Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Public Trust Board Meeting: Wednesday 13 March 2024

TB2024.22

Title:	**NHSE Trust Board Self-Certification for Protecting and Expanding Elective Capacity (Progress Update)**

Status:	**For Discussion**
History:	**Elective Care Recovery Group (ECRG)**
	Trust Management Executive 31st August 2023
	Trust Board 13th September 2023
	Regional Tiering Meeting 29th January 2024
	Trust Management Executive 29th February 2024

Board Leads:	**Sara Randall, Chief Operating Officer**
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Confidential:	**No**
Key Purpose:	Strategy, Assurance, Performance

Executive Summary

1. Following the paper submitted to Trust Board on the 13th September 2023 regarding a further national publication in respect of elective recovery, focussing particularly on Outpatients (https://www.england.nhs.uk/long-read/protecting-and-expanding-elective-capacity/), this briefing paper provides a progress update to our earlier response, as requested by the national team, to the key lines of enquiries outlined within the publication.

2. NHS England (NHSE) outlined three key lines of enquiry as a form of next steps for outpatient transformation:

    - Revisit Trust plans on outpatient follow up reduction to identify more opportunity for transformation.
    - Set an ambition that no patient in the 65-week ‘cohort’ (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023.
    - Maintain an accurate and validated waiting list by ensuring that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with December 2022 validation guidance) by 31 October 2023, and ensuring that Referral to Treatment (RTT) rules are applied in line with the RTT national rules suite and local Access Policies are appropriately applied.

Recommendations

The Trust Board is asked to note the progress made on the assurance provided.

Self-certification

1. Validation	Assured	Evidence	Rationale	Action & Predicted Impact
a. The board has received a report showing current validation rates against pre-covid levels and agreed actions to improve this position, utilising available data quality (DQ) reports to target validation, with progress reported to Board at monthly intervals. This should include use of the nationally available LUNA system (or similar) to address data quality errors and identify cohorts of patients that need further administrative and clinical validation.	Partially	Board paper July 2023, TB2023.63 Trust Response to Elective Care to 2023/24 Priorities	Current validation rates for over 26 week wait pathways have been reported to Board in July 2023. Limitations of the current validation reports have been outlined. Briefing paper on Validation Strategy reported at ECRG in August 2023	A proportion of **DQ management** is already undertaken across the PTL. **New validation tool due to go-live end of March 2024** with a full programme of training across the organisation. System will provide accurate rates of validation, together with distinct validation cohorts. A sustainable DQ Group will be considered relating to RTT pathways following the launch, led by the **Director of Data and Analytics** with support from the Elective Access Team, EPR team and operational teams from Clinical Divisions.
b. The Board has plans in place to ensure that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with validation guidance) by 31 October 2023, and has sufficient technical and digital resources, skills and capacity to deliver against the above or gaps identified.	Fully	Buckinghamshire, Oxfordshire & Berkshire West (BOB) Outpatient Steering Group submission	Business case outlines approach based on two previous pilots of engaging with patients digitally with a view to validate whether they wished to remain or not on the waiting list. Project launched and validation concluded.	All pathways **above 40-weeks are strictly validated** for month end submission with further validation carried out across the entire PTL. **Patient Engagement validation deployed in October** for all eligible patients (exc. vulnerable etc) waiting between 12 and 51 weeks. With the long waiters fully validated and eligible patients engaged at 66%, this equated to **89% validation** (based on non-eligible patient engagement being out of scope).

c. The board ensures that the RTT rules and guidance and local access policies are applied, and actions are properly recorded, with an increasing focus on this as a means to improve data quality. For example, Rule 5 sets out when clocks should be appropriately stopped for 'non-treatment'. Further guidance on operational implementation of the RTT rules and training can be found on the Elective Care IST FutureNHS page. A clear plan should be in place for communication with patients.	Fully	PTL assurance	Weekly Patient Tracking List (PTL) meetings held guided by RTT experts with operational teams. Weekly Executive-led assurance meetings in place for escalation and oversight.	**RTT Website reconstructed** to further improve staff engagement with the RTT rules and policy. Both internal and external **training sessions have been offered** to Divisional teams. **The new RTT validation tool** will also provide intelligence on validation outcomes and highlight training opportunities to support the correct application of RTT rules.
d. The board has received a report on the clinical risk of patients sitting in the non RTT cohorts and has built the necessary clinical capacity into operational plans.	Partially	Daily PTL reports Weekly Worklist reports Demand & Capacity modelling plus Business Planning	Daily PTL reports are distributed across the operational staff group to manage total waiting lists. Weekly worklists specific to EPR flow is distributed and taken through divisional operational meetings Demand and Capacity modelling undertaken has factored some elements of non-RTT activity	The new RTT validation tool to be expanded to include **non-RTT data** enabling standardised level of oversight and grip with validation and training. Inclusion of more non-RTT waiting lists into weekly Assurance meetings. ToR and R&Rs are to be formally introduced. Assess D&C modelling approach to include total waiting list, not partial elements. Non-RTT cohorts identified to inform 2024/25 operational planning.
2. First appointments	**Assured**	**Evidence**	**Rationale**	**Action & Predicted Impact**
a. The Board has signed off the Trust's plan with an ambition that no patient in the 65 week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023.	Partially	Board paper July 2023, TB2023.63 Trust Response to	Agreed milestone dates for each pathway stage have been briefed in TME and the monitoring	**Exceptions to the October target date** for first appointments to be seen to ensure plans are economically viable and spend is not

		Elective Care to 2023/24 Priorities	arrangements have been included within the M4 Integrated Performance Report.	created where there is little to no conversion to admission (low risk). All 1st appointments were planned to be seen **by end of January** at the very latest.
b. The Board has signed off the Trust's plan to ensure that Independent Sector (IS) capacity is being used where necessary to support recovery plans. To include a medium-term view using both insourcing and outsourcing, the Digital Mutual Aid System (DMAS), virtual outpatient solutions and whole pathway transfers. National support and information on utilisation of the Independent Sector is available via the IS Co-ordination inbox england.iscoordination@nhs.net	Fully	Elective Recovery Fund (ERF) Process	Agreed ERF for both insourcing and outsourcing services. OUH has signed up to DMAS with several requests for mutual aid made to date.	**Contracts in place** for Spinal services with IS Providers as no uptake via DMAS. **Agreement in-year for ERF schemes** to be reallocated to focus on ISP activity. Urology **secured HVLC activity via ISP** and recent agreement on some more complex cases to be undertaken by an ISP. Orthopaedics secured a substantial proportion of **activity to be undertaken by an ISP**. ENT continues to run some of its **activity via an ISP.** Neurophysiology also **supported by an ISP.**
3. Outpatient follow-ups	**Assured**	**Evidence**	**Rationale**	**Action & Predicted Impact**
a. The Board has received a report on current performance against submitted planning return trajectory for outpatient follow-up reduction (follow-ups without procedure) and received an options analysis on going further and agreed an improvement plan.	Partially	Outpatient Steering Group (OPSG) and ECRG	OPSG slides available monthly with performance metrics on follow up activity vs 2019/20 baseline	Follow up activity currently performing above submitted Operating Plan. Priority of work to be conducted via the OPSG **has been agreed and plans underway** to recover the position strategically. A deep dive benchmarking paper has been shared to support clinical services identify specialties where there may be opportunities to reduce follow ups.

b. The Board has reviewed plans to increase use of Patient Initiated Follow Up (PIFU) to achieve a minimum of 5%, with a particular focus on the Trust's high-volume specialties and those with the longest waits. PIFU should be implemented in breast, prostate, colorectal and endometrial cancers (and additional cancer types where locally agreed), all of which should be supported by your local Cancer Alliance. Pathways for PIFU should be applied consistently between clinicians in the same specialty.	Partially	Outpatient Steering Group and Cancer Improvement Group	PIFU pathways have been in place for Breast, Prostate and Endometrial cancers with a Project Initiation Document (PID) Approved in July 2023 for Colorectal Cancers. Non-cancer PIFU activity being under-reported due to difficulty of data capture	Implement the Colorectal Cancer PID: **4 months to deliver when started**. **Agree a strategy to allow adoption of PIFU** implementing appropriate processes and the underlying technology. **Promote current workflow** focussing on high volume specialties and complete need assessments to mitigate failure of on-boarding using examples in place such as Rheumatology. **The Digital plan** also includes scoping work to improve the administration of several end-to-end pathways (including PIFU)
c. The Board has a plan to reduce the rate of missed appointments (DNAs) by March 2024, through: engaging with patients to understand and address the root causes, making it easier for patients to change their appointments by replying to their appointment reminders, and appropriately applying Trust Access Policies to clinically review patients who miss multiple consecutive appointments.	Fully	Outpatient Steering Group	DNA performance is excellent compared to national benchmarking. Digital reminders in place	Health inequalities **analysis undertaken** by cross referencing DNAs with Oxfordshire Population Health (HEI) and has not identified any significant variation. **Wayfinder Programme implemented**, allowing patients to access their appointment information. Reminders implemented across specialties. Patient rescheduling facilities through digital interaction with hospital system in pilot stage with **plans to roll-out from Q1 2024/25**
d. The Board has a plan to increase use of specialist advice. Many systems are exceeding the planning guidance target and achieving a level of 21 per 100 referrals. Through job planning and clinical templates, the Board understands the impact of workforce capacity to provide advice and has considered how to meet any gaps to meet minimum	Partially	Outpatient Steering Group	Advice and Guidance (A&G) pre-referral stage has optimum uptake from Primary Care.	**Options Appraisal to be presented** to the Board to decide whether to move A&G management via eRS or another System.

levels of specialist advice. The Trust has utilised the Outpatient Recovery and Transformation (OPRT) and Get It Right First Time (GIRFT) checklist, national benchmarking.			A&G post-referral is partly in place. A&G activity is being under-reported due to difficulty of data capture.	**Prioritising initiatives** to reduce follow up activity allowing clinicians the capacity to facilitate more new activity including A&G. **Evaluate** Outpatient services against national **GIRFT guidance** and make recommendations. **Resource to be identified and work prioritised.**
e. The board has identified transformation priorities for models such as group outpatient follow up appointments, one-stop shops, and pathway redesign focussed on maximising clinical value and minimising unnecessary touchpoints for patients, utilising the wider workforce to maximise clinical capacity.	Partially	Outpatient Steering Group	GIRFT guidance Multiple Pathways Analysis	**Assess GIRFT outpatient guidance** to support redesign of clinical pathways that can be proposed specialty level **Clinical Advisory Groups to adopt**. Discussions underway with services Analysis of patients waiting on multiple pathways to identify themed specialty links to consider Multi-Professional Clinics or same day services to improve patient experience and reduction in visits to secondary care. Discussions underway with services

4. Support required	**Assured**	**Evidence**	**Rationale**	**Action & Predicted Impact**
The Board has discussed and agreed any additional support that maybe required, including from NHS England, and raised with Regional colleagues as appropriate.	Fully	This checklist was discussed on 13th September 2023.		