

Meeting Title	Board of Directors		
Date	22 <sup>nd</sup> July 2021	Agenda item	Bo.7.21.9

## Elective Recovery Update Position

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Purpose of the paper	Update on Elective Recovery	
Key control		
Action required	To note	
Previously discussed at/informed by		
Previously approved at:	Committee/Group	Date

### Key Options, Issues and Risks

#### Impact of the Pandemic on Elective Activity

##### Timeline:

- 1/3/20 - The first community COVID case was reported in Bradford.
- 17/3/20 - The first COVID positive inpatient admitted to BTHFT.
- 1/4/20 - Three surgical wards closed to redeploy staff to support COVID wards
- 3/4/20 - Second intensive care unit opened.
- May 20 - Five inpatient wards were dedicated to COVID positive patients along with the 2 ICUs.
- May 20 - Average number of inpatients per day of both confirmed and suspected COVID positive patients was 82 per day (Figure 1). The average number of patients on ICU was 11 per day and the average on NIV outside critical care was 15 per day.

Our single site model and the significant demand placed on the organisation to meet the needs of a population disproportionately hit by the pandemic have resulted in an inability to ringfence wards, theatres and workforce to preserve elective activity (Graph 1).

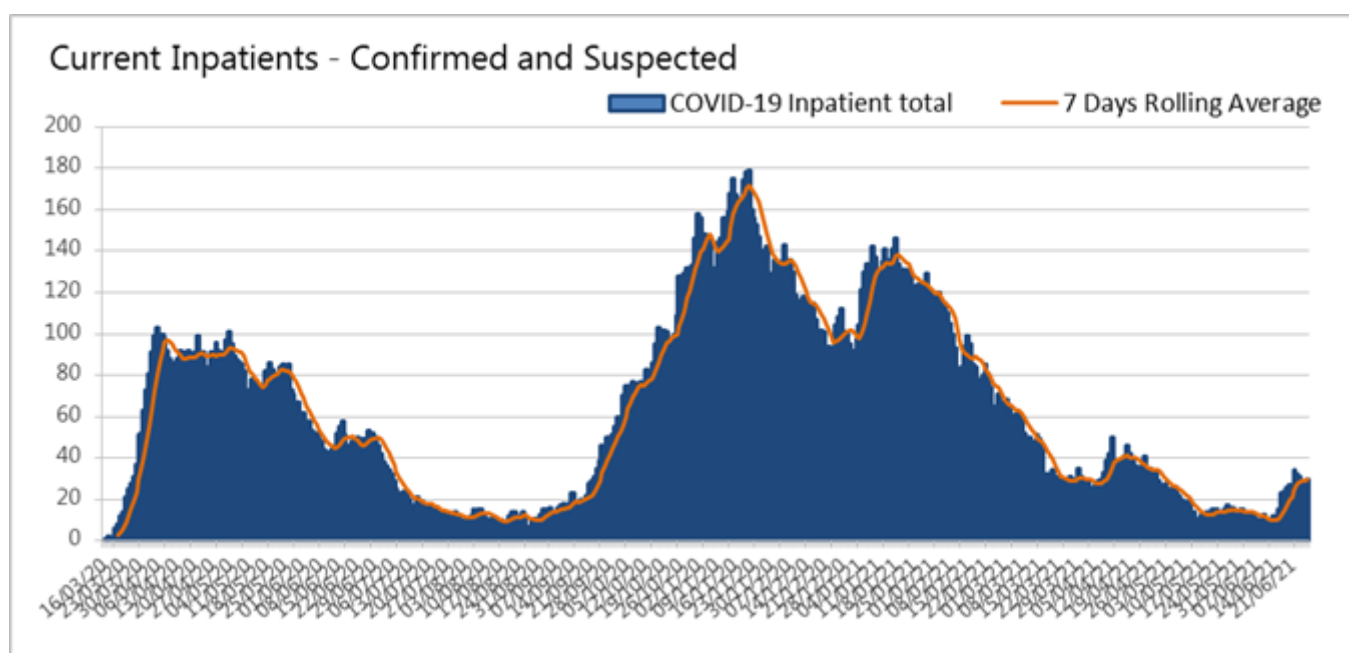
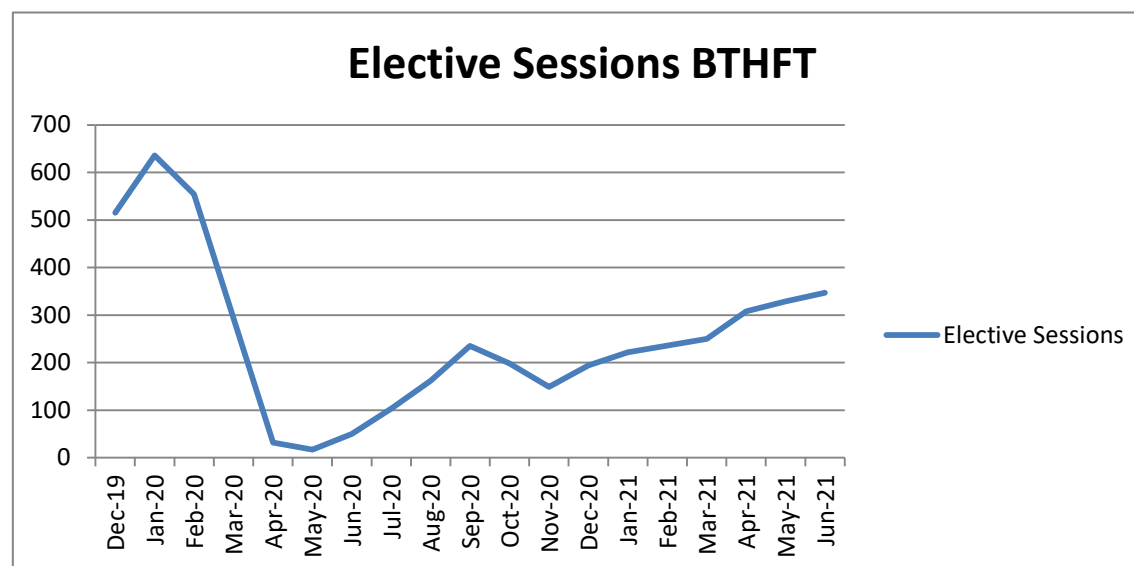


Figure 1: COVID positive inpatient numbers from March 2020 to June 2021

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The creation of the second intensive care unit and expansion of non-invasive ventilation capacity across the organisation required the redeployment of the majority of theatre staff and anaesthetists to critical care roles. This left behind a much smaller team to maintain urgent activity for acutes, trauma and life-threatening complications of cancer. Surgical ward nursing and medical teams supported both critical care and the COVID wards. This position persisted to a greater or lesser extent in line with demand through a second surge in September, October and December and into 2021 with theatre staff redeployment only ending in March 2021 at the point which the organisation returned to a single ICU.



Graph 1: Change in elective session delivery

There remains a compromise to elective and non-elective COVID negative critical care capacity. IPC precautions in place to manage critically ill COVID patients who are undergoing Aerosol Generating Procedures (Invasive and Non-invasive Ventilation) effectively limit ICU capacity to 50% of its pre-Pandemic bed number as soon as there are greater than 2 COVID positive patients. Critical care was open to its full pre-pandemic COVID negative capacity for the first time since March 2020 on 7/6/21 but required segregation again by 27/6/21.

National guidance showed that COVID infection in the perioperative period was shown to increase mortality and morbidity significantly. In line with national recommendations from the Royal Colleges and NHS England to minimise the risk of COVID infection in the perioperative period segregated pathways for elective and urgent surgical patients were created. The first ultra-green elective ward, ward 14 opened, alongside an ultra-green theatre suite in Nucleus theatres in June 20. Ultra-green patients for elective surgery initially isolated for 14 days but latterly socially distance for 14 days prior and isolate for 72 hours prior to admission and must have a negative COVID swab 72 hours prior to surgery. This along with stringent IPC precautions on the wards and theatre has achieved zero post-operative COVID infections. This enforced segregation will have the positive effect of adding predictability to the elective ward and theatre capacity which would have once be compromised by fluctuating non-elective demand however it has presented some new challenges with regards non-elective capacity.

During the Pandemic BTHFT has seen an expansion in our urgent surgical capacity with theatre sessions utilised to manage urgent as opposed to elective patients. The need for a ring fenced ultra-clean pathway means that urgent patients requiring surgery within the 2 week lead time for social distance, isolation and swabbing, need to be accommodated by a separate pathway including wards as well as theatre.

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Prior to COVID-19 such patients would have been accommodated in and amongst elective patients on wards and on our acute and trauma lists in the first instance but when this was insufficient added to elective sessions or result in an elective session cancellation. For some specialities the potential for urgent cases was factored into how they utilised elective capacity, with a potential redundancy that reduced efficiency. However we now require additional urgent capacity for all surgical specialities to compensate for this refinement and the additional IPC precautions that delay the turn-a-round between cases. In addition to this broader focus on urgent care, WYVAS, the centralisation of arterial surgery from Calderdale and Huddersfield NHS Foundation Trust and Airedale NHS Foundation Trust to BTHFT on 18/11/20 has led to an increase in theatre sessions dedicated to vascular surgery and vascular interventional radiology.

	Plastics Acute	Acutes	Trauma	Vascular
Avg. April 2019	5	10	9	8
Avg. Current	5	15	14	11.5
% Current Vs 2019	100%	150%	155%	144%

Table 1: Increase in urgent theatre capacity

Elective ward capacity has been limited by social distance and a necessity for wards to open, close and move location with surges in COVID and general Non-elective demand and their associated staff redeployments. This in combination with compromised critical care capacity has contributed to under-utilisation of available theatre sessions.

Essential capital works such as the ventilation works within ENT theatres affecting five operating theatres means that our physical capacity is also constrained at this point in time. We have also had to adapt to accommodate capital projects.

Having overcome the numerous challenges to elective theatre activity presented by the pandemic over the 12 months between March 2020 and March 2021 our recovery to baseline remains impacted by the following key issues:

1. An ongoing requirement to provide additional urgent theatre capacity in order to comply with IPC practices.
2. COVID demand within the bed base both on the wards and in ICU which limits bed availability for elective patients.
3. Closure of five theatres as part of essential ventilation upgrades until Q3 2021/22.
4. Ongoing establishment vacancies particularly within theatres.
5. Continued focus of internal theatre capacity on the more complex Priority 2 patients at BRI site adhering to strict clinical prioritisation leading to increased complexity reducing patients per session throughput.

### Restoring elective activity and delivering clinical priority

#### Clinical Prioritisation

We continue to prioritise the highest clinical priority patients (P2), assigning available theatre capacity in line with P2 backlogs and new P2 additions which includes cancer diagnosis and treatment.

In terms of cancer performance our focus has resulted in positive impact on 2 week wait allowing BTHFT to remain above the national average and peer group (Figure 3) and for 62 days recover close to pre-Pandemic baseline (Figure 4).

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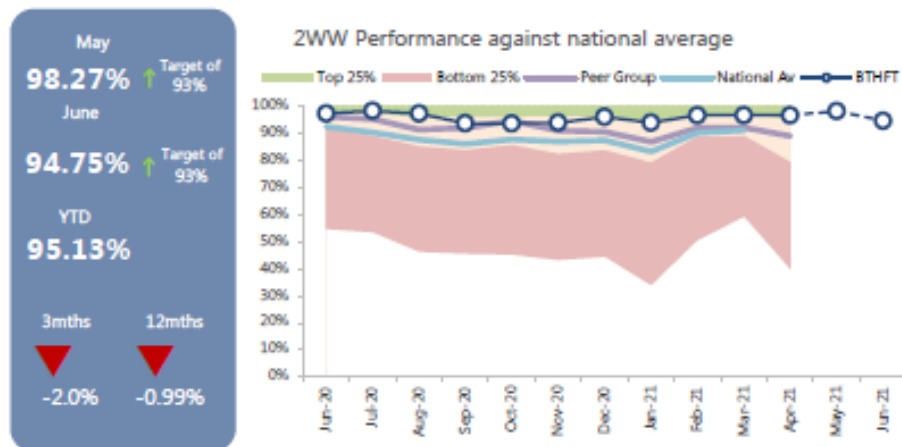


Figure 3: 2 week wait performance

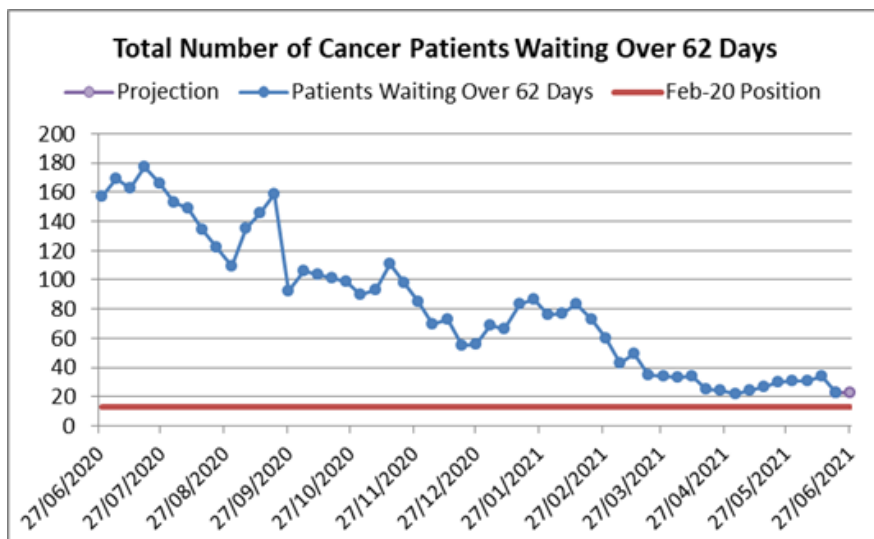


Figure 4: Total cancer patients waiting over 62 days

For all Priority 2 patients we have been able to drive down the median and mean waiting time across our specialities and are continuing to focus our efforts to bring this down further to within 4 weeks from decision to admit to operations.

Treatment Function	31/03/2021			25/05/2021			24/06/2021		
	Total P2	Mean (wk)	Median (wk)	Total P2	Mean (wk)	Median (wk)	Total P2	Mean (wk)	Median (wk)
Breast	48	3.1	3	47	3.6	2	43	5.8	2
Urology	109	7	4	117	6.3	3	136	5.1	3
Gynaecology	59	16.8	5.5	51	10.1	4	51	9.1	4
OMFS	42	12.3	9	51	22.5	14	63	16.6	4
ENT	81	20.3	11	102	14.2	5	127	12.4	5
Pain	76	18.3	8	86	9.8	5	66	8.7	5
T&O	70	21.4	10.5	56	13.5	6	56	11.3	5.5

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Ophthalmology	99	10.6	8	106	10.8	7.5	106	9.7	6
Vascular	54	23.4	21	58	13.6	6	57	14.5	7
General Surgery	212	16.7	8	233	15.3	8	208	13.2	7
Paediatrics incl Urology	19	18.9	20	36	13.7	8	20	14.8	10
Plastics	329	19.1	11	277	15.8	12	250	13.2	12
	1198			1220			1183		

Table 3: Change in P2 waiting times

### Independent Sector and System Collaboration

From the beginning of the pandemic BTHFT has received assistance from the Ramsay group and worked collaboratively with the ANHST, CCG and Yorkshire Clinic (YC) to share the available IS capacity in line with the relative clinical priority of the patients waiting and overall waiting list size. This included periods where capacity was dedicated solely to patients referred to the acute providers. Up until April 2021 surgery was delivered via a subcontract arrangement with activity recorded against BTHFT SUS data.

Currently we have the following under a subcontract arrangement contributing to recovery of our diagnostic position and cancer performance:

- Endoscopy
  - Yorkshire Clinic
  - Westcliffe
- Echocardiogram
  - Yorkshire Clinic
  - Westcliffe
- Plastic Surgery
  - Westcliffe
- Breast Surgery
  - Yorkshire Clinic

These subcontracts have assisted diagnostic recovery and significant in roads towards DM01(Figure 5) and Fast track performance (Figure 6)

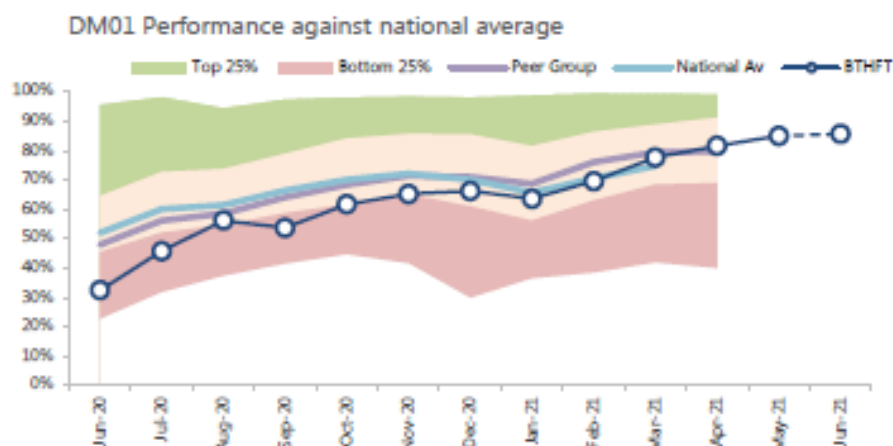


Figure 5: DM01 performance

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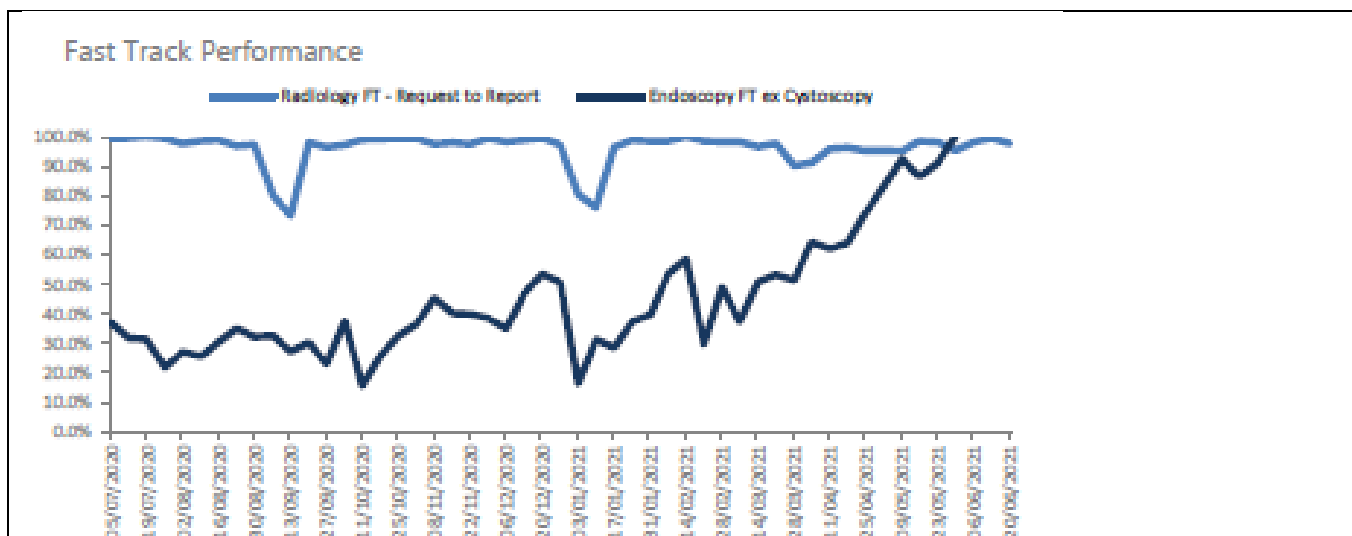


Figure 6: Fast Track diagnostic performance

From April 21 we have entered into a new agreement with the CCG and YC for Q1/Q2 taking into account a system level view of the waiting times and clinical priority, and a desire by the YC to resume a pre-COVID portfolio of operations. This activity is contracted on the basis of an Inter Provider Transfer and as a result will not be recorded against BTHFT SUS data but has allowed us to expedite the care of 1887 of our longest waiting patients and reduced the total number of patients waiting over 40 weeks on an RTT pathway (Figure 7).

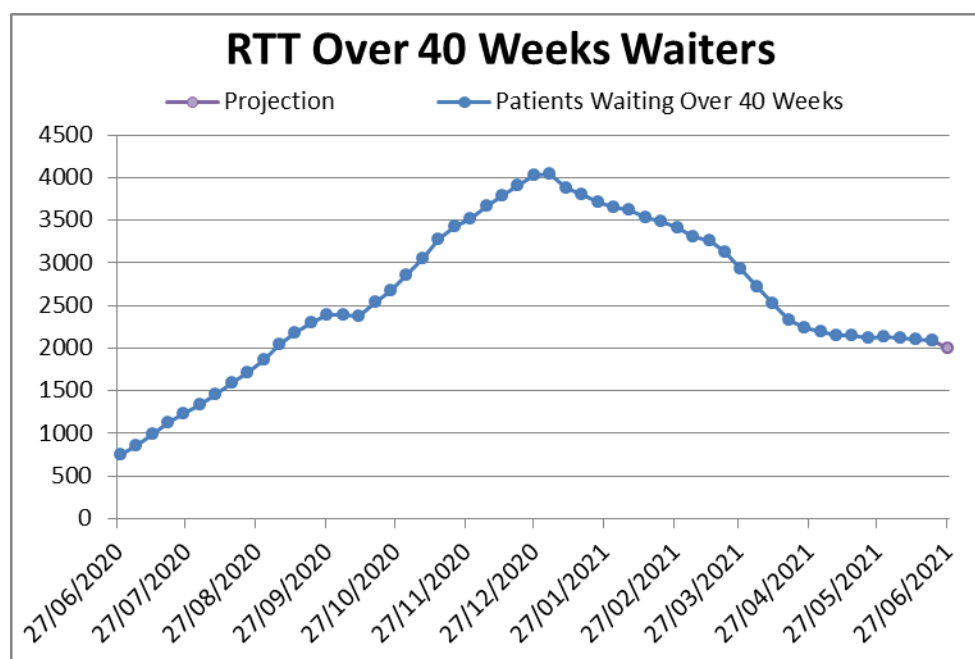


Figure 7: Total patients waiting over 40 weeks on an RTT pathway

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## Current Position

Despite the significant clinically driven improvements our in delivery of elective ordinary and daycase activity continues to be compromised and places us at the bottom of NEY as result of the factors outlined; urgent surgery capacity, workforce and Estate (Figure 8 ).

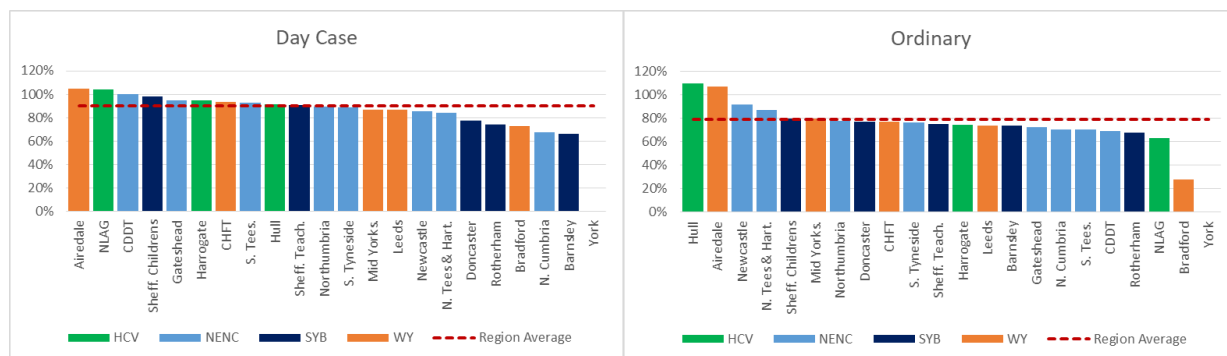


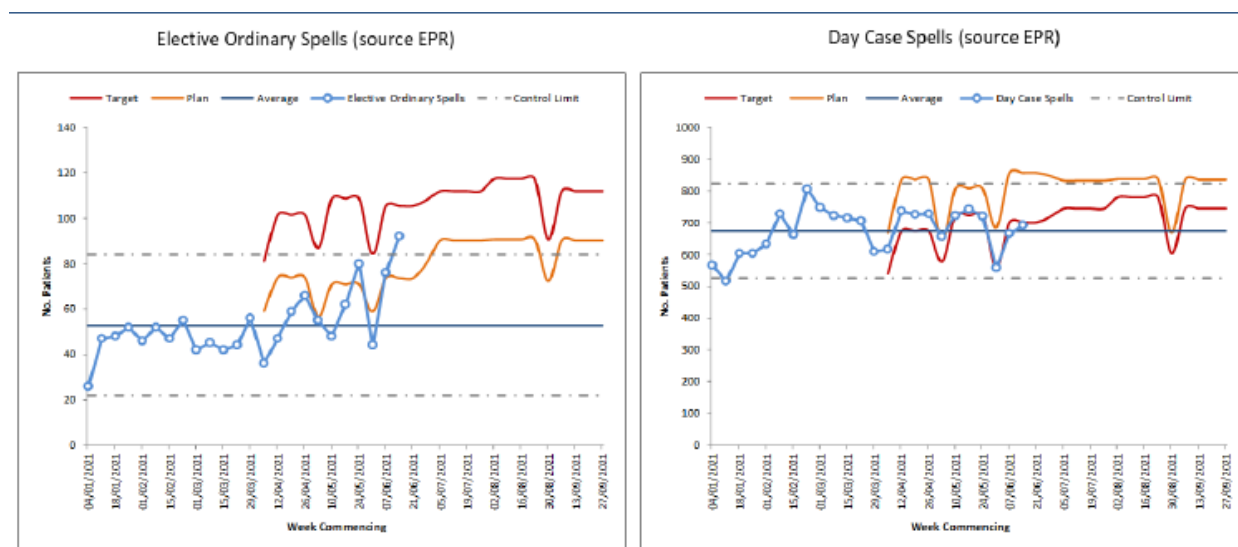
Figure 8: NEY WAR data

Extension of the subcontracts will continue to support Endoscopy recovery but currently recovery will be drawn out into 2022.

Colonoscopy	Flexible Sigmoidoscopy	Gastroscopy
FT: <b>Jun 21</b>	FT: <b>May 21</b>	FT: <b>May 21</b>
Urgent: <b>Feb 22</b>	Urgent: <b>Aug 21</b>	Urgent: <b>Aug 22</b>
Routine: <b>Mar 22</b>	Routine: <b>Mar 22</b>	Routine: <b>Nov 21</b>

Table 5: Projected dates for backlog clearance in endoscopy

We are currently delivering our ERF plan (Figure 9) but must continue to work on strategies to increase capacity and secure that position.





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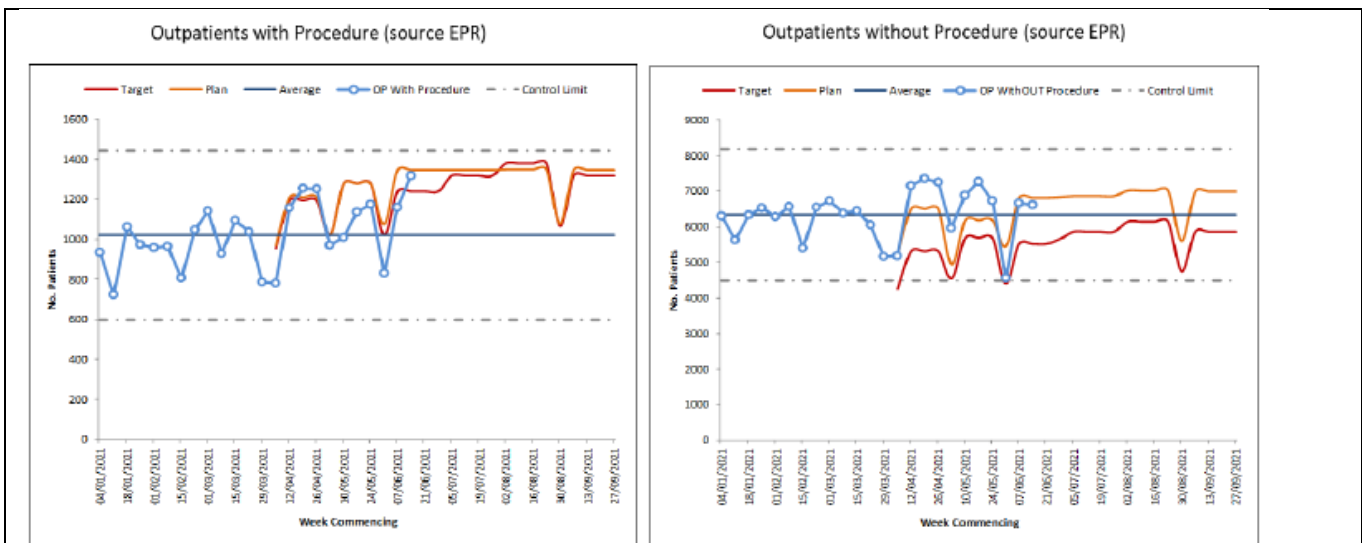


Figure 9: Delivery against ERF plan and target

### Next Steps

#### Focus on theatre utilisation

We have already begun to see improve session productivity highlighted by a divergence between the increase in sessions/ day and operations per day through May and June (Figure 10).

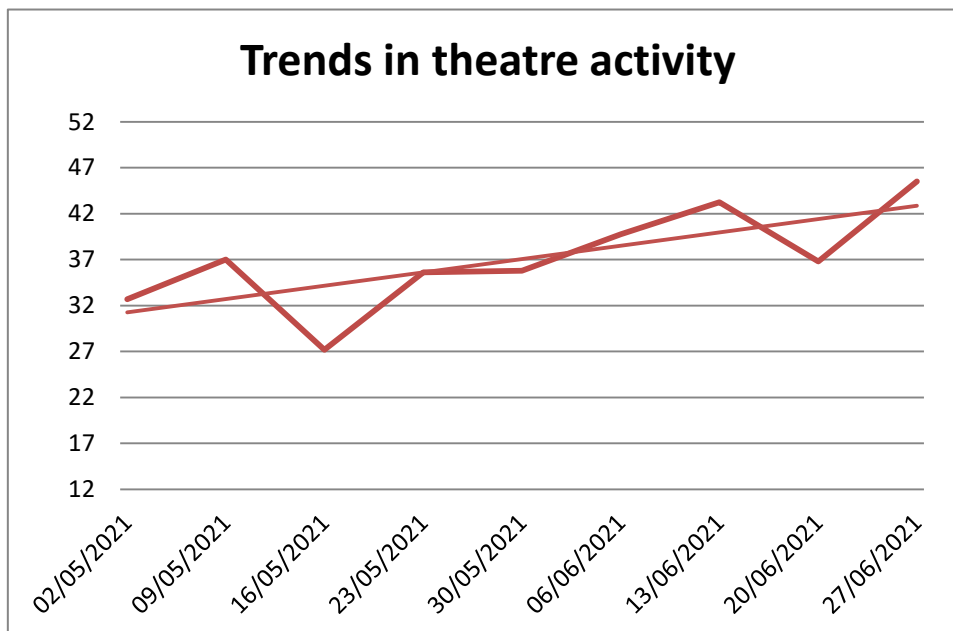


Figure 10: Trends in theatre activity. Cases per day (Red).

Our Theatre Recovery workstream will focus on theatre session utilisation and cases per session to return to the 2019/20 baseline and then on to the NHS benchmarking mean values to maximise delivery in the available capacity.



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### Insourcing

The trust is unable to increase elective activity as a result of a number of factors of which a shortfall in theatre workforce establishment is a key driver (Risk 2944). Insourcing will help deliver workforce to supplement current establishment adding capacity to deliver P2 clearance down to a median wait of 4 weeks in Q3, and expedite endoscopy recovery in Q2

### Acute Provider Collaboration

We will continue to develop our partnership with ANHST to share waiting lists in ENT and Ophthalmology and expedite care for the longest waiting patients as a system approach.

Continued engagement in WYAAT Elective Coordination Group and the High Volume Low Complexity initiative leading the development of a regional hub for benign gynaecological surgery.

### Look closely at health inequalities

In step with partners across WYAAT we have been looking in detail at the characteristics of those patients on our PTL (Patient Treatment List) to better understand whether those waiting for treatment are disadvantaged on the basis of minority ethnic heritage, living with a Learning Difficulty/Disability or as a consequence of economic inequalities/poverty. Additional analysis and engagement at a speciality level is required to particularly understand the nuances and contributing factors influencing waiting times for those from minority ethnic groups or who are economically disadvantaged according to the Index of Multiple Deprivation (IMD) categories. This work will include ensuring as far as we are able that the relevant information is captured within the Electronic Patient Record (EPR) to support more sophisticated analysis.

With respect to Learning Difficulties/Disabilities there is additional work required to increase the quality, extend and accuracy of the data captured in EPR. There is a comprehensive programme of work engaging the lead nurse for Learning Disabilities to improve routine data capture in this context.

Analysis has identified a total of 20 patients currently on the waiting list with a learning disability flag/status recorded. 13 of these patients are on a Referral to Treatment (RTT) pathway with 4 patients listed as clinical priority 2, 4 patients clinical priority 3 and 5 patients with clinical priority 4. In addition 7 patients have no current clinical priority listed. A programme of work to actively confirm their P status has started.

In line with decisions made across WYAAT the board is invited to confirm its support for actively promoting to the top of the inpatient waiting list within their P status cohort those patients living with a learning difficulty/disability.

### **Recommendation**

The Board are asked to note the following:

- Continued progress toward recovery that will be further augmented by improved utilisation, insourcing and recruitment - potential risk to this would be a 4<sup>th</sup> COVID wave and the funding position for H2 2021/22.
- Improved overall waits and improvement in position as a result of the combination of activities already undertaken which include improved internal utilisation, outsourcing and insourcing of patient activity.

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- That as an organisation we continue to broadly be driven by clinical priority aiming to reduce median wait times for the highest priority patients (P2) to 4 weeks.
- To note the ongoing work to understand in greater detail whether patients from minority ethnic groups or from groups of lower economic status are exceptionally disadvantaged when it comes to waiting times for treatment in those pathways where this information is recorded.
- To accept the recommendation that patients living with a learning difficulty with a confirmed P status are actively prioritised ahead of other patients within the same P status cohort. To make strenuous efforts to determine the P status of those patients living with a learning difficulty on the PTL whose P status is not yet decided and to respond as above re prioritisation consequently. Following Board approval the Clinical Reference Group, Business Intelligence and Operational colleagues will work up the process by which this will be enacted.

Risk assessment						
Strategic Objective	Appetite (G)					
	Avoid	Minimal	Cautious	Open	Seek	Mature
To provide outstanding care for patients						
To deliver our financial plan and key performance targets						
To be in the top 20% of NHS employers						
To be a continually learning organisation						
To collaborate effectively with local and regional partners						
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	Low		Moderate	High	Significant	
Explanation of variance from Board of Directors Agreed General risk appetite (G)	Risk (*)					

<b>Benchmarking implications (see section 4 for details)</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>
Is there Model Hospital data relevant to the content of this paper?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is there any other national benchmarking data relevant to the content of this paper?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Risk Implications (see section 5 for details)</b>	<b>Yes</b>	<b>No</b>
Corporate Risk register and/or Board Assurance Framework Amendments	<input type="checkbox"/>	<input type="checkbox"/>
Quality implications	<input type="checkbox"/>	<input type="checkbox"/>
Resource implications	<input type="checkbox"/>	<input type="checkbox"/>
Legal/regulatory implications	<input type="checkbox"/>	<input type="checkbox"/>
Diversity and Inclusion implications	<input type="checkbox"/>	<input type="checkbox"/>
Performance Implications	<input type="checkbox"/>	<input type="checkbox"/>

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<b>Regulation, Legislation and Compliance relevance</b>
<b>NHS Improvement: (please tick those that are relevant)</b> <input type="checkbox"/> Risk Assessment Framework <input type="checkbox"/> Quality Governance Framework <input type="checkbox"/> Code of Governance <input type="checkbox"/> Annual Reporting Manual
<b>Care Quality Commission Domain:</b>
<b>Care Quality Commission Fundamental Standard:</b>
<b>NHS Improvement Effective Use of Resources: Clinical Services</b>
<b>Other (please state):</b>

<b>Relevance to other Board of Director's Committee: (please select all that apply)</b>					
Workforce	Quality	Finance & Performance	Partnerships	Major Projects	Other (please state)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>