Meeting Date	**23 March 2021**	**Agenda Item**	**3.3**
Report Title	**Planned Care Update Report**		
Report Author	Craige Wilson, Deputy Chief Operating Officer		
Report Sponsor	Rab McEwan Chief Operating Officer		
Presented by	Craige Wilson, Deputy Chief Operating Officer		
Freedom of Information	Open		
Purpose of the Report	The Health Board has experienced unprecedented pressures in scheduled care as a result of Covid-19. Demand in unscheduled care during the pandemics first wave had severely limited scheduled care activity across the pathway (outpatients, diagnostics and treatment stages) as services were temporarily halted or resources redirected. Although improving monthly since April with an increase in both face-to-face and virtual working, the subsequent safety restrictions in capacity due to infection control measures continues to restrict overall scheduled care activity, thereby increasing waiting list volumes and wait times along the pathway.		
Key Issues	This report brings together a number of key activities to update the committee on the work underway to improve our scheduled care system. The key issues are: • The recovery and redesign of outpatient services in line with essential services guidance and the *National Outpatient Strategy*. • The development and delivery of surgical services in line with Welsh Government guidelines and the Royal College of Surgeons *Clinical Guide to Surgical Prioritisation during the Coronavirus Pandemic* • The progress in the redesign of key clinical services within scheduled care, in response to these challenges, including referral management, outpatient delivery, surgical services and risk.		

Specific Action Required *(please choose one only)*	Information	Discussion	Assurance	Approval
	☐	☐	☒	☐
Recommendations	The Committee is asked to:- • Note the systemic performance changes to our planned care system • Note the actions already taking place across the system - within outpatients and surgery in particular - in line with national guidelines and best practice. • Note the progress, to date, in the redesign of key clinical services within scheduled care.			

PLANNED CARE UPDATE

1. INTRODUCTION

The Health Board has experienced unprecedented pressures in a scheduled care system that has fundamentally changed during 2020/21 due to the impact Covid-19.

We have seen significant changes in our referral/demand patterns into secondary care, the volume of available capacity across the pathway stages (outpatients, diagnostics, treatment, and follow up), as well as the volume and nature of the activity we are delivering within each of those stages.

Whilst demand (i.e. referrals into secondary care) continue to increase weekly to pre-Covid levels, the wider planned care system remains constricted due to the impact of Covid-19 and the imposition of infection control measures. This ongoing mismatch between demand and capacity has inevitably increased both waiting times and waiting list volumes across all stages of planned care.

These unparalleled changes to the planned care system is not unique to Swansea Bay University Health Board and has been widely reported across other NHS Wales Health Boards and within the wider NHS family in the UK.

2. BACKGROUND

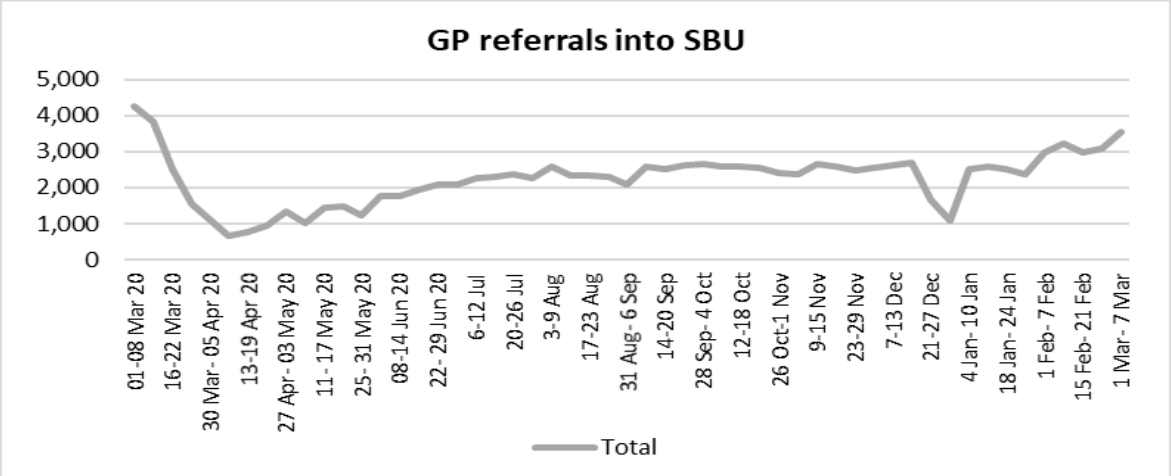
Outpatients
The Health Board has complied with the Essential Services guidance on the recommencement of services, and as part of its Reset and Recovery Plans is continuing to transform outpatient services in line with the National Outpatient Strategy.

The Health Board re-established its Outpatients Clinical Redesign and Recovery Group in June 2020 with the aim to promote good practice and to develop at scale system wide changes such as: virtual appointments, See on Symptoms (SOS), Patient Initiated Follow Up (PIFU), self-management and group consultations.

Since quarter 2, the Delivery Group outpatient leads have implemented their plans for recovery including the re-start of essential services in line with Welsh Government guidance on face-to-face capacity. A Quality Impact Assessment (QIA) process was set-up corporately to manage the re-start, to control footfall into sites, and to ensure the safety of patients and staff with regards to infection control measures for covid-19.

Capacity to offer patients face-to-face appointments has therefore been significantly reduced, and the level of activity is currently operating is now at around 70% pre-Covid levels. The main contributors to this is the need to reduce footfall to enable social distancing in waiting rooms and communal spaces, and the time required between patients to ensure areas are thoroughly cleaned for infection control purposes. Consequently the number of virtual consultation has increase to around 40% of the total number of appointments (new and follow up).

Since the initial reduction in 'additions to stage 1 (OP) waiting list' in March/April 2020, we have seen a regular weekly increase towards pre-lockdown levels (see below). This increase in additions to outpatient waiting list, at the same time as the capacity restrictions outlined above, has increased the volume of those patients waiting at outpatient stage.



Graph 1. Number of stage 1 additions to waiting list per week

Table 1 – RTT Specialties Stage 1 26 week volumes (February 2021)

The table below shows the specialties and volumes of the top 9 highest volume specialities. These make up 83% of the current total outpatient waiting list (21,208) and are therefore the specialties that need greatest focus as part of the recovery plan,

Outpatient Waits over 26 Weeks	
Specialty	
T&O	2855
Ophthalmology	2717
ENT	2645
General Surgery	1882
Gastroenterology	1869
Gynaecology	1651
OMFS	1503
Dermatology	1368
Urology	1064
	17554

At present in response to the demand and capacity gap resulting from Covid-19, and the lengthening waiting times, the Health Board is responding in three thematic ways: improving demand management, improving activity and efficiency of existing capacity, increasing capacity options (including alternative venues for providing services).

The table below provides an overview of some of the work stream areas being managed at present:

Table 2 – Health Board Outpatient Improvement Work (Overview)

Theme	Examples
Improving Demand Management (Preventing unnecessary referral and attendance)	- Increasing spread and use of DrDr and query line functions to reduce the number of follow up patients - Increase spread and use of Consultant Connect, 5 of the top 10 specialties currently have this system in place, the remainder scheduled by June together with service specification. - Performance review of e-referral system
Improving Activity and Efficiency (Optimise current available capacity)	- Increase spread and use virtual appointments, including Attend Anywhere system - Improved waiting list management (ongoing clinical and administrative validation, cashing up clinics etc.) - Improved pathway management and discharge to alternative pathways (e.g. PIFU and SOS) - DNA monitoring and management
Increasing Capacity (Creating alternative capacity options)	- Opportunities for evening and weekend working - Alternative accommodation options (e.g. Swansea university) - Group consultations options (e.g. rheumatology, dermatology) - Options for role-extension

This work will continue to be managed through the Outpatients Clinical Redesign and Recovery Group with support from the Health Boards transformation team, planned care, and clinical leaders, in line with Welsh Governments National Outpatients Strategy.

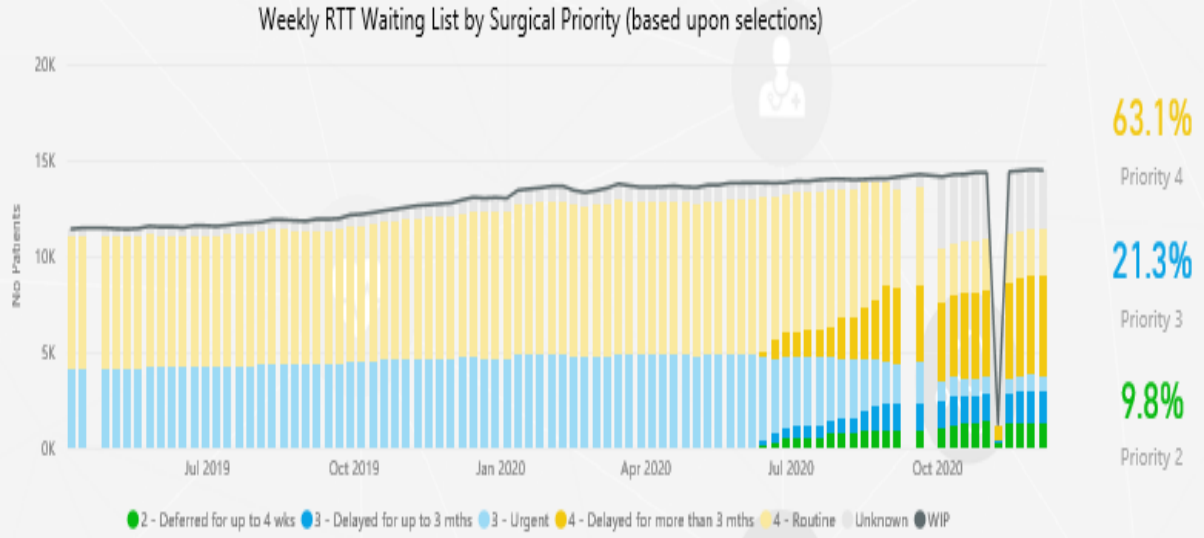
Surgical Services

Due to the capacity restrictions caused by Covid-19, the Health Board in keeping with other Health Boards in Wales, continues to deliver surgical services in line with the Royal College of Surgeons *Clinical Guide to Surgical Prioritisation during the Coronavirus Pandemic* – ensuring the restricted surgical capacity available is clinically prioritised for those identified as most clinically urgent.

These efforts are taken in conjunction with Welsh Governments 'four harms' principle around the impact of Covid, in order to balance the direct clinical risks to our patients from Covid, with the indirect clinical risk Covid may have in displacing planned care activity.

Clinical prioritisation of all treatment stage RTT patients, against RCS guidelines, continues on a weekly basis by the specialty teams. New live monitoring mechanisms have been introduced to support this rollout using the health boards Power BI resources within Digital Intelligence.

To support the transition to having all treatment stage patients assessed against these detailed guidelines, assumptions on existing RTT priority categories have been used in order to produce a temporary proxy RCS score (where an assessment has yet to occur) in order to assess likely overall waiting list demand for surgical capacity (below). Currently approximately 10% of all treatment-stage RTT patients are reported within Category 2 priority.



Graph 2: Treatment Stage RTT patients by Clinical Priority by week

Since the introduction of RCS prioritisation of treatment-stage patients earlier in the year, demand from Priority 2 patients has increased ahead of the available capacity. This demand has accelerated as the clinical review process described above has improved - leading to an increasing trend in those patients waiting for P2 treatment. However, booking numbers (those patients booked for treatment) continues to improve, providing a level of assurance around the reliability of service delivery in this new demand/capacity system.

The current lack of access to both local and regional independent hospital capacity to support category 2 workload has limited the Health Boards available capacity options to Health Board hospital sites only. Improved access to regional capacity options, including other health boards and independent hospital capacity, will form part of 2021/22 recovery plan.

Operationally, the surgical teams continue to manage services in line with the Essential Services Guidance, managed through the operational structures within the Delivery Groups to ensure flexibility and rapid decision-making in light of the second-wave of Covid-19 and with reference to the 'four harms' principle. Work also continues through the established Surgery and Theatres planning groups along several identified work streams to support surgery including:

- Orthopaedics at Neath Port Talbot (development of business case for longer term sustainability)
- Theatre capacity and patient prioritisation
- Pre-assessment
- PACU work stream
- Emergency and Trauma Operating

Table 2 - Stage 4/5 Waiting List over 36 weeks (Feb 2021)

Surgical Waiting Times over 36 weeks	
Specialty	
Orthopaedics	4063
Ophthalmology	2130
General Surgery	1887
ENT	1206
Plastics	1003
Gynaecology	877
Spinal	721
OMFS	535
	12422

Table 2 shows the specialties with the highest numbers of patients on a surgical waiting list over 36 weeks. These specialties make up 91% of the total waiting list at this stage (13,564)

Table 3 – Stage 4/5 Waiting List over 52 weeks (Feb 2021)

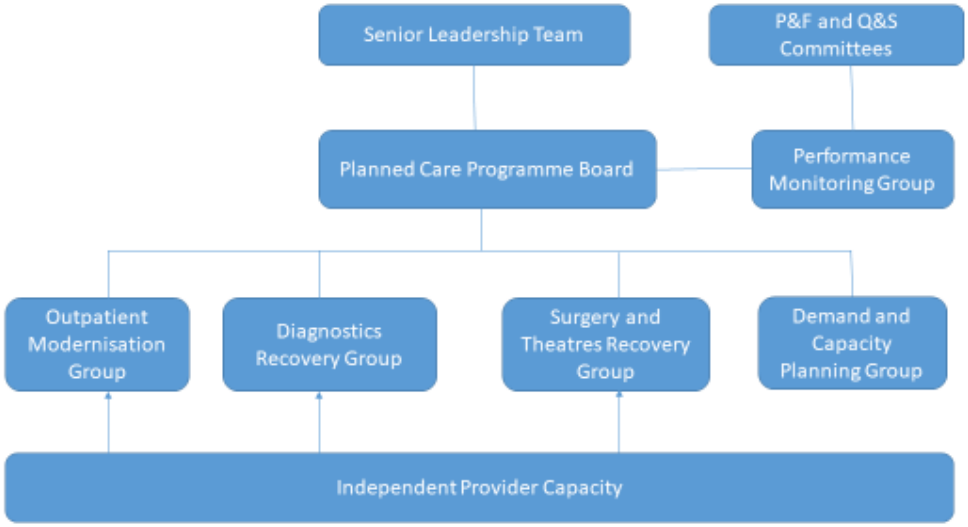
Surgical Waiting Times over 52 weeks	
Specialty	
Orthopaedics	3602
Ophthalmology	1885
General Surgery	1473
ENT	1014
Plastics	812
Gynaecology	691
Spinal	598
OMFS	469
	10544

As can be seen in Table 3, the same specialties make up the vast majority (95%) of the waiting list of patients over 52 weeks. These surgical specialties therefore have to be the focus of the Planned Care Recovery Programme.

Whilst RTT waits will continue to be calculated and recorded to ensure total waiting times are captured and understood, initial discussions with Welsh Government and the NHS Wales Health Boards around the development of a wider, more clinical risk-based, performance framework within scheduled care (not just treatment-stage patients) have begun. It is hoped these measures, based on our experiences under Covid to date, may better support ongoing risk-stratification of scheduled care waiting lists and ensure appropriate prioritisation and access of our most clinically urgent patients.

Planned Care Recovery Programme

To enable rapid progress the planned care interim transition arrangements below are proposed with the establishment of a Planned Care Programme Board (PCPB).



The following leadership roles are proposed for the PCPB:

- Senior Responsible Officer: Craige Wilson Deputy Chief Operating Officer
- Clinical Lead: Connor Marnane, ENT Consultant
- Strategy Lead: Karen Stapleton: Assistant Director of Strategy

The Clinical Reference Groups supporting Planned Care Programme Board each have a management, clinical and strategic lead. These groups will focus on the delivery of over aching goals for the Planned Care Programme together with the individual targets for each specialty.

Demand and capacity analysis are currently being undertaken for each specialty and an improved trajectory for each will be set and monitored through the Performance

Monitoring Group. These in turn will be reported through to the Performance and Finance Committee.

3. GOVERNANCE AND RISK ISSUES

The risks associated with the delivery of RTT targets and surgical access times more broadly are significant. Increasing waiting times for planned care carries an increased risk for patients waiting to access services, whilst increasing waiting list volumes (of those patients) increases that risk at a Health Board population level.

For patients waiting to access treatment-stage services, (i.e. surgery), this risk is mitigated through the widespread application of the Royal College of Surgeons Clinical Guide to Surgical Prioritisation and ensuring our surgical patients are prioritised by clinical need.

For patients earlier in their pathways, where there is less clinical information, such detailed prioritisation is more difficult to complete. However, there are ongoing conversations with Welsh Government to explore this issue further in order to provide a uniform approach across Wales.

4. FINANCIAL IMPLICATIONS

There are no immediate financial implications of this report, but consideration will be made through the Annual Plan process for schemes which have delivered benefits during the pandemic. Assessment of the financial implications will be made once these areas are agreed.

Discussion have yet to be had regarding the financial implications of planned care around the traditional RTT 26/36 week performance framework targets.

5. RECOMMENDATION

The Committee is asked to:-

- Note the systemic performance changes to our planned care system
- Note the actions already taking place across the system - within outpatients and surgery in particular - in line with national guidelines and best practice.
- Note the progress, to date, in the redesign of key clinical services within scheduled care.

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☐
	Co-Production and Health Literacy	☐
	Digitally Enabled Health and Wellbeing	☒
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☒
	Excellent Staff	☒
	Digitally Enabled Care	☒
	Outstanding Research, Innovation, Education and Learning	☐
Health and Care Standards		
(please choose)	Staying Healthy	☒
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☒

Quality, Safety and Patient Experience

Delivery of improved scheduled care performance will decrease access times for patients, improve patient experience and resource utilisation, as well as promote increased flow through the secondary care system.

Financial Implications

There are no immediate financial implications of this report, but consideration will be made through the IMTP process for schemes which have delivered benefits during the pandemic. Assessment of the financial implications will be made once these areas are agreed.

Discussion have yet to be had regarding the financial implications of planned care missing the traditional RTT 26/36 week performance framework targets.

Legal Implications (including equality and diversity assessment)

There are currently no known legal or equality and diversity impacts. Patients are being treated based on clinical need in line with best-practice guidelines. .

Staffing Implications

As with finance, there are no immediate staffing implications (save for the possible impact of Covid on staff sickness rates). Longer term development of redesigned services may require staffing development or recruitment programme in order to make services sustainable. Again, consideration would be made through the IMTP process.

Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)	
The '5 Ways of Working' are demonstrated in the report as follows: ○ **Long Term** – Actions within this report are for 2020/21 but are likely to have longer term impact in terms of improved access and patient experience ○ **Prevention** – Some of the service modernisation mentioned within these services will help prevent health deterioration ○ **Integration –** Clinical pathways are delivered across primary and secondary care. ○ **Collaboration –** Clinical pathway review and redesign within scheduled care, crosses Health Board boundaries and require collaboration across the NHS system. ○ **Involvement –** Partner organisations, patients, Corporate and Delivery Units are key in identifying performance issues and identifying opportunities to improve quality, safety and performance which are fit for purpose and meet the needs of our citizens.	
Report History	Planned Care report/s received at previous 2020 Committee meetings.
Appendices	