Assurance Statement		Support/Materials	Thoracic and Ambulatory Response	STA Response	Cardiology Response
1	**Excellence in basics**				
	Has any patient waiting over 26 weeks on an RTT pathway (as of 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?		The Thoracic and Ambulatory PTL is reviewed and discussed on a weekly basis at Trust PTL. Due to the size of PTL, patients waiting over 30 weeks are regularly reviewed, however the process of reviewing those over 26 weeks needs to be refined to ensure they are validated.	As per T&A response.	The Cardiology PTL is validated on a weekly basis with a strong focus on all patients above 18 weeks. This is reported through the Trust's PTL meeting on a Tuesday. Validation of individual patient pathways is captured through Lorenzo and feeds into the Trust's Patient Pathway Plus system. In addition, the Cardiology operations team hold a separate weekly 6-4-2 meeting with the bookings team to review bookings over the coming six-week period and ensure that plans are in place for all patients waiting above 36 weeks in line with the Divisional RTT improvement action plan. The 6-4-2 meeting also encompasses outpatient clinics and demand.
	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	N/A for T&A	N/A for cardiac or thoracic surgery	As a tertiary centre the department continue to receive referrals for patients with stable angina. These patients will have been treated in secondary care with risk reducing management or lifestyle interventions such as ACE inhibitors, anti-anginal's, weight management or smoking cessation, prior to being referred to RPH for invasive treatment. These patients are added to the waiting list as appropriate and are treated in line with NICE and AoMRC best practice guidelines.

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2	**Performance and long waits**				
	Are plans in place to virtually eliminate RTT waits of over 104w and 78w (if applicable in your organisation)?		There are no patients waiting above 104 weeks. The division has had two patients above 70 weeks recently and plans are in place to prevent them being a 78-week breach. Plans are in place to reduce the RTT waits to eliminate waits of over 40 weeks which are reviewed on a weekly basis.	There are no patients waiting above 104 weeks. The division has no +78w waits. Plans are in place to reduce the RTT waits to eliminate waits of over 40 weeks which are reviewed on a weekly basis.	The Cardiology PTL does not have any patients exceeding waits of over 104w or 78w. However, it is worth noting that the division are continuing to observe an increasing number of patients who are referred for treatment from secondary care later in their pathway without definitive treatment so may be requested to accept a referral for a patient who may be above these thresholds.
	Do your plans support the national ambition to virtually eliminate RTT waits of over 65 weeks by March 2024?		Plans are in place to reduce the RTT waits to eliminate waits of over 40 weeks which are reviewed on a weekly basis. Of those on the PTL, the largest proportion with long waiters are within RSSC and detailed plans are in place to reduce this. There is also a small proportion of ILD patients and a contributory factor to delays are rheumatology appointments at CUH which needs to be reviewed.	There are currently 2 patients over 65 weeks. Work to increase theatre capacity and utilisation continues, with current target date of September to open to 5.5 theatre model. Plans are in place to reduce the RTT waits to eliminate waits of over 40 weeks which are reviewed on a weekly basis. Plans are in place to review the longest waiters and allocate to the surgeons with shorter waiting lists if clinically appropriate. Additional work includes diverting new referrals to a generic pool (unless consultant specific), so that	The Division is working collaboratively with partners to review treatment pathways and explore opportunities to supply mutual aid to reduce waiting times across the system.

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				patients are allocated the soonest date with any appropriate surgeon.	
3	**Outpatients**				
	Are clear system plans in place to achieve 25% OPFU reduction, enabling more outpatient first activity to take place?	NHSE GIRFT guidance	Within Thoracic and Ambulatory, plans are in place to introduce PIFU appointments, specifically within RSSC which has the largest proportion of patient follow ups. This will reduce the number of those requiring a follow up, however plans need to be formulated to demonstrate the potential impact and how this works towards the 25% OPFU reduction. Conversations are also in the early stages regarding PIFU within oncology services.	All cardiothoracic surgical patients receive a FU appointment, which is appropriate to the clinical care so there are no plans to reduce. Work has been done to create shorter FU appointments for thoracic oncology surgical patients to free up capacity for first patient appointments.	In terms of outpatients, pathways are being developed and implemented for cohorts of patients who are applicable to PIFU (patient-initiated follow-up). The largest cohort of patients within cardiology sit under the pacing service and have been initiated on the remote follow-up service whereby patients are issued remote monitoring boxes and can send readings from their cardiac rhythm devices directly to the department for analysis and advice. Pathways are also being created for patients with cardiac sarcoidosis and patients who are post SVT and AF ablation. Introducing PIFU to a wider cohort of Cardiology patients will help drive down unnecessary follow-up appointments and create capacity for increased new patient appointments.
	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 1st December 2022	The Thoracic and Ambulatory PTL is reviewed and discussed on a weekly basis at Trust PTL. Any patient still requiring an appointment is highlighted within this meeting. Further escalation is also carried out via the Divisional Director. PTL meetings are also utilised to highlight patients who may potentially breach to bring	As per T&A response	Outpatients are included as part of the weekly validation undertaken by the division. Clinic utilisation is reviewed through weekly trust wide and divisional 6-4-2 meetings.

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			forward appointments if possible. Appointments are booked up to six weeks in advance. Weekly 642 meetings review clinical utilisation and highlights clinics where capacity is still available.		
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 7th October 2022 BSG/ACPGBI FIT guideline and supporting webinar	N/A to the trust	N/A to the trust	N/A
	Where is the trust against full roll-out of teledermatology?	Suspected skin cancer two week wait pathway optimisation guidance	N/A to the trust	N/A to the trust	N/A
	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	N/A to the trust	N/A to the trust	N/A
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	Planning meetings are held three times a week to ensure diagnostic capacity is prioritised for urgent suspected cancer activity.	As per T&A response	N/A

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	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?		N/A due to the type of diagnostics the trust carries out (PET, CTNB and EBUS)	As per T&A response	N/A
	How does the trust compare to the benchmark of a 10-day turnaround from referral to test for all urgent suspected cancer diagnostics?		All patients are discussed at the next available planning or MDT and tests are requested the following day. Diagnostics are monitored on a weekly basis and reported through Trust Access meetings, as well as ICB Cancer Operational Board. Average turnaround for diagnostics is under 10 days. Any delays are highlighted through weekly PTL meetings and escalated.	As per T&A response	N/A
	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	NHS England >> 2023/24 priorities and operational planning guidance NHS England >> Revenue finance and contracting guidance for 2023/24 Perioperative care pathways guidance	As part of screening and risk assessment for perioperative care, falls risk, frailty score and MUST score are routinely collated. Additional screening is also undertaken in terms of chest x-rays, routine bloods and group and save. In addition, the preadmission service has started to record the patients' weight to optimise conversations around health. Patients are also seen by a pharmacist and anaesthetist within clinic.	1. All patients referred to a surgical consultant will have a discussion regarding perioperative risk factors and will be reviewed by the cardiac support nurse team.	N/A

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	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 ready for surgery. 5. Patients must be involved in shared decision-making conversations		Staff signpost patients to the British Heart Foundation and dietary advice is given for any patient with a BMI of over 25. For short notice patients, the division is working on plans to increase the pre assessment clinics to five days a week to optimise the patients pre-admission service and personalised support for post operative recovery. Further work is also ongoing to see how the service can support and optimise pre-hab for patients. Referrals are also made to dietitians, occupational therapy, SaLT and to safeguarding and or social care team as needed.		
	Where is the trust/system against the standards of 85% capped theatre utilisation and 85%-day case rate?		Within Thoracic and Ambulatory, our day case rate is currently 75% year to date. A high proportion of the admissions are day case and the trend shows an upward increase with additional demand.	There are no cardiothoracic day cases. Theatre utilisation for May was 70%.	The annual average cath Lab utilisation in 2022/23 was 81.3%. Utilisation has been adversely affected by industrial action taken by both the nursing and medical teams which has resulted in a reduction of activity to maintain patient safety.

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	Is full use being made of protected capacity in Elective Surgical Hubs?		N/A for T&A	N/A for cardiothoracic surgery	N/A
	Do diagnostic services meet the national optimal utilisation standards set for CT, MRI, Ultrasound, Echo and Endoscopy?	https://future.nhs.uk/NationalCommunityDiagnostics/groupHome	N/A for T&A, while the division does use the bronchoscopy suites, this falls under the cardiology division.	We are meeting the required 6-week diagnostic standards for cardiac CT and are working towards meeting the diagnostic standard for MRI but do have a longer waiting list. Ultrasound is undertaken but only on specific pathway patients and inpatients. Endoscopy N/A.	Echo capacity was reduced throughout 2022/23 in accordance with a shortage of skilled echo physiologists. The division has invested heavily in developing of staff within the trust to grow a more robust workforce. Activity has resumed to its normal levels and a working group has been established to implement a recovery plan.
	Are any new Community Diagnostic Centres (CDCs) on track to open on agreed dates, reducing DNAs to under 3% and ensuring that they have workforce in place to provide the expected 12 hours a day, 7 days 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 these patients?		The CDC at Ely has recently opened. The division continues to contribute to discussions around how some diagnostic services can be provided within the CDC, specifically within respiratory physiology.	Surgical patients that are referred to the trust are generally referred with diagnostics performed at the referring site, with RPH patients receiving diagnostics here. Typically, the types of diagnostics that a cardiothoracic patient require would not be delivered in a CDC setting e.g., angiogram/TOE or CT cardiac angiogram.	N/A
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	www.dmas.nhs.uk	The division is in discussion with CUH to provide capacity for bronchoscopies which would then free up endoscopy suites within CUH for backlog in alternative endoscopy	N/A for cardiothoracic surgery.	The division have been involved in providing mutual aid at an ICS level, to CUH, for outpatient waits in patients with atrial fibrillation. A total of 50 patients have been accepted for appointments at RPH and are being

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	other providers? Is DMAs being used to offer or request support which cannot be realised within the ICB or region?		procedures. We have a second bronchoscopy suite which is not in use. A pilot has recently taken place to test the processes		filtered into outpatient clinics for review alongside routine demand.
	Has Independent Sector capacity been secured with longevity of contract? Has this capacity formed a core part of planning for 2023/24?		N/A	N/A	The division has not sought to contract capacity through the independent sector.
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		Most of our services are specialised commissioned services (circa 72%). Recovery plans do not specify how services are commissioned and prioritises based on clinical urgency and chronological order.	Yes. Cardiothoracic surgery at RPH incorporates pulmonary thromboendartectomy (PTE), for which RPH is the national centre. These patients are tracked through the PTL, and this procedure has its own capacity built into the elective capacity template,	The divisional recovery plan encompasses all pathways to ensure equity between specialised and non-specialised commissioned services.
	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?		The service is re-introducing outreach clinics and increasing postal services where appropriate where health inequality has been identified to reduce the gap in access to services.	Unable to comment against this standard	The ICB CVD strategy seeks to address system health inequalities. The Chair of the CVD strategy is based at RPH so RPH have a leading voice in these discussions.
	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	N/A	N/A	N/A