Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 12 July 2023

TB2023.63

Title:	**Trust Response to Elective Care 2023/24 Priorities**

Status:	**For Discussion**
History:	**Elective Care Recovery Group 26 June 2023, Trust Management Executive 29 June 2023**

Board Lead:	**Chief Operating Officer**
Author:	**Sunil Johal, Deputy Director of Elective Care**
Confidential:	**No**
Key Purpose:	Strategy, Assurance, Policy, Performance.

Executive Summary

1. The joint letter published 23 May 2023 from Sir James Mackey, Sir David Sloman, Dame Cally Palmer, and Professor Tim Briggs regarding Elective Care Priorities in 2023/24 has asked Boards within Providers and Systems to use a specific checklist to ensure elective recovery plans and actions have been undertaken, giving assurance to the elective ambitions set out nationally.
2. The high-level review gives the Board assurance; however, several areas and approaches are recommended for review and support the direction of change required to provide a more complete level of assurance.
3. This paper provides a summary of the key issues and areas of focus, together with associated recommendations.

Recommendations

4. The Trust Board is asked to discuss the assurance provided by the outcome of the Trust-wide elective assessment against the national checklist.

Contents

1. Purpose

1.1. The purpose of the paper is to provide visibility to the board on the joint letter published on 23 May 2023 from Sir James Mackey, Sir David Sloman, Dame Cally Palmer, and Professor Time Briggs regarding elective care priorities in 2023/24.

2. Background

2.1. Nationally, elective and cancer recovery remains a significant challenge although long waiter performance has been trending as an improvement. The Trust is committed to continue to improve and deliver the ambitions set for 2023/24 as outlined in our operating plans.

2.2. A letter was published by Sir James Mackey, Sir David Sloman, Dame Cally Palmer, and Professor Tim Briggs thanking all Providers for their continued focus and effort on elective and cancer recovery, recognising the challenges found with industrial actions. The letter continues to express focus on delivering the next ambitions, as set out in the Operational Planning Guidance. The three key performance deliverables and metrics are:

a. Virtually eliminate elective waits of over 65 weeks for Referral to Treatment (RTT) – March 2024

b. Reducing the cancer 62 Day backlog

c. Meeting the 28 Day Faster Diagnosis Standard (FDS) – March 2024

2.3. The letter set out the key priorities for the year ahead as summarised below:

2.3.1. **Excellence in basics**: improving and maintaining data quality, validation, clinical prioritisation, and maximising booking rates.

2.3.2. **Performance and long waits**: continued recovery of 78 and 65 weeks, and recovery of 62-day cancer backlog in conjunction with delivering 28-day FDS, which will now involve a new tiering mechanism for challenged Trusts.

2.3.3. **Outpatients**: productivity actions to deliver 25% reduction in follow up activity compared to 2019/20 and repurpose more capacity towards new appointments using frameworks and programmes such as GIRFT and Action on Outpatients.

2.3.4. **Cancer pathway redesign**: focussing on funded improvement schemes via the Cancer Alliance including Lower Gastrointestinal (LGI), Skin and Prostate Best Practice Timed Pathway (BPTP) redesign.

2.3.5. **Activity**: improved utilisation of the Community Diagnostic Centres (CDC) and acute diagnostic capacity to reduce cancer backlogs and improve FDS, as well as general step up on activity to mitigate loss impacted by ongoing industrial actions.

2.3.6. **Choice**: early and clear collaborative plans working with Independent Sector Providers (ISP) to provide long waiting patients with choice for where and when they would want their treatment.

2.4. The letter also set expectations for Systems to outline and evidence actions to minimise inequality across services, continue to address recovery of Children and Young People (CYP) services and reduce elective activity gaps between CYP and adults, and equitably recover specialised complex services in balance with high volume activity.

3. Board Checklist

3.1. The letter includes a Board checklist, which asks Boards to review and assure plans are in place to deliver these objectives.

3.2. As well as the Board checklist, a service level checklist will be developed to allow solutions to be implemented where challenges are identified. These will be tracked through the Trust's Elective Care Recovery Group, with escalation to the Trust Management Executive as appropriate.

3.3. The current Board checklist, which includes actions to maintain assurance and to address any areas of limited assurance is provided below.

Checklist Areas	Detail	Assured	Evidence	Rationale	Action & Predicted Impact
Excellence in basics –	Validation of all >26 weeks waits within the last 12 weeks	Partially	76.5% validated	• Limitations to current validation tool	• New tool under development with go-live due end of August 2023 • Expect an improved position however unable to quantify without testing capabilities of new tool • 18 Week RTT Training campaign to be relaunched
	Referrals being made for Evidence Based Intervention	Partially	Availability of report	• Limitations due to availability of report on Evidence Based Interventions (EBI)	• Delayed integration of EBI solution will be revisited across Oxfordshire system • Manual review of EBI codes on OUH waiting list to be undertaken
Performance and Long Waits	Plans in place to virtually eliminate RTT waits of over 104 weeks and 78 weeks	Fully	Specialty-level plans	• Plans are in place however residual risk remain: - Paediatric and adult spinal capacity, including PICU - National supply of corneal grafts - Inter-provider transfers >78 weeks / >104 weeks	• Divisional plans to work with the Portland Hospital and Royal National Orthopaedic Hospital for spinal patients • Close working with NHS Blood & Transplant Team for corneal graft supply to maximise treatments

	Do plans support the national ambition to virtually eliminate RTT waits of over 65 weeks by March 2024	Fully	Specialty-level plans Elective Recovery Funded (ERF) schemes	• Plans in place with pathway milestone targets to assure delivery by March 2024 • Risks remain with challenged specialties (stated above 78 weeks)	• Close monitoring of 65-week tracker at specialty level through weekly Executive-led Assurance meetings with operational leaders
Outpatients	Are clear system plans in place to achieve 25% Outpatient Follow Up (OPFU) reduction, enabling more outpatient first activity to take place?	Partially	Ranked 14th nationally for New to Follow Up ratio performance	• Specialty level review of pathways to ensure patients are not followed up in secondary care where no clinical value is added • End to End Process Map completed that identify digital enablers to deliver Patient Initiated Follow Up • New to Follow ratio has improved 2 years running	• Review of all GIRFT guidance and documentation to enable clinical and pathway redesign • Digital support required for transformation work enabling improved Patient Initiated Follow-Up workflow • April and May 2023 total follow up activity was 138,585 against a plan of 114,779
	Do you validate and book patients in for their appointments well ahead of time, focussing on completing first outpatient appointments in a timely way, to support with diagnostic flow	Fully	65 week cohort tracker report	• Specialty-level plans are focussed on ensuring outpatients and diagnostic milestones are in place to support overall treatment pathway delivery • Agreed key milestone dates to see patients at first appointment, follow-up/diagnostic, and	• Weekly tracker to monitor actual performance against agreed plans taken through weekly Executive-led Assurance meetings.

	and treatment pathways?			admission are agreed at specialty level	
Cancer pathway re-design	Where is the Trust against full implementation of FIT testing	Fully	80%	• Trust adopted the revised guidelines and sends GP's reminders of the criteria when compliance is not met	• Turnaround time for FIT test supplies to ensure GP's are receiving required amount and timely
	Where is the trust against full roll-out of tele-dermatology?	Fully	Directory of Service	• Trust has developed a strong relationship with primary care practices and offer tele-dermatology services	• Await outcome of national audit of Artificial Intelligence system to support referral triage and decision making
	Where is the trust against full implementation of sufficient mpMRI and biopsy capacity to meet the best practice timed pathway for prostate pathways?	Fully	Agreed pathway since 2016	• Pre-biopsy multiparametric MRI with Gadolinium-based contrast is the standard for diagnostic and staging prostate MRI scans, and has been in use in Oxford since its introduction in 2016	• Review of emerging evidence for biparametric MRI scans in prostate cancer
Activity	Are clear system plans in place to prioritise existing diagnostic capacity for urgent suspected cancer activity?	Fully	Cancer Improvement Programme	• Urgent and suspected Cancer diagnostic activity is prioritised however Patient Choice is a delaying factor to CTC pathway compliance. • More plans required in agreement within System to utilise CDC to support 62-	• Involvement of the Patient Engagement Team to support uptake and communication is now underway. • Lung pathway fully up and running within CDC. Prostate pathway reviewed however image quality deemed not suitable. Further review of all pathways to be completed

				Day backlog and FDS compliance • Theatre utilisation is reviewed at the Trust Productivity Committee and at Divisional Performance Review meetings • CDC activity to be further expanded and optimised.	• NOC is a recognised Elective Surgical Hub. Reviewing resilience and expansion • CDC imaging activity providing additional capacity in place. Physiological measurement supporting Pre-Operative such as Blood pressure and ECG is being developed • Theatre capacity for challenged specialties is under regular review to ensure that there is capacity for cancer and urgent patients as well as long waiting patients. This will be supported by a new theatre demand and capacity model.
	Is there agreement between the Trust, ICB and Cancer Alliance on how best to ensure newly opening CDC capacity can support 62-day backlog reductions and FDS performance?	Fully	Weekly Assurance reports	• Agreement is in place for Lung cancers' Rapid Early Diagnostic Service (REDS) to be fully implemented at the CDC. Work is underway to address minor elements of complex lung pathways to be fully implemented at the CDC in Q3. • Breathlessness and enhanced respiratory service • Monthly performance monitoring via Integrated Care Board (ICB)	• Continued evaluation of other Tumour FDS pathways via the CDC are underway through the Cancer Improvement Programme. To improve the surgical flow, preoperative assessment is also being implemented at the CDC once the digital infrastructure is in place in Q2.

				• Diagnostic features in weekly Executive-led Assurance meetings	
	How does the Trust compare to the benchmark of a 10-day turnaround from referral to test for all urgent suspected cancer diagnostics?	Partially	Weekly Assurance Report	• For May, Ultrasound (US) and Positron Emission Tomography (PET) are above the 10 days benchmark. Pathology turnaround time for May is within 10 days for all tumour sites except Haematology & Lymphoma (13 days) and Skin (10.8 days).	• The mitigation for US is to continue to perform additional sessions and provide extra capacity through Independent Sector Providers (ISP) support. This should be online by June 2023. For PET CT (Computerised Tomography), an alternative supplier has been sourced for Prostate-Specific Membrane Antigen (PSMA) which will improve resilience. Business cases have been submitted to replace two scanners, which will reduce downtime and improve throughput due to technological advances; these should be installed in Q4 2024/25. In the interim, additional fluorodeoxyglucose (FDG) capacity has been sourced with a partner provider in Thames Valley.
	Are plans in place to implement a system of early screening, risk assessment and health	Fully		• Health Screening Questionnaires are used at Pre-Operative Assessment. Clinical Prioritisation using the Royal College of Physicians guidance has been adopted for all theatre	

	optimisation for anyone waiting for inpatient surgery?			procedures along with a mandatory requirement for clinicians to confirm harm or no harm upon adding to the inpatient waiting list and re-prioritisation reviews • Health optimisation is offered and available to patients from the OUH Here for Health Service	
	Are patients supported to optimise their health where they are not yet fit for surgery?	Partially	Prehabilitation report	• Prehabilitation services are in place and a trial of a new digital prehabilitation system is being piloted within Colorectal and Head and Neck at a Cancer Alliance level, and locally in Upper GI	• Depending on results from pilot, expansion and adoption of digital solution to be discussed for implementation
	Where is the Trust/System against the standards of 85% capped Theatre Utilisation and 85% day case rate?	Fully	88.7%	• Theatre utilisation for elective care was 88.7% for May 2023, this uses the Trust's approach to measurement, and this is uncapped	• Continue to monitor through Trust Theatre Productivity Group

	Is full use being made of protected capacity in Elective Surgical Hubs?	Fully		• The Nuffield Orthopaedic Centre (NOC) is part of the second wave of accreditation to be classified as an Elective Surgical Hub. • Accreditation will support dedicated and ring-fenced High Volume Low Complexity (HVLC) work and this will be pivotal to supporting the reduction of long waiting patients.	• Work has commenced on the accreditation process, and this will comprise submitting evidence against the assessment criteria for hub sites, and a site visit. • A business case has been approved for 3 additional Anaesthetists to support delivery and increase potential productivity at the NOC.
	Do diagnostic services meet the national optimal utilisation standards set for CT, MRI, Ultrasound, Echo, and Endoscopy?	Fully		• Diagnostics carried out through the CDC deliver above the set standards. South East have the second most active CDC, behind Midlands due to their use of Pathology services.	• Echocardiography is planned to be provided at the CDC in Q3 if recruitment is successful. • The utilisation of MRI, CT and US is closely monitored at weekly and monthly performance meetings, with adjustments being made to ensure optimal throughput.
	Are any new Community Diagnostic Centres (CDCs) on track to open on agreed dates, reducing DNAs (Did Not Attends)	Partially	8%	• Workforce is in place for 12 hours each day services are delivered. • Further utilisation of the CDC is being worked up. • Average DNAs are currently 8% at the CDC which is due	• Work is ongoing to reduce DNA rates within the Key Performance Indicators (KPI).

	to under 3% and ensuring that they have the workforce in place to provide the expected 12 hours a day, 7 day a week service?			to patient and referrer awareness of facilities.	
	Are Elective Surgical Hub patients able to make full use of their nearest CDC for all their pre and post-op tests where this offers the fastest route for those patients?	Not met		• Work is underway to implement the digital infrastructure to support pre op services at the CDC in the near future but not post-operative.	• Digital solution for pre-operative could easily be extended to post operative diagnostics where appropriate
Choice	Are you releasing any Mutual Aid capacity which may ordinarily have been utilised to treat non-urgent patients to treat	Fully	DMAS requests	• Urology services have uploaded requests for mutual aid via DMAS to support recovery of long waits • No uptake from other providers for Spinal cases via DMAS	• All challenged specialties have been asked to request support via DMAS portal. • Working up mutual aid outside of DMAS is allowed, therefore contracts are being drawn up for Spinal support

	clinically urgent and long-waiting patients from other providers? Is Digital Mutual Aid System (DMAS) being used to offer or request support which cannot be realised within the ICB or region?				
	Has Independent Sector capacity been secured with longevity of contract? Has this capacity formed a core part of planning for 2023/24?	Fully	Operating Plan	• ERF schemes include the use of Independent Sector Providers, such as • Cherwell Hospital – Ophthalmology • Portland London – Paediatric spines	• Long term plans to appraise backlog clearance versus sustainable recovery is required
Inclusive recovery	Do recovery plans and trajectories ensure specialised commissioned services are enabled to recover at an equitable rate to non-specialised	Partially	Operating Plans	• Business Planning process undertaken across divisions, which would include specialist commissioned services • Service level detailed plans to evidence equitable provision of activity for specialist commissioning	• Service level checklist to be enacted

	services? Do system plans balance high volume procedures and lower volume, more complex patient care			and low volume high complexity throughput	
	Have you agreed the health inequality actions put in place and the evidence and impact of the interventions as part of your operational planning return? Was this supported by disaggregated elective recovery data?	Fully	Health Inequalities Steering Group	• This is supported by disaggregated elective recovery data and specific health inequalities dashboards measuring waiting times for long waiting patients, Cancer and P2 patient waiting times by factors relating to health inequalities, including the Index of Multiple Deprivation (IMD), patients' ethnicity, age and gender.	• The Trust has a Health Inequalities Steering Group which leads the Trust's response to tackling health inequalities and a focus on health inequalities is scheduled to be included in the Quarterly Divisional Performance Review meetings, chaired by the Chief Executive
	Are Children and Young People (CYP) explicitly included in elective recovery plans and actions in place to accelerate progress to tackle	Fully	65 week tracker dashboard	• Progress is tracked consistently with all other speciality groups within a weekly 65-week dashboard that includes a trajectory for patients to achieve zero patients wating over 65-weeks by 31 March 2024	• Continue close monitoring via 65 week dashboard

	CYP elective waiting lists?				

4. Conclusion

4.1. The responses to the checklist questions show some areas of partial assurance for the Board.

4.2. The Trust Management Executive has agreed the actions in the checklist to support delivery of elective recovery.

.

5. Recommendations

5.1. The Trust Board is asked to discuss the assurance provided by the outcome of the Trust-wide elective assessment against the national checklist..

Classification: Official

Publication reference: PRN00496

To:
- NHS acute trusts:
  - chairs
  - chief executives
  - medical directors
  - chief operating officers

cc.
- NHS regional directors
- Cancer alliance managing directors
- ICB chief executives

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

23 May 2023

Dear Colleagues,

Elective care 2023/24 priorities

Thanks to your continued focus and effort on elective care and cancer recovery we have managed, through the exceptional efforts of your teams, to drive a significant reduction in the number of long waiting patients over recent months.

Despite a very challenging environment, where ongoing industrial action has seen planned care particularly hard hit, the number of patients waiting over 78 weeks has decreased from 124,911 in September 2021 to 10,737 at the end of March 2023, and the number of patients with urgent suspected cancer waiting longer than 62 days has decreased from a peak of 33,950 last summer to 19,023 at the end of March 2023.

We now look ahead to further reduction in 78 week waits, following the disruption from industrial action and delivering our next ambitions, as set out in Operational Planning Guidance, of virtually eliminating 65 week waits, reducing the 62-day backlog further, and meeting the Faster Diagnosis Standard, by March 2024. This letter sets out our priorities, oversight and support for the year ahead as well as including a checklist for trust boards to assure themselves across the key priorities (annex 1).

First, we should acknowledge the progress made over the last year or so:

- Since the beginning of February 2022, the NHS has treated more than 2m people who would otherwise have been waiting 78 weeks by the end of March 2023 (ie: the “cohort”).
- The number of patients waiting 65 weeks has reduced from 165,885 in September 2021 to 95,001 in March 2023.

- The cancer 62 day backlog has reduced year-on-year for the first time since 2017.
- The NHS has seen a record 2.8 million referrals for urgent suspected cancer, with the early diagnosis rate now higher than before the pandemic.
- In February 2023, the NHS achieved the faster diagnosis standard (FDS) for the first time since it was created.

Your leadership, collaboration with colleagues and across providers, innovation and tenacity has led to these improvements for patients and should give confidence for the future, despite the continued complexity of the environment that we are all working in.

Recognising the challenges and the complexity you are all dealing with, we thought it would help to set out the key priorities for the year ahead:

1. **Excellence in basics**
   - Maintaining a strong focus on data quality, validation, clinical prioritisation and maximising booking rates have contributed massively to our progress. We need to retain a clear focus on these things.

2. **Performance and long waits**
   - Continue to reduce waits of over 78 weeks and those waiting over 65 weeks.
   - Make further progress on the 62-day backlog where this is still required in individual providers, whilst pivoting towards a primary focus on achieving the Faster Diagnosis Standard.
   - To support this, we have reviewed and refreshed our tiering approach to oversight, so that we can be sure that we are focusing on those providers most in need of support. This refresh has been communicated to tiered providers.

3. **Outpatients (productivity actions annex 2)**
   - We know there is massive potential in our outpatient system to adjust the approach, engage patients more actively and significantly re-focus capacity towards new patients.

4. **Cancer pathway redesign**
   - In 2023/24 Cancer Alliances have received a funding increase to support implementation of priority changes for lower GI, skin and prostate pathways (included in annex 1). All trusts should now have clear, funded plans in place with their Alliance for implementation.

5. **Activity**

- Ensure that the increasing volume of diagnostic capacity now coming online is supporting your most pressured cancer pathways. ICBs have been asked to prioritise CDC and acute diagnostic capacity to reduce cancer backlogs and improve the FDS standard, as set out in the letter from Dame Cally Palmer and Dr Vin Diwakar.
- Generally, we all need to see a step up in activity over the coming months, as we recover from the ongoing impact of industrial action.

6. **Choice**

- A major contributor to our collective progress over this last year has been the way organisations and systems have worked together to accelerate treatment for long waiting patients. This includes work with the Independent Sector (IS) who have stepped up to help in this endeavour. We know this will continue to be important this year and we encourage all systems and providers to crystalise their plans to work together (including IS) early in the financial year to give us the best chance of success.
- We expect that patient choice will be an increasingly important factor this year, as set out in the Elective Recovery Plan, with some technological advances to support this. We will communicate this more fully when plans have been finalised.

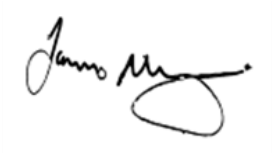
Moreover, it is crucial that we continue to recover elective services inclusively and equitably.

- Systems are expected to outline health inequality actions put in place and the evidence and impact of the interventions as part of their planning returns. Disaggregated elective recovery data should support the development of these plans.
- A collective effort is needed to continue to address the recovery of paediatric services. Provider, system, and regional-level elective recovery plans should set out actions that will be put in place to accelerate CYP recovery and ensure that elective activity gap between CYP and adults is reduced, a best practice toolkit has now been published to help achieve this.
- Systems are expected to continue to recover specialised service activity at an equitable rate to that of less complex procedures, ensuring a balance between high volume and complex patient care requirements.

Included with this letter is the board checklist (annex 1). This tool has been designed to be the practical guide for boards to ensure they are delivering against the ambitious objectives set out in the letter above.

Thank you again for all your efforts since the Elective Recovery Plan was published. Together, we have made laudable progress in reducing long waits and transforming services, as set out in the plan. We can all take confidence in this as we move on to the next stages of the recovery plan and continue to improve care for patients. If any support is required with these actions, please let us know.

Yours sincerely,



Sir James Mackey
National Director of Elective Recovery
NHS England

Sir David Sloman
Chief Operating Officer
NHS England

Dame Cally Palmer
National Cancer Director
NHS England

Professor Tim Briggs CBE
National Director of Clinical Improvement
NHS England

Chair
Getting It Right First Time (GIRFT) programme

Annex 1: Board checklist

We ask that boards review the checklist below to assure plans to deliver our elective and cancer recovery objectives over the coming year. There is national support available in each of these areas, please contact england.electiverecoverypmo@nhs.net to discuss any support needs.

The three key performance deliverables and metrics we need to focus on are:

- Virtually eliminate waits of >65w by March 2024
- Continue to reduce the number of cancer patients waiting over 62d
- Meet the 75% cancer FDS ambition by March 2024

	Assurance statement	Support/materials
1	**Excellence in basics**	
	Has any patient waiting over 26 weeks on an RTT pathway (as at 31 March 2023) not been validated in the previous 12 weeks? Has the 'Date of Last PAS validation' been recorded within the Waiting List Minimum Data Set?	
	Are referrals for any Evidence Based Interventions still being made to the waiting list?	Release 3 will be published on 28 May. It focuses on the following specialties: breast surgery, ophthalmology, vascular, upper gastrointestinal surgery, cardiology, urology, and paediatric urology
2	**Performance and long waits**	
	Are plans in place to virtually eliminate RTT waits of over 104w and 78w (if applicable in your organisation)?	
	Do your plans support the national ambition to virtually eliminate RTT waits of over 65 weeks by March 2024?	
3	**Outpatients**	
	Are clear system plans in place to achieve 25% OPFU reduction, enabling more outpatient first activity to take place?	NHSE GIRFT guidance

	Assurance statement	Support/materials
	Do you validate and book patients in for their appointments well ahead of time, focussing on completing first outpatient appointments in a timely way, to support with diagnostic flow and treatment pathways?	Validation toolkit and guidance NHS England » Validation toolkit and guidance published on 1st December 2022
4	**Cancer pathway re-design**	
	Where is the trust against full implementation of FIT testing in primary care in line with BSG/ACPGBI guidance, and the stepping down of FIT negative (<10) patients who have a normal examination and full blood count from the urgent colorectal cancer pathway in secondary care?	Using FIT in the Lower GI pathway published on 7*th* October 2022 BSG/ACPGBI FIT guideline and supporting webinar
	Where is the trust against full roll-out of teledermatology?	Suspected skin cancer two week wait pathway optimisation guidance
	Where is the trust against full implementation of sufficient mpMRI and biopsy capacity to meet the best practice timed pathway for prostate pathways?	Best Practice Timed Pathway for Prostate Cancer
5	**Activity**	
	Are clear system plans in place to prioritise existing diagnostic capacity for urgent suspected cancer activity?	Letter from Dame Cally Palmer and Dr Vin Diwakar dated 26 April 23.
	Is there agreement between the Trust, ICB and Cancer Alliance on how best to ensure newly opening CDC capacity can support 62 day backlog reductions and FDS performance?	
	How does the Trust compare to the benchmark of a 10-day turnaround from referral to test for all urgent suspected cancer diagnostics?	

	Assurance statement	Support/materials
	Are plans in place to implement a system of early screening, risk assessment and health optimisation for anyone waiting for inpatient surgery? Are patients supported to optimise their health where they are not yet fit for surgery? Are the core five requirements for all patients waiting for inpatient surgery by 31 March 2024 being met? 1. Patients should be screened for perioperative risk factors as early as possible in their pathway. 2. Patients identified through screening as having perioperative risk factors should receive proactive, personalised support to optimise their health before surgery. 3. All patients waiting for inpatient procedures should be contacted by their provider at least every three months. 4. Patients waiting for inpatient procedures should only be given a date to come in for surgery after they have had a preliminary perioperative screening assessment and been confirmed as fit or ready for surgery. 5. Patients must be involved in shared decision-making conversations.	NHS England » 2023/24 priorities and operational planning guidance NHS England » Revenue finance a contracting guidance for 2023/24 Perioperative care pathways guidance
	Where is the trust/system against the standards of 85% capped Theatre Utilisation and 85% day case rate?	
	Is full use being made of protected capacity in Elective Surgical Hubs?	
	Do diagnostic services meet the national optimal utilisation standards set for CT, MRI, Ultrasound, Echo and Endoscopy?	https://future.nhs.uk/NationalCommunityDiagnostics/groupHome
	Are any new Community Diagnostic Centres (CDCs) on track to open on agreed dates, reducing DNAs to under 3% and ensuring that they have the workforce in place to provide the expected 12 hours a day, 7 day a week service? Are Elective Surgical Hub patients able to make full use of their nearest CDC for all their pre and post-op tests where this offers the fastest route for those patients??	

	Assurance statement	Support/materials
6	**Choice**	
	Are you releasing any Mutual Aid capacity which may ordinarily have been utilised to treat non-urgent patients to treat clinically urgent and long-waiting patients from other providers? Is DMAS being used to offer or request support which cannot be realised within the ICB or region?	www.dmas.nhs.uk
	Has Independent Sector capacity been secured with longevity of contract? Has this capacity formed a core part of planning for 2023/24?	
7	**Inclusive recovery**	
	Do recovery plans and trajectories ensure specialised commissioned services are enabled to recover at an equitable rate to non-specialised services? Do system plans balance high volume procedures and lower volume, more complex patient care	
	Have you agreed the health inequality actions put in place and the evidence and impact of the interventions as part of your operational planning return? Was this supported by disaggregated elective recovery data?	
	Are children and young people explicitly included in elective recovery plans and actions in place to accelerate progress to tackle CYP elective waiting lists?	CYP elective recovery toolkit

Supporting guidance and materials are available on the Elective Recovery Futures site: https://future.nhs.uk/ElectiveRecovery

Annex 2: Outpatients (OP) productivity action

As set out in the 2023/24 Priorities and Operational Planning Guidance, systems are expected to deliver in line with the national ambition to reduce follow-ups by 25% against the 2019/20 baseline by March 2024. To note this excludes appointments where a procedure takes place. Further technical guidance (that covers other exclusions) is here.

Expected actions

In order to work towards achieving the 25% follow-up reduction target, trusts are expected to focus on the following within the first quarter of the year:

- Embed OP follow-up reduction in trust governance mechanisms
- Engage with clinical leads for specialties about the significance of the 25% follow-up reduction target, building on GIRFT guidance
- Review clinic templates to ensure they are set up to enable a 25% reduction in follow-up appointments
- Validate patients waiting for follow-ups to identify any who do not need to be seen
- Ensure continued and expanded delivery of patient initiated follow up (PIFU) in all major OP specialties, particularly accelerating uptake in specialties with the longest waits (ENT, gynaecology, gastroenterology and dermatology)
- Ensure patients who no longer need to be seen in secondary care are appropriately discharged, in line with clinical guidelines
- Work to reduce appointments that are missed by patients (DNAs), in line with NHS England guidance, including by:
  - Understanding the most common reasons why patients miss appointments, building on available national support
  - Making it easier for patients to cancel or reschedule appointments they don't need eg through sending a response to an appointment reminder
- Local analysis of patients on multiple pathways or those with multiple follow-ups.
- Consider conducting a retrospective clinical review of a sample of OP follow-up activity in at least two specialties with the longest waits, to identify where an alternative pathway of care could have been used (eg discharge, PIFU, appointment met through alternate means).

Payment

Reducing OP follow-ups is incentivised by the NHS payment scheme, where follow-up appointments are covered by a fixed payment element, and first appointments are covered by a variable element.

Support available

Competing priorities will always make it difficult to focus on making these changes. Continued support will be available through:

- Data packs for each tiered trust, and top ten other trusts with high OP follow up reduction opportunity
- Clinically-led conversations with tiered trusts from National Clinical Directors, GIRFT clinical leads, and OP clinical leads
- Operational support to amend clinic templates
- Support to improve equity of access through the national Action on Outpatients programme.