Greater Manchester Joint Commissioning Board

Date: 20 July 2021

Subject: GM Elective Recovery and Reform Update

Report of: Laura Marsh, Programme Director, GM Elective Recovery and Reform Programme

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PURPOSE OF REPORT:

The purpose of this report is to provide the Committee with an update regarding the current position, in relation to elective recovery and the key initiatives underway as a system, to support recovery through transformation. The report also includes details of the work being undertaken to support patients while they are waiting.

KEY ISSUES TO BE DISCUSSED:

The report provides a summary of the elective recovery achieved to date (as a percentage of pre-Covid activity levels). It sets out the governance arrangements for the oversight of recovery and reform through the GM Elective Recovery and Reform Board that reports to both the GM Hospital cell and the GM Community Co-ordination cell. Seven Clinical Reference Groups (CRGs) have been established for the specialties facing the biggest backlogs and where there is opportunity to transform, with membership from across the clinical pathway.

Due to the size of the challenge faced, in addition to maximising productivity, transformation of outpatients and additional waiting list initiatives, GM is developing a model for elective hubs that can provide protected elective capacity during times of increased urgent care pressure.

The paper describes the expected income in relation to the national Elective Recovery Fund and the associated gateway criteria assessment required from June to Sept 21. This importantly includes consideration of the system approach to reducing health inequalities through recovery.

Finally, the paper outlines the work underway to communicate with patients regarding the GM elective recovery approach and the ‘Waiting Well’ approach.

RECOMMENDATIONS:

The Greater Manchester Joint Commissioning Board is asked to:

- Note the current GM position in relation to elective recovery (as a percentage of pre-Covid levels of activity)
- Note the elective recovery work underway through the Clinical Reference Groups, GM Recovery Group and the GM Elective Recovery and Reform Board.
- Note the position in relation to the Elective Recovery Fund and the consideration of localities regarding costs within primary care related to elective recovery.
- Note the update in relation to communications to patients regarding elective recovery and the Waiting Well approach.

CONTACT OFFICERS:

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SYSTEM ENGAGEMENT

GM Elective Recovery Group, GM Elective Recovery and Reform Programme Board, GM Hospital Gold and Community Co-ordination Cells, Provider Federation Board

PRIMARY CARE ADVISORY GROUP (PCAG)
GP Board and Primary Care Cell members are represented on GM Elective Recovery and Reform Programme Board

PROVIDER FEDERATION BOARD (PFB)
PFB receive regular updates on Elective Recovery from the Board

WIDER LEADERSHIP TEAM (WLT)
n/a

STRATEGIC PARTNERSHIP EXECUTIVE BOARD (PEB)
n/a

GM CCG DIRECTORS OF COMMISSIONING (DOCS)
Directors of Commissioning receive regular updates on Elective Recovery and are represented on the Programme Board

GM CCG CHIEF FINANCE OFFERS (CFOS)
Chief Finance Officers receive regular updates on Elective Recovery and are represented on the Programme Board

GM LA HEADS OF COMMISSIONING (HOCS)
n/a

1. Current Elective Recovery Position

1.1 Following the relative decline in the number of hospital admissions and critical care demand relating to Covid19, recovery of elective activity has progressed across GM, as outlined in the table below. As a system we have seen particularly strong recovery in both outpatients and diagnostics (partly reflecting the efforts made in transforming delivery that commenced prior to Covid).

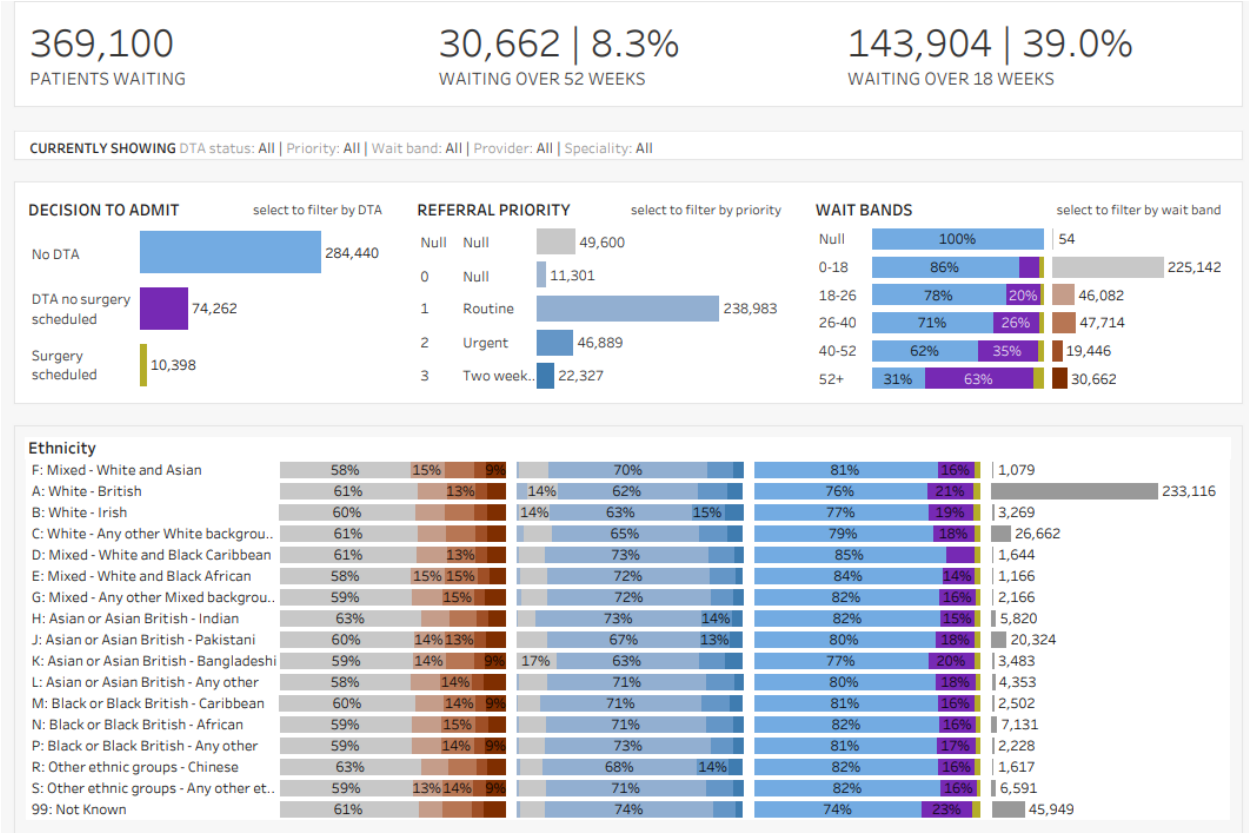
Figure 1: GM Elective Recovery position (as a % of pre-Covid levels)

	England average	North West Average	GM
Daycase	90%	88%	89%
Ordinary elective	90%	93%	89%
First Outpatient	91%	110%	125%
Follow-up Outpatient	97%	105%	111%
CT scans	106%	106%	106%
MRI scans	94%	97%	96%
Colonoscopy	105%	114%	99%
Flexi-sigmoidoscopies	67%	58%	89%
Gastroscopies	91%	80%	89%

(Data source: NW restoration of critical services report end June 21)

1.2 The GM Elective dashboard indicates that the total number of patients waiting is 369,100 patients. The number of 52 week waits has been reducing since March 21 to 30,662 patients (8.3% of total waiting list) (see Figures 2 and 3). The three specialties with the biggest number of patients waiting over 52weeks are Trauma and Orthopaedics, General Surgery and ENT.

Figure 2: GM Elective dashboard



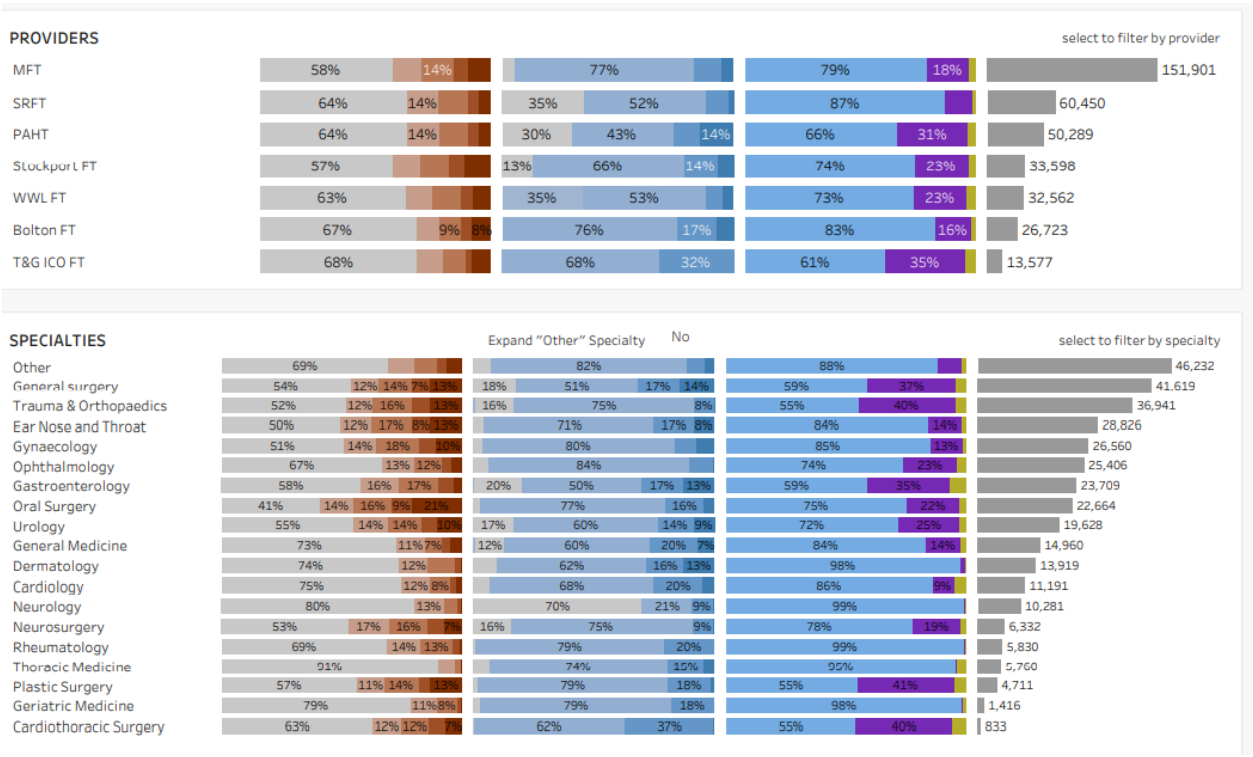
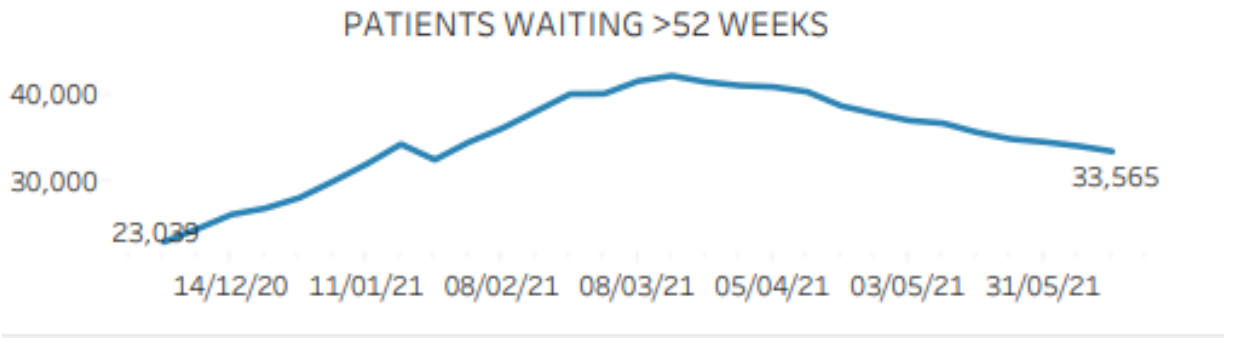


Figure 3: Number of GM patients waiting more than 52 weeks



2. Working collaboratively on elective recovery and reform

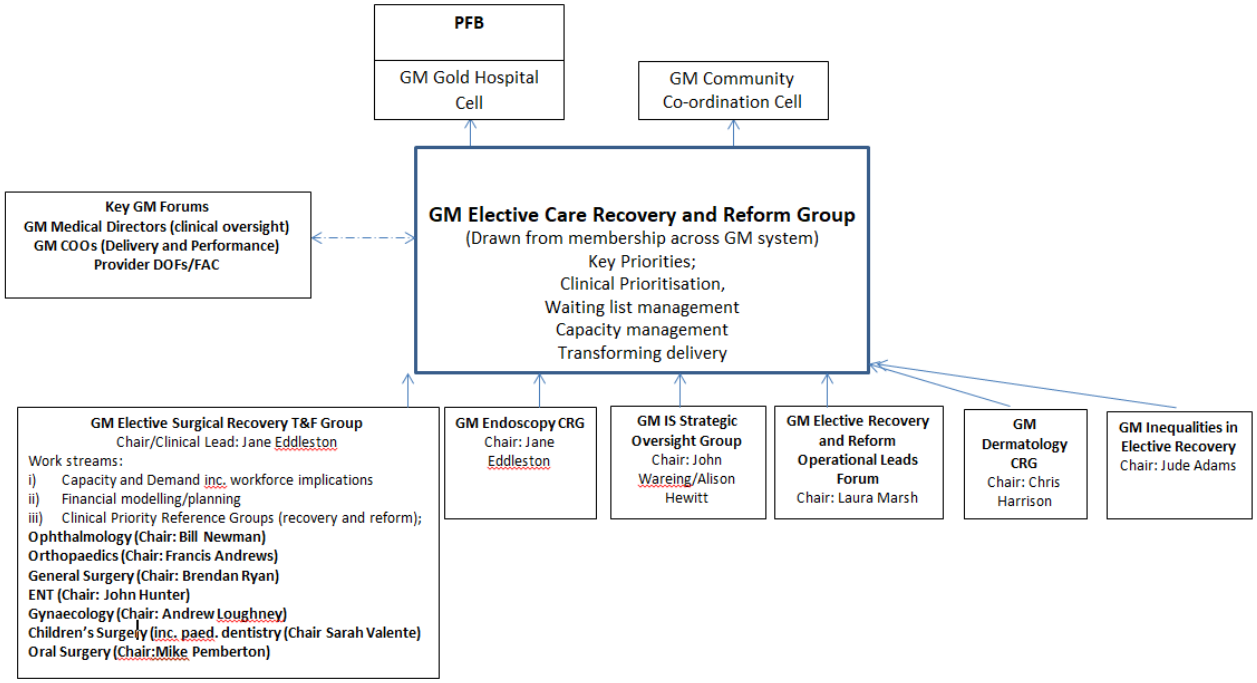
2.1 Throughout the pandemic and as recovery has progressed, all GM organisations have adhered to the principle of prioritising on the basis of clinical urgency. Using the national prioritisation system, P2 patients (those that need to have their surgery within a month) have remained a priority. GM has an agreed system-wide approach to ongoing clinical validation, to ensure

minimisation of harm and that those patients that have deteriorated whilst waiting are appropriately escalated.

2.2 In reflecting on our plans for elective recovery, both from an individual organisational perspective and collaboratively across the system based on regional feedback, there is an expectation that GM undertakes further action to address the overall waiting list. This includes realisation of the opportunities identified through analysis of the available regional data intelligence detailing opportunities identified through GIRFT, Model Health System, Rightcare etc.

2.3 Restoration and reform of elective care within GM is being overseen through the GM Elective Recovery and Reform Programme Board through the governance described below.

Figure 4: GM Elective Governance



2.2 A summary of the GM Elective Recovery and Reform Programme plan is included as Appendix 1.

2.3 The seven GM Clinical Reference Groups (CRGs) detailed above have been established within those specialties facing the biggest challenge in relation to elective recovery (Ophthalmology, Orthopaedics, ENT, General Surgery, Children's Surgery, Gynaecology, Oral Surgery) i.e. largest backlogs. Each CRG is chaired by an Executive Medical Director with clinical membership from each GM Acute Trust as well as primary care and Allied Health Professionals, GM commissioners and operational leads.

2.2 Each CRG has developed a clinically-led recovery plan that reflects population health needs and looks to harmonise clinical pathways, standards and ways of working to improve value and clinical outcomes. To date each CRG has utilised specialty-level dashboards within Tableau to identify and challenge variation between organisations, progress mutual aid for surgical recovery of prioritised procedures and driven increased utilisation of available Independent Sector capacity. The dashboards include a clearance rate based on current activity levels for each Trust. Further work is now required to map the plans for recovery into trajectories for improvement.

2.3 As part of the approach to recovery, each CRG is reviewing the opportunities identified from the regional/national intelligence from GIRFT and the Model Health System clinical indicators. This includes a gap analysis of GM current delivery against the published GIRFT High Volume Low Complication pathways (see Appendix 2), as well as other high volume pathways agreed as GM priorities. Each CRG has been tasked with consideration of transformation opportunities across the whole pathway of care, not just focusing on theatre

productivity, but also in terms of alternatives to referral, diagnostics that can be completed in the community, use of Advice & Guidance and Patient Initiated Follow Up etc. Ensuring the input of clinicians across the pathway of care within each CRG is crucial to achieving transformation within recovery. This will be achieved both through ensuring primary care representation on the CRGs but also ensuring regular engagement on progress with recovery through GP Board, Primary Care cell etc.

2.3 Further to work on maximising productivity and provision of additional Waiting List Initiatives, discussions have also commenced within CRGs regarding the formation of elective hubs, a concept which has been tested in other regions during Covid. Elective hubs can take a number of different forms, as described in Figure 4 and offer the opportunity both to maximise capacity but also to protect elective capacity during further Covid surges/winter pressures.

2.4 The development of the elective hub approach is most progressed within orthopaedics, where there are already a number of Trust sites without a co-located A&E and are therefore more protected from urgent care fluctuations in demand. The orthopaedic hubs will focus primarily on the delivery of high volume pathways (day cases) across 6 days initially, potentially extending to 7 days. It is proposed that the orthopaedic hubs are progressed as a test case, to understand how elective hubs can operate most effectively, before roll out more widely

Figure 5: Elective hubs models

Elective hub models

Elective hub sites allow utilisation of the existing estate to the maximum benefit, enabling focus on clearing backlog at a system level.

Different models should be chosen appropriate to local circumstances:

- Developing hub sites which are Covid-19 protected
- Single specialty
- Multiple specialty

Advantages

- Safe for patients
- Safe for staff – shielding staff happy to work
- Efficient – standard testing and minimal IPC in theatre

GIRFT GETTING IT RIGHT FIRST TIME NHS

Emergent Elective Hub Models within London

Hub Model	One-off, intensive "drives"	Mutual aid	Hub delivered outside BAU	Hub delivered as BAU	Hub dedicated & delivered as BAU
Definition	• Hub embedded within general hospital • No physical separation between hub and other operating flows • Short-term focus on specific pathways • May include some movement of patients and staff	• Hub may be standalone or embedded • Hospitals make theatre capacity available to other teams • Short-term focus on specific pathways • May include some movement of patients and staff	• Hub may be standalone or embedded • Additional capacity created by teams working extended days/ weekends • May include some movement of patients and staff	• Hub embedded within general hospital • No physical separation between hub and other operating flows • Permanent list dedicated to hub activity • Routine movement of patients and staff	• Hub physically separated from other operating flows; may be separate site • Permanent list dedicated to hub activity • Routine movement of patients and staff
Example	Example BHRUT "bones blitz"	Example Moorfields/RFL paediatric list	Example Orpington	Example Riverside, Charing Cross Hospital	Example SWELEOC, Croydon Hospital

Elective_Hub_Models.pdf

(Source: GIRFT HVLC Guide published May 21)

3. Elective Recovery Fund and Gateway assessment

3.1 Nationally, £1billion has been made available as the Elective Recovery Fund to incentivise the delivery of additional secondary care elective activity. A paper was approved by the Financial Advisory Committee in June that described the ERF forecast against the latest activity plan equates to £90m. Whilst GM should absolutely work to receive the maximum possible value of ERF, particularly given the impact on patients, the system will have a working assumption of £45m, the ICS's fair shares equivalent of ERF.

3.2 After offsetting the risk for CCGs relating to Independent Sector Contracts, 65% of the remaining funding will go to providers based on their performance and the remaining 35% will be retained at GM to support overall system delivery and GM wide schemes e.g. modular endoscopy unit. Once the Trust costs of additional activity is considered, it is proposed that localities also consider additional costs to primary care that relate to elective recovery e.g. provision of additional services that reduce the need for outpatient appointments etc.

3.3 The planning guidance makes clear access to the Elective Recovery Fund is through the delivery of thresholds (increasing from April through to July based on a percentage of 19/20 actuals) and progress against five gateway criteria; Clinical Validation of waiting lists, addressing health inequalities, transforming outpatients, system-led recovery and people recovery (see Appendix 2 for details). The thresholds are based on value rather than activity. It is understood that there will also be a focus on the reduction of long waiters as part of the ERF gateway assessment.

3.4 The submitted GM plan sets out our trajectories for planned activity and current performance is above the necessary benchmarks for access to the fund. Ensuring delivery against the gateway criteria will therefore be crucial to ensuring this level of activity is re-numerated across the system. The Regional Office will have responsibility for assessing progress against the criteria. This will then be moderated across regions at the national level to ensure criteria are being consistently applied. To support this, a series of questions and proposed evidence has been produced for each gateway. The gateway criteria assessment is not being applied to April and May however has commenced for June, with a submission required against each gateway criteria by 7th July 2021.

4. Reducing health inequalities in elective recovery

4.1 Across GM, we have established the GM Reducing Health Inequalities in Elective Recovery Group that brings together representatives from all localities with Business Intelligence, clinical leaders, personalised care leads and population health expertise. This forum seeks to understand what the data is telling us about the impact of Covid19 for those waiting for elective care and

any disproportionate impact on particular cohorts of the population. This will then help to determine the initiatives already underway within individual localities that can be scaled across the system to reduce health inequalities in our recovery approach, as well as any additional initiatives we will look to implement.

5. Pipeline development

5.1 To compliment the work described above, GM has developed a pipeline of opportunities to further increase elective capacity, should capital investment become available. These propositions have been brought together across GM through submissions from each Trust and prioritised/reviewed at Provider Federation Board. This includes opportunities such as the development of 'Green Sites'/Hubs, increase of surgical capacity on current sites and increase of diagnostic capabilities. Prioritisation has been based on consideration of workforce challenges/pressures, reducing health inequalities and future proofing service provision against future urgent care waves including potential further waves of Covid and/or winter pressures. We are currently awaiting confirmation from the national team as to whether this capital will be made available to GM.

6. Communications to patients and Waiting well framework

5.1 A GM core communications narrative document, supported by a communications pack has been developed by the GM Communications team and circulated to all Trusts and CCGs across GM, to support with communication in relation to elective recovery. The core narrative will continue to be updated, including key messages, as recovery progresses to ensure we keep patients informed.

5.2 A small subgroup of communication leads has been established to progress additional initiatives that will support communications to patients on the waiting list. For example development of a GM-wide patient letter that could provide an update to all patients on the recovery approach and who to contact if their symptoms have deteriorated.

5.2 In addition, the GM Elective Recovery and Reform Programme are developing a 'Waiting Well' framework; a repository of information for patients of the resources available to them while they are waiting for their outpatient appointment and/or procedure. This includes signposting to national and regional resources, as well as being adaptable at locality/Trust level, to include bespoke local offers for particular geographies or cohorts of patients. The outline design is included in Figure 6 however further work is being undertaken with Bolton and Stockport localities, working with patients/their representatives. Further work is also underway on how more vulnerable patients could be supported to use/access this information e.g. via social prescribers.

Figure 6: Outline of GM Waiting Well framework (working draft)

7. RECOMMENDATIONS

7.1.1 The Greater Manchester Joint Commissioning Board is asked to:

- Note the current GM position in relation to elective recovery (as a percentage of pre-Covid levels of activity)
- Note the elective recovery work underway through the Clinical Reference Groups, GM Recovery Group and the GM Elective Recovery and Reform Board.
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- Note the update in relation to communications to patients regarding elective recovery and the Waiting Well approach.

Appendix 1: GM Elective Programme Plan

Theme	Initiative	Responsibility	GM Elective Recovery and Reform Programme role
Clinical Prioritisation/ Waiting list management	Surgical recovery within prioritised specialties (Orthopaedics, Ophthalmology, ENT, Gynaecology, Oral Surgery, General Surgery, Children's Surgery)	Individual GM Trust	Maximise productivity and speed of recovery through enabling collaboration/standard approaches, set GM standards and principles
	Surgical/non-surgical recovery within remaining specialties	Individual GM Trust	No role unless additional specialties prioritised at GM
	Clinical validation; inpatient, diagnostics	Individual GM Trust	Identifying where additional support required, define GM agreed approach, reporting

			into NW
	Tracking performance improvement	Individual localities	Identifying where additional support is required at an organisational level, setting trajectories, reporting into NW
	Patient communications	Individual localities to adapt messages and ensure local roll out	Set agreed GM-wide messages and approach to patient comms re: recovery Develop new mechanisms to support patient waiting e.g. 'waiting well' and oversee roll out
	Reducing health inequalities	Individual GM Trusts/localities	Sharing best practices, defining GM approach, tracking impact
	Understanding impact of GM-wide initiatives	Individual localities	Identifying when initiatives should be expedited/stopped, reporting on progress into ERF assessment process
Maximising Capacity	Use of Independent Sector	Individual GM Trusts and CCGs	Co-ordination of usage across GM, ensuring alignment with system priorities
	Theatre productivity	Individual GM Trusts	Identifying where additional support required, maximising usage, identifying and sharing best practice, setting standards, reporting into NW
	Development of GM Elective hubs	Provider Collaborative	Defining GM approach, co-ordination across CRGs and aligning with available GM capacity

Transforming Delivery	Outpatient transformation including implementation of; Advice & Guidance PIFU Virtual clinics	Individual localities	GM policies, identifying where additional support required, maximising usage, identifying and sharing best practice, reporting into NW
	Digital innovation e.g. MyRecovery app	Individual GM Trusts/localities	Securing pump priming/ funding, engaging organisations in pilot, sharing best practice and learning, aligning to GM digital strategy

Appendix 2: National GIRFT High Volume, Low Complication pathways for adoption by ICSs

Speciality	Specific procedures (90%-95% Day Case)
ENT	• Tonsillectomy • Tympanoplasty • Septoplasty • Mastoidecetomy • Stapediectomy • Endoscopic sinus surgery
General Surgery	• Laparoscopic cholecystectomy • Inguinal hernia • Paraumbilical hernia
Gynaecology	• Diagnostic laparoscopy • Endometrial ablation • Hysteroscopy • Laparoscopic hysterectomy • Vaginal hysterectomy
Ophthalmology	• Cataract
Orthopaedics	• Anterior cruciate ligament reconstruction • Therapeutic shoulder arthroscopy • Total hip replacement • Total Knee replacement • Uni Knee replacement • Bunions
Spines	• Lumbar decompression/discectomy • Cervical spine decompression/fusion • Medical branch/facet joint injections • Lumbar nerve root blocks/therapeutic epidurals • One or 2 level posterior lumbar fusion
Urology	• Bladder outflow obstruction • Bladder tumour resection • Cystoscopy Plus • Minor peno-scrotal surgery • Uteroscopy and stent management

Data source: GIRFT HVLC Guide May 21

Appendix 2: Elective Recovery Fund Gateway assessment

Gateway 1: Clinical Validation, waiting lists and long waits			
Assessment Questions		**Proposed KPIs & Supporting Evidence for each Question**	**KPI Source**
Assessment Question 1 Are governance structures in place to ensure monthly data validation for the waiting lists MDS?		**Supporting Evidence and KPIs** • No KPIs – regional assessment via the WLMDS Checklist and supporting evidence from system	**Source:** N/A **Timing:** N/A
Assessment Question 2 Are systems carrying out clinical validation of waiting lists in line with the national programme and timelines?		**Supporting Evidence and KPIs** • Percentage of admitted waiting list that has a P code • Percentage of P2 patients waiting more than 5 weeks with a completed review	**Source:** ER Dash **Timing:** June
Assessment Question 3 Is shared decision making between patients and clinicians embedded in day-to-day practice and treatment reviews?		**Supporting Evidence and KPIs** • Percentage reduction in low-value evidence based interventions • Regional assessment that effective processes are in place	**Source:** ER Dash **Timing:** June
Assessment Question 4 Is completion of the WLMDS on trajectory for full submission during Q1?		**Supporting Evidence and KPIs** • Percentage completion of MDS total list, 52+, 104+ waits (vs. PTL) • Percentage completion of MDS p-code and time band for both waiting list and activity	**Source:** ER Dash **Timing:** June
To be supported by additional guidance distributed by Gateway Leads such as the WLMDS Checklist			

Gateway 2: Addressing Health Inequalities

Assessment Questions	Proposed KPIs & Supporting Evidence for each Question	KPI Source
Assessment Question 1 Has referral analysis been completed in line with the criteria set out within the Gateway?	**Supporting Evidence and KPIs** • Submission of analysis report and summary of progress against criteria as set out in guidance	**Source**: Report **Timing:** N/A
Assessment Question 2 Is there progress towards delineating reporting by ethnicity and IMD?	**Supporting Evidence and KPIs** • Progression towards collection of PIFU, A&G and VC data by age, disability, ethnicity and IMD across 3 key services/specialties • Percentage of WLMDS with ethnicity recorded (when available)	**Source:** local Population Health management portal/PTL Tool **Timing:** N/A
Assessment Question 3 Is the data in Assessment Question 1 and Assessment Question 2 being presented at Provider Board as part of routine performance data reporting?	**Supporting Evidence and KPIs** • Evidence that data captured under Assessment Question 1 and 2 are being presented as part of Board Performance packs at Provider Level	**Source:** Board Performance Packs **Timing:** Ongoing
To be supported by additional guidance distributed by Gateway Leads		

Gateway 3: Transforming Outpatients

Assessment Questions	Proposed KPIs & Supporting Evidence for each Question	KPI Source
Assessment Question 1 Are regular data and reporting processes in place to count the volume of PIFU and A&G services and the impact of local initiatives?	**Supporting Evidence and KPIs** • Attainment against roadmap as detailed in supplementary guidance	**Source:** TBC **Timing:**
Assessment Question 2 Has the system implemented Advice and Guidance (or alternative) to reduce unnecessary outpatient referrals?	**Supporting Evidence and KPIs** • Percentage increase of patients on A&G from baseline	**Source:** ER Dash **Timing:** July
Assessment Question 3 Has the system implemented Patient Initiated Follow-up (PFU) or similar alternative in at least three major outpatient (OP) specialties per Provider?	**Supporting Evidence and KPIs** • Percentage increase of patients on PIFU (or alternative) pathways from baseline	**Source:** TBC **Timing:**
Assessment Question 4 Have systems developed plans for implementing outpatient telephone and video consultations?	**Supporting Evidence and KPIs** • Percentage of outpatient consultations carried out virtually	**Source:** ER Dash **Timing:** June
To be supported by additional guidance distributed by Gateway Leads		

Gateway 4: System Led Recovery

Assessment Questions	Proposed KPIs & Supporting Evidence for each Question	KPI Source
Assessment Question 1 Are the Patient Tracking Lists (PTLs) being managed at a system level?	**Supporting Evidence and KPIs** • No KPIs – regional assessment	**Source:** **Timing:**
Assessment Question 2 Are systems fully utilising the IS?	**Supporting Evidence and KPIs** • Independent Sector utilisation compared to plans	**Source:** ER Dash **Timing:** June
Assessment Question 3 Are system working arrangements maturing?	**Supporting Evidence and KPIs** • Submission of plans detailing development of Elective Activity Coordination Hubs (EACH)	**Source:** Plans **Timing:** Ongoing

To be supported by additional guidance distributed by Gateway Leads

Gateway 5: People Recovery

Assessment Questions	Proposed KPIs & Supporting Evidence for each Question	KPI Source
Assessment Question 1 Is the system effectively monitoring staff wellbeing?	**Supporting Evidence and KPIs** • Monitoring of referral patterns to Occupational Health service • Evidence of Board Level conversations surrounding health and wellbeing • Assurance that health and wellbeing conversations are taking place with all staff, such as through the Pulse survey • Use of wellbeing dashboard through Model Health system	**Source:** Wellbeing Dashboard, board papers, Occupational Health referrals
Assessment Question 2 How effectively is staff wellbeing and managed in line with circulated guidance?	**Supporting Evidence and KPIs** • Confirmation of appointment of Wellbeing Guardians • Plans to increase rate of annual leave and allow flexibilities such as buying back leave	**Source:** Annual leave records
Assessment Question 3 How robust are the plans in place for staff recruitment and retention?	**Supporting Evidence and KPIs** • Tracking and assessing staff availability, sickness, absence and leaving by staff group • Identification of high risk staff groups, cohorts and services • Retention plans for priority groups	**Source:** Sickness absence, retention and recruitment data (ESR)
Assessment Question 4 Is the system taking active steps towards addressing workforce inequalities?	**Supporting Evidence and KPIs** • Submission of plans to address inequalities based on the latest WRES findings • Plans for Line Manager training on inclusion	**Source:** WRES data, staff networks

To be supported by additional guidance distributed by Gateway Leads