Sheffield Teaching Hospitals
NHS Foundation Trust

Executive Summary

Report to the Board of Directors

Being Held on 25th July 2023

Subject	Elective Priorities – Board Assurance
Supporting TEG Member	Michael Harper, Chief Operating Officer Mark Tuckett, Director of Strategy and Planning
Author	Balbir Bhogal, Performance and Information Director David Griffin-Mead, Assistant Chief Operating Officer
Status[1]	D & N

PURPOSE OF THE REPORT

The paper sets out the national Elective Priorities for 2023/24 and the Trust's position against the required assurance statements.

KEY POINTS

- Sir James Mackey (National Director of Elective Recovery NHSE), Sir David Sloman (Chief Operating Officer NHSE), Dame Cally Palmer (National Cancer Director NHSE) and Professor Tim Briggs (National Director of Clinical Improvement NHSE) wrote to NHS acute trusts on 23 May 2023 to confirm the elective care priorities for 2023/24. The letter is included in Appendix 1.
- The three key performance deliverables were described as:
    - Virtually eliminate waits of >65w by March 2024
    - Continue to reduce the number of cancer patients waiting over 62 days.
    - Meet the 75% cancer FDS ambition by March 2024
- The 7 Key areas of assurance required are:
    - Excellence in basics
    - Performance and long waits
    - Outpatients
    - Cancer pathway redesign
    - Activity
    - Choice
    - Inclusive recovery
- Boards of Directors are required to review the checklist within the letter to assure plans to deliver elective and cancer recovery objectives.
- A self-assessment exercise has been undertaken with Care Groups and has identified strong assurance in some areas and further work required in others.
- Detailed action plans will be developed with each Care Group to close gaps identified gaps in assurance.
- SYB partners are sharing their assurance statements through the Diagnostic and Elective Oversight Group.

IMPLICATIONS[2]

Aim of the STHFT Corporate Strategy		✓ **Tick as appropriate**
1	Deliver the Best Clinical Outcomes	✓
2	Provide Patient Centred Services	✓
3	Employ Caring and Cared for Staff	
4	Spend Public Money Wisely	
5	Deliver Excellent Research, Education & Innovation	
6	Create a Sustainable Organisation	

RECOMMENDATIONS

The Board of Directors are asked to:

1. **NOTE** the current levels of assurance against the 22 standards and work through PCOG to continue to increase assurance in specific areas.
2. **ADVISE** on any further actions required.

APPROVAL PROCESS

Meeting	Date	Approved Y/N
TEG	19 July 2023	Y
Board of Directors	25 July 2023	

[1]

Status: A = Approval
A* = Approval & Requiring Board Approval
D = Debate
N = Note

[2] Against the six aims of the STHFT Corporate Strategy 'Making a Difference – The next Chapter 2022-27'

1. Background

NHS England set out the elective priorities for the current year with the aim of delivering the following three objectives:

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

7 key areas were identified to support the delivery of these objectives:

- Excellence in basics
- Performance and long waits
- Outpatients
- Cancer pathway redesign
- Activity
- Choice
- Inclusive recovery

Providers have been asked to self assess themselves across the seven areas and provide Board level assurance that these standards are in place to support the delivery of the elective priorities. Across the Acute Federation, it has been agreed to share the outcome of the assessment at the Diagnostic and Elective Oversight Group.

2. Self Assessment

Each Care Group was asked to provide a self assessment against each applicable standard. The feedback has been assimilated and will be shared with the Performance and Caseload Overview Group to oversee action plans where gaps in assurance exist. The table below summarises the rating of the 22 assurance standards:

Table 1 - Summary of self assessment by rating

Assurance rating	Green	Amber	Red	N/A	Total
Number of standards	8	12	0	2	22

A trust wide statement against each standard is included in Appendix 2.

3. Next Steps

Action plans for ensuring assurance can be obtained in the Amber categories will be managed through the Performance and Caseload Overview Group at a Care Group level.

4. Recommendations

The Board of Directors are asked to:

1. **NOTE** the current levels of assurance against the 22 standards and work through PCOG to continue to increase assurance in specific areas.
2. **ADVISE** on any further actions required.

Appendix 1 – Letter from NHSE, 23rd May 2023.

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.

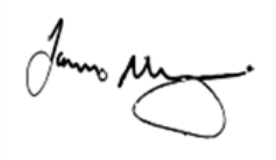
Moreover, it is crucial that we continue to recover elective services inclusively and equitably.

- 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.

Appendix 2 – Trust Self Assessment on Elective Priorities

	Assurance statement	TRUST	Comment
	Excellence in basics		
1.	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?		Processes are well established to support validation. Resource gaps in services and prioritisation to other tasks result in not all patients being validated in the correct validation timeframe. 65% of patients waiting over 26 weeks have been validated in the last 12 weeks. Waiting list minimum data set includes the 'date of last PAS validation'.
2.	Are referrals for any Evidence Based Interventions still being made to the waiting list?		EBI process in place
	Performance and long waits		
3.	Are plans in place to virtually eliminate RTT waits of over 104w and 78w (if applicable in your organisation)?		Plans in place and agreed with NHS E to deliver 104 weeks and 78 weeks by end of Q2.
4.	Do your plans support the national ambition to virtually eliminate RTT waits of over 65 weeks by March 2024?		Trajectory in place
	Outpatients		
5.	Are clear system plans in place to achieve 25% OPFU reduction, enabling more outpatient first activity to take place?		Further work to formalise plan for outpatient follow up reduction. Focus has been on the rollout of PIFU and the introduction of advice and guidance. This should result in the creation of additional new capacity.
6.	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?		Processes in place to support booking. Capacity constraints and Industrial action has interrupted booking processes

	Cancer pathway re-design		
7.	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?		Extensive engagement with SYBCA/Primary Care to encourage FIT at referral. 67.8% of referrals have a FIT recorded at triage (data completeness is not 100%). 9% of referrals had a FIT <10 (n. 59). 8% of patients with a FIT result recorded at colon have a FIT score <10. Patients will only progress to test where clinical concerns remain, as per NICE guidance.
8.	Where is the trust against full roll-out of teledermatology?		The trust is in a position to receive and manage referrals in-line with teledermatology principles. Discussions are ongoing with SYBCA and Primary Care to secure engagement from referrers.
9.	Where is the trust against full implementation of sufficient mpMRI and biopsy capacity to meet the best practice timed pathway for prostate pathways?		mpMRI provision is in line with demand and we are now 'hot reporting' same day MRI. Gap on biopsy capacity but discussions ongoing with our services, SYBCA and ISP to agree a plan and timescale.

	Activity		
10.	Are clear system plans in place to prioritise existing diagnostic capacity for urgent suspected cancer activity?		Process in place
11.	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?		STH has not progressed a traditional CDC model as staffing rather than equipment is our rate limiting factor. We have progressed with some CDC type provision with offsite phlebotomy. We have worked with ISP to secure additional diagnostic imaging capacity at place with further capacity coming online.
12.	How does the Trust compare to the benchmark of a 10-day turnaround from referral to test for all urgent suspected cancer diagnostics?		Significant work has been done to improve turnaround times with significant successes in radiology. We are compliant for the majority of diagnostic imaging. Histopathology TATs vary significantly by tumour type based on data limitations from our LIMS (unable to separate cancer and non-cancer samples) with some specific tumour sites in excess of 10 days. Surgical diagnostics vary by tumour site (e.g. 30 days+ for prostate biopsy). Surgical recovery plans are being progressed.

13.	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.		A number of pathways have effective pre- operative screening in place and health optimisation plans. The delivery of elective backlog reduction will help to bring forward pre-operative assessments. At present patients are being contacted at 6 months rather than 3 months given the volume of patients waiting and the need to increase activity levels. Once waiting times are reduced the Trust will work towards dates being offered after screening and fitness for surgery. Services are working hard at ensuring that shared decision making is in place with patients.
14.	Where is the trust/system against the standards of 85% capped Theatre Utilisation and 85%-day case rate?		Trust benchmarks well but is under the 85% standard for both targets 80.4% capped theatre utilisation against an Acute provider median of 77.3% and Shelford median of 78.6%. 81.8% day case rate against an Acute provider median of 80.8% and Shelford median of 77.2%.
15.	Is full use being made of protected capacity in Elective Surgical Hubs?		Trust has invested in Orthopaedic hub which will be fully operational from January 2024

16.	Do diagnostic services meet the national optimal utilisation standards set for CT, MRI, Ultrasound, Echo, and Endoscopy?		MRI, CT and Ultrasound delivering. Further work underway to optimise Endoscopy and Echo utilisation. Challenges with workforce and booking capacity have impacted utilisation.
17.	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??	N/A	
	Choice		
18.	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?		Full engagement with DMAS process and participation in providing mutual aid where possible
19.	Has Independent Sector capacity been secured with longevity of contract? Has this capacity formed a core part of planning for 2023/24?		The MSK COBIC contract has independent sector capacity identified as part of the core capacity planning. Arrangements are in place with a number of other specialties where there are core capacity gaps.
	Inclusive recovery		
20.	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		Clinical priority and chronological booking ensure that services are recovering at an equitable rate. Specific capacity and pathway routes (theatre admissions lounge) have been put in place to accelerate high volume low complexity (HVLC) alongside the delivery of the complex long waiting pathways.

21.	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?		Analysis has been undertaken on the elective waiting lists to consider health inequalities variables. No specific issues identified. Front end booking processes are constantly being refined to ensure that the patients is at the centre of the process. Close engagement with primary care is in place where patients cancel or do not attend appointments. Further deep dive work is underway to identify the clinical pathways that may need particular focus
22.	Are children and young people explicitly included in elective recovery plans and actions in place to accelerate progress to tackle CYP elective waiting lists?	NA	