East Suffolk and North Essex NHS Foundation Trust

Public Trust Board

8 July 2021

Report Title:	Elective Care Accelerator Programme
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Previously considered by:	N/A

☐ **Approval** ☐ **Discussion** ☑ **Information** ☑ **Assurance**

Executive Summary

The Suffolk and North East Essex Integrated Care System (SNEE ICS) is part of the national programme to recover NHS waiting lists known as the elective accelerator programme and this is to support the government initiative to bring faster treatment to patients following a growth of waiting lists caused by the COVID-19 pandemic.

The SNEE ICS have been awarded access to £10m funding to support delivery of programmes to enable achievement of 100% elective activity from end of July 2021, together with further schemes to increase and sustain delivery to achieve 120% from the end of September 2021.

The approach for delivery will be through:

- Additional Activity
- Improved Productivity
- Transformed processes and patient pathways of care

The ESNEFT philosophy of Time Matters is the golden thread running through every change outlined within the accelerator programme.

To continue the work done pre COVID together with the learning from COVID to establish the key principles of moving forward.

This report aims to set out the key elements of work, to provide assurance to the board of the work underway and planned in order to accomplish the accelerator requirements.

Action required of the Board

The Board is asked to receive and note the report.

Link to Strategic Objectives (SO)		**Please tick**
SO1	Keep people in control of their health	☑
SO2	Lead the integration of care	☑
SO3	Develop our centres of excellence	☑
SO4	Support and develop our staff	☑
SO5	Drive technology enabled care	☐

Risk Implications for the Trust *(including any clinical and financial consequences)*	If we do not we have services that meet the need of the local population during and post Covid, this may lead to prolonged waiting times which may give rise to suboptimal outcomes for patients.
Trust Risk Appetite	Compliance/Regulatory: The board has a minimal risk appetite when it comes to compliance with regulatory issues. It will meet laws, regulations and standards unless there is strong evidence or argument to challenge them
Legal and regulatory implications *(including links to CQC outcomes, Monitor, inspections, audits, etc.)*	Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17 Health and Safety at Work Act
Financial Implications	None specifically for this report.
Equality and Diversity	None specifically for this report.

Contents

1. INTRODUCTION

The SNEE ICS is part of the national programme to recover NHS waiting lists known as the elective accelerator programme and this is to support the government initiative to bring faster treatment to patients following a growth of waiting lists caused by the COVID-19 pandemic.

The SNEE ICS have been awarded access to £10m funding to support delivery of programmes to enable achievement of 100% elective activity from end of July 2021, together with further schemes to increase and sustain delivery to achieve 120% from September 2021. Alongside the requirement to increase the percentage of activity, there is a requirement to reduce our waiting times for our longest waiting patients.

The approach for delivery is through: -

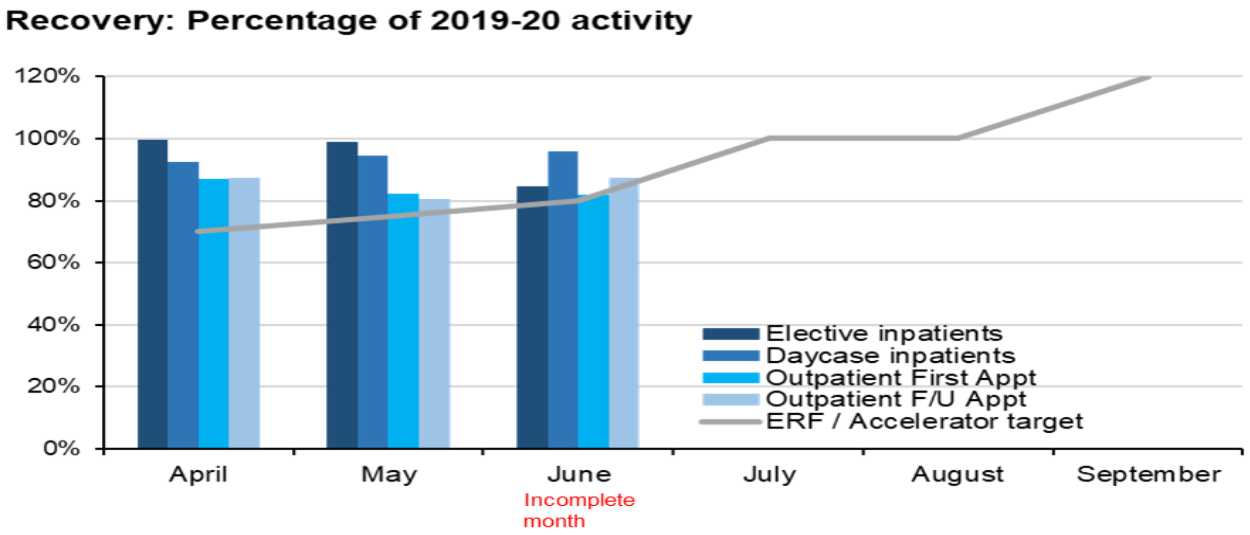
- Additional Activity
- Improved Productivity
- Transformed processes and patient pathways of care

Examples of what works well in Suffolk and North East Essex will feed into regional and national plans for elective recovery. ESNEFT and other SNEE members; West Suffolk Hospital, North East Essex & Ipswich and East and West Suffolk commissioning groups, Anglia Community Trust and Allied Health Professionals are working together to rapidly recover routine services and to deliver treatment to those waiting in most urgent clinical cases and waiting longest. The SNEE will be using the Getting it Right First Time (GIRFT) best practice pathways and other improvement programmes to support ideas and transformation in the region.

In the last 6 weeks the focus has been to:

- Determine divisional and speciality plans, to enable delivery of 100% activity by the end of June 2021 and 120% by the end of September 2021 against the 19/20 baseline. This included where teams set out their 'asks' for additional money to support increases in activity, together with how they would deliver this and what transformation support they required.
- Understand the opportunities available for improving pathways and pull together plans for delivery.
- Finalise the trajectories of maximum waiting times by end of September 2021.

1.1 Current Progress



2. ADDITIONAL ACTIVITY

The Trust forecast plans of activity is as per Section 6. Each specialty has forecast the additional activity to deliver 100% from July, together with further schemes to increase and sustain delivery to achieve the 120% target from October 2021.

Schemes identified to date are as follows:

- Creation of additional ward space to increase elective bed base for additional planned care, offering of decant facility and resilience to support beds in case of a 3rd Covid wave.

- Additional clinic sessions have been arranged by clinical teams, more than 18,000 outpatient appointments were carried out across the Trust (week commencing 14 June 2021) which is more patients compared to any other week, in the whole of last year, with 25.4% of these appointments held virtually. The teams are continuing to increase outpatient capacity, with many services planning 'bumper weekends' helping us see more patients more quickly.

- Clinical teams are exploring the option to set up a Saturday morning additional clinic each week (Hot Clinic) to support patients coming through ED that need an urgent General Medical appointment that otherwise would have resulted in multiple other visits to them Trust. This results in an improved patient experience for more urgent cases outside of the emergency remit.

- Additional theatre sessions at weekends.

- Clinical prioritisation to identify any patients whose condition requires more urgent treatment.

- Ophthalmology team have proposed a mobile "bus" to provide glaucoma and diabetes testing to address the current backlog (5,000 patients). The proposal will be for the mobile unit to undertake "clinics" within areas of deprivation as these account for 44% of the backlog. It will provide additional clinical space without further increasing the footfall on the Trust sites. This proposal is currently at the Business Plan stage, if successful it is anticipated the service will commence in October 2021.

- One major impact from the pandemic, has been the significant reduction of non-urgent elective activity. Despite some elective, diagnostic and outpatient work being diverted to the independent sector sites, the referral to treatment (RTT) position is now a position where significant numbers of patients have waited over a year for their treatment. As we commence recovery, where trusts are attempting to reinstate elective programmes, West Suffolk Hospital (WSH) have experienced problems with the RAAC planks in their buildings, which has resulted in a reduction elective admissions for a number of months. The anticipated restart date for work in the WSH theatres is the 4th October, and they have been looking at methods of how they can increase elective work in the interim.

  A business case for the leasing of an additional temporary theatre (Vanguard) has been approved for the system. WSH will use this until October 2021, which will then be available for use by ESNEFT. Primarily this will be for Day case procedures.

  The unit will be sited close to the main building, and attached by a covered, heated walkway, so that patients can be moved from the Vanguard unit into the main building. The Vanguard unit will be equipped with a theatre team, so that we will only need to source an anaesthetist, (assuming general anaesthetic cases), the surgeon, and a small level of administration support initially. It is anticipated that the unit will deliver between 1300-1600 cases across the next 12 months depending upon case mix.

- Throughout the pandemic, both of the local independent hospitals, the Nuffield in Ipswich and Ramsay Oaks in Colchester, provided significant assistance through additional elective activity for our urgent patients, or hosting parts of our services whilst the acute sites dealt with the issues that were prevalent at the time. This activity was nationally mandated, and then managed at local level, with the trust responsible for deciding how best to use the facilities made available to us.

  Since April, this has changed as there is no such mandate in place, instead there is a national provider framework contract that independent providers were invited to sign up to, which both Nuffield and Ramsay did. Under this new agreement there is no compulsory release of activity as there was under the previous arrangement, instead capacity is released under local negotiation, and then patients are outsourced to the providers, although it should be noted that for elective work, as many of our consultants also work in the private sector, the patient does not have to see a different clinician for their treatment, unless they agree to do so.

  Both of the private hospitals are offering a reduced level of elective work to that which we had last year, but the ESNEFT diagnostic teams have been using the independent sector to supplement our own capacity.

  This agreement is discussed and reviewed quarterly, and levels are already set for Q2, and have been discussed for Q3.

3. TRANSFORMATION

3.1 GIRFT 29 Pathways

Getting it Right First Time (GIRFT) national team have provided 29 High Volume Low Complexity (HVLC) best practice pathways (detailed in appendix b). These span across 6 specialities and are identified as areas of focus to utilise best practice, theatre efficiencies and productivity for the following:

1. Trauma and Orthopaedics including spinal surgery
2. Ophthalmology
3. Urology
4. ENT
5. Gynaecology
6. General Surgery

The drive for top decile of GIRFT performance of clinical outcome, productivity and equity of access forms a key element in our transformational set of changes.

The Transformation Team have engaged with the operational and clinical teams to map the existing pathways for the 29 HVLC pathways for both Ipswich and Colchester teams; (i.e. 58 in total). These have been compared with the GIRFT best practice pathways and a gap analysis undertaken for all of the pathways. The next stage, which includes data analysis to identify practice differences between Ipswich and Colchester sites, are engaging with the Operational and Clinical teams to share learning and agree opportunities for improvements. At the same time, they are working with the CCG colleagues to develop the “front” and “end” stages of the pathway so the full pathway is considered from when the patient presents to the GP through to support within the Community following discharge.

The final stage will be to support the teams to implement the agreed opportunities and bring about improvements. Early findings suggest several areas which can be improved, together with some examples of where we are already achieving (and in some cases over-achieving in relation to these pathways); e.g. at Ipswich, 12 cataracts performed per list for scheduled HVLC clinics, where the national best practice defines 10 per list.

3.2 Transformation of key national improvement programmes

There are 3 specialty priority areas which have been set nationally:

- Musculoskeletal and Orthopaedics (MSK)
- Ophthalmology
- Cardiology

Each of these improvement programmes are clinically led in the region and supported by a range of clinical, operational and transformation teams. Each have initial national/regional workshops established, with national improvement teams, together with the National Clinical GIRFT lead; (Tim Briggs), setting out the expectations and system data packs for us to work through. The initial MSK workshop took place in June and follow up 'MSK ICS Programme Boards' are commencing in July 21. The SNEE Ophthalmology and Cardiology are to hold their initial workshops in July with planned dates for associated ICS programme boards to follow.

Each programme will have data and statistics published in the Model Hospital which will be used to evaluate progress in the SNEE and by providers.

3.3 BAAGS

(Blue Card Discharge**, A**dvice & Guidance**, A**ttend Anywhere**, G**ood news by letter and **S**traight to Test**)**

3.3.1 Blue Card Discharge

To support specialties with their outpatient appointment clinical capacity, divisions and specialties are ensuring they are aware of the "Blue Card Discharge" process. i.e. the ability to discharge a patient from the outpatient service, but offering a route back into the service for an agreed length of time, initiated by the patient themselves, as 'patient initiated follow up' appointment (PIFU). The Trust is exceeding the current national target of implementing Blue Card Discharge for 3 specialties and is continuing to expand on this service across the organisation. This enables the patient to initiate their own follow up if required and ensures that patients do not attend for appointments that are not needed. It reinforces the principle of Time Matters for both the patient and the clinical team. It also facilitates the standard for a 25% reduction in follow up appointments. May 2021 figures show that 2183 patients were discharged via the PIFU option, (showing a continual increase 'month-on-month' from 200 in May 2020), with 21 specialties at Ipswich and 16 at Colchester now having the blue card (PIFU) system in place.

3.3.2 'Attend Anywhere' (video conferencing) & telephone appointments; i.e. Virtual appointments

Where applicable, virtual sessions (i.e. telephone calls or video conferencing) are being held rather than 'face to face' to reduce the need for patients to come into the hospital for their appointments unless it's absolutely necessary. The target of 25% of all outpatient appointments to be held virtually is currently being maintained across ESNEFT, however current figures show that the percentage of virtual appointments held has reduced from previous months during the peak of the pandemic. This is mainly due to the teams having worked through as many virtual appointments as they can, but now accelerating the number of face to face appointments for those patients needing to come into the hospital. In May 2021, just over 19,000 appointments were held virtually.

The focus of work with specialties is now, highlighting differences in practice between sites for consideration and where the % of virtual appointments achieved earlier in the pandemic has now reduced, working to understand the rationale for the changes. Also to improve data quality.

Other Trusts have been sharing good practice to support the accelerator programme which the SNEE members and ESNEFT will look to see if they can transfer to the Suffolk and North East Essex region. Examples of these are theatre efficiency programmes, high intensity lists and staff passports.

3.3.3 Good News by Letter

The reduction of face-to-face Outpatient consultations by informing the patient of 'good news' outcomes by letter. This will enable the clinical team to discharge patients back to primary care without the need for a follow up appointment, thus saving the patient unnecessary travel time and expense of having to attend a hospital appointment.

3.3.4 Straight to test

Patients are sent straight for a diagnostic test rather than creating an outpatient appointment as the first step. Depending on the results of the diagnostic test patients are either booked a follow up appointment with the consultant to discuss interventions or sent a 'good news' outcomes by letter.

An Outpatient workshop is being scheduled for July2021. This will be to understand what further step changes can be implemented, over and above what is already detailed in this paper.

4. PRODUCTIVITY

To support increased productivity, the following are initiatives which are underway:-

4.1 Toolkit of options to manage outpatient follow up backlogs

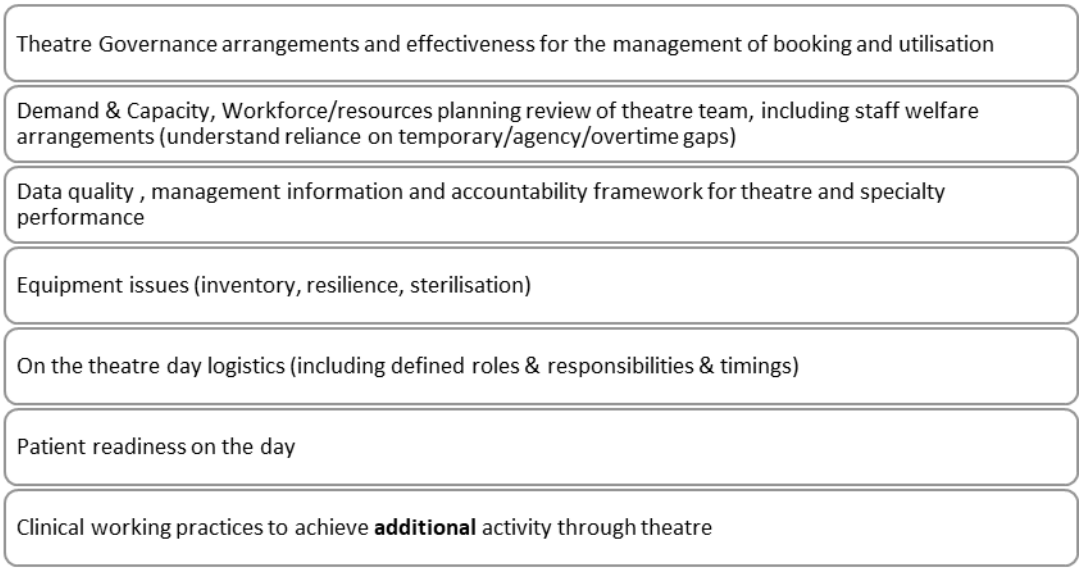
A "toolkit" to support specialities to reduce their long waits and increase capacity was devised. One of the options was for the clinical teams to review their patients, identify those who had been waiting longer than 6 months from their expected follow-up date, and agree which patient cohorts could be contacted by admin team(s), to understand if they still require an appointment and if so, whether it could be virtual as opposed to face-to-face. The clinicians have provided the script in some specialties, along with the appropriate patient cohort. As a result to date, 221 patients have been discharged with a further 20 discharged with a blue card for 'patient initiated follow up' (PIFU), as a direct route back into the hospital if needed. Ten patients who still require an appointment, have opted for this to be virtual rather than face to face. The transformation team have been working through the above, with the specialties and the follow up backlogs are monitored regularly to assess the impacts.

As a result of the work performed across the teams around management of outpatient follow ups in the past two months, the numbers of patients who are overdue by more than 6 months for their expected follow up appointment have decreased from 11,456 to 9,763; showing a reduction of 14.78%. There are many differences within these figures, where some specialties have delivered a significant reduction and others haven't. This detail is being worked through between specialty and site to share lessons and enable further reductions over the coming weeks.

4.2 Theatres

Theatre efficiency programme is integral to supporting the SNEE accelerator programme incorporating good practice prescribed by the GIRFT programmes.

The objective is to eliminate inefficiencies and challenges that impact on good theatre flow, aim to create additional capacity in the theatre provision to offer the opportunity for more patients to be treated. The work stream encompasses the following key themes:



To align to the accelerator programme, the initial focus is the MSK pathway to theatre, the programme is planned to the end of September and the theatre areas are Constable at Colchester and East Theatres in Ipswich.

The work streams embed 'every contact counts' principles in any change. Any changes made to administrative, clinical and operational encounters are relevant and effective that contribute to the patient coming to the Trust and receiving treatment as planned.

Post Covid the teams are working hard to list patients fully on theatre lists and avoid cancellations of theatre lists. This means early understanding of the current capacity of estate, workforce and supporting staff to fully utilise for treatment and to support utilisation of theatres at 85%. Part of this programme, looks to supporting operational teams embed the 6-4-2 booking principles and unblocking any barriers that prevent the following occurring:

- 6 weeks in advance of treatment in theatre the lists are confirmed as required by services to deliver care
- 4 weeks in advance of treatment in theatre the lists are confirmed to surgeon
- 2 weeks in advance of treatment the list is locked and patients are booked (with flexibility to reschedule if a patient is subsequently unwell to attend after the 2 weeks).

4.3 Pre-operative assessment (POA)

The programme of work is due to commence in July 21. Outcomes of prior review existing POA arrangements and capacity will be reviewed to understand the detail plan. Transformation will support the operational implementation of the new clinical system Synopsis. Synopsis is a pre op assessment system which offers the assessment of patients digitally. Questionnaires can be completed by the patient from home or in clinic with the clinicians help and then used during the pre-operative assessment by nurses, doctors and anaesthetists. It will reduce the use of paper and communicates with other IT systems and therefore captures the clinical information for review in one place. The outcome of the system will be to reduce the length of time a patient is in clinic and creates additional capacity to pre assess patients.

Additionally, an external company, Johnson & Johnson were brought in to support the trust with some diagnostic work to look at process as well as capacity and demand within the pre-assessment clinics on both sites. The trust received their report 28th June and is currently reviewing a set of recommendations.

4.4 Patient Waiting List Reviews

Specialities have undertaken review of the longest waiting patients over 98 weeks, with the exception of one speciality, all have been given a date for their operation or procedure and all will have been seen by the end of July 2021.

We are monitoring this on a week by week basis working closely with the services and forward identifying those patients which will breach 98 weeks (reducing to 78 weeks). This will ensure that by the end of September we have no patients waiting over 78 weeks for treatment.

The Outpatients team are contacting patients that have been waiting longer than 6 months for a first outpatient appointment ensuring that they still require to be seen. As a result more than 1200 patients who no longer required an appointment have been removed from the waiting list.

4.5 Interaction with NHSE/I (National Improvement Team)

We have met with a Senior Improvement Manager from NHSE/I for a facilitated completion of self-assessment tool – Intensive Support Team (IST) Elective Care Waiting List Quality Improvement Checklist and we were 90% compliant. No further work needs to be carried out in respect of this but it gives reassurance around the management of our waiting lists. We have asked also for details of good practice with regards to effective communications for moving patients around and are waiting on feedback to assist with how we manage our patients particularly with regards to mutual aid within the IST.

4.6 Mutual Aid

System working is underway to establish mutual aid across the 3 sites (ESNEFT and WSH) with a review of waiting times for treatment and where there is disparity and opportunity, to transfer patients, through agreed Standard Operating Practices (SOPs). A number of services have already instigated this change Ophthalmology and ENT (with West Suffolk) and General Surgery; Oral Surgery and Gynaecology (across the ESNEFT sites). Patients are now being referred to alternative sites. This will be an ongoing piece of work to enable patients to be treated more timely, as well as ensuring that we can provide parity of service for care to be given due to chronological waiting times, but still supporting patient choice for their site of treatment.

4.7 Clinical Prioritisation

National Guidance was issued indicating that all patients waiting on a surgical waiting list needed to the clinically reviewed and an appropriate P code allocated. These P codes indicated the timescale within which treatment should take place. All patients who have waited longer than 3 months were contacted and asked if they still required the surgery and if so they were offered a virtual appointment to discuss their ongoing care. The administrative team ringing the patients also asked if they needed further support with the following 4 areas.

1	Financial
2	Mental Health Support
3	Social Support
4	Physical Wellbeing

If the patient indicated that they did require the support then an ongoing referral was made to our community colleagues to contact the patient to initial that support.

4.8 Inequalities and COVID19

A substantial amount of analysis has been undertaken to form an early understanding of health inequalities and inequalities in access to services across the ESNEFT economy. In particular, this looks to understand the link between population health, deprivation and ethnicity. Much of this work has been undertaken to support the work of the Health Inequalities Working Group, with key findings shared with the ICS.

Thus far, data analysis has been undertaken to investigation the relationship between:

- Adult and child obesity admissions and deprivation
- ED attendances, deprivation and ethnicity
- Access to elective services, equality of waiting times, deprivation and ethnicity
- Cancellations and did not attend rates and deprivation
- COVID-19 mortality, smoking prevalence, and deprivation

Key findings include:

- A clear and significant relationship between deprivation and child obesity rates, both nationally and within the ESNEFT catchment. Child obesity rates are around three times higher in the top 10% most deprived areas compared to the 10% least deprived.
- Patients living in the top 20% most deprived areas in the ESNEFT catchment attend A&E more frequently, spend a longer time in A&E before departure, and are less likely to be admitted than those living in areas that are more affluent.
- Patients from the most deprived areas have spent less time on the RTT waiting list compared to patients in other deciles.
- Cancellation rates are higher for patients from the most deprived areas.
- In more affluent areas the uptake of the COVID-19 vaccines is significantly higher and there is also a lower rate of smoking than more deprived areas. COVID-19 mortality is significantly higher in the most deprived areas.

With much of this work still very nascent and interpretation limited to high-level correlations, further data analysis is being undertaken to better understand the root causes of these trends, as well as to understand the interactions with comorbidities and demographic factors such as age.

5. RISKS

Risk to delivery of 100% activity from end July, stepping up to 120% by end Sep and (sustainably going forward):-

Risk	Risk Area	Impact	Mitigation
Third Covid wave	Staffing and theatres / Bed availability	All areas depending upon the level of a third surge	Detailed bed modelling in accordance with SAGE predictions, organisational surge planning exercise and preparedness
Inability to recruit and retain sufficient staff to deliver the increased activity	Theatres, wards, outpatients.	Inability to secure	Divisional detailed plans in place, understanding of detail of workforce needed. Mutual Aid processes and protocols in place across ICS Accelerator funding to secure fixed term resources
Inability to deliver outpatient activity at 120% due to insufficient physical capacity	Physical capacity constraints – in relation to social distancing rules	Inability to deliver the full 120% outpatient activity based on current space utilisation	Smoothing out of outpatient use of rooms across 7 days per week. Outreach clinics in community setting Further improvement around use of virtual clinics

6 FORECAST DELIVERY

6.1 Maximum wait times

With the exception of Oral Surgery, all specialities have plans in place to have no patients waiting over 98 weeks by the end of July 2021, with the aim to have no patients waiting over 78 weeks by the end of September. Oral Surgery plans are still being defined due to the change in workforce and will be completed by July 2nd.

Ipswich

Service	Over 78	Over 98	Over 104
General Surgery	30/09/2021	31/07/2021	-
Gynaecology	30/08/2021	-	-
Oral			
Spinal	31/07/21	-	-
T&O	31/08/21	-	-
Urology	30/09/21		

Colchester

Service	Over 78	Over 98	Over 104
Gastro	30/08/2021	31/07/2021	-
General Medicine	30/07/2021	-	-
General Surgery	30/09/2021	31/07/2021	-
Gynaecology	30/08/2021	-	-
IR	31/5/2021	-	-
T&O	30/09/2021	-	-
Urology	31/08/2021	-	-

6.2 Additional activity

Plans are on track to deliver 100% activity by the end of July2021, as demonstrated on page 4 and 120% by the end of September, taking into account the risks as outlined within this document.

7. NEXT STEPS AND RECOMMENDATIONS

- To finalise the oral maximum wait time reduction plan.
- To review and finalise the detail of specialty plans to achieve 120% activity by the end of September.
- To continue to work with clinical divisions to monitor weekly progress against plans as set out in their trajectories to achieve and sustain the accelerator targets.
- To review the set of recommendations from Johnson & Johnson around pre-op assessment and commence the approach to deliver.
- To finalise and commence improvements against the opportunities identified from the GIRFT HVLC pathways.
- To hold an outpatient transformation workshop, to identify any further opportunities.
- To complete the business case and progress the option around use of an ophthalmology mobile unit.
- Patient stories and cultural / social movement around appropriate accelerated use of virtual appointments for outpatient transformation.
- To complete the work around analysing further opportunities and variances between sites and specialties, for increased use of BAAGS in outpatient transformation.
- To progress mutual aid across the ICS, optimising parity of services and maximising use of resource.
- Commenced use of the Vanguard unit and access to independent sector.
- Deliver bumper weekends to increase activity.
- Introduce further hot clinics; i.e. general medicine.
- Deliver theatres efficiencies as outlined in the theatre programme.
- Commence set of clinically-led ICS programme boards for delivery of end-to-end improvements for eye care, cardiac and MSK services.
- To continue, and further develop, the close working relationships with the independent sector sites, in order to identify opportunities for additional capacity.

APPENDIX A

List of 29 GIRFT Pathways

Orthopaedics

- GIRFT elective hip or knee replacement pathway
- Anterior Cruciate Ligament Reconstruction pathway
- Bunions pathway
- Therapeutic shoulder arthroscopy for rotator cuff repair OR sub acromial decompression pathway
- Total hip replacement pathway
- Total Knee Replacement pathway
- Uni Knee Replacement pathway

Spinal

- Posterior Lumbar Decompression / Discectomy pathway
- One or Two Level Posterior Fusion surgery (PLF / TLIF / PLIF) pathway
- Lumbar Nerve Root Block/Epidural pathway
- Lumbar Medial Branch Block/Facet Joint Injections pathway
- One or Two Level Anterior Cervical Discectomy & Fusion/Disc Replacement
- (ACDF/CDR), Posterior Cervical Foraminotomy pathway
- Urology
  - Male bladder outflow surgery pathway
  - Bladder outflow obstruction pathway
  - Bladder tumour resection pathway (in cases of breakdown in cancer services)
  - Cystoscopy plus (rigid cystoscopy, endoscopic lower urinary tract procedures)
  - Minor peno-scrotal surgery pathway

ENT

- Endo sinus surgery pathway
- Nasal airway surgery pathway
- Myringoplasty pathway
- Tonsillectomy pathway

Ophthalmology

- NHSE/I Low Complexity Day case Cataract Surgery Pathway

General Surgery

- Inguinal Hernia pathway
- Laparoscopic Cholecystectomy pathway
- Paraumbilical Hernia pathway

Gynaecology

- Operative laparoscopy pathway
- Endometrial ablation pathway
- Hysteroscopy pathway
- Laparoscopic hysterectomy (with or without removal of ovaries) pathway
- Vaginal hysterectomy (anterior/posterior vaginal wall repair) pathway