Elective Recovery across the Nottingham and Nottinghamshire ICS

The purpose of this document is to inform City Council, Health Scrutiny Committee of the ICS approach to managing 'Elective Recovery' and reduce waiting times for elective care that formed during the Covid-19 Pandemic.

Context

The Nottingham and Nottinghamshire system has been working collaboratively over recent years to transform our healthcare system with social care partners. This system wide approach formed the basis of our Clinical and Community Services Strategy and associated clinical pathways which cover; primary, community, and secondary care. It is now essential to build on this to ensure 'Elective Recovery' following the onset of Covid-19.

Our collective aim is to offer high quality integrated care in the right setting, to support patients to stay well, make best use of resource and reduce health inequalities. The impact of Covid-19 required the system to respond to the immediate challenges presented by the pandemic. However, this has also given us a strong basis for joint working as a system to build on and a platform to develop and implement our wider system transformation plans.

Elective Waiting Lists

At the outset of the global pandemic, under national direction, our hospitals responded to high numbers of patients with Covid-19 requiring urgent and complex care. This meant that like all other health systems, non-urgent elective procedures ceased for a period which in turn has increased the numbers of patients waiting for non-urgent elective treatment. All health systems are currently working to reduce waiting lists as part of 'Elective Recovery'. Throughout the pandemic, however, Nottingham and Nottinghamshire continued to perform better than many health care systems in terms of ensuring that those time critical surgical procedures (e.g. cancer) were undertaken.

Whilst waiting times for surgical treatment have increased as a result of Covid, our waiting times against the national 18-week Referral to Treatment standard are proportionate compared to other local health systems across our region and slightly better than the national position.

However, the current urgent care pressure on our hospitals and other parts of the system has an impact on elective waiting times. In addition, our staff worked relentlessly during the peak of the pandemic and need time to recover by taking annual leave. Anaesthetists, particularly, have supported critically ill patients in critical and high dependency care and are a key element of the workforce now required to increase the throughput of planned operations. In order to optimise

productivity and ensure staff wellbeing it is essential to care for staff during this recovery period.

Some patients have chosen to wait for a variety of reasons, but they will remain on the waiting list and will have their procedure when they feel ready. There was a reduction in the number of referrals at the beginning of the pandemic and in the early stages of recovery, however referrals are now returning to a level that we would generally anticipate.

Patients with health concerns have been encouraged to seek advice and avoid delay in diagnosis, which is particularly important for patients with a potential cancer diagnosis.

Planned Care Transformation

Whilst the initial focus was the immediate response to the Covid-19 Pandemic, working together strengthened the level of collaboration as a system which in turn supports our Elective Recovery. Built around our existing transformation priorities and clinical pathways, the Planned Care Transformation Programme has been developed with the patient at the centre of our design.

We have agreed system priorities that respond to the immediate current pressures on our waiting lists and the wider opportunities for medium to longer term transformational change. This builds on our aim to support patients to stay well and offer community-based care where appropriate which is the basis of the Clinical and Community Services Strategy.

The Planned Care Transformation Programme consists of 3 core work streams:

- Cancer Programme; to provide earlier diagnosis across a range of areas including the Targeted Lung Health Check Programme and Rapid Diagnostic Centres.
- Diagnostics Programme; increasing diagnostic capacity and reducing waiting times. Dependant on national funding we aim to implement Community Diagnostic Hubs in the future.
- Elective and Outpatient Transformation; providing GPs with access to consultant advice and guidance, supporting patients to stay well with shared decision making in place, and implementing evidence based clinical pathways. In addition, our hospitals continue to offer virtual out-patient consultations where clinically appropriate and are maximising capacity based on national best practice.

Our programme is clinically led with plans developed by front line services and delivery is supported by managers across all organisations in the health system.

Pathway redesign has been prioritised based on waiting list pressures and the opportunities afforded by transformational change. In order to successfully deliver sustainable change, redesign of 2 key specific pathways is underway:

- **Eye Health.** Prevention of deteriorating eye health, with community-based care to enable conditions to be diagnosed and treated outside of the acute hospital.
- **Orthopaedics.** To offer integrated community-based care with a focus on keeping well, conservative treatment and support where clinically appropriate. Hospitals are also working together to maximise all capacity, share learning and to ensure that opportunities to increase acute productivity are taken.

Further discrete pathway redesign will follow sequentially in parallel with wider system plans to offer integrated community-based care, supporting patients to stay well with a focus on population health management. Working with health and care partners this will span primary, community and secondary care.

Despite ongoing challenges in urgent care demand there is excellent engagement across the system, underpinned by agreed principles of joint working, shared methodology and clear decision making as an ICS. The work programme is being successfully implemented however we anticipate that we will continue to deliver this transformational change over several years.

Accelerator Programme

In May 2021 the CCG successfully bid for 'Elective Accelerator' funding as one of 10 sites to support elective recovery over a 3-month period between May and July. Discrete schemes were agreed by our community and acute providers which enabled an additional 24,768 patients to be seen or diagnosed under the programme. A proportion of the funding was spent on buying new equipment such as a mobile endoscopy unit and other equipment to aid future sustainability.

In summary this enabled:

- more patients to have a diagnostic test: including endoscopy and an ophthalmology diagnostic hub
- more patients to be seen in a clinic or virtually
- more patients to have surgery within ophthalmology, orthopaedics, and general surgery

The pilot finished at the end of July and has informed our elective recovery. We have identified those schemes which will have the greatest impact on waiting times that we can take forward as part of our transformation programme.

Managing Waiting Lists

The impact of our elective recovery and transformational change will continue, and we anticipate good progress over the short and medium term. Meanwhile we are clinically prioritising patients on waiting lists so that patients with cancer or urgent care needs are treated without delay. At the same time, we are taking every step to prevent unnecessary waits for simple procedures not requiring admission.

This approach to clinical prioritisation is fully in line with National Guidance from the Royal College of Surgeons. This defines clinical priorities as follows:

- P1 Surgery within 72 hours
- P2 Surgery within 1 month
- P3 Surgery within 3 months
- P4 Surgery over 3 months
- P5 Patients who deferred treatment due to COVID concern (remaining on list)
- P6 Patients offered 2 dates for treatment but declined to accept for non Covid reasons and are removed from the list

Our senior clinical leaders retain oversight of this as a system to ensure that patients with urgent clinical need or cancer are treated without unnecessary delay across all organisations. Clinical teams within our hospitals have detailed oversight of patients on waiting lists and they define the level of clinical priority with regular reviews in place.

During the height of the Covid-19 Pandemic our health system including our local hospitals worked closely together to make best use of all capacity to treat patients with mutual aid offered between health and care partners. This collaborative approach continues and has clear benefits for our patients. We have developed a system ‘Elective Hub’ which has oversight of all waiting lists so that we use all available capacity fairly, prevent inequity of access and ensure patients are offered dates for their procedure as quickly as possible. This detailed review is undertaken on a weekly basis and includes NHS and Independent Sector providers so that patients can be offered care at other providers where appropriate. We have also undertaken detailed analysis of our waiting lists to ensure that we continue to take action to avoid health inequalities.

We recognise that some patients with less urgent needs have waited longer, and so hospitals have written to patients to explain the reasons for the wait with advice on staying well and a contact number for further information if needed. Information is sent by letter with some updates by text.

Managing Winter Pressures

Over the summer the health and care system experienced pressure from urgent care demand. These pressures are still evident across primary, community and secondary care with increased urgent admissions to hospital. Exacerbated by workforce issues due to staff availability, sickness, and vacancies; the impact is wide ranging and has an impact on elective recovery.

It is therefore essential to have robust system wide plans to deal with the ongoing pressures that we are likely to experience during winter.

Importantly our ambition is to enable patients to be discharged and cared for at home where clinically appropriate. We have undertaken detailed modelling to test how many community and acute beds we are likely to need and discharge requirements based on likely demand. This has informed our winter planning, therefore Health and Care Partners system wide are taking joint action to support safe timely discharge home and wider winter planning.

Key issues related to discharge delays:

- Increased numbers of patients who are medically fit for discharge occupying an acute bed
- Community beds / interim care home beds may be occupied with longer stays for patients awaiting packages of care
- General workforce shortages across health and social care with reduced availability of home care preventing discharge home first

Joint planning is underway with additional beds identified and we are working closely with voluntary sector organisations. There are solutions being actively progressed to support the home care market and secure staffing.

Summary

The management of our waiting lists is clinically prioritised supported by an approach to Elective Recovery with clinical leadership and strong system engagement to underpin delivery. It is appropriately aligned to system wide planning for winter pressures and reflects longer term transformation opportunities.