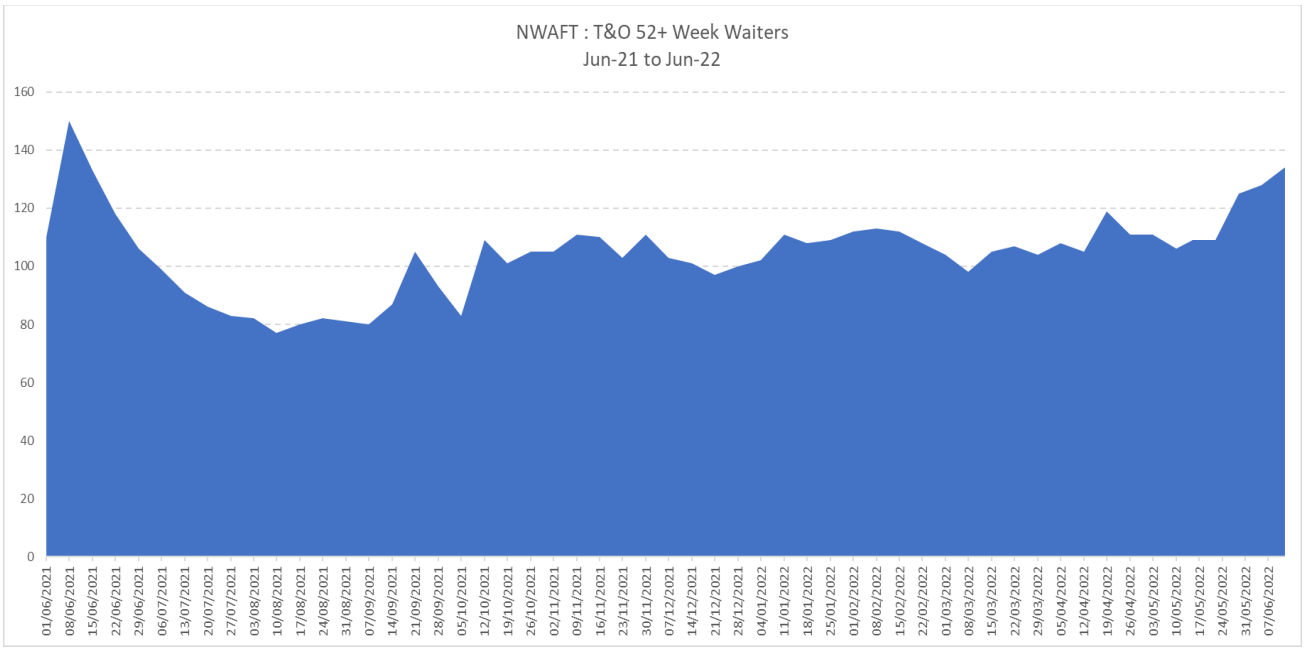
9. APPENDICES

9.1 Appendix 1 – Orthopaedic waiting list see below.
Appendix 2 - Equality and Health Inequalities Impact Assessment

Appendix 1 – Orthopaedic Waiting list

The two tables below show the long waiting position at NWANGLIAFT for patients waiting over 104 weeks and then 52 weeks in Orthopaedics.





In comparison Cambridge University Hospitals (CUH) waiting list had a higher volume of long waiting patients which were over 104 weeks (shown below). During November – March patients were transferred and treated at NWANGLIAFT. Whilst the 52 week waits remain higher at CUH the very long waiting patients have levelled across the system.