AGENDA ITEM No:

City of Westminster

Policy and Scrutiny Committee

Date:	19 April 2021
Classification:	General release
Title:	NHS NW London ICS update on elective surgery
Report of:	Senior Accountable Officer
Cabinet Member Portfolio	Portfolio (as listed at www.westminster.gov.uk/cabinet)
Wards Involved:	All
Policy Context:	NHS NWL covid-19 acute recovery
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1. Executive Summary

Overall, NW London has maintained a greater level of elective activity in Wave 2 compared with Wave 1 thanks largely to the hard work and dedication of NHS staff and improved Covid-19 protected pathways, which have enabled many more planned procedures to continue.

We have been able to care for Covid-19 patients whilst also treating the more clinically urgent elective patients (those who are clinically assessed as needing treatment within 4 weeks, including patients on cancer pathways).

Although waiting times for elective care did not increase at the same rate in wave 2 as wave 1, in line with the national picture in the NHS, we do still have a significant number of patients waiting for planned care, some over 52 weeks.

To address this, we have established a joint acute care board and programme to guide and coordinate developments across all key areas, including: planned surgery.

Our immediate focus is on making sure we step services back up in a way that prioritises clinical need and minimises the risk of Covid-19 infection, whilst we also maintain more intensive care capacity than pre-pandemic to ensure we are able to respond quickly to a possible third wave. And we want to do that while also ensuring

our staff get the space and support to fully recuperate, the needs and views of our patients are at the core of our plans and we actively address health inequalities.

We have developed a huge amount of learning from our response and improved collaboration with our partners across our integrated care system to take this programme forward.

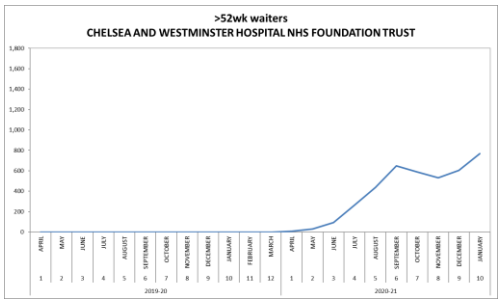
2. Background

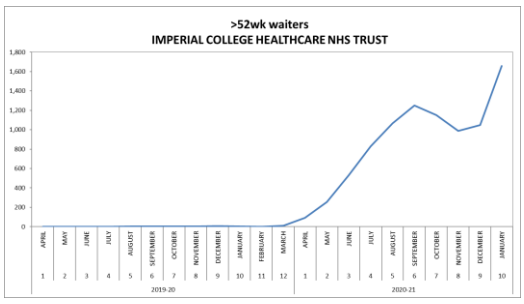
Our staff have provided the best possible care for thousands of patients with Covid-19 as well as thousands more with other urgent or emergency conditions over the past year. However, like the rest of the NHS, this has meant we have had to postpone planned operations, procedures and outpatient appointments for patients with less urgent needs. Many staff have been redeployed to help care for patients with Covid-19 and we have had to introduce additional infection prevention and control measures that have limited the number of patients we can treat on site.

We have learnt a lot between waves one and two of Covid-19 and we managed to safely maintain more planned care during the second wave, while also successfully treating more Covid-19 patients. But many patients with non-urgent conditions have now been waiting for treatment or advice for a long time and this situation will get worse before it gets better as we continue to prioritise patients with the greatest clinical need and as more people are likely to seek care as we move out of the pandemic. The NW London ICS is the largest system in London, currently we have the second lowest number of patients waiting over 52 weeks.

Waiting times for patients awaiting routine care have increased across the NHS, including at both Chelsea & Westminster Hospital Foundation Trust and Imperial Hospital Foundation Trust. In particular, we now have a significant number of patients who have been waiting over 52 weeks.

Referral to Treatment Time over 52wks for Chelsea & Westminster Foundation Trust and Imperial College Hospital Trust:





Data Source: Consultant-led Referral to Treatment Waiting Times, NHSE Statistics
Caveats: Provider-level data only, site-level data not available in national dataset

Our clinicians are undertaking a systematic 'harm review' to understand whether anyone waiting for care is likely to be suffering – or has suffered - any harm as a result of the delay to their treatment and to identify remedial action. Our clinicians are also continuing to review each of their patients to be clear about how urgently treatment is needed. We have continued to provide planned operations and other treatment for patients who we know need treatment within two weeks, either within

our own hospitals or in the independent sector. This has allowed us to maintain our urgent cancer care pathways.

3. Going forward

We have developed a huge amount of learning from our response to the pandemic as well as much better ways of collaborating across our integrated care system. We think we can do more to harness our collective resources, join-up our care and reduce unwarranted variations in access and outcomes.

We have established a joint acute care board and programme to guide and coordinate developments across all key operational areas, including: planned surgery, cancer care, outpatients, intensive care, urgent and emergency care and diagnostics and imaging. The board includes the chief executives, medical directors, nursing directors and chief operating officers of the acute trusts and the chief executive and chief of staff of the integrated care system as well as two lay partners and lead directors for finance, human resources, digital and communications and engagement

The initial phase of the acute care programme relating to elective care, guided and co-ordinated by the acute care board, therefore includes:

- **Fairer waiting times**: There are differences in waiting times and waiting list management across different specialties and hospitals and so we are exploring the development of a single view of waits across our hospitals. This will help us develop more consistent approaches to how waiting lists are managed and, potentially, to offer patients who have been waiting a while for treatment the opportunity to transfer to a hospital with more capacity, helping to create a fairer approach to access.

- **Re-starting 'fast-track surgical hubs'**: Last September, as part of a wider NHS initiative, we identified 14 surgical facilities across our hospitals that could have a good degree of separation from other facilities. These facilities were then dedicated to one or more of 29 specific, routine operations (across six specialties) where evidence has demonstrated improved quality and efficiency if a surgical team undertakes high numbers of these procedures following the same process, systematically. We were then able to offer these procedures at one of the corresponding facilities – sometimes called 'fast-track surgical hubs' - to patients from across our hospitals' waiting lists, in order of clinical priority. These services had to be suspended through wave two but have now begun to restart them, with the aim to have them all running at full capacity again by the end of April.

Outpatient services

- **Faster access to acute and specialist advice**: We're putting in place processes to enable GPs to get advice and guidance quickly and easily from specialist colleagues in the acute trusts when needed. Evidence from our pilots indicates that up to a third of patients referred to hospital can get the

care and support they need in primary care if specialist advice and guidance is available, avoiding unnecessary waits for an outpatient appointment. Improved processes are also ensuring any blood tests, imaging and other diagnostics needed to inform outpatient consultations are booked and undertaken in advance of the outpatient appointment.

- **Telephone and video consultations**: We had to quickly move as many outpatient consultations as possible to telephone or video during the pandemic to minimise the risk of Covid-19 infections. They have not always worked smoothly but we are continuing to build in improvements to our processes and ways of working and to find better ways of identifying and supporting patients who have difficulty in accessing care in this way. We would like to maintain high quality, virtual outpatient appointments for a significant proportion of our patients.

We are working to return to at least 80 per cent of our pre-pandemic activity by June 2021 – and to continue increasing our capacity from there - which means we will be able to safely treat all urgent patients and many with less urgent needs who have been waiting a long time. But, because we expect to see more people join the waiting list as we emerge from the second Covid-19 wave, we expect our long waits to continue to climb for a while. And we will continue to see growing health and care demand generally, as a factor of population changes and new diagnostics and treatments.

It's therefore really important that we also plan for longer-term, more strategic and sustainable improvements. We want to work with patients and wider stakeholders, drawing on evidenced best-practice and deeper collaboration, to build further on improvements to models of care and care pathways.

If you have any queries about this Report or wish to inspect any of the Background Papers, please contact Report Author.

APPENDICES:

For any supplementary documentation; especially from external stakeholders or documents which do not fit this template.

BACKGROUND PAPERS

This section is for any background papers used to formulate the report or referred to in the body of the report.