Appendix 3

The Leeds Teaching Hospitals NHS Trust

Adults, Health and Active Lifestyles Scrutiny Board

11 February 2025

Elective Care Briefing Paper

Key points	
1. Elective care in health is provided across the system – by community providers, the independent sector and the mental health trust. This paper considers (secondary and tertiary) elective care provided by Leeds Teaching Hospitals NHS Trust.	For information
2. The total waiting list reported is for patients waiting to start their first episode of treatment and does not include patients under continuing care	For information
3. There was significant growth in the number of patients waiting and the length of waits for some patients during and after the COVID-19 pandemic	For information
4. LTHT is making significant progress in reducing waiting times for patients	For information
5. LTHT is among the top 25% of Trusts for average waiting times and the % of patients waiting over 18-weeks	For information

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1. Summary

This paper is intended to update the Adults, Health and Active Lifestyles Scrutiny Board on Leeds Teaching Hospitals NHS Trust's (LTHT) total referral to treatment (RTT) waiting list and the numbers of patients experiencing very long waits (over 65 week waits) for treatment.

It is important to note that LTHT is one of a number of providers of elective care in Leeds. Elective care is generally referred to in relation to 'secondary' care following a referral from primary care or self-presentation by patients to an Accident and Emergency department or other self-referral pathway. It is important to note that the community trust, mental health trust and numerous independent sector organisations in Leeds deliver elective care to patients across the city.

The paper describes recovery following the growth of Leeds Teaching Hospital Trust's (LTHT's) total RTT waiting list as a consequence of the COVID-19 pandemic. It describes the delay to recovery caused by the strikes by a number of staff groups over a period of 18 months after December 2022.

Like most NHS Trusts nationally LTHT continues to have relatively small numbers of patients waiting over 65 weeks for treatment in areas where capacity is challenged. However, patients on the waiting list at LHT have the 21st shortest waiting time in the country (of 119 acute and combined NHS Trusts).

2. Total Waiting List

The total waiting list (TWL) for planning and reporting purposes refers to the Trust's total number of incomplete RTT pathways. This represents only those patients waiting to commence their first episode of treatment following a new referral and therefore does not represent patients waiting for additional episodes of treatment or review following initial treatment.

The size of our waiting list is determined by number of additions to the waiting list and the rate at which these are removed. It is generally perceived that this relationship is therefore:

- the number of referrals received (waiting list additions)
- activity, or the number of patients seen treated (waiting list removals).

It should be noted that activity / treatment delivered only results in a removal from a waiting list if it is defined as providing the first definitive treatment for a patient (or confirmation that treatment is not required). At this point the activity becomes something that stops the patient's RTT 'clock'

The key to understanding waiting list changes therefore becomes:

- the number of referrals received (waiting list additions)
- activity / number of patients seen or treated on admitted or non-admitted pathways
- the RTT clock stops (waiting list removals) generated by this activity

Clock stops are influenced by activity delivered, but it is not a 1:1 ratio. Patients may have multiple outpatient attendances and elective episodes that result in a single clock stop. Therefore, activity is important, but more important when considering impact on total waiting list is whether we deliver activity that progresses the patient to treatment and discharge.

It should be noted that the total number of patients waiting for treatment does not correlate absolutely with the length of waits our patients experience. This is because the total waiting list is comprised of numerous specialty and sub-specialty waiting lists with differing demand and capacity challenges.

Furthermore, these individual waiting lists are comprised of patients who have differing clinical urgency for treatment. As a result patients referred to some specialties or those with certain conditions will always be considered a priority for treatment, meaning that patients are not only considered for treatment in terms of longest wait first.

The Trust had experienced some success in the reducing the total waiting list in the months prior to the COVID-19 pandemic, reducing the numbers on the waiting list from 65,196 in May 2019 to 56,460 by February 2020, which was the last month before activity was impacted by actions taken to address the COVID-19 pandemic.

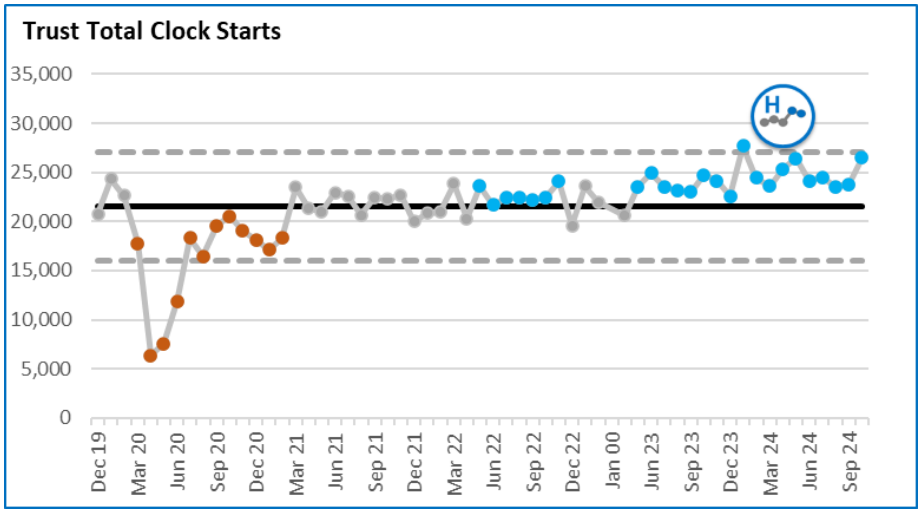
- 18 week referral to treatment (RTT) was 86.36% in February 2020.
- LTHT ranked 43rd of 118 reporting Trusts for RTT in February 2020.

During the first 3 months of the pandemic the waiting list reduced in size as routine referrals were paused and discharging patients from care was prioritised – although throughout this period referrals for patients requiring urgent review or with suspected cancer were encouraged. This resulted in the total waiting list falling to a low of 45,638 by the end of June 2020.

Once restrictions on referrals into the Trust were lifted and referral rates recovered close to pre-pandemic levels the waiting list began to grow as capacity for treatments and outpatient review remained restricted until 2022. By the end of September 2022, the waiting list had grown to 91,819 patients. From October 2022 growing activity rates and validation of waiting lists resulted in four months of reduction in the waiting list, but the impact of strike action by medical and nursing staff has resulted in growth in the waiting list during February to September of 2023 and this has continued to impact us with industrial action ongoing until February 2024.

3. Clock Starts / Clock Stops

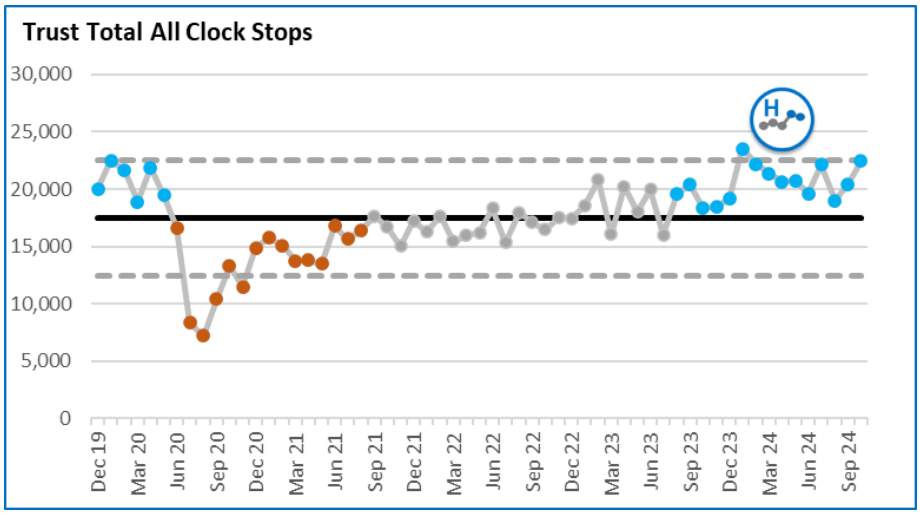
RTT clock starts are generated by referrals to the Trust for treatment. The volumes of these are shown below. LTHT is the 9th largest Trust for numbers of clock starts and stops (Sept 2024).



The biggest volume of clock starts comes from GP referrals, but significant numbers are also generated by patient attendances on acute pathways that go on to generate elective treatment requirements. As a major tertiary service LTHT has a significant volume of patients referred from other hospitals on an already active clock – where a patient has been referred to a local service,

waited, been reviewed and found to be too complex for the local service to treat. The clock does not restart once these patients are then referred on to a tertiary service.

It is worth noting that clock start volumes are greater than clock stops. This is because of ROTT (removals other than treatment) which occur when patients are removed from a waiting list without treatment. This can occur if a patient has accessed services in more than one Trust or where the patient decides not to proceed with planned treatment.



It should also be noted that not all patient treatment activity results in RTT 'clock stops' and patients being removed from the RTT waiting list. It is therefore important to monitor the number of pathways closed in addition to activity. This is shown on the chart above, which illustrates the growth in clock-stopping activity which has recently peaked at levels not seen since prior to the COVID-19 pandemic with mean clock stops at over 20,000 per month.

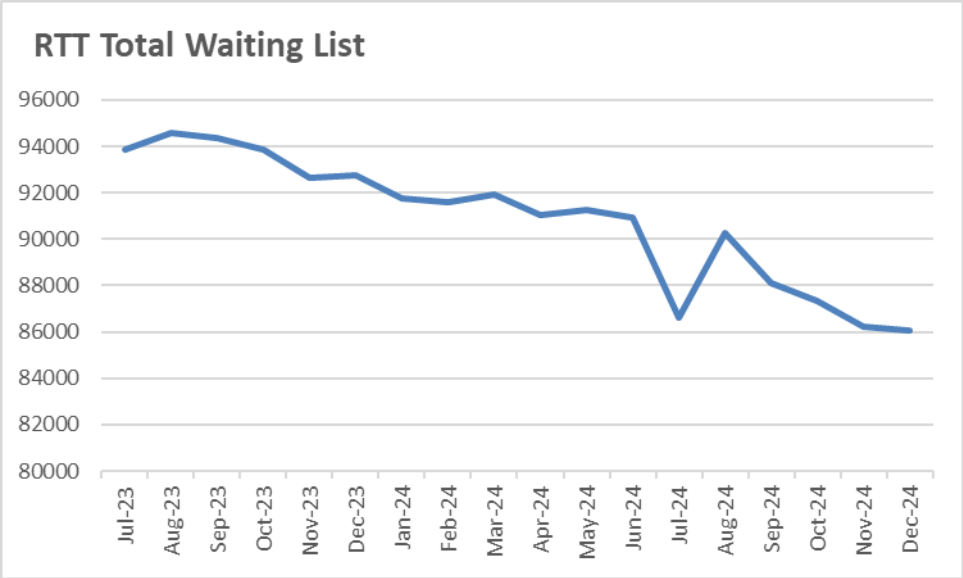
Maintaining high levels of activity is essential to continue to reduce both the longest waiting times for our patients and the number of patients on our waiting lists.

Non-admitted (outpatient) clock-stopping activity did not return to the pre-pandemic mean of 15,500 clock stops per month until November 2022. In part, this was due to additional reviews required for long-waiting patients in order to confirm treatment plans and any deterioration in the condition of patients who experienced extended waits for treatment.

The backlog of activity and extended waits for some patients means that there has been an increase in patients requiring more than one intervention to complete their treatment. Only one such intervention will stop and RTT clock and so a greater volume of activity is required overall to generate the number of clock stops previously seen. As waiting times reduce fewer additional treatments will be required and our rate of clock stops will accelerate.

The chart above illustrates how the TWL was falling prior to the COVID-19 pandemic but then grew in the post-pandemic period as referral rates into the Trust exceeded capacity available because restrictions on activity continued as social distancing and COVID screening measures remained in place. However, waiting list growth slowed significantly as these restrictions eased.

The Trust finished the year 2023/24 with a TWL of 91,942 patients. The growth seen during that year was attributable to industrial action taken during the year, which impacted on activity levels during the first quarter of 2024. Reductions in the size of the Trust's TWL have accelerated as the frequency of industrial action reduced end then ended in spring/early summer. This is shown in the chart below which illustrates the reduction in TWL size since the peak of 94,568 in August 2023.



A reduction in the overall volume of patients on our waiting list is important to enabling us to continue to reduce the maximum waiting times for patients and to further reduce waiting times for patients in the coming years. The Trust has performed well at controlling the growth in its waiting list since the pandemic. LTHT is the ninth biggest trust in the country in terms of the number of RTT clock starts and clock stops each month (patients beginning and ending an elective pathway). However, LTHT has only the 21st largest waiting list in the country.

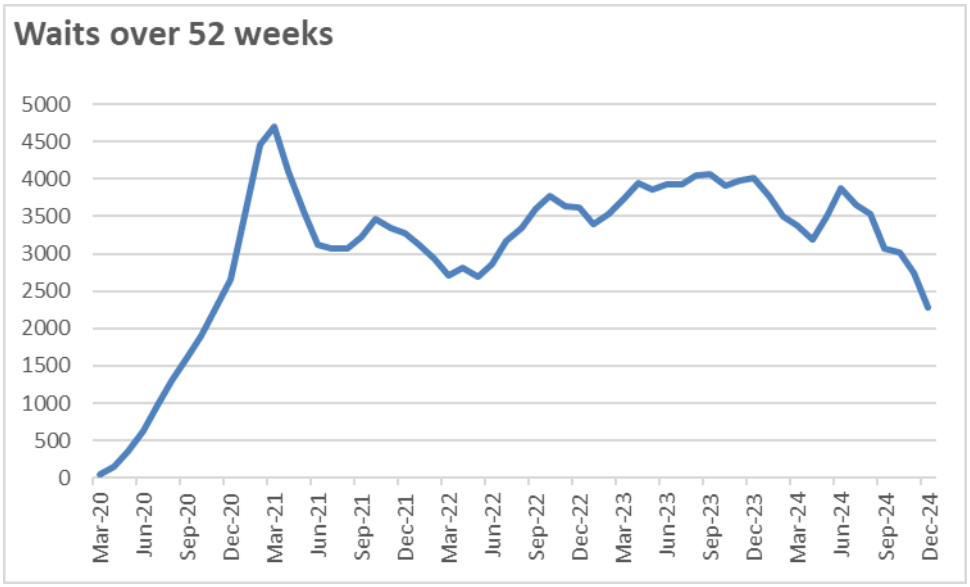
4. RTT Standard (18 weeks)

The patients on a waiting list for first treatment with LTHT at the end of November 2024 had waited an average wait of 11.32 weeks. This is the 21st shortest wait in the country for those awaiting treatment (of 119 acute and combined NHS Trusts).

64.8% of patients on our waiting list have waited less than 18 weeks for treatment (the RTT constitutional standard). This places LTHT 26th in the country in the delivery of this standard. There are 30 specialties within the Trust who are delivering against the constitutional standard of 92% of patients on their waiting list having waited less than 18 weeks.

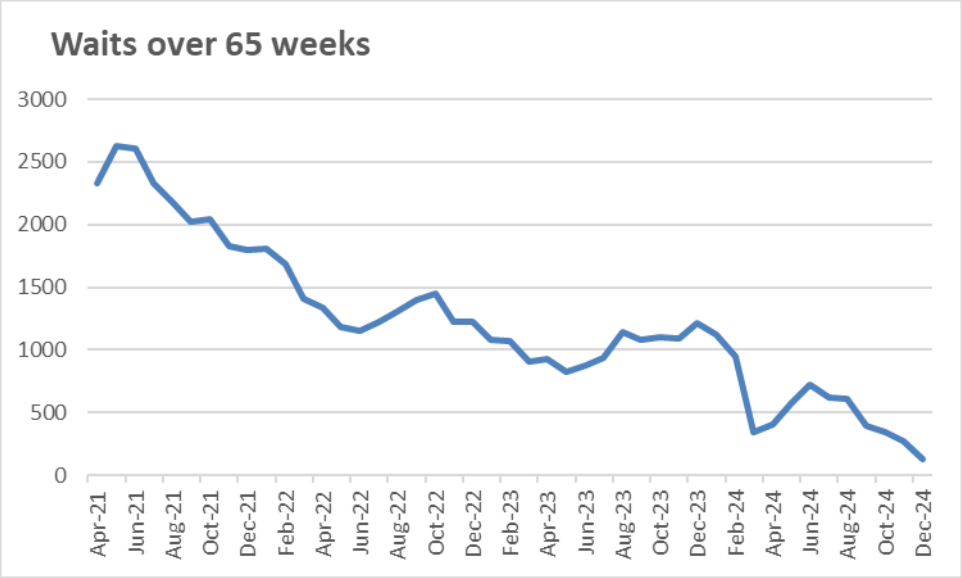
5. Waits over 52-weeks

The number of patients waiting over a year for treatment has also continued to improve. across our CSUs with our 52-week wait position improving month on month from 3,875 at the end of June 2024 to 2,283 at the end of December 2024. The growth and subsequent reduction in waits of over a year is illustrated in the chart below.



Prior to the COVID-19 pandemic the volumes of patients waiting over a year was low across the NHS with fewer than 100 patients reported by LTHT. These were therefore recorded as a cohort figure with monthly records not recording the length of wait over 52 weeks. This was changed in April 2021 when numbers waiting by week were recorded up to 104 weeks.

The chart below shows the number of patients waiting over 65 weeks at LTHT from April 2021. The number peaked in May 2021 at 2,623 and at December 2024 this was down to 132 patients.



The Trust's approach to reducing waiting times is to deliver sustainable long term reduction in the volumes of patients waiting and at the same time reducing the longest waits across all specialty areas.

There are a small number of CSUs who continue to experience challenges in reducing waiting times to below 65-weeks. Within these services there has been particular challenges in delivering the additional capacity for non-urgent elective work that is required to reduce maximum waiting times.

Weekly meetings with the COO and Deputy COO have been held with these CSUs to review both capacity requirements and actions being taken to reduce the numbers waiting over 65 weeks and there is weekly monitoring of all waiting time risk areas.

Accelerating the clearance of the backlog of long waits presents challenges to all services that continue to have patients waiting over 65-weeks. For some services there are greater challenges in ensuring that capacity available for routine elective activity meets the ongoing demand into these services. These challenges are not unique to LTHT with some services across the country experiencing growing demand and a capacity shortfall.

This is further complicated at LTHT as cancer and urgent tertiary workloads have grown significantly over recent years. This is in part due to challenges faced outside of Leeds to maintain services as consultants have retired or moved jobs. Our services work with the West Yorkshire Association of Acute Trusts (WYAAT) to review how our services are aligned to deliver capacity that is sufficient for both complex and routine activity.

6. NHS England *"Reforming Elective Care for Patients"*

On 6th January 2025, the NHS published the new plan to reform elective services. With over 6.3m patients on waiting lists from October 2024 and over two fifths of these being for over 18 weeks, the Reforming Elective Care paper highlights the need to move away from a focus on only those longest waiting patients.

The reform commits to increasing the percentage of patients treated within 18 weeks for elective treatment to 65% nationally by March 2026, and returning to constitutional standard of 92% by March 2029. Each provider is expected to deliver a minimum 5% improvement on their current RTT delivery and activity will be funded within total system allocations for 2025/26.

To deliver these commitments, a set of priorities have been published covering four areas, which involve collaboration between NHSE, ICBs and NHS elective care providers. These are:

- **empowering patients** by giving them more choice and control, and by establishing the standards they can expect to make their experience of planned NHS care as smooth, supportive and convenient as possible
- **reforming delivery** by working more productively, consistently – and in many cases differently – to deliver more elective care
- **delivering care in the right place** to make sure patients receive their care from skilled healthcare professionals in the right setting
- **aligning funding, performance oversight and delivery standards**, with clear responsibilities and incentives for reform, robust and regular oversight of performance, and clear expectations for how elective care will be delivered at a local level

A number of commitments are provided with the aim of returning to delivering the 18-week standard by March 2029. By March 2026 it is stated that the percentage of patients waiting less than 18-weeks for elective treatment will be 65% nationally. There are a number of specific actions associated with these priorities including greater use of the NHS App to enable choice of providers for patients, increased diagnostic capacity via community diagnostic centres, increased availability of advice and guidance for GPS and increased use of patient initiated follow-up pathways.

The publication is available at NHS England » Reforming elective care for patients