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Elective recovery planning supporting guidance

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Contents

1. Introduction

This section outlines the requirements for system plans to recover elective services.

The pandemic has placed considerable strain on planned service delivery, which was already under pressure before the pandemic. Consequently, there are now significant waiting lists across the country and potentially more patients still to come forward. Our plans will need us to do things differently, creating additional capacity and changing for the better the way services are delivered, while giving patients more control over their experience in the NHS.

We have set out a clear plan for how we will recover elective services in Delivery plan for tackling the COVID-19 backlog of elective care (the Delivery Plan). The plan sets out our key ambitions for the next three years:

1. Eliminating the longest waits of over two years, except when it is the patient's choice, by July 2022. Following this, the ambition is to eliminate waits of over 18 months by April 2023 and waits of over one year by March 2025, except where patients choose to wait longer or in specific specialties. Long-waiting patients will be offered further choice about their care, and over time, as the NHS brings down the longest waits from over two years to under one year, this will be offered sooner.
2. Diagnostic tests are a key part of many elective care pathways. Our ambition is that 95% of patients needing a diagnostic test receive it within six weeks by March 2025.
3. The NHS has continued to prioritise cancer treatment throughout the COVID-19 pandemic and since March 2021 we have consistently seen record levels of urgent suspected cancer referrals. To maintain this focus, our ambition is that, by March 2024, 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days. This will contribute to the existing NHS Long Term Plan ambitions on early diagnosis. Local systems have also been asked to return the number of people waiting more than 62 days from an urgent referral back to pre-pandemic levels by March 2023.

4. For patients who need an outpatient appointment, the time they wait can be reduced by transforming the model of care and making greater use of technology. We will work with patient groups and stakeholders to better monitor and improve both waiting times and patients' experience of waiting for first outpatient appointments over the next three years.

To deliver these ambitions, we have set an ambitious goal to deliver around 30% more elective activity by 2024/25 than before the pandemic, after accounting for the impact of an improved care offer through system transformation, and advice and guidance (A&G). The NHS will continue to work to return to pre-pandemic performance as soon as possible, with an ambition in 2022/23 for systems to deliver over 10% more elective activity than before the pandemic and to reduce long waits.

This means that over 10% more patients will complete treatment than in 2019/20 through a combination of:

- more completed pathways per RTT rules
- more pathways completed in primary care with the support of specialist advice. This will be measured through the number of onward referrals avoided through specialist advice based on data from the new system Elective Recovery Outpatient Collection (EROC).

As in 2021/22 systems will be able to earn additional elective funding based on delivery against an equivalent value-based activity target of 104% of the 2019/20 baseline. This will rely on moving back to and beyond pre-pandemic levels of productivity as soon as the context allows this, consistent with latest UK Health Security Agency (UKHSA) guidance.

Delivery of 104% of value-based activity is expected to support delivery against the 110% completed pathways activity target set out above due to:

- A focus on new outpatient attendances, facilitated by a reduction in follow-up activity as per the 2022/23 NHS Operational Planning and Commissioning Guidance and the personalised outpatient plan element of the Elective Recovery Plan (with each provider and system required to reduce reviews by a minimum of 25% by March 2023). Systems are expected to plan how the redeployment of the released capacity will be used to increase elective activity that increases completed pathways.

- The planned increase in pre-referral A&G. Delivery against the stated ambition could contribute an estimated 6 percentage points towards the completed pathway activity target. The contribution towards the value-based activity target is expected to be less than 1 percentage point, because the value of each of these pathways is significantly lower than the value of an average pathway.

Integrated care system (ICS) plans need to set out the activity, financial plans and transformation goals for elective delivery, including how identified health inequalities will be addressed. Activity plans must deliver more than 104% of pre-pandemic value weighted elective activity levels nationally and systems and providers need to agree plans that reflect this ambition, including going further for those that are able to. Each system and trust must understand where waiting list challenges exist locally and what is driving them, and ensure that it has a plan to deliver improvement in 2022/23.

Further details on the approach to measurement of pathway, A&G and value-based activity is set out in further technical guidance which can be found on our FutureNHS NHS Planning platform.

2. Elective recovery plans and trajectories

System plans should reflect the four key delivery themes set out in the Elective Recovery Plan:

- expand capacity to reduce waiting times and reduce the extent to which care is disrupted by other pressure in the system
- prioritise treatment based on clinical urgency, making use of alternative providers if people have been waiting a long time for treatment
- transform the physical estate and have a planned approach to separating elective care delivery and moving the location of services to drive productivity, including through community diagnostic centres, surgical hubs and improved patient pathways

- enable greater transparency on waiting times and develop tailored offers of support and advice for patients while they wait.

System delivery plans should describe the elective inpatient, outpatient and diagnostic activity required for adults and children and young people (including cancer and specialised services) that address these delivery themes, while laying the foundations for further acceleration of activity over the remainder of the three-year period to 2024/25. This should include, in narrative submissions, detail on changes that will support moving back to and beyond pre-pandemic levels of productivity as soon as the context allows this, consistent with latest UKHSA guidance.

The independent sector has a significant role to play in supporting the NHS as trusted partners to recover elective services, as they have throughout the pandemic. Systems will incorporate local independent sector capacity as a core element of elective recovery plans to deliver improved outcomes for patients and reduce waiting times sustainably. Narrative submissions need to include specific detail on how the system will maximise use of independent sector provider (ISP) capacity.

Systems will need to look at how they are managing demand across the system, including ISP capacity, and how separation of capacity can be further embedded, including the system clinical strategy to increase the share of high-volume surgical activity taking place in ringfenced elective surgical hubs. Systems and providers should consider how capacity is offered to equalise waiting list management, how optimal referral management will happen at system and provider level, how constitutional and legal commitments to shared decision-making and choice are met and how perioperative care teams will be stood up. Referrals should also reflect the investment into local high volume low complexity (HVLC), diagnostic and surgical hubs.

Addressing health inequalities remains a key element of elective recovery and narrative detail will be required on how system plans will ensure inclusive recovery and reduced health inequalities where they are identified. A number of specific commitments are also required as part of assurance on how health inequality data is used locally (see Section 6: Assurance of plans).

Provider elective activity plans will be funded as per the aligned payment and incentive (API) rules in the National Tariff, with payment linked to the actual level of activity delivered. Where systems do not deliver agreed goals, then allocated funding will not

be earned. Further details are set out in the Revenue finance and contracting guidance for 2022/23. Plans should fully reflect the additional revenue and capital funding available for elective recovery over the period:

- £1.5 billion of capital above that funded within core envelopes has been made available to the NHS over three years to support new surgical hubs, increased bed capacity and equipment to help elective services recover.
- £2.3 billion to transform diagnostic services, including at least 100 community diagnostic centres (CDCs) across England to permanently increase diagnostic capacity.

Trajectory submissions will be required in relation to:

- Long waiting patients, showing the elimination of waits over 104 weeks as a priority by July 2022 and how this position is maintained through 2022/23 (except where patients choose to wait longer); elimination of waits over 78 weeks by March 2023; plans for a reduction in waits over 52 weeks; and plans to return the cancer 62+-day waiting list to pre-pandemic levels by March 2023.
- A 25% reduction in outpatient follow-up (OPFU) by March 2023 (see Section 3: A new approach to outpatients – personalised outpatients programme).

Through plans, systems should ensure they are working with all providers to implement best practice transformation approaches, including maximising day case activity as well as theatre utilisation, supported by optimal scheduling, and significantly reducing OPFU activity.

3. A renewed approach to outpatients – personalised outpatients programme

Systems will be required to determine and submit the rate of follow-up reduction across their local providers to deliver at least a 25% reduction against 2019/20 activity levels by March 2023. They should also plan how the redeployment of the released

capacity will be used to increase elective clock-stops or reduce clock-starts, for example:

- recovery of the elective backlog through delivery of more outpatient first appointments and interventions such as surgery
- conducting A&G in co-ordination with primary care
- supporting junior doctors to feel confident in discharging patients when it is clinically safe and appropriate to do so
- further training for the medical, nursing and allied health professional (AHP) workforce, ensuring all our people are confidently working to the top of their licence
- tackling urgent and emergency care pressures and wider healthcare delivery priorities, such as cancer.

This will require a system-level approach with primary care services, and wider partnerships working with the voluntary, community and social enterprise (VCSE) sector and other organisations. Delivering this ambition should be anchored in the principle of personalised follow-up tailored to the individual's clinical need, circumstances and preferences. Careful consideration of individuals' needs will be required to ensure that health inequalities are addressed.

Plans for Personalised Outpatient Programme activity should be backed with effective digital support and rapid access to specialist advice for patients on patient initiated follow-up (PIFU) pathways to enable and empower self-management, including through the My Planned Care portal.

As part of the Personalised Outpatients Programme systems should:

- expand the uptake of PIFU to all major outpatient specialties, moving or discharging 5% of all outpatient attendances to PIFU pathways by March 2023
- ensure personalised stratified follow-up pathways are fully implemented for breast, bowel and prostate cancers, and plans are in place to roll out for at least three other cancers including endometrial cancer
- deliver 16 specialist advice requests, including A&G, per 100 outpatient first attendances by March 2023

- continue to offer both video and telephone consultations for outpatient services where clinically appropriate, with a minimum of 25% of consultations taking place via this route
- ensure teledermatology services are available for patients and clinicians in every service receiving urgent suspected skin cancer referrals
- explore other means by which to reduce the overall number of outpatient attendances, including through improved discharge procedures and more effective administrative processes.

4. Empowering patients

An important pillar of recovering elective services will be the creation of a transparent, well-informed means of patients viewing information on waiting times, guidance on self-management of symptoms and targeted support to help prevent deterioration among those waiting to access services.

To support this ambition, we have launched a national patient communication platform, My Planned Care, that will include:

- Specialty-level waiting list information by provider to enable people to better understand how long they may have to wait for their first outpatient appointment, treatment or surgery
- information specific to a range of procedures to give people a better understanding of how they can support their own health while on the waiting list.

The platform will comprise 139 acute hospital subsites where people can find information relating to their elective wait. Systems are asked to include their approach to maintaining effective communication with patients in their narrative submission, including how they will ensure that providers engage with the national platform. Work is also underway to understand how this information can be made available through the NHS App, with an enhanced communication offer for patients.

Systems should also review their approach to targeted support information for patients, supporting patients to prepare for surgery and co-developing personalised

plans providing them with the information and guidance to prepare for the best possible outcomes.

Systems should consider how patients are offered choice of providers (NHS and available ISPs) at the point of referral into elective pathways. This should include review of primary and secondary care operating principles, to confirm processes are in place to ensure patients have a shared decision-making conversation which enables them to make an informed choice across all available system capacity.

Systems should consider what additional support or services for patients on the elective pathway is available through local voluntary and community groups. This may include work with primary care networks to recruit additional social prescribing link workers, care co-ordinators, and health and wellbeing coaches.

From April 2023, all providers will be asked to establish perioperative care co-ordination teams. These teams could consist of, for example, care co-ordinators, nurses and perioperative physicians who will carry out assessments of health needs to inform pre- and post-operative care and identify surgical risk factors. They will identify low-risk patients who do not need to attend face-to-face preoperative assessment and patients who could be treated in elective hubs focused on providing HVLC surgery. In 2022/23, systems and providers may look to strengthen perioperative pathways, through recruiting to and embedding these teams. An early implementer programme will run through 2022/23 to help develop best practice and learning will be shared via the FutureNHS platform.

5. Submission requirements

Providers and commissioners are asked to agree activity plans based on the total allocated funding. Provider elective activity plans will be funded as per the API rules in the National Tariff, with payment linked to the actual level of activity delivered. Where systems do not deliver agreed goals, then allocated funding will not be earned. Further details are set out in the Revenue finance and contracting guidance for 2022/23. Plans should fully reflect the additional revenue and capital funding available for elective recovery over the period and the full year impact of investments made under the Targeted Investment Fund (TIF) in H2 2021/22.

Activity plans must deliver more than 104% of pre-pandemic value weighted elective activity levels nationally and systems and providers need to agree plans that reflect this ambition. Plans will need to be signed off by system and providers' chief executives before submission.

The components of the elective recovery plan are:

- Activity plans at provider and system level.
- Trajectories against each of the waiting list/time goals.
- A short narrative submission to provide an overview of how the system will develop the required capacity infrastructure to deliver the plan, including:
    a. cross-system management of demand, including ISP capacity; and how separation of capacity can be further embedded
    b. detail of actions to maintain effective communication with patients
    c. changes that will support moving back to and beyond pre-pandemic levels of productivity as soon as the context allows this, consistent with latest UKHSA guidance
    d. system plans to ensure inclusive recovery and reduced health inequalities where they are identified.

6. Assurance of plans

System plans will only be signed off if the region clearly demonstrates the features below, through a combination of the submitted plan trajectories, narrative submissions and assurance statements.

- That activity plans support national delivery in excess of 104% of pre-pandemic value weighted elective activity levels.
- That activity plans support a reduction in long-waiting patients, including the elimination of waits over 104 weeks by July 2022, elimination of waits over 78 weeks by March 2023, reductions in waits over 52 weeks where possible, and the recovery of the cancer 62+-day waiting list to pre-pandemic levels by March 2023.

- System-level planning across care sectors and between children's and adult's transition services to reduce unnecessary outpatient appointments and follow-up for children. Delivery of integrated care plans for children and young people, consistent with the NHS Long Term Plan priorities for them.
- That activity planning process is aligned across NHS providers and ISPs to ensure an agreed holistic view of available capacity and activity delivery.
- An ongoing commitment to the clinical validation and prioritisation programme, including the conduct of three-monthly reviews for patients waiting over 52 weeks and at least weekly reviews for those waiting longer than 62 days on a cancer pathway. This builds on the NHS Long Term Plan expectation of six-monthly reviews for long-waiting patients.
- An equality and health inequalities impact assessment has been completed and published, or a date given when it will be published by, for elective recovery plans locally.
- ICSs and trusts have as required published board papers that include an analysis of waiting times disaggregated by ethnicity and deprivation:
    a. Use waiting list data (pre and during the pandemic), including for clinically prioritised cohorts, to identify disparities in relation to the bottom 20% by Index of Multiple Deprivation (IMD) and Black and minority ethnic populations.
    b. Prioritise service delivery by taking account of the bottom 20% by IMD and Black and minority ethnic populations for patients on and not on the waiting list, including through proactive case finding.
    c. Use system performance frameworks to measure access, experience and outcomes for Black and minority ethnic populations and those in the bottom 20% of IMD scores.
    d. Evaluate the impact of elective recovery plans on addressing pre-pandemic and pandemic-related disparities in waiting lists, including for clinically prioritised cohorts.
    e. Demonstrate how the ICS's senior responsible officer (SRO) for health inequalities will work with the board and partner organisations to use local population data to identify the needs of communities experiencing inequalities in access, experience and outcomes, and ensure that

performance reporting allows monitoring of progress in addressing these inequalities.

- Evidence of a system approach to waiting list management and improved quality of the system's patient tracking list (PTL) through:

  a. Waiting list minimum dataset submissions that are of sufficient quality to enable switch-off of the weekly referral to treatment (RTT) PTL aggregate return (or a date when this will be possible).

  b. <2% data quality issues recorded consistently in the waiting list minimum dataset within the National Data Quality Programme (LUNA) to ensure improved accuracy of the waiting list.

7. Monitoring performance

All systems and providers will be monitored, and should be monitoring themselves, against the key elective recovery performance priorities for 2022/23:

- over 10% more patients completing treatment than in 2019/20
- 104% of the pre-pandemic elective activity on a value basis
- eliminating waits over 104 weeks by July 2022, eliminating waits over 78 weeks by March 2023 and reducing waits over 52 weeks
- reducing cancer 62+-day waiting list size to pre-pandemic levels by March 2023
- 25% reduction in OPFUs by 2023
- increasing diagnostic capacity to a minimum of 120% of pre-pandemic activity levels to meet local need and support elective recovery.

Other KPIs systems and providers should monitor locally include:

- cancer first treatment activity
- total waiting list size, including disaggregation by deprivation and ethnicity
- P1/P2 clearance times, as measured by the ratio of the number of P1/P2 patients on the waiting list to the number of P1/P2 patients treated per week
- RTT performance

- average (median) waiting time, including disaggregation by deprivation and ethnicity
- ratio of specialist advice requests per 100 first outpatient appointments (OPFAs) (target 16/100)
- % of outpatient appointments delivered via video and telephone (target 25%)
- number of elective clock-starts and clock-stops
- proportion of cancer patients who have first treatment within 31 days of urgent suspected cancer referral
- P2/D2 and P3/D3 patients treated within target time
- day case and outpatient surgery rates (% of British Association of Day Surgery (BADS) procedures)
- theatre utilisation rates.

8. Support available

A broad range of support is available for systems through national programme teams, FutureNHS pages and an NHS England and NHS Improvement planning support framework, with further detail as follows:

- We recognise regions and systems will vary in their planning and modelling infrastructure and therefore the expertise and resource they have available will differ. With this is mind, we have appointed a number of external delivery partners to actively support ICS teams to develop ICS owned recovery plans to deliver against future demand and capacity challenges. Please get in touch with your relevant NHS England and NHS Improvement regional contacts and (if in the Recovery Support Programme) your improvement director to access this support offer. [Further information on this support offer can be accessed on the FutureNHS platform.]
- National planning tools held within Foundry, including the Strategic Planning Tool and the Health Inequalities Improvement Dashboard, to support systems to bring together the data to support a full picture of the waiting list and cancer waiting, capacity and workforce.
- Integrated care boards (ICBs) and trusts should work with their Cancer Alliance(s) to develop the plan, drawing in particular on existing resources and

support around optimal timed pathways, non-specific symptom pathways, key interventions in the lowest performing pathways (eg lower GI/FIT implementation, skin/teledermatology) and personalised stratified follow-up.

- For outpatient transformation priorities, ICBs and trusts can draw on support from regional and embedded system National Outpatient Transformation Programme (NOTP) teams, including a series of support webinars, specialty-specific guides for PIFU, clinical advisers, investment and advice from NHSX on appropriate technology, and analytic insight on existing and potential PIFU activity. Additional support materials are available through the PIFU FutureNHS page. A framework and support tools for the Personalised Outpatient Programme is available on the NHS Planning FutureNHS collaboration platform to help providers manage their waiting lists. To access any of this support, please contact england.outpatient-transformation@nhs.net.
- There are also FutureNHS pages for referral optimisation and virtual consultation with resources and guidance. These can be accessed at Referral optimisation and Virtual consultation
- The HVLC demand and capacity modelling is available to all systems via the Getting It Right First Time (GIRFT) team and more information on how to access this offer and the data submission requirements is available by emailing england.girft.hvlc@nhs.net. HVLC data and non-elective data packs have been shared with all systems. These packs outline key opportunities for improvement with further detail available on the Model Hospital System. Webinars for systems on how to use the Model Hospital System are available for systems as required; for more information please email england.girft.hvlc@nhs.net.
- North of England Commissioning Support Unit (NECS) is co-ordinating the development and uploading of both waiting time data and provider-level content onto the My Planned Care platform. NECS' dedicated inbox, platform.myplannedcare@nhs.net, will be able to provide technical guidance and support for developing and uploading clinical content.
- The National Choice team is available to provide support, information and advice via england.choice@nhs.net. Regional personalised care leads will support systems to identify local voluntary and support offers. For access to the FutureNHS page, please contact the My Planned Care team at

england.myplannedcare@nhs.net. Free e-learning on shared decision-making is available through the Personalised Care Institute.

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