Classification: Official

NHS England

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

cc.
- NHS England regional directors

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

4 August 2023

Dear Colleagues,

Protecting and expanding elective capacity

In May, we wrote to you outlining the priorities for elective and cancer recovery for the year ahead. Last week, as part of the winter letter, we also asked you to maintain as far as possible ring-fenced elective and cancer capacity through winter.

We would like to thank you for your continued hard work in these areas, in the face of significant wider operational challenges, including ongoing industrial action. Thanks to the efforts put in by staff across the NHS, we have now virtually eliminated pathways waiting over 78 weeks, down by 94% since the peak of 124,000 in September 2021 (and now representing c0.1% of the total list), and significantly decreased the number of patients with urgent suspected cancer waiting longer than 62 days from a high of 34,000 to around 21,000 today.

However, one area where we know there remains more to do is outpatients. We have listened to your feedback on the support you need for this transformation and have set out the next steps below.

National support for outpatient transformation

To support outpatient transformation, we have met with royal colleges, specialist societies and patient representatives to agree a way forward, working in partnership, to champion and enable outpatient recovery and transformation. At the 'call to arms', colleges agreed to:

- review their guidance on outpatient follow-ups
- support new approaches to increasing wider outpatient productivity, including reducing variation in clinical templates, patient discharge, and following clinically-informed access policies.

Publication reference: PRN00673

Together with this clinical leadership, we need to build on the expectation of freeing up capacity and increasing productivity. This can be achieved through reducing follow up appointments with no procedure, fully validating RTT waiting lists, reducing variation in clinical templates, moving to patient-initiated follow-up where appropriate, following clinically-informed access policies and implementing new ways of working, such as group outpatient follow ups, reviewing clinical pathways and workforce models.

We are continuing to provide support to trusts in this area, through the following:

- Regional support
- NHS England's GIRFT outpatient guidance
- Action on Outpatients series
- The Model Health System
- Support to specific trusts via NHS England's GIRFT Further Faster programme, NHSE Tiering programme and Elective Care Improvement Support Team (IST) – learning from the Further Faster programme will be shared in the Autumn
- Access to additional capacity through the NHS Emeritus Consultant programme
- Luna weekly data quality report, which can be accessed by contacting lunadq@mbihealthcaretechnologies.com and Foundry data dashboards
- RTT rules suite
- Elective Care IST Recovery Hub - FutureNHS Collaboration Platform
- Guidance on shared decision making.

Next steps on outpatient transformation

With the majority (c80%) of patient waits ending with an outpatient appointments, we need to increase the pace in transforming outpatient services to release capacity for patients awaiting their first contact and diagnosis. This will be particularly important ahead of and during winter, when pressure on inpatient beds can be at its highest. Nationally, achieving a 25% reduction in follow up attendances without procedures would provide the equivalent to approximately 1m outpatient appointments per month.

This letter therefore sets out further detail on three key actions that we are asking you to take:

- Revisit your plan on outpatient follow up reduction, to identify more opportunity for transformation.
- Set an ambition that no patient in the 65-week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023.

- Maintain an accurate and validated waiting list by ensuring that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with December 2022 validation guidance) by 31 October 2023, and ensuring that RTT rules are applied in line with the RTT national rules suite and local access policies are appropriately applied.

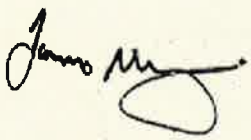
We are now asking trusts to provide assurance against a set of activities that will drive outpatient recovery at pace. This process will require a review of current annual plans, detailing the progress that can be made on outpatients transformation. As part of the above priorities, we are asking each provider to ensure that this work is discussed and challenged appropriately at board, undertake a board self-certification process and have it signed off by trust chairs and chief executives by **30 September 2023**.

The details of this self-certification can be found at Appendix A. Please share this letter with your board, key clinical and operational teams, and relevant committees.

If you are unable to complete the self-certification process then please discuss next steps with your regional team.

Thank you again for colleagues' efforts in this area, which are making a real difference to the timeliness of care we deliver to patients. We look forward to receiving your returns and, as always, if you need to discuss this in more detail, or support in conducting this exercise, please contact england.electiverecoverypmo@nhs.net.

Yours sincerely,



Sir James Mackey
National Director of Elective Recovery
NHS England

Professor Tim Briggs CBE
National Director of Clinical Improvement
Chair, Getting It Right First Time (GIRFT) Programme
NHS England

Appendix A: self-certification

About this self-certification

To deliver elective and cancer recovery ambitions, high-quality waiting list management and ambitious outpatient transformation are vital. We are now asking trusts to complete this return to provide assurance on these recovery plans.

Nationally and regionally, we will use this to identify providers requiring more support, as well as areas of good practice that can be scaled up to accelerate recovery. Please return this to NHS England by **30 September 2023**, via NHS England regional teams.

Guidance for completing the self-certification

The return asks for assurance that the board has reviewed and discussed specific outpatient operational priorities and has signed off the completed checklist. Please return this to your NHS England regional team.

Trust return: [insert trust name here]

The chair and CEO are asked to confirm that the board:

Assurance area	Assured?
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. 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. 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.	

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.	
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. 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	
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. 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. 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. 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	

data (via the Model Health System and data packs) to identify further areas for opportunity. 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.	
4. Support required The board has discussed and agreed any additional support that maybe required, including from NHS England, and raised with regional colleagues as appropriate.	

Sign off

Trust lead (name, job title and email address):	HARVEY McENROE, CHIEF OPERATING OFFICER, harvey.mcenroe4@nhs.net
Signed off by chair and chief executive (names, job titles and date signed off):	(CHAIR RPH) 29/09/23 (CEO) 29/9/2023.

Protecting and expanding elective capacity

	Assurance Statement	Thoracic and Ambulatory Response	RAG	STA Response	RAG	Cardiology Response	RAG	Clinical Admin	RAG
1	**validation**								
	The Board has received a report showing current validation rates against pre-covid levels and agreed actions to improve this position, utilising available data quality (DQ) reports to target validation, with progress reported to Board at monthly intervals. This should include use of the nationally available LUNA system (or similar) to address data quality errors and identify cohorts of patients that need further administrative and clinical validation.	Validation report is validated and presented monthly in the Trust access meeting chaired by COO. Validation of individual patient pathways is done via EPR system Lorenzo that feeds into the Trust's Patient Pathway Plus system. PTL validated weekly and presented weekly to COO at Trust PTL meeting. Patients are scheduled using both length of wait and clinical need.		Validation report is validated and presented monthly in the Trust access meeting chaired by COO.Validation of individual patient pathways is done via EPR system Lorenzo that feeds into the Trust's Patient Pathway Plus system. PTL validated weekly and presented weekly to COO at Trust PTL meeting. Patients are scheduled using both length of wait and clinical need.		Validation report is validated and presented monthly in the Trust access meeting chaired by COO.Validation of individual patient pathways is done via EPR system Lorenzo that feeds into the Trust's Patient Pathway Plus system. PTL validated weekly and presented weekly to COO at Trust PTL meeting. Patients are scheduled using both length of wait and clinical need.		Validation report is validated and presented monthly in the Trust access meeting chaired by COO.Validation of individual patient pathways is done via EPR system Lorenzo that feeds into the Trust's Patient Pathway Plus system.	
	The Board has plans in place to ensure that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with validation guidance) by 31 October 2023, and has sufficient technical and digital resources, skills and capacity to deliver against the above or gaps identified. We are developing a range of digital support offers for providers to improve validation.	Weekly Validation takes place for patients over 12 weeks on our PTL with updated comments added including pending actions. Internal Divisional meetings also take place weekly with our bookings team to ensure we are meeting as much demand as possible with the available capacity. As of 12 September 24% are validated. We are also exploring how we could use digital solutions to make contact with patients as part of the validation process.		Patients who are waiting more than 12 weeks are validated weekly via PTL by the surgical division and clinical admin. Comments updated with current status, actions chased. Collaborative working between clinical, operational and clinical teams to optimise care/treatment. The Access Policy is applied.		Weekly Validation takes place for patients over 12 weeks on our PTL with updated comments added including pending actions. Internal Divisional meetings also take place weekly with our bookings team to ensure we are meeting as much demand as possible with the available capacity.		Patients who are waiting more than 12 weeks are validated weekly via PTL by the divisions and clinical admin. Comments updated with current status, actions chased. Patients who have a booking date in the next 6 weeks are contacted to confirm appointment date.	
	The Board ensures that the RTT rules and guidance and local access policies are applied and actions are properly recorded, with an increasing focus on this as a means to improve data quality. For example, Rule 5 sets out when clocks should be appropriately stopped for 'non-treatment'. Further guidance on operational implementation of the RTT rules and training can be found on the Elective Care IST FutureNHS page. A clear plan should be in place for communication with patients.	Trust Access policy in place. Data quality is also monitored via Trust Access weekly and discussed during weekly PTL meetings.		RTT actions clock stop,DQ error, plan for each patient is discussed and monitored at PTL every Tuesday and escalated at Trust Access weekly.		Trust Access policy used when Validating using the correct terminology and actions in line with RTT training.		All clinical admin team have their RTT training regularly monitored via montly performance meeting. Actions like clock stop ,DQ error, plan for each patient is discussed and monitored at PTL every Tuesday.	
	The Board has received a report on the clinical risk of patients sitting in the non RTT cohorts and has built the necessary clinical capacity into operational plans.	Non RTT cohorts are monitored and also escalated via the risk register due to backlogs in waits. Review of service pathways are ongoing including the introduction of PIFU.						NA	
2	**First appointments**								
	The Board has signed off the trust's plan with an ambition that no patient in the 65 week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023.	Outpatient appointments and utilisation of clinics is monitored via the weekly 642 meeting to ensure capacity is filled. Long waiters over 40 weeks are monitored via Trust Access.		Outpatients appointments are monitored via PTL with 6-4-2 giving governance that the patients booked for next 6 week period and capacity is filled. Patients are tracked through Trust access system. Work to bring first appointments forward commenced.		Outpatients appointments are monitored via PTL with 6-4-2 giving governance that the patients booked for next 6 week period and capacity is filled. Patients are tracked through Trust access system. Work to bring first appointments forward commenced. We also have an internal 6-4-2 within the division to ensure we are maximising capacity as much as possible.		Outpatients appointments are monitored via PTL with 6-4-2 giving governance that the patients booked for next 6 week period. Long waiting patients above 40 weeks are also monitored via Trust access system.	
	The Board 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	WLI being structured to support the recovery plan, focusing on outpatient activity and provision of one stop clinics.		WLI plans in-house in place to recovery activity.		WLI currently being structured to support the recovery plan. We're also trialling Virtual clinic systems within specialist pathways.		WLI are planned to support the recovery plan. Mutual aid system is also widely used in Cardiology	
3	**Outpatient follow-ups**								

	Assurance Statement	Thoracic and Ambulatory Response	RAG	STA Response	RAG	Cardiology Response	RAG	Clinical Admin	RAG
	The Board has received a report on current performance against submitted planning return trajectory for outpatient follow-up reduction (follow-ups without procedure) and received an options analysis on going further and agreed an improvement plan.	PIFU pathway is almost established for RSSC where our largest backlog is. Also scoping other specialties to ensure clinic capacity is optimised for 1st appointments. Governance needs to be put into place regarding monitoring performance to reduce OPFU.		N/A for Surgical patients at this time.		PIFU pathway is being looked at for some of our EP pathways with a view to create more slots for New Patients to be seen. Discussion currently happening with Digitial and RTT DQ Lead.		PIFU pathway is being introduced in RSSC with Clinical admin helping to implement the digital part of PIFU.	
	The Board 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.	PIFU pathway is almost established for RSSC where our largest backlog is. Also scoping other specialties to ensure clinic capacity is optimised for 1st appointments. Governance needs to be put into place regarding monitoring performance to reduce OPFU.		N/A for Surgical patients at this time.		Please see above.		As above. PIFU is considered as one of the main programmes for Outpatient transformation .RSSC is the main focus currently with clinicians planning to use PIFU pathway along similar guidelines.	
	The Board has a plan to reduce the rate of missed appointments (DNAs) by March 2024, through: engaging with patients to understand and address the root causes, making it easier for patients to change their appointments by replying to their appointment reminders, and appropriately applying trust access policies to clinically review patients who miss multiple consecutive appointments.	Reducing DNA by using digital initiatives such as questionnaire, understanding reason DNA, better appointment time, place and date are being scoped as a high priority. The questionnaires are being trialled in RSSC initially before further rollout. Also reviewing geographical areas of patients in terms of missed appointments to determine outreach services and to optimise postal services.		Reducing DNA by using digital initiatives such as questionnaire, understanding reason DNA, better appointment time, place and date are being scoped as a high priority		Working with bookings team to establish common themes and trends within our DNA rates. Working to include further checkpoint to bring down rates.		Reducing DNA by using digital initiatives such as questionnaire, understanding reason DNA, better appointment time, place and date are being scoped as a high priority	
	The Board has a plan to increase use of specialist advice. Many systems are exceeding the planning guidance target and achieving a level of 21 per 100 referrals. Through job planning and clinical templates, the Board understands the impact of workforce capacity to provide advice and has considered how to meet any gaps to meet min levels of specialist advice. The Trust has utilised the OPRT and GIRFT checklist, national benchmarking data (via the Model Health System and data packs) to identify further areas for opportunity.	GIRFT is used in all divisions to explore opportunities		GIRFT is used in all divisions to explore opportunities		GIRFT is used in all divisions to explore opportunities		GIRFT is used in all divisions to explore opportunities	
	The Board has identified transformation priorities for models such as group outpatient follow up appointments, one-stop shops, and pathway redesign focussed on maximising clinical value and minimising unnecessary touchpoints for patients, utilising the wider workforce to maximise clinical capacity.	Outpatients transformation programme forms one of the three pillars for COO transormation programme.Clinic utilisation,reducing DNA,PIFU,Virtual Clinics are some of the initial initiatives of the programme. Reviewign use of outreach clinics and ability to provide one stop clinic during outreach. Also to explore potential use of CDCs for community sleep studies.		Plan to increase same day admissions for surgical patients		Plans to increase the use of Virtual Clinics and also one stop clinics for pre assessments reducing the need for Treat and Return within our Tavi Pathway.		Outpatients transformation programme forms one of the three pillars for COO transormation programme.Clinic utilisation,reducing DNA,PIFU,Virtual Clinics are some of the initial initiatives of the programme.	
4	**Support Required**								
	The Board has discussed and agreed any additional support that maybe required, including from NHS England, and raised with regional colleagues as appropriate.	Representation at regional level for both Planned and Unplanned care.		Representation at regional level for both Planned and Unplanned care.		Representation at regional level for both Planned and Unplanned care.		Representation at regional level for both Planned and Unplanned Care.	