Healthier Communities, Outstanding Care

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Public Board of Directors

All reports MUST have a cover sheet

Subject:	Elective Recovery Plan 2020/2021	**Date:** 24th August 2020
Prepared By:	Helen Hendley, Deputy Chief Operating Officer (Elective Care)	
Approved By:	Simon Barton, Chief Operating Officer	
Presented By:	Simon Barton, Chief Operating Officer	

In response to Phase 3 of the NHS response to COVID19, this paper sets out the Trust's elective recovery plan for the remainder of 2020/21.		
	Approval	X
	Assurance	X
	Update	
	Consider	

Strategic Objectives

To provide outstanding care	To promote and support health and wellbeing	To maximise the potential of our workforce	To continuously learn and improve	To achieve better value
X			X	X

Overall Level of Assurance

	Significant	Sufficient	Limited	None
Indicate the overall level of assurance provided by the report -		X		

Risks/Issues

Financial	X
Patient Impact	X
Staff Impact	X
Services	X
Reputational	X

Committees/groups where this item has been presented before

- Medical Managers - 18th August
- Recovery Group – 19th August
- Recovery Committee – 19th August

Executive Summary

The overarching aim of the recovery plan is to ensure there is sufficient capacity to meet a return to near-normal levels of activity from August until winter and to sustain this level of activity for the remainder of 20/21. To do this the Trust will take account of lessons learned during the first COVID peak; lock in beneficial changes and ensure appropriate support is in place for patients and colleagues.

From August 20/21and beyond this will be achieved through the delivery of the following key objectives:

- Fully restoring cancer services;
- Return to full elective operating and diagnostic timetables at KMH, Newark and maximise use of capacity in the Independent Sector;
- Expand the delivery of non-face to face contact for outpatient appointments;
- Adapt and adopt new ways of working and learning from COVID;
- Ensure staff welfare is paramount;
- Provide clear and consistent communication with our patients, GPs and system partners.

Since mid-July (ahead of the phase 3 letter), specialty and service level plans have been developed to establish the level of activity that can safely be restored within the constraints of IPC, staffing availability and financial and physical resource. It is important to note that in the context of this plan cancer activity is fully restored and remains a priority focus for the organisation

By delivering the objectives the forecast level of restored activity by October is within 10% of the challenging phase 3 ask – Table 1.

Opportunities to continue to close the activity gap will continue across the Nottinghamshire system and will be assessed in line with any changes in national guidance.

Table 1: Summary assessment of activity levels August – October

	Day case	Elective	OP Procedures	OP First	OP Follow Up
Phase 3 ask:					
August	70%	70%	70%	90%	90%
September	80%	80%	80%	100%	100%
October	90%	90%	90%	100%	100%
Assessment from Divisions					
August	66%	58%	62%	80%	98%
September	68%	76%	76%	90%	96%
October	80%	83%	86%	94%	97%

Key
>10% of ask
10% or less

This plan should be read in conjunction with the Trust winter plan and pandemic surge plan. The relationship and interdependencies with the winter plan are relatively low risk and whilst (as in previous years) the plan will be to convert the elective orthopaedic ward to medicine for January and February, the plan to increase activity at Newark and on-going use of the Independent sector negates the resulting reduction in elective beds.

The impact of a second surge on the elective recovery plan, most notably the corresponding requirement for increased critical care capacity needs to be further modelled. It is assumed that the levels of elective activity would not reduce to the same levels that were seen in the first surge.

Elective Recovery Plan 2020/21

Introduction

On 30th January 2020 NHS England and NHS Improvement declared a Level 4 National Incident, triggering the first phase of the NHS pandemic surge response. In line with national instruction during phase 1, routine planned care was paused from Mid-March. Whilst the timing of phase 2 nationally was from 29th April with a focus on clinically urgency, the Trust during phase 1 and 2 continued to deliver cancer and other time critical operating and diagnostic procedures. Face to face outpatient appointments and attendances were significantly reduced, non-face to face (telephone and other virtual) appointments continued throughout the pandemic surge.

Phase 3 commenced from 31st July 2020 and set out a clear ambition to recover the maximum elective activity possible between "now and winter" making full use of the NHS capacity currently available, as well as independent hospitals. The phase 3 letter reiterated there is a careful balance to be struck between the need to be ambitious and stretching for our patients so as to avoid patient harm, while setting a performance level that can be delivered safely and within existing constraints.

To summarise the elective element of the letter focuses on delivery of:

- In September at least 80% of last year's activity for both overnight electives and for outpatient/day case procedures, rising to 90% in October (while aiming for 70% in August);
- A swift return to at least 90% of last year's levels of MRI/CT and endoscopy procedures, with an ambition to reach 100% by October.
- 100% of last year's activity for first outpatient attendances and follow-ups (face to face or virtually) from September through the balance of the year (and aiming for 90% in August)
- Trusts, working with GP practices, should ensure that, between them, every patient whose planned care has been disrupted by Covid receives clear communication about how they will be looked after, and who to contact in the event that their clinical circumstances change.
- Restore full operation of all cancer services, including screening services;
- Reduce the number of patients waiting for diagnostics and/or treatment longer than 62 days on an urgent pathway, or over 31 days on a treatment pathway, to pre-pandemic levels, with an immediate plan for managing those waiting longer than 104 days;
- Clinically urgent patients should continue to be treated first, with next priority given to the longest waiting patients, specifically those breaching or at risk of breaching 52 weeks by the end of March 2021.

Background

The overarching aim of the recovery plan is to ensure there is sufficient capacity to meet a return to near-normal levels of activity from August until winter and to sustain this level of activity for the remainder of 20/21. This recovery plan does not (in most cases) deliver a reduction in the backlog of activity that has accumulated since Mid-March, however the Trust with support from system partners will continue to identify opportunities to deliver >100% activity level whilst being mindful of the potential impact on staff and associated costs.

The specialty and service level plans have been developed by the clinical teams and Divisions and are aligned to assumptions made in the Trusts winter plan and pandemic surge plan. In line with the Trust approach to winter planning the key principles underpinning the plan are:

- Patients are at the centre of our decision making;
- Reduce the risk of cross infection;
- Lead and support colleagues in line with IPC Guidelines, CARE values ensuring staff wellbeing is paramount;

- Learn from local, regional and national experience of COVID;
- Deliver elective care in line with clinical prioritisation

For the remainder of 2020/21 this will be achieved through the delivery of the following key objectives:

- Fully restoring cancer services
- Return to full elective operating and diagnostic timetables at KMH, Newark and in the Independent Sector, noting that this will be impacted on if there is a surge for ITU capacity
- Maximise non face to face contact for Outpatient appointments
- Adapt and adopt learning from COVID and new ways of working
- Ensuring staff welfare is paramount
- Provide clear and consistent communication with our patients, GPs and system partners

Level of activity restored between now and winter

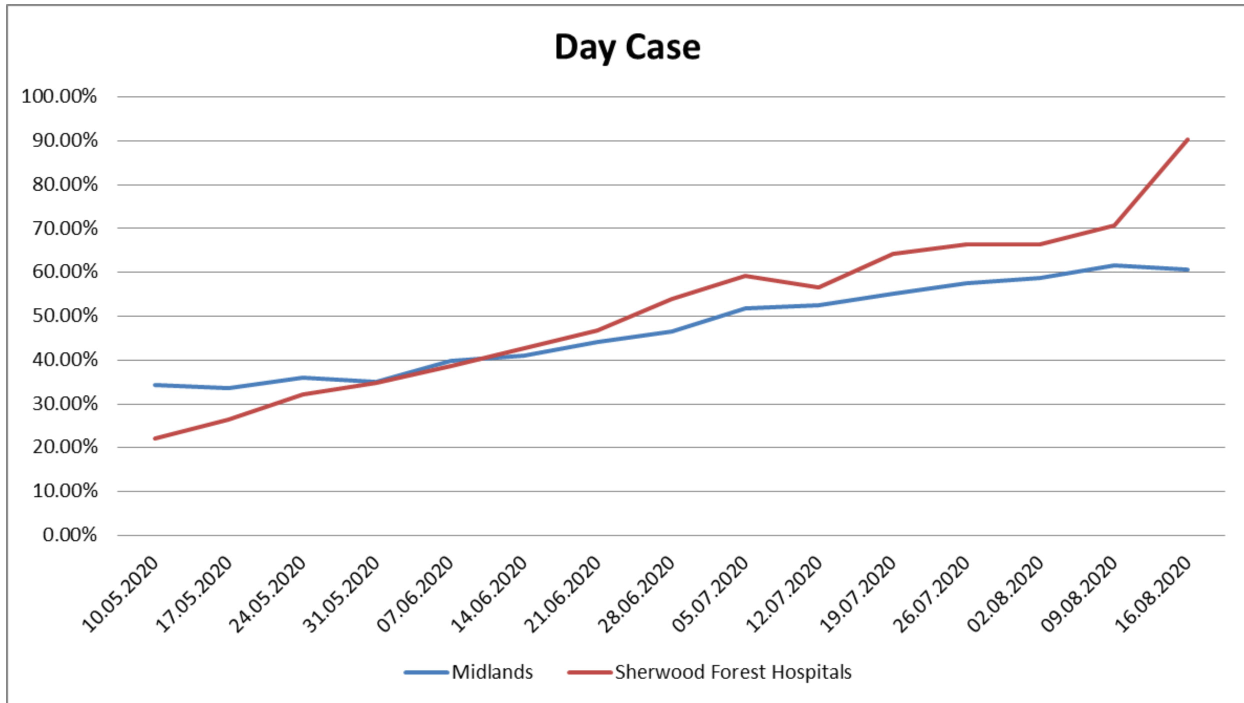
Table 2 below summarises the overall elective activity levels as at July 2020 were 84% when compared to July 2019 (year to date 75%). Note this is a relatively crude measure due to casemix and requires triangulation with SUS (Secondary User Service) data.

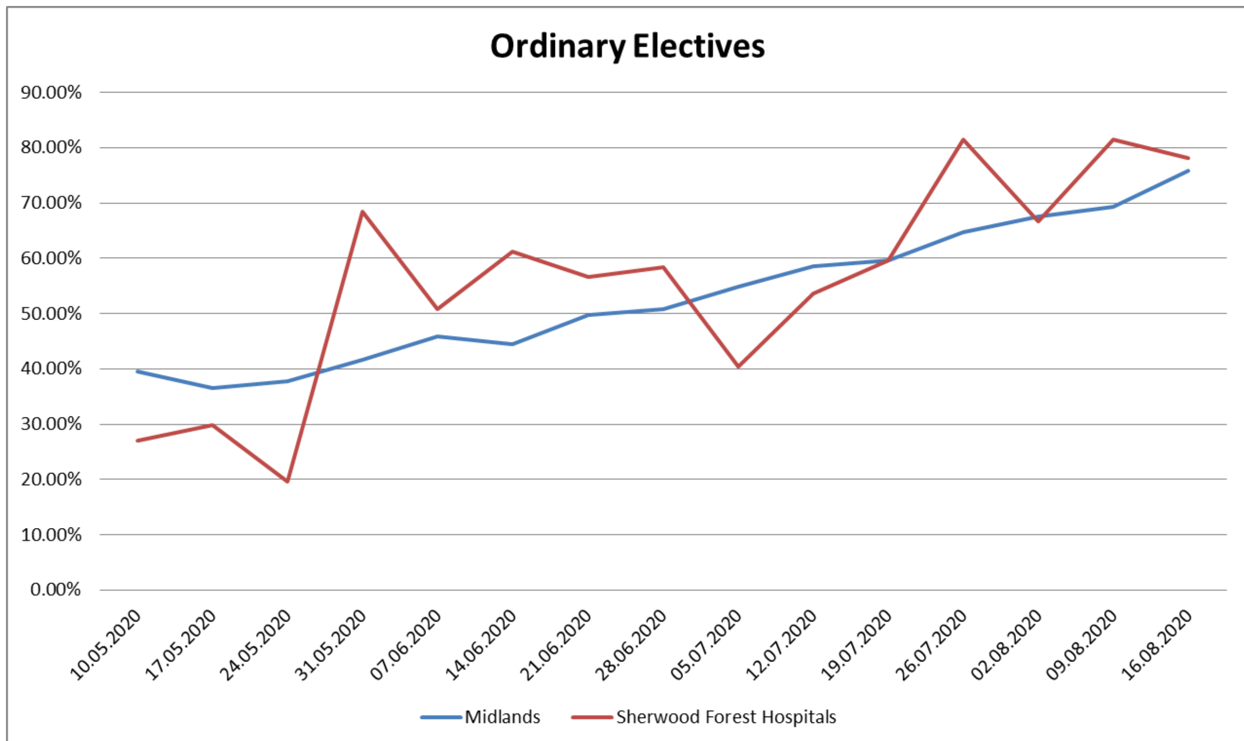
Outpatient follow ups at 97% are performing well. First appointments (face to face) remain constrained by social distancing measures in the OP waiting areas. Outpatient procedures, day case activity and elective surgery are constrained by IPC measures relating to aerosol generating procedures (AGPs). Within the day case point of delivery radiology activity is restored to 90 - 100%, endoscopy at 65% and day case surgery at 62%.

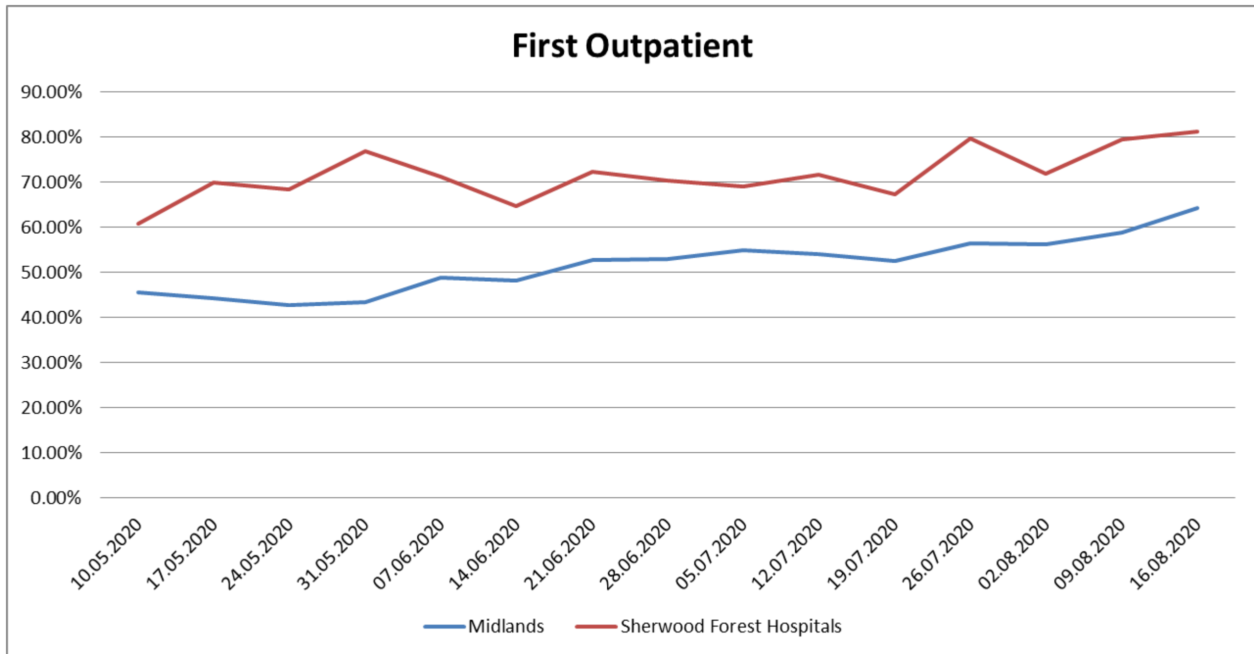
Table 2: Activity levels using SLAM

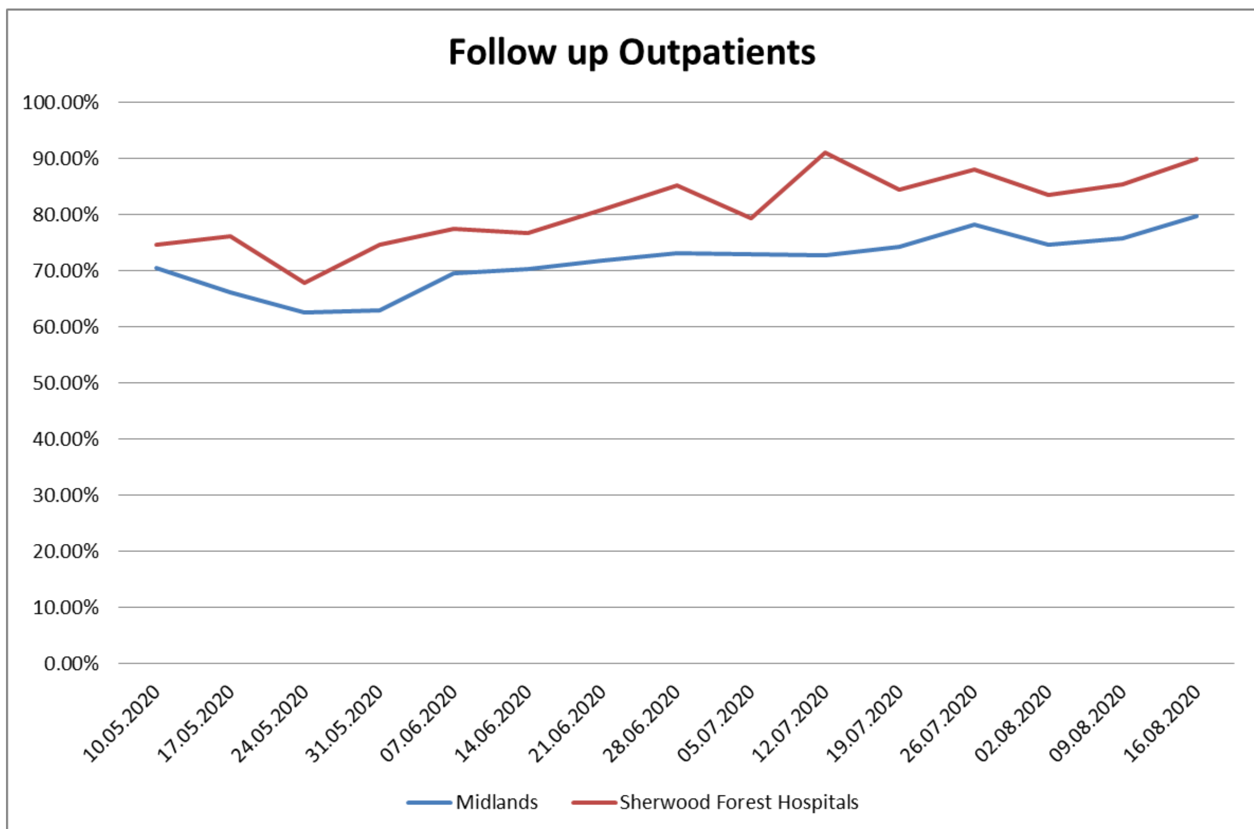
Trustwide								
Activity Actual		Point of Delivery						
Year	Month	Day case	Elective	OP Procedures	OP First	OP Follow Up	Grand Total
19/20	April	2,619	484	4,736	6,782	19,168	33,789
	May	2,728	483	4,666	7,333	19,508	34,718
	June	2,615	565	4,359	6,648	18,213	32,400
	July	2,853	570	5,045	7,955	21,056	37,479
1920 Total		**10,815**	**2,102**	**18,806**	**28,718**	**77,945**	**138,386**
20/ 21	April	609	109	1,038	4,673	14,987	21,416
	May	715	178	1,336	5,016	15,195	22,440
	June	1,220	303	2,383	6,027	18,826	28,759
	July	1,802	323	2,852	6,004	20,461	31,442
2021 Total		**4,346**	**913**	**7,609**	**21,720**	**69,469**	**104,057**
YTD Activity %		40%	43%	40%	76%	89%	**75%**
Month 04 (July)%		63%	57%	57%	75%	97%	**84%**

Additional benchmarking suggests that the Trust is currently delivering better than the regional recovery position.









More specifically for radiology diagnostics tests the Trusts is ranked third highest in the regions for CT activity, ranked 11th from 23 Trusts for MRI activity and ranked 4th for non-obstetric ultrasound activity. This position is a significant achievement; however specific pockets of activity remain constrained such as CT Cardiac. Plans are in place to support all radiological diagnostics that are yet to fully restore.

Recovery trajectories by point of delivery

Since mid-July (ahead of the phase 3 letter), specialty and service level plans have been developed to establish the level of activity that can **safely** be restored within the constraints of IPC, staffing availability and financial and physical resource. It is important to note that in the context of this plan cancer activity is fully restored and remains a priority focus for the organisation.

Each specialty has developed a bridge from a baseline activity level with clear actions to deliver an increase in activity or where appropriate the clear rationale and reasons why a return to normal level is not possible. For some specialties the remaining risks are non covid related such as the availability of locum or substantive staff, clinic space or the impact trauma surges can have on elective orthopaedics.

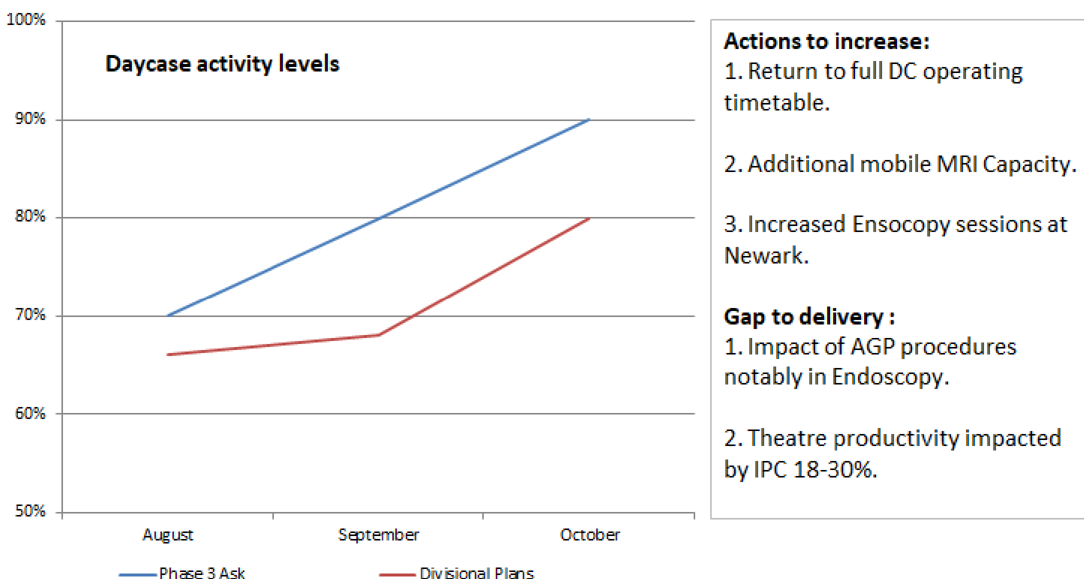
Throughout the pandemic surge, clinical teams have looked to new ways of working to ensure that patients who need specialist advice or treatment have access to do so in clinical priority. The most notable change in practice has been the shift to non-face to face outpatient appointments.

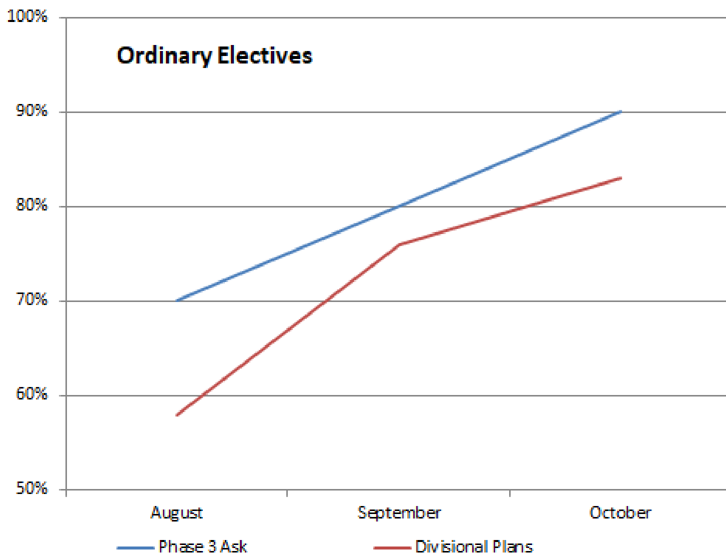
Pre-pandemic the volume of non-face to face activity was 3.1%; at the peak of the pandemic surge it was 78.2%. As lock-down restrictions were lifted there has been a gradual increase of face to face activity. As of the end of July 2020 50.8% of activity was undertaken non-face to face. The face to face proportion has increased due to patients requiring interventions such as diagnostics and physical examinations and is particularly relevant to those patients just starting on their care pathway. Where an outpatient appointment is clinically necessary, the national benchmark is that at least 25% could be conducted by telephone or video including 60% of all follow-up appointments. The Outpatient transformation programme will lead on the work to deliver the benchmark position.

Where clinically appropriate non-face to face activity will continue and further embedding of video consultations will aid in this.

Other opportunities to adapt and adopt new ways of working will be shared across the Nottinghamshire system, the regional team and via the national "Future NHS" hub.

Table 3: Summary recovery trajectories by point of delivery





Actions to increase:

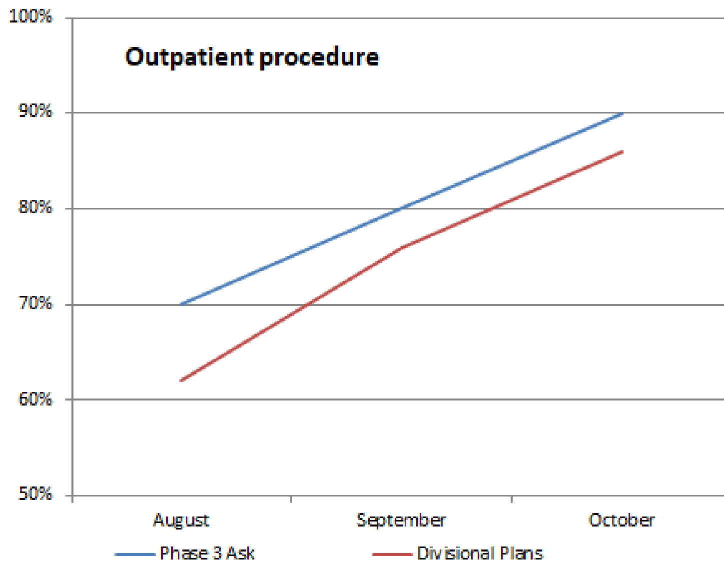
1. Return to full operating timetable at KMH in September.

2. Increased Orthopaedic activity at Newark.

3. Ongoing use of the Independent Sector.

Gap to delivery :

1. Theatre productivity impacted by IPC 18-30%.

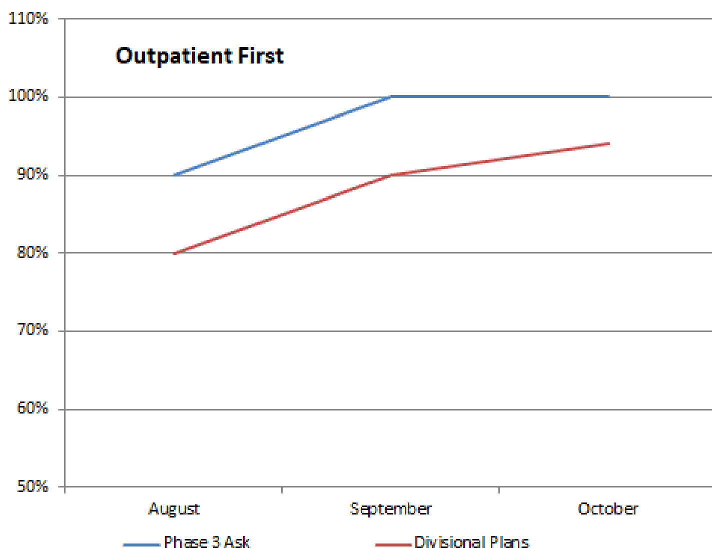


Actions to increase:

1. Review OP capacity to support rooms running side by side

Gap to delivery :

1. Impact of AGP procedures notably in ENT



Actions to increase:

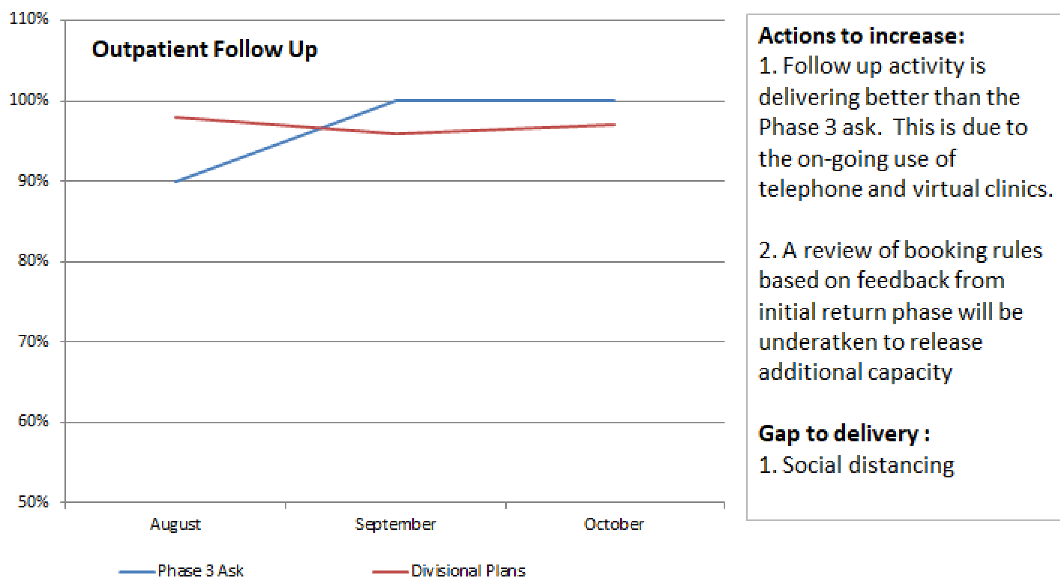
1. Re-align booking rules for KMH and NWK based on feedback from initial return phase.

2. Virtual clinics (ENT / T&O)

3. Restart community service (Ophthalmology)

Gap to delivery :

1. Social distancing



Actions to increase:
1. Follow up activity is delivering better than the Phase 3 ask. This is due to the on-going use of telephone and virtual clinics.

2. A review of booking rules based on feedback from initial return phase will be underatken to release additional capacity

Gap to delivery :
1. Social distancing

At the heart of the specialty and service planning assumptions is the safe delivery of activity in clinical priority order. Current plans do not deliver the requirements in the phase 3 letter, however they do in most instances deliver within 10% of the ask.

The root cause for day case and elective activity remaining lower than the required ask is the impact of IPC measures on productivity within Theatres and Endoscopy. Whilst additional capacity has been secured in the Independent sector (IS) it does not close the gap and remains dependent on SFH staff working in the IS. A system wide approach will be taken to review the opportunities at a specialty level to close specific gaps.

For outpatients, a review on social distancing measures underpinned by a clear risk assessment, or using technology to trigger when a patient can attend the waiting area are opportunities currently being explored to close the relatively small OP gap.

The first submission of the elective recovery plan (and wider ask in the phase 3 letter) is due to be submitted to NHSI/E by 1st September. An assessment across the region will be undertaken to determine if the Trust plans are in line with other peer organisations.

More locally, the Nottinghamshire plans for elective and day case activity are relatively consistent, NUH are forecasting a higher return for endoscopy activity and SFH a higher return for outpatient activity.

Delivery against the plans will be via the Trust Recovery Group (chaired by the Chief Operating Officer) and will report to the monthly Recovery Committee; a sub-committee of the Trust Board. More detailed patient by patient actions will be monitored via the weekly RTT (Long wait) meeting chaired by the Deputy Chief Operating Officer.

ICS assumptions

Whilst local assumptions and constraints have been applied to the recovery plans, a key set of ICS assumptions have been set to ensure consistency across the Nottinghamshire system. These are:

- 2WW referrals to return to pre-COVID levels in Quarter 3;
- Use of the Independent Sector is critical to continue to prioritise cancer and urgent cases, reduce 104+ and 62 day backlogs and deliver a reduction in long wait (40+) patients;

- Routine referrals will return to 90% of Pre-COVID levels from by March 2021;
- Long wait (40+ patients) will be prioritised after cancer and urgent activity
- OP will be 25% non-face to face for new appointments / 60% for follow up
- ERS will be available for directly bookable appointments when the ASI backlogs deem it to be equitable and fair to do so.
- Lung Health checks to commence Spring 2021
- Planning is done on the basis of the existing cost of current capacity.

The first draft activity submission as at 21/08/20 applies the recovery % as defined by the specialty plans. The output is shown in table 4 as follows:

Table 4: Key trajectories in Phase 3 elective submission plan

Indicator	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
The total number of incomplete RTT pathways at the end of the month	26,690	27,762	28,535	30,302	30,700	30,299	29,694	29,236	28,949	28,714	28,702	28,358
Number of 52+ Week RTT waits	15	47	125	217	346	324	302	280	258	236	214	192
Cancer 62 day pathways waiting 63 days or more	76	233	163	108	101	74	66	59	81	60	41	33

Costs

At the end of Month 4 (July 2020) the Trust prepared a financial forecast for the remainder of 2020/21, which estimates the costs to the Trust over the period August 2020 to March 2021 (M5-M12) will increase by £15.0m compared to an extrapolation of costs reported for April 2020 to July 2020 (M1-M4). The overall forecast includes additional expenditure in relation to elective recovery, anticipated emergency demand and winter capacity requirements, as well as the continued costs of Covid-19 (e.g. PPE and testing costs).

A review of the forecast outturn compared to the elective recovery plan has identified that circa £2.3m of potential costs would not have featured in the Month 4 forecast, most notably the costs of additional endoscopy capacity which has been estimated at £1.8m. The phase 3 letter sets out an intention to move towards a revised financial framework from Month 7 (October) onwards, however this is yet to be finalised nationally.

The ICS is advising that system allocations are expected at the end of August / early September. In the meantime the Trust finance team are seeking clarification on how costs above existing run rate will be reimbursed, whilst further refining the forecast estimates in line with the development of activity and workforce plans.

Financial tracking will be reported to the Recovery Group, Trust Management Team and then reported to the Board of Directors monthly as part of the SOF performance report to provide assurance

Risks

There are four keys risks to delivery:

1. Staffing is the most concerning risk to safely staff this plan. In the event of a 2nd COVID surge this becomes the rate limiting factor to maintain capacity. The risk is heightened where there are small teams, consultant vacancies and/or a dependency on locum capacity.

2. Infection, prevention control (IPC) measures and the impact that aerosol generating procedures and social distancing constraints have on productivity.

3. Physical capacity, notably the impact if there is a surge in ITU bed requirement, the availability of mobile diagnostic capacity to underpin radiology and endoscopy plans. And on-going access to the Independent sector.

4. The financial regime for the period October 2020 to March 2021 is yet to be finalised; there is a risk that the financial framework does not provide sufficient funding to cover the additional costs of providing capacity to deliver near-normal levels of activity.

Staff well-being

Ensuring the wellbeing of the Trust workforce has been paramount during the pandemic surge and continues to be critical to the next phase of restoration. At the start of the pandemic a COVID-19 wellbeing and welfare strategy was mobilised, and this included enhanced access to advice and guidance, wellbeing tools and resources and dedicated psychological support.

The restoration of elective activity will remain within job plan or contracted hours in the first instance. Where it is safe and appropriate do so additional sessions will be sought.

There is an active recruitment programme commencing, with additional staff to supplement the existing workforce during the restoration and over the winter and potential 2nd COVID surge.

The Trust are also looking at alternative service models, understanding how to blend in new roles and support a strategic workforce model to address the challenges not only in short term but over the next 5 years.

Workforce projections until March 2021 have been forecasted and are aligned to the activity and financial projections. The projections include known developments, including the assumptions of increased capacity for Critical Care, recruitment of International Nurse (x47) and Trainee Nurse Associates (x20). In addition the Trust is forecasting an increase in bank usage during winter and in preparation for a potential 2nd COVID surge

Communicating with patients

During the pandemic surge the Trust has used a variety of methods to communicate with patients. In the early stages two telephone helplines were established, one specifically for Cancer patients and the second for all patients whose appointment or treatment date had been affected. At the start of June the Chief Executive wrote an open letter to all patients published locally and via social media. A further letter was sent to all patients waiting >18weeks to apologise for the delay in the next step.

The Trust is cognisant of the volume of letters that have been sent locally, from neighbouring Trusts and GPs and nationally to patients who have been shielding. Letters have been inconsistent and have caused confusion.

The phase 3 letter clearly states that Trusts, working with GP practices, should ensure that, between them, every patient whose planned care has been disrupted by COVID receives clear communication about how they will be looked after, and who to contact in the event that their clinical circumstances change.

A communication plan is being led by the ICS clinical reference group supported by system wide and local communications teams. As confidence in the recovery plans is met, the messaging and support given to patients is now in position to be clearly communicated.

Next steps

From now until October, the objective is to deliver the actions and levels of activity as determined by the specialty and service level plans. Additionally the Trust will:

- Continue to identify opportunities to deliver >100% activity level through adapting and adopting learning from other organisations and supporting system wide innovation;
- Submit the SFH element of the ICS recovery plan by 1st September 2020. Noting that no request to submit a performance forecast has been made, the Trust will continue to monitor performance via the monthly SOF;
- Strengthen Newark as an elective / cold site throughout winter and continue to use the Independent Sector;
- Review social distancing and the application of IPC in line with national guidelines;
- Maintain non-face to face OP activity where safe and appropriate to do so.
- Report progress to the monthly Recovery committee