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Date	11 September 2023	Agenda item	E.9(2).23.9

Protecting and Expanding Elective Capacity Self-Certification

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Lead Director	James Taylor, Deputy Chief Operating Officer	
Purpose of the paper	To provide detail for Board assurance on specific elements of our recovery plans	
Key control		
Action required	To note	
Previously discussed at/informed by		
Previously approved at:	**Committee/Group**	**Date**

Key Options, Issues and Risks

Introduction

On August 4th 2023 providers received a letter from NHSE entitled 'Protecting and expanding elective capacity' emphasising that to deliver elective and cancer recovery ambitions, high-quality waiting list management and ambitious outpatient transformation are vital. NHSE are now asking providers to complete a return to provide assurance on these specific elements of our recovery plans.

Included with the letter is a Self-certification document (Appendix 1) that requires the Chair and CEO of providers confirm that the Board are assured on 3 key areas:

1. Validation
2. First Appointments
3. Outpatient Follow Up

This paper provides additional detail for each key area in order to provide that assurance presented as per the Self-certification checklist that is to be returned to NHS England by **30 September 2023**, via NHS England regional teams.

Self-certification checklist

1. Validation

The Board:

a) 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.

Following the implementation of our EPR the Trust identified a risk relating to the impact that incorrect data capture might have on patient care. This incorporated data input and data processing issues caused by user and/or system error. The scope of this risk included but was not limited to information held on our various waiting lists. Actions to mitigate this risk and therefore improve the associated data quality are

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aligned with the prevent-correct-clear model we have implemented and the underpinning approaches within the operational access structure and an issue resolution support structure.

During 2022/23 we compared the LUNA key lines of enquiry and the validation toolkit to our existing approaches and validation priorities. This was also subject to an external audit and where we received positive assurance.

As we progress in 2023/24 we have identified that specific elements relating to waiting list validation were of national interest and have incorporated these in the Delivering Operational Excellence objectives for the next 18 months. This will result in the full adoption of the validation toolkit and clearer reporting of validation efforts aligned to the language used in national reports/ the LUNA dashboard. Validation rates pre and post COVID may not be the best measure of success for our approach and KPI showing a reduction in error rates and data quality cohorts will be included in future performance reports instead.

b) 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. We are developing a range of digital support offers for providers to improve validation.

Over 90% of our RTT waiting lists over 12 weeks have been digitally contacted followed by clinical validation for those who wish to be discharged. We continue this process weekly as patients hit a milestone of 12, 26 and 52 weeks wait with no appointment in the last 8 week and no appointment booked in the next 4 weeks. Preceding the patient contact our access team technically validate as patients hit a milestone of 11, 25 and 51 weeks.

A full review of the WLMDS reporting process is underway. This will allow us to accurately demonstrate the validation dates associated with the technical, administrative and clinical processes we have adopted.

c) 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.

Our Access Policy review is being completed, guided by an Access Policy published at WYAAT level to align the acute providers. Our Corporate Access Team ensures RTT rules and guidance are applied via technical validation. They also ensure correction of DQ errors and feed themes into issue resolution, weekly access, and training / education processes. Our objective is to embed prevention with our administrative and clinical teams via education, communication and revisiting local real time validation. We have revisited visibility of RTT codes in clinics to aid correct recording and provided an advice line to front line staff to support RTT queries as they arise. We are targeting support to areas based on feedback from validation processes and DQ error rate metrics and provide drop in sessions where admin teams can work with validation specialists to review their waiting lists. EPR training in relation to pathway correction and encounter selection across admin and clinical staff has started, supported by investment in training resource. We are also looking at the feasibility of mirroring CHFT process for administrative and clinical validation that utilises EPR to communicate a list of patients for review and care progression.

d) 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.

Non-RTT waiting lists report have been generated weekly pre and post COVID with the access team, CSUs and CPBS working concurrently to validate the patients and arrange follow up. Non-RTT has remained on an equal footing with RTT hence the number of patients beyond their 'see by date' on a non-

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RTT follow up waiting list has reduced over the last three years,

There are specific services areas where overall numbers remain high and demand exceeds capacity meaning waits beyond 'see by dates. This will be addressed as part of the 2023/24 Delivering Operational Excellence plan, with objectives focused on accelerating the validation and digital and remote options to conclude patients pathways with a parallel reduction of 'unnecessary follow up orders' either by wholesale pathway change or an increased use of PIFU.

The Corporate Access Team is working towards completing technical validation of all patients above 12 months past see by date during August 2023 and above 3 months past see by date by years end. Specialties with patients noted to be 12 months past see by date are being asked to review patient records and action any outstanding plans. Early indications are that those patients recorded as the longest waits have already concluded their pathways and appointments are no longer required. No harms have been highlighted. Our text message model in place for the RTT patients will be utilised to contact patients between 3 and 12 months past their see by date.

In parallel with validating and appointing the current patients on the non-RTT waiting list, we are reviewing the infrastructure around the process to create waiting list that goes through the layers of validation more rapidly and can be used to plan capacity more effectively and have real time information to quantify clinical risk. Progress will be reported via the performance reporting to F&P Academy and Board.

2. First appointments

The Board:

a) 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.

CSU's have been asked to complete administrative validation of RTT patients down to 30 weeks wait and were set the target on August 7th, for all patients waiting over 30 weeks to be given a new patient appointment (NPA) before 30th September 2023. This is being tracked via the RTT huddles and Access meeting.

Our current position is that we have 883 patients at NPA stage that will breach 65w by March 23. 780 are now booked before end of October (88%).We are at risk of not achieving the ambition of appointed and seen 103 patients:

- 43 will be brought forward into September/October as capacity allows
- 60 patients require booking into Community Paediatrics and will be seen by December at the latest where their RTT clock will stop. This is our primary risk, as the service does not have any available appointments in September and October. Options to increase capacity are being explored include extending a locum contract and mutual aid subject to patient and pathway complexity (offer from Harrogate District Foundation Trust).

The risk to achievement of this ambition is the ongoing impact of industrial action which causes cancellations of elective activity in order to focus medical cover to the non-elective pathways.

b) has signed off the trust's plan to ensure that Independent Sector 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, 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

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We are currently being supported by some activity through the independent sector either through insourcing or outsourcing support however our waste reduction plans are predicated on this support reducing as we have progressed through the financial year. Our WYAAT IS coordinator indicates that capacity is limited and there is no additional external funding to support access to any remaining opportunity.

3. Outpatient follow-ups

The Board:

a) 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.

Currently follow up appointment attendances are 103% of baseline year to date. In the context of recovering an RTT and Non-RTT back log reducing follow appointment number is a challenge and we are undertaking clinically driven pathway changes that include:

1. Reducing the need for secondary care appointments altogether through E-consult and Advice Guidance
2. One-stop appointments that deliver the secondary care decision and advice in 1 appointment
3. Increase in PIFU

Our planned engagement with the CSU leadership team will give them an opportunity to present their strategy for addressing this as part of our journey to Clinical and Operational Excellence.

We are introducing more PIFU options via EPR and are hopeful that this will reduce face to face FU requests.

We have introduced Digital Forms for both triage and outpatient follow-up. By completing a Digital Form patients are clinically reviewed / validated with a virtual follow-up ensuring they receive personalised stratified follow-up.

b) has reviewed plans to increase use of PIFU to achieve a minimum of 5%, with a particular focus on the trusts' 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.

This is an area of high focus and we have been working closely with colleagues from NHSE and ICB to agree and implement a revised SOP. Clinical engagement sessions have been held with each specialty to present PIFU opportunities. However at this stage utilisation of PIFU remains below 5%.

The charts below show utilisation of PIFU by Treatment Function Code (TFC). The overall current position is that approximately 2% of patients are discharged to PIFU.

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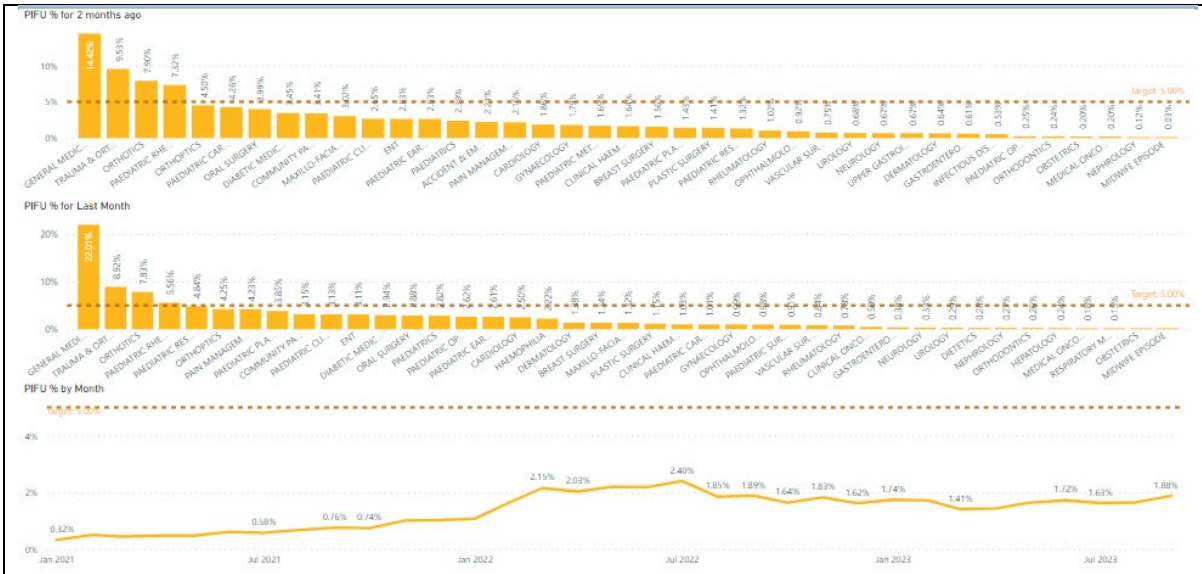

Digital PIFU is now live. This provides consistent message to patients i.e. a text / email the following day with a link or telephone number to access the service.

Personalised Stratified Follow Up is in place for cancer, but this surveillance is very different to PIFU. For example, for prostate there is an added complexity of requiring a scheduled PSA blood test result for the nurse led surveillance appointment.

Personalised Stratified Follow Up (PSFU) is operative in the following pathways:

- Breast – Curative Intent, Adjuvant, non-complex pathway with agreed pathways in place and an established process for the self-management and planned clinic follow up ensuring endocrine treatment therapy is switched at the required intervals and mammography surveillance enrolment activated. Patients can also quickly activate appointments both through urgent telephone and FTF contact with new breast related concerns.
- Colorectal - Low Risk Standard < T3 & Intensive Risk Pathway >T4 in surveillance pathways. These pathways have recently been updated working towards new changes in both risk pathways scanning regimens for CT & MRI through surveillance testing schedule.
- Gynaecology – Endometrial 1A surveillance pathway in place. Regionally and locally working towards 1B becoming operational.
- Prostate - nurse led follow up consultations with PSA monitoring in pathway.

c) 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.

- We have shared DNA guidance with all clinical staff to ensure the right outcomes are being implemented when a patient DNAs multiple times, we know that that DNA'ing an appointment is a good predictor of future DNAs.

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- Patients get a text to tell them about their appointments as soon as we book them, if they don't open the text we send them a letter.
- We also send patients a reminder text 3 days before their appointment. So in the majority of cases, we know that the patients have the letter, can see they've read it, and we've texted them at least twice.
- In an effort to reduce DNAs we have been testing Reminder "nudge" messages to create a bigger impact.
- We are testing these text messages further in high volume specialties (Colorectal, ENT & Paediatric ENT, Gen Surgery, Neurology, Paediatrics, Plastics, T&O and Upper GI), and should see some new data evolving towards the end of November.
- We are working on identifying patients who consecutively miss appointments to alert CSUs and ensure early clinical review.
- We are call confirming 48hrs before appointments across some CSUs where admin resource allows and planning to roll out further over Q3.
- We are amongst a select group of DrDoctor clients testing machine learning to predict DNAs. This is still in its early stages of testing and as yet has seen no results to counter the current biggest single predictor of a DNA which is having already had a DNA, with Indicies of Deprivation and age being key indicators.
- We are progressing patient flexibility and choice where possible to minimise DNAs:
    - In March 21 patients were given the option to change or cancel their appointment at any time of the day via the online patient portal or by text message, without needing to call our Central Patient Booking Service. Patients can now use the portal to change/cancel their appointment 24/7.
    - Advanced Scheduling is now in place. Advanced Scheduling will allow patients to see any available slots and request the date/time that suits them best.
    - See Me Sooner will go live in Autumn and will build on Advanced Scheduling by allowing patients not only to see, select and request their preferred appointment but will allow patients to write this back directly into EPR.

d) 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 min levels of specialist advice. The Trust has utilised the OPRT and GIRFT checklist, national benchmarking

We are above the current target of 16 per 100 referrals and are working closely with Primary Care to increase the usage but also utilisation of the GP Assist Process to enable Primary Care Clinicians to check the available information on certain conditions before making a referral at all. Better use of GP Assist means a reduced requirement for Advice and Guidance or E Consult referrals.

Our GM and CD for CPBS/ Medical Record and Outpatients have worked with CSUs to complete the GIRFT checklist to benchmark their services against the current GIRFT recommendations for outpatient activity. As with options to reduce follow ups there further work required to engage specialties agreeing actions to adopt the recommendations.

e) 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.

Digital Forms are now being used widely across the Trust improving the capacity of specialties to gather key information and deliver specialist advice e.g. Physiotherapy Pregnancy Education had a backlog in

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Jan'23 and now have no waiting list. They originally undertook group, then video group, then a recording session in a digital form and the offer of a drop-in video clinic once a week and now have a >70% response rate to the digital form.

Recommendation

Work is in progress to address the 3 key areas:

1. Validation
2. New Appointments
3. Outpatient Follow Ups

At provider level our processes around validation and visibility of patients are well developed but with opportunity to improve this further.

Continuing our focus on long waiting patients and chronological booking has put us in a strong position to deliver the latest target for NPA with plans to deliver the appointments (in Community Paediatrics) before the end of the calendar year.

'Ambitious outpatient transformation' is still to be realised. Tools such as PIFU, Advice and Guidance and Digital alternatives are available and the GIFRT recommendations have been shared across the CSUs. Work through the Act as One Access workstream continues to promote Assist pathways and whole system working.

Our next step will be to encourage CSUs to integrate outpatient transformation in their strategy to achieve Operational Excellence through 2023/24 and 2024/25.

Risk assessment						
Strategic Objective	**Appetite (G)**					
	Avoid	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
To provide outstanding care for patients						
To deliver our financial plan and key performance targets						
To be in the top 20% of NHS employers						
To be a continually learning organisation						
To collaborate effectively with local and regional partners						
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	**Low**		**Moderate**	**High**	**Significant**	
	Risk (*)					
Explanation of variance from Board of Directors Agreed General risk appetite (G)						

Benchmarking implications (see section 4 for details)	**Yes**	**No**	**N/A**
Is there Model Hospital data relevant to the content of this paper?	☐	☐	☐
Is there any other national benchmarking data relevant to the content of this paper?	☐	☐	☐
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	☐	☐	☐

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Risk Implications (see section 5 for details)	Yes	No
Corporate Risk register and/or Board Assurance Framework Amendments	☐	☐
Quality implications	☐	☐
Resource implications	☐	☐
Legal/regulatory implications	☐	☐
Diversity and Inclusion implications	☐	☐
Performance Implications	☐	☐

Regulation, Legislation and Compliance relevance
NHS Improvement: (please tick those that are relevant) ☐Risk Assessment Framework ☐Quality Governance Framework ☐Code of Governance ☐Annual Reporting Manual
Care Quality Commission Domain:
Care Quality Commission Fundamental Standard:
NHS Improvement Effective Use of Resources: Clinical Services
Other (please state):

Relevance to other Board of Director's Committee: (please select all that apply)					
Workforce	Quality	Finance & Performance	Partnerships	Major Projects	Other (please state)
☐	☐	☐	☐	☐	☐