Agenda Item 8

LEICESTER, LEICESTERSHIRE AND RUTLAND JOINT HEALTH SCRUTINY COMMITTEE – 18 DECEMBER 2023

RESTORATION AND RECOVERY OF ELECTIVE CARE

REPORT OF LEICESTER, LEICESTERSHIRE AND RUTLAND HEALTH SYSTEM

Purpose of the Report

1. The purpose of this report is to provide the Committee with an update on the elective care recovery progress for the patients of Leicester, Leicestershire and Rutland (LLR) with a specific focus on the scale of the impact for those people living in within the Leicestershire County boundary who are on the University Hospitals of Leicester NHS Trust (UHL) list for elective care, diagnostics and/or treatment.

Context

2. Before the Covid-19 pandemic (March 2020), Leicester, Leicestershire and Rutland's (LLR's) health providers had a total of 66,000 on its waiting list. The UHL waiting list includes patients with a physical health need, diagnostics and/or treatments including cancer, for both paediatrics and adults.

3. The size of the wating list more than doubled following the pandemic with 130,835 patients waiting by October 22. UHL has the 10th largest RTT (Referral to Treatment) waiting list nationally based on September 23 published data.

4. Nationally, the overall waiting list is continuing to grow and is at a record high, despite the reduction in the longest waits.

5. However, UHL has seen a reduction in the overall waiting list since the start of the year (April 23 117,318) and is on track to achieve the waiting list target within the operational plan of 103,000 by the end of March 24.

6. UHL has also seen significant progress made on reducing waiting times for those patients waiting the longest for definitive treatment. UHL has virtually eliminated all patients waiting longer than 2 years for treatment. With a forecast to get to zero patients waiting 78 weeks by the end of February 2024.

7. Whilst the impact of cumulative Industrial Action has been significant, we have still managed to improve the waiting times for patients across the board. Patients, in general, are receiving their care sooner now than they were 12 months ago. With the plans we have in place, we believe we will be able to say this again in 12 months' time.

8. The three key principles of the elective improvement plan are: improving our **processes and productivity**; increasing **capacity** in the right areas; and having the **support of partners** to help us improve.

9. The ambitions and actions in the plan are clinically led and are informed by evidence and feedback from across UHL.

Elective Recovery

78-week wait position and forecast

Table 1 78week wait trajectory- Route to zero

Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
143 actual	92 actual	96	54	25	0	0

10. The end of October position was 92 for UHL. This is an improvement of 51 from the end of September. The cumulative impact of repeated Industrial Action (IA) is having a significant effect on the speed of recovery, this is most notable on the admitted pathways where the capacity lost cannot be re-created. The capacity that is available is prioritised for specialities with large cancer backlogs which means that non cancer patients may have to wait longer.

11. Furthermore, in October winter pressures have started to impact and there has been a growing increase in cancellations, particularly within paediatrics. Therefore, the trajectory to get to zero for 78-week waits has deteriorated from a forecasted zero position by the end of December to zero by February 24.

65-week wait position and forecast

12. Modelling suggests that UHL 65-week position remains ahead of the national target for most specialities and we continue to make progress towards this target of 0 by the end of March 2024. There is risk to achieving this target, particularly with winter pressures and industrial action, and we will do all we can to mitigate this risk.

13. Focus remains on driving down the number of patients waiting for their first Outpatient appointment (OPA) in the 65-week cohort. As of 4/12/23, 713 patients are waiting their first OPA within the 65-week cohort. 48% of these patients have a first OPA before the 31st December.

52-week wait position and forecast

14. The 52-week actual position as at 13/11/23 is 5,010 and March 24 cohort is 21,190. Ten specialities make up 82% of the March 24 cohort, see table 3 below. Performance is currently better than our operational plan, with continued improvement forecast based on current activity levels.

Table 2 Top speciality waits, March 24, 52-week cohort

Adult Specialties	Combined	Admitted	Non-Admitted	% Total Cohort
Gynaecology	3,321	357	2,964	16%
Ophthalmology	2,489	563	1,926	12%
Gastroenterology	1,915	180	1,735	9%
ENT	2,053	216	1,837	10%
Cardiology	2,032	439	1,593	10%
Maxillofacial Surgery	1,312	157	1,155	6%
Urology	1,363	292	1,071	6%
Orthopaedic Surgery	1,414	791	623	7%
Gen Surg incl.	930	238	692	4%
Spinal Surgery	515	160	355	2%

Total waiting-list

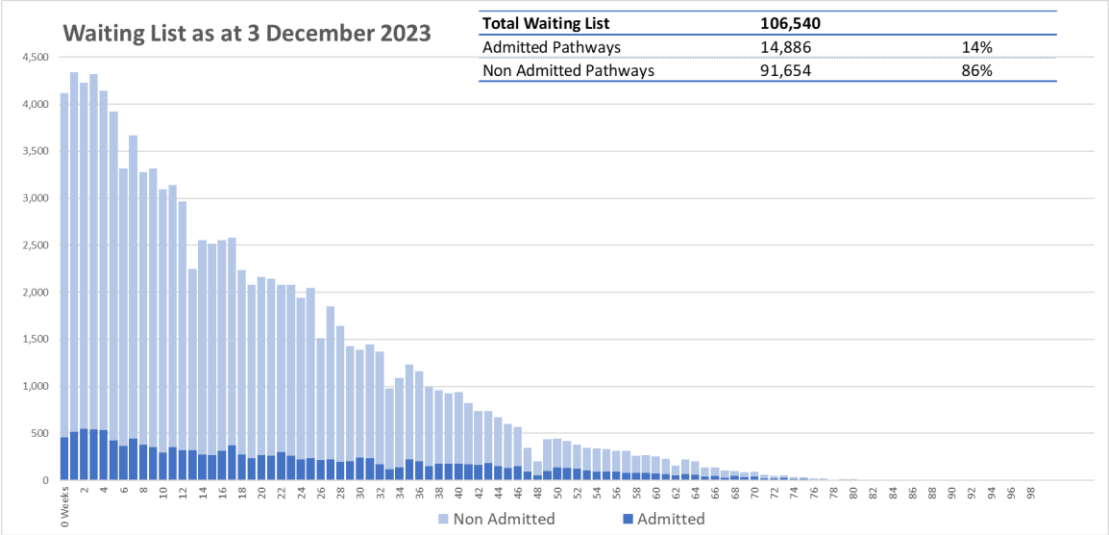
15. The total waiting list continues to buck the national trend showing a reduction in overall waiting list size, making a significant improvement in October due to a number of focused interventions. Such as, the focus on the first outpatient appointments by 31st October for patients within the 65week wait cohort; a new 12-week validation cycle to enable text messaging every two weeks to commencing 2nd October, the first cycle resulted in circa 1,600 patients being appropriately removed from the waiting list; a technical validation exercise commenced 4th October addressing data quality errors in lower waiting pathways.

16. The number of patients being added to the waiting list has started to increase and so far for 2023/24 has a higher monthly average than pre-pandemic of 2019/20. See table 4 below.

Table 3 Clock starts- how many new patients are joining the waiting list each year

Year	Clock Starts Total	Average Monthly
2019/20	291,418	24,285
2020/21	204,417	17,035
2021/22	238,908	19,909
2022/23	257,320	21,443
2023/24 (7 mo Apr - Oct)	173,249	24,750

Shape of waiting list



Productivity Objectives and Interventions:

There are two core streams: Theatre Productivity and Outpatient Improvement.

17. Key interventions include:

- Focus on daycase utilisation;
- GIRFT (Getting it Right First Time) Further Faster Engagement- implementing best practice in the management of elective care;
- Digital validation e.g. improving our communications with patients through 2-way text messaging;
- Digital pre-operative questionnaires (aim to reduce clinical on the day cancellations);
- My pre-op programme (electronic pre-assessment, avoiding the need for face to face pre-operative assessment where clinically appropriate)
- Strengthened governance;
- Outpatient DNA Florey's (a florey is a questionnaire sent by text message, to collect structured data) identified opportunity of 23% reduction in DNAs possible;
- PIFU (Patient Initiated Follow-up) focus, with additional admin training provided. The aim being that this will release capacity to see patients who need to be seen, reducing waiting times for clinic appointments.

18. Outcomes so far include:

- Improvement in Average Case per List year to date;
- Theatre utilisation improved from 70% to 75% overall;

- Daycase rates for TURBT (Urology) have gone from 16% in 20/21 to 42% in 22/23. Over 100 patients not requiring an admission.
- High Volume Low Complexity- orthopaedics 'LEAP' pathway launched which has led to a significant reduction in length of stay for knees from 4.8 in 22/23 to 3.0 in Oct 23 and for hips 5.4 in 22/23 to 3.2 in Oct 23. The first day case hip procedure was carried out in November.
- PIFU (Patient Initiated Follow-up) delivering 3.3% in October 23 from 2.1% in April 23. Stretch targets have recently been introduced for each speciality based on GIRFT best practice.
- Overall follow-ups are significantly below plan (greater than 25% reduction), increasing clinic capacity for patients waiting to be seen.

Diagnostics

Hinckley Community Diagnostic Centre

19. £24.6m of National capital investment secured. Currently in the process of agreeing the phasing of the spend over the remainder of this year and next year with NHSE.

20. Will include services such as CT, MRI, X-ray and ultrasound facilities, as well as providing clinical rooms for phlebotomy, endoscopy, and outpatient procedures.

21. When fully operational the CDC will provide capacity for up to 89,000 tests or appointments each year – noting this is not all new activity as some services are currently provided from Hinckley.

22. Construction is due to begin in early 2024 with the unit set to be built around December 2024 and operational from January 2025.

23. There will be disruption to services whilst the ground works and building works take place. Daycase services and Endoscopy will be accommodated in other facilities as locally as possible.

24. An Outline Planning application has been submitted - Planning Committee to take place on 16/01/24.

Summary

1. There continues to be good progress made on the reduction of those patients waiting longest for definitive treatment. Please see appendix 2 RTT (Referral To Treatment) graphs.

2. There is significant improvement work underway to improve productivity and efficiency across a suite of indicators. Outcomes so far show the progress being made, whilst acknowledging the is further opportunity to explore.

Officers to Contact

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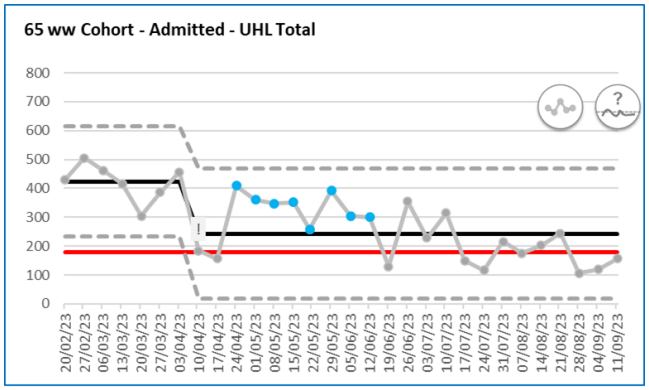
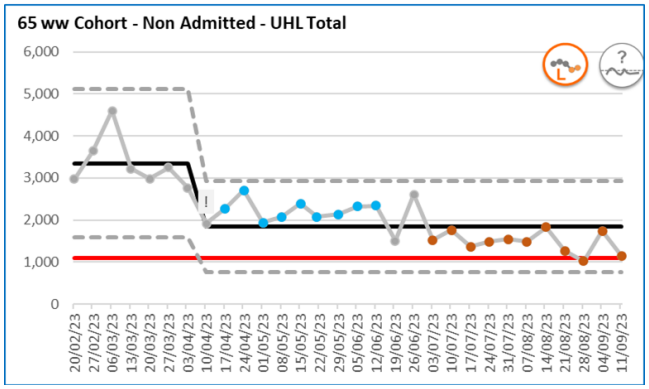
Appendix 1: Impact of Industrial Action:

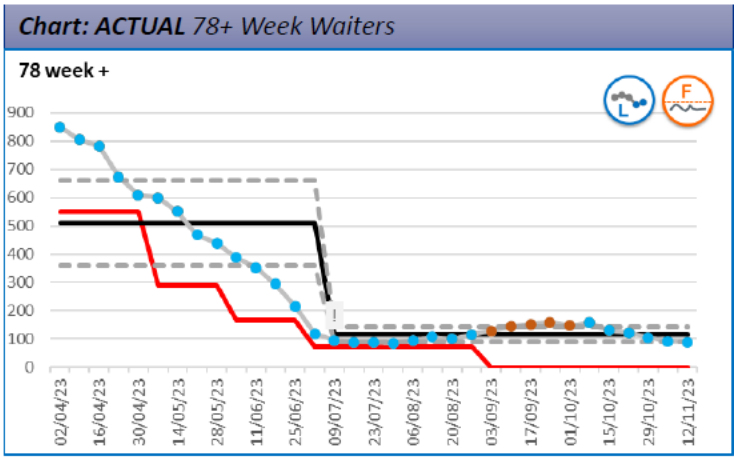
Industrial action has had a significant impact on elective activity, including:

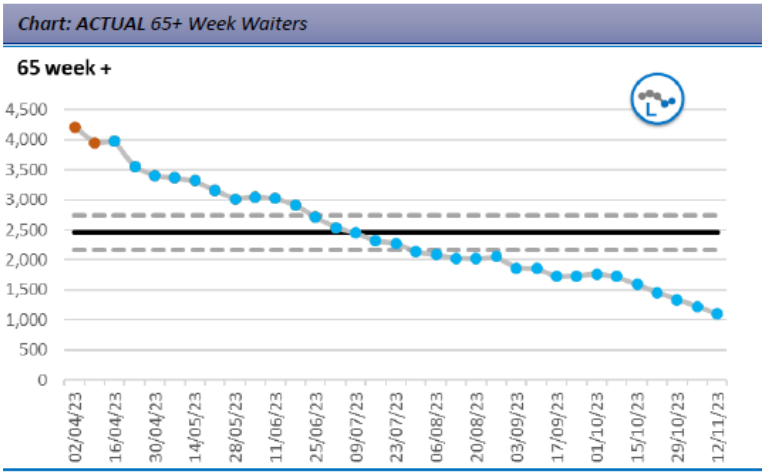
Reduction in 65 week wait clearance rate: Charts 1 and 2 (below) show our average reductions in 65ww cohorts for the year, and you can see a reduction in clearance rate in July and August (the orange dots). We monitor on a specialty level in weekly performance meetings. Despite this, all specialties are currently still managing to continue to reduce their long waiter cohorts.

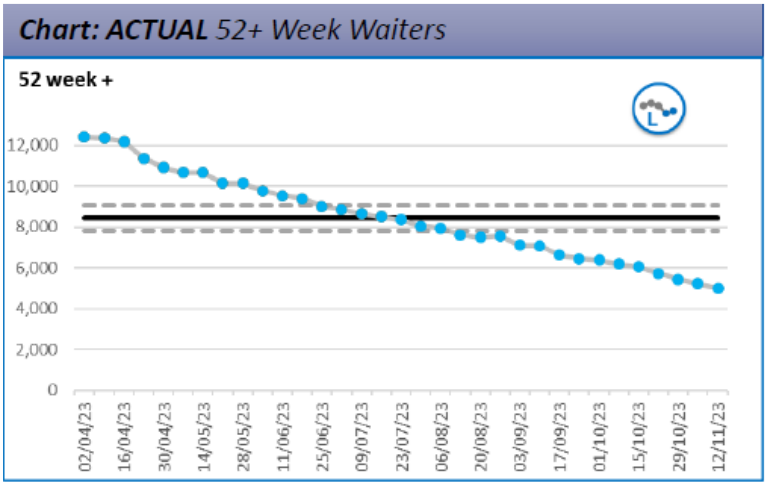




Appendix 2 RTT graphs







University Hospitals of Leicester NHS
NHS Trust

Appendix 3 Elective Care Glossary of Terms

Elective Care Glossary of Terms June 2023

Active monitoring
A waiting time clock may be stopped where it is clinically appropriate to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures at that stage. A new waiting time clock would start when a decision to treat is made following a period of active monitoring (also known as watchful waiting). Where there is a clinical reason why it is not appropriate to continue to treat the patient at that stage, but to refer the patient back to primary care for ongoing management, then this constitutes a decision not to treat and should be recorded as such and also stops a waiting time clock If a patient is subsequently referred back to a consultant-led service, then this referral starts a new waiting time clock.

Active monitoring can also be applied, following clinical review and agreement, when a patient has declined or cancels two previously agreed appointments or admission offers.

Admission
The act of admitting a patient for a day case or inpatient procedure.

Admitted pathway
A pathway that ends in a clock stop for admission (day case or inpatient).

Bilateral (procedure)
A procedure that is performed on both sides of the body, at matching anatomical sites. For example, removal of cataracts from both eyes.

Care Professional
A person who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.

Clinical decision
A decision taken by a clinician or other qualified care professional, in consultation with the patient, and with reference to local access policies and commissioning arrangements.

Consultant
A person contracted by a healthcare provider who has been appointed by a consultant appointment committee. He or she must be a member of a Royal College or Faculty. Consultant-led waiting times exclude non-medical scientists of equivalent standing (to a consultant) within diagnostic departments.

Consultant-led
A consultant retains overall clinical responsibility for the service, team or treatment. The consultant will not necessarily be physically present for each patient's appointment, but he/she takes overall clinical responsibility for patient care.

Convert(s) their UBRN
When an appointment has been booked via the NHS e-Referral Service, the UBRN is converted. (Please see definition of UBRN).

DNA – Did Not Attend

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