REPORT TO:	**NHS SOMERSET INTEGRATED CARE BOARD** **ICB Board Part A**	**ENCLOSURE:** **G**
DATE OF MEETING:	**22 May 2025**	
REPORT TITLE:	**Update on Elective Strategy Development**	
REPORT AUTHOR:	**Stephen Rosser, Interim Associate Director of Planned and Specialised Care**	
EXECUTIVE SPONSOR:	**David McClay, Chief Officer for Strategy, Digital and Integration**	
PRESENTED BY:	**Stephen Rosser, Interim Associate Director of Planned and Specialised Care**	

PURPOSE	DESCRIPTION	SELECT
Approve	To formally receive a report and approve its recommendations, (authorising body/committee for the final decision)	☐
Endorse	To support the recommendation (not the authorising body/committee for the final decision)	☐
Discuss	To discuss, in depth, a report noting its implications	☒
Note	To note, without the need for discussion	☒
Assurance	To assure the Board/Committee that systems and processes are in place, or to advise of a gap along with mitigations	☐

LINKS TO STRATEGIC OBJECTIVES
(Please select any which are impacted on / relevant to this paper)

- ☒ Objective 1: Improve the health and wellbeing of the population
- ☒ Objective 2: Reduce inequalities
- ☒ Objective 3: Provide the best care and support to children and adults
- ☒ Objective 4: Strengthen care and support in local communities
- ☐ Objective 5: Respond well to complex needs
- ☐ Objective 6: Enable broader social and economic development
- ☒ Objective 7: Enhance productivity and value for money

PREVIOUS CONSIDERATION / ENGAGEMENT

Previous discussion and consideration at Management Board and other working groups.

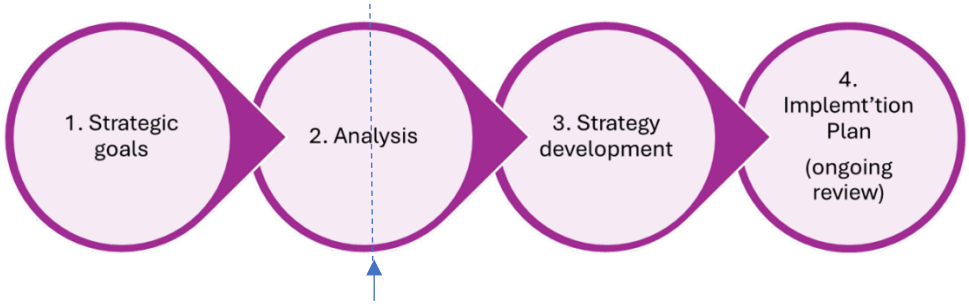
REPORT TO COMMITTEE / BOARD

The Board is asked to note and discuss the draft strategic goals set out and the initial quantitative analysis undertaken.

1. **Background**

This paper provides a briefing to Board on the development of the Elective Care Strategy. Work on the strategy was paused during the Operational planning round and has recently resumed. The paper seeks comment from Board members on the strategic goals and initial quantitative analysis.

2. **Initial progress**



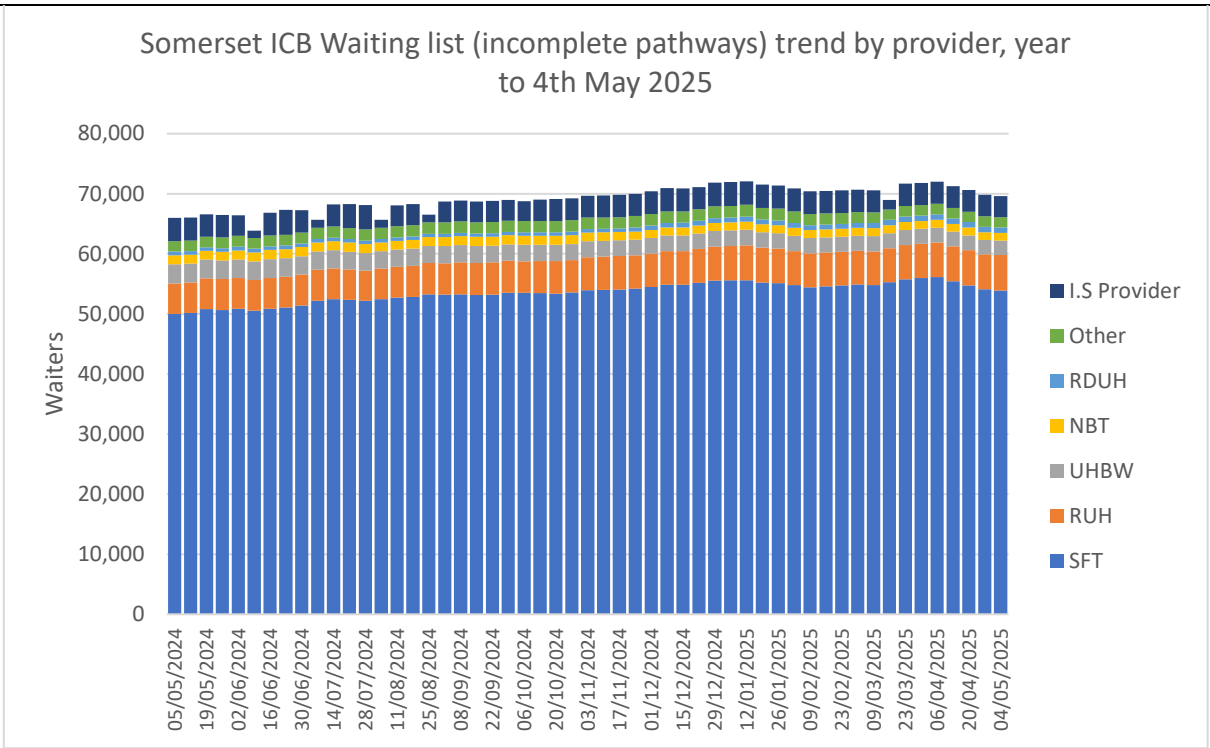
It is important to set out and agree the strategic goals the Somerset system is keen to secure over the next 10 years. The emerging goals are to:

a) Develop confidence in our demand forecasting capabilities and to work with providers to refine their capacity plans, aligning performance within the financial resource available.
b) Develop a deeper understanding of what's important to residents and to commission pathways of care that more closely meet their needs.
c) Improve the overall quality of the elective care offer, working with providers to maximise their operational efficiency and productivity.
d) Deliver the NHSE ambition of a digital front door for care by expanding the range of information, tasks and support available to residents through the NHS app and supporting the adoption of digital products to maximise efficiency.
e) Identify priority pathways and redesign the delivery model through co-producing care pathways with those working in the service, improving communication and relationships between professionals.
f) Revise the way in which elective lists are managed and performance is reported upon, with the aim of placing greater emphasis on health inequality, socio-economic factors and outcomes, in addition to existing quality metrics such as time. Currently, there is limited data available relating to wider population issues such as individuals absent from work pending treatment and similar measures.

The Somerset system has in place an Elective Care Board which oversees the delivery of elective care performance on behalf of the system. An elective care Working Group has recently been stood up to coordinate the development of a long term (10 year) strategy. The Group has built on the modelling work undertaken for the Operational Planning round to develop a capacity and demand model. The early focus is on more traditional metrics of the number of people (activity) and waiting times.

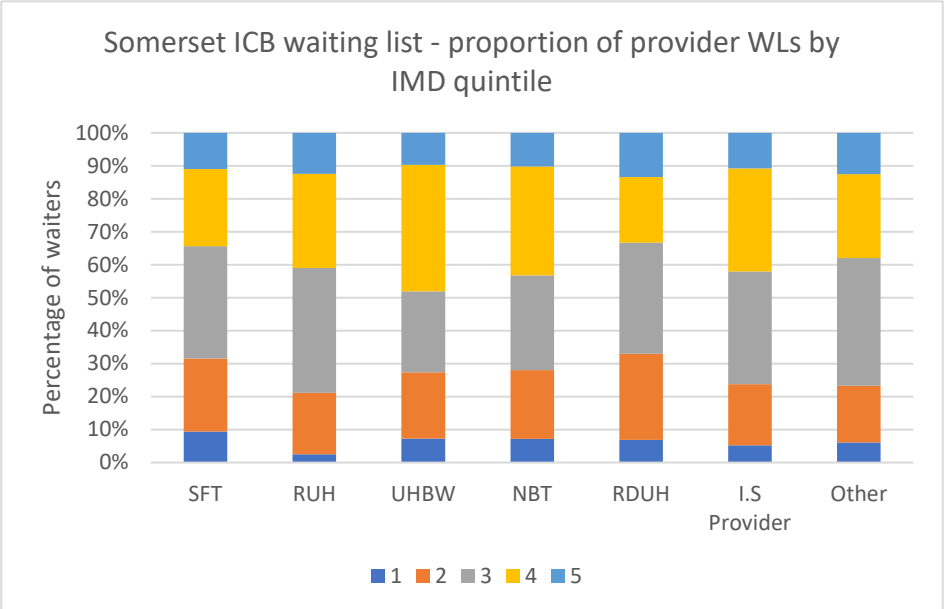
3. **Context and Case for Change**

3.1 The total waiting list for Somerset ICB has grown in recent years. The current picture of this waiting list is set out below however it should be noted the list at Somerset Foundation Trust is currently undergoing extensive validation (as part of an NHSE initiative) and therefore the current number may be overstated.



3.2 As outlined earlier in this paper, data on the socio-economic impact of people waiting for care (for e.g. absent from work pending surgery) is not readily available.

Analysis of the waiting list by Index of Multiple Deprivation (IMD) is available and is set out below. With the exception of the RUH, who make up a small proportion of Somerset ICB activity, we can see that when compared to the IS providers, NHS providers have a greater proportion of people from most deprived areas on their waiting lists (with 1 being the most deprived areas). The potential driver for this is discussed further below.



3.3 In summary – the current position reflects years of continued growth in the number of patients waiting for treatment within secondary care, that this has resulted in increased waiting times, and that this has a disproportionate impact on those individuals from areas of higher socioeconomic deprivation as we know that:

a) NHS waiting times are greater than those in the IS, and:

b) The NHS waiting lists have a higher proportion of those from more deprived areas.

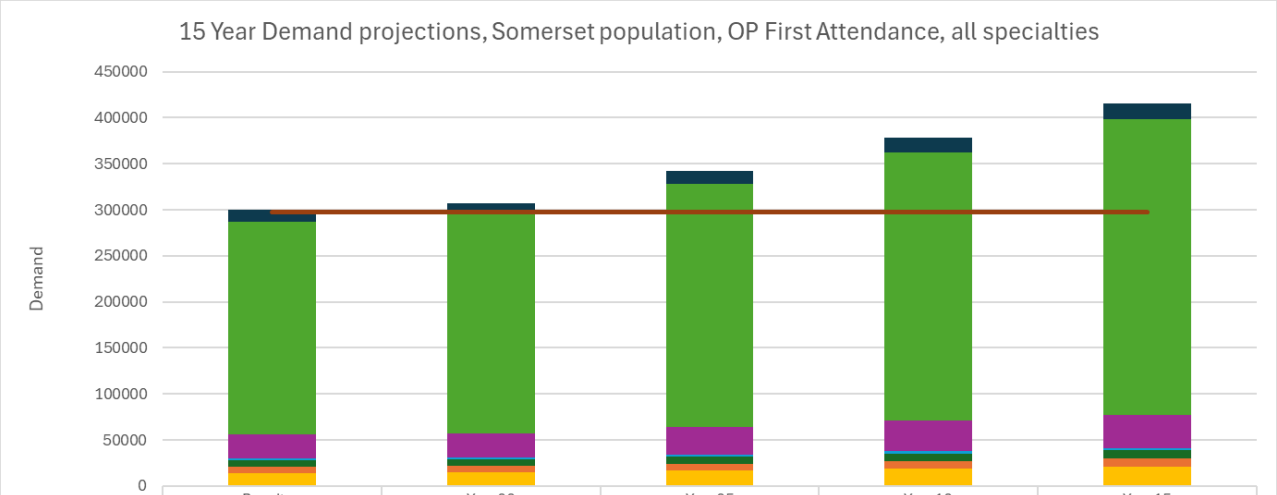
This fact is recognised by Somerset Foundation Trust who have implemented some safety netting processes for patients on their waiting lists, for example prioritising those who have a pending referral for a mental health service.

4. Future Modelled Changes

4.1 To inform a 10 year strategy we have begun to develop a data model projecting future growth in demand for secondary care elective services. There is more detail on the modelling approach, assumptions and current projections included in the appendix slides, however this is summarised below. This will be supplemented by resident and clinical engagement to understand what's important to stakeholders, and research into best practice in managing elective demand. This output will then be built into the proposed strategy

4.2 Current projections:

From an activity perspective the current modelling unsurprisingly indicates a growing gap between known capacity and projected demand. This analysis highlights the need to redesign the model of care, focus on maximising what residents value and enable clinicians to work in very different ways in order to treat demand differently, such as the ongoing optimisation of advice and refer.



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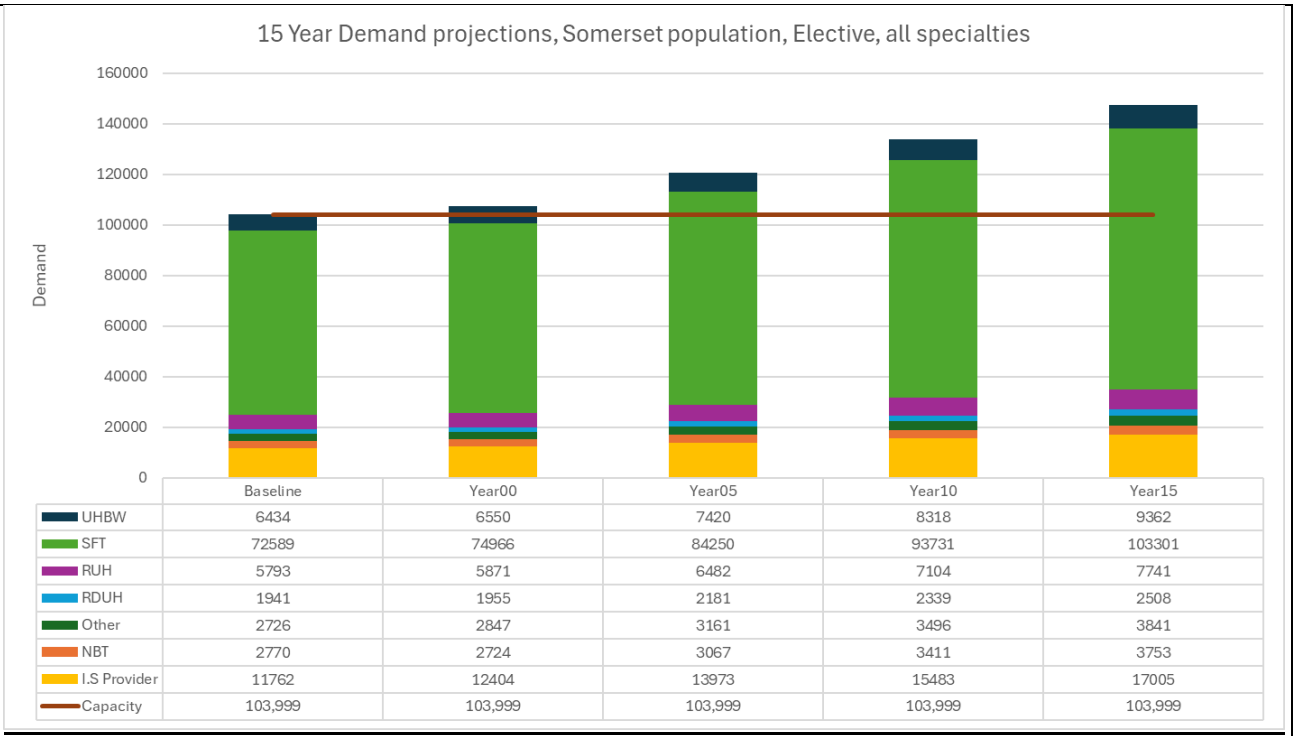

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I.S Provider	11762	12404	13973	15483	17005
Capacity	103,999	103,999	103,999	103,999	103,999

4.3 Geography and patient flows:

4.3.1 Modelling of patient flows to the IS providers has been undertaken to ensure that we understand which geographic areas are being served by these providers, and also to understand the breakdown by social deprivation of patients using the IS providers vs the NHS waiting lists. Note that IS activity for the purposes of this work includes only IS activity that is NHS-funded.

4.3.2 As stated above the evidence is that those patients on IS waiting lists are in general from less deprived areas than those on NHS waiting lists. However, the evidence of the patient flows suggests this is in large part a reflection of geography, and those IS providers with a more deprived catchment area have a waiting list composition more comparable to that of the NHS.

4.4 Assumptions to be modelled in:

4.4.1 Impact of productivity within the NHS sector and how this will increase capacity in the short and long term.

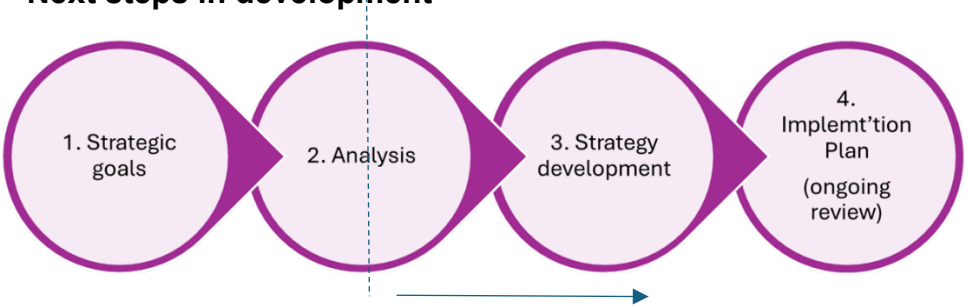
4.4.2 Impact of projections for IS utilisation;

4.4.3 Impact of known demand management measures such as the increased utilisation of Advice & Guidance and the SFT A&R model;

4.4.4 Impact of known increases in system capacity coming online – e.g. Community Diagnostic Centre at YDH, surgical centre at MPH.

4.4.5 Impact of currently unknown changes that emerge from analysis of resident needs and preferences; clinical engagement in developing the future model of elective care based on the draft clinical redesign principles; and implementing the nationally defined changes in the Elective Reform Plan and the forthcoming 10 Year Plan.

5 **Next steps in development**



5.1 To continue to develop and refine the capacity and demand model – identifying specialities and pathways of greatest growth;
5.2 Undertake engagement and gain feedback from the public regarding their priorities for elective care;
5.3 Review of best practice and research output;
5.4 Engagement with system colleagues from the independent provider sector;
5.5 Clinical engagement on the overall design of the elective model
5.6 Incorporation of priorities from the Elective Reform and 10 Year Plan (when published).
5.7 Collation of the above and articulation of draft Strategic Plan for discussion and finalisation.

6. The proposal is to return to Board in September with a draft strategy for discussion.

Appendix 1 – 'Elective Strategy Development' is attached, which contains supporting data.

IMPACT ASSESSMENTS – KEY ISSUES IDENTIFIED (please enter 'N/A' where not applicable)	
Reducing Inequalities/Equality & Diversity	The enclosed report is an update on the development of the strategy. An EIA will be completed as part of its development. Consideration is being given as to how the analysis undertaken quantifies the impact the existing elective care model may have on areas with differing IMD scores. The strategy itself will set out how any disparity will be addressed over time.
Quality	The next phase of the work will be collating resident experience of elective care and what matters most to them into the future. It will draw on research of best practice models and seek to build those quality features into the commissioned model of the future. This however needs to be met within the financial envelope available.
Safeguarding	N/A
Financial/Resource/ Value for Money	The ongoing modelling will include an affordability factor as there is finite resource to support the reduction in waiting lists.
Sustainability	Will be factored into final version.
Governance/Legal/ Privacy	The Somerset systems approach to delivery of the 2025/26 performance requirements for elective care is set out within our Operational Plan.
Confidentiality	Open information.
Risk Description	There's an overall risk to capacity given the forthcoming changes to organisational form. Work on the development of the strategy had been paused during the Operational planning round and further delays are not anticipated.

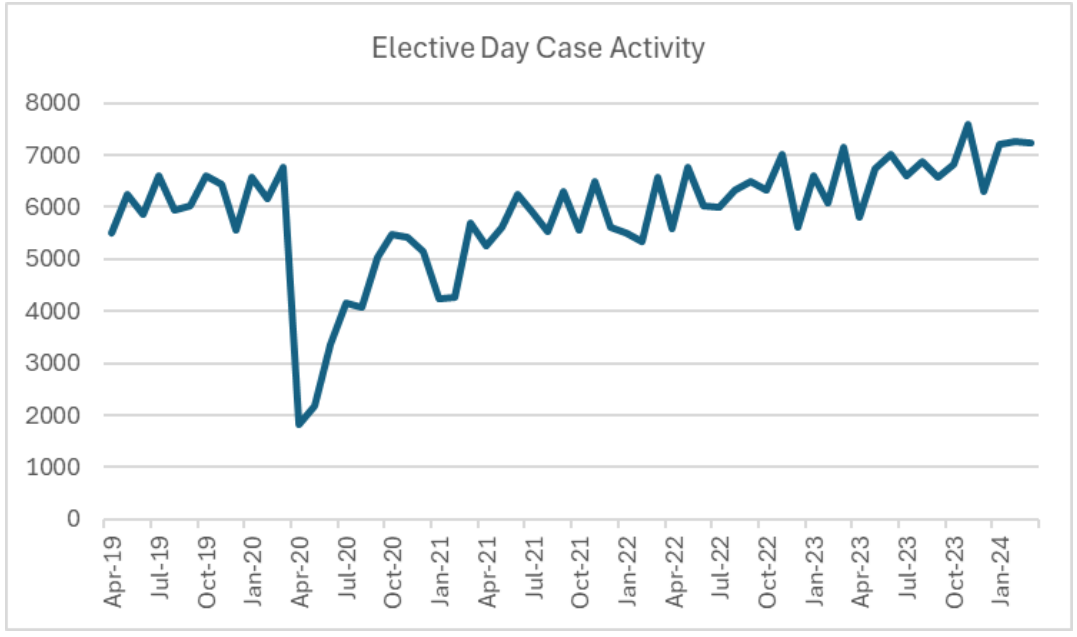
APPENDIX 1

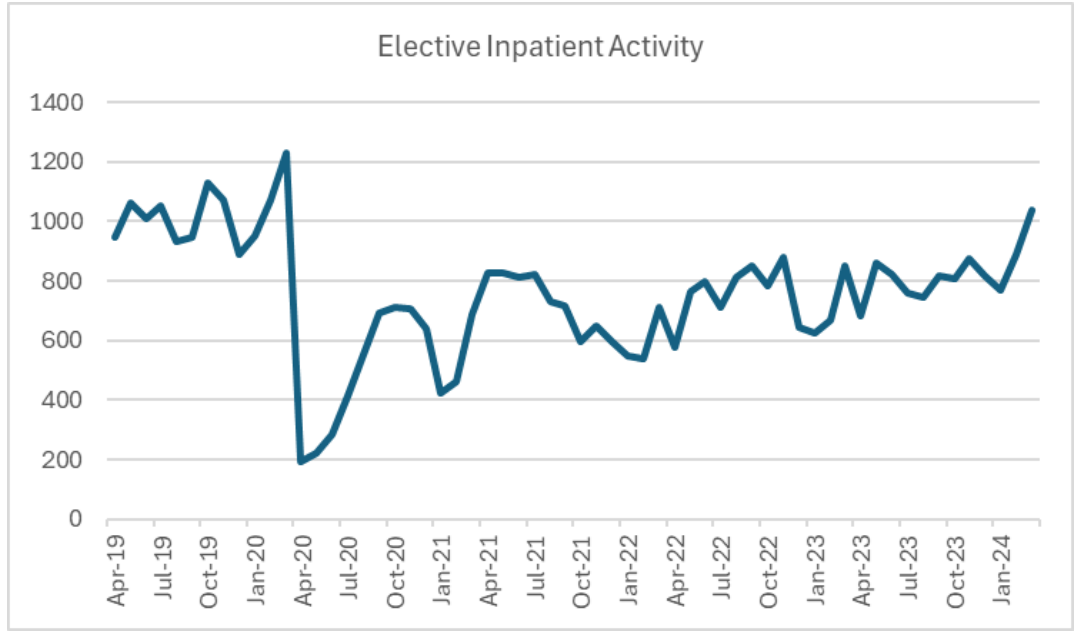
Elective Strategy Development

Somerset ICS 2025

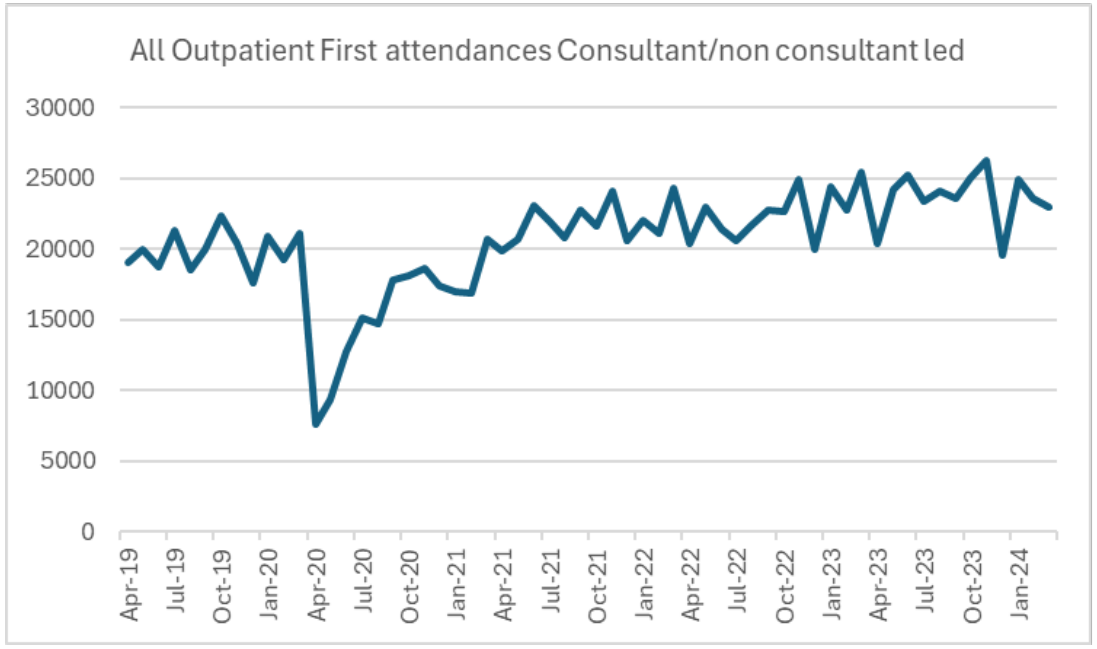
Current State Analysis

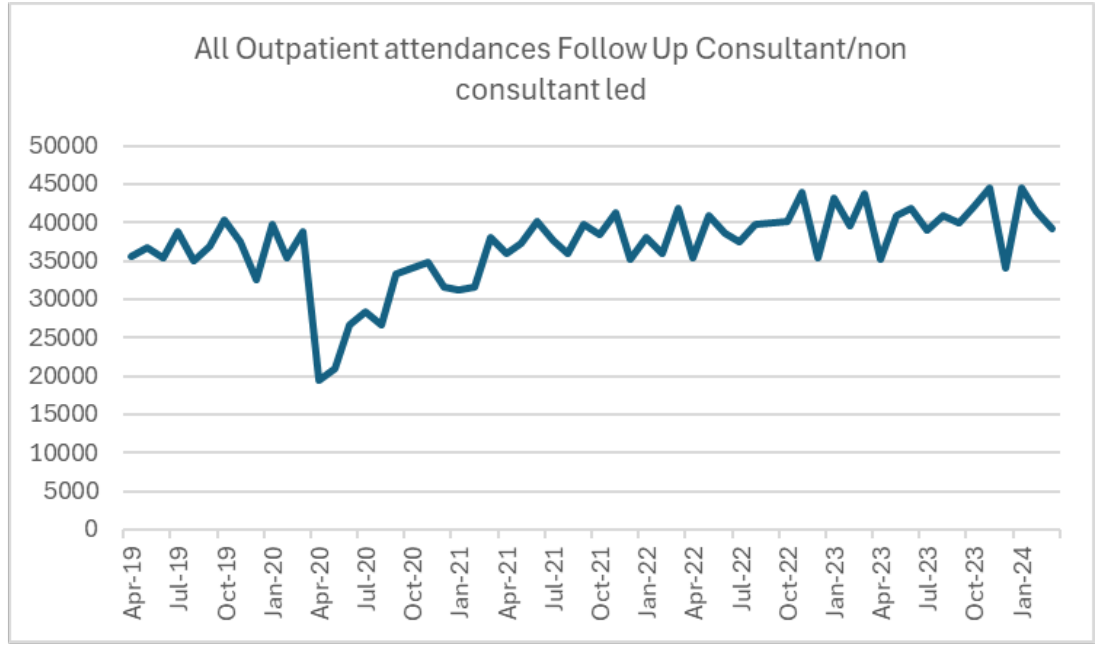
Case for Change: Recent trends in activity



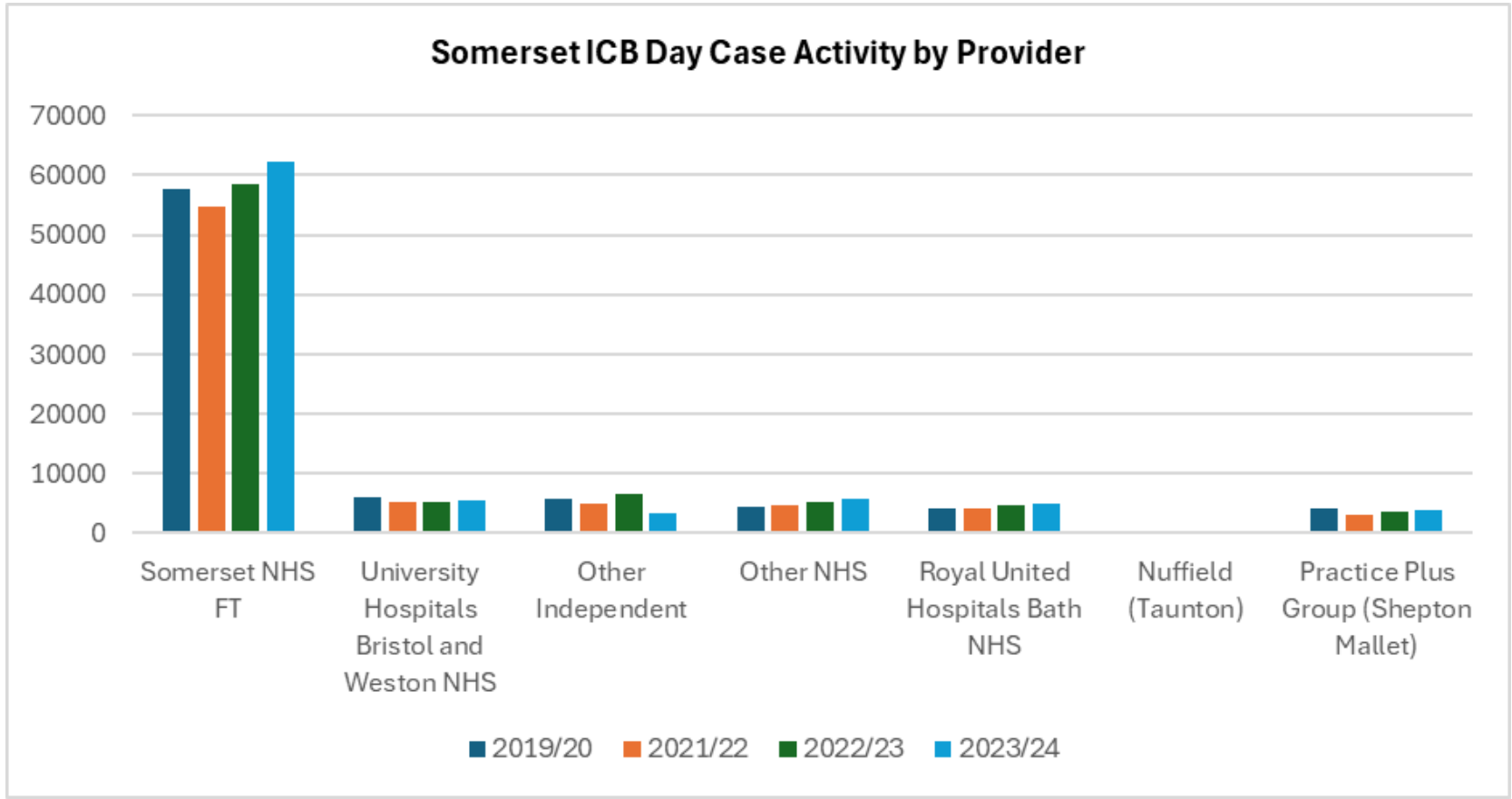


Recent trends in activity





Activity split by provider



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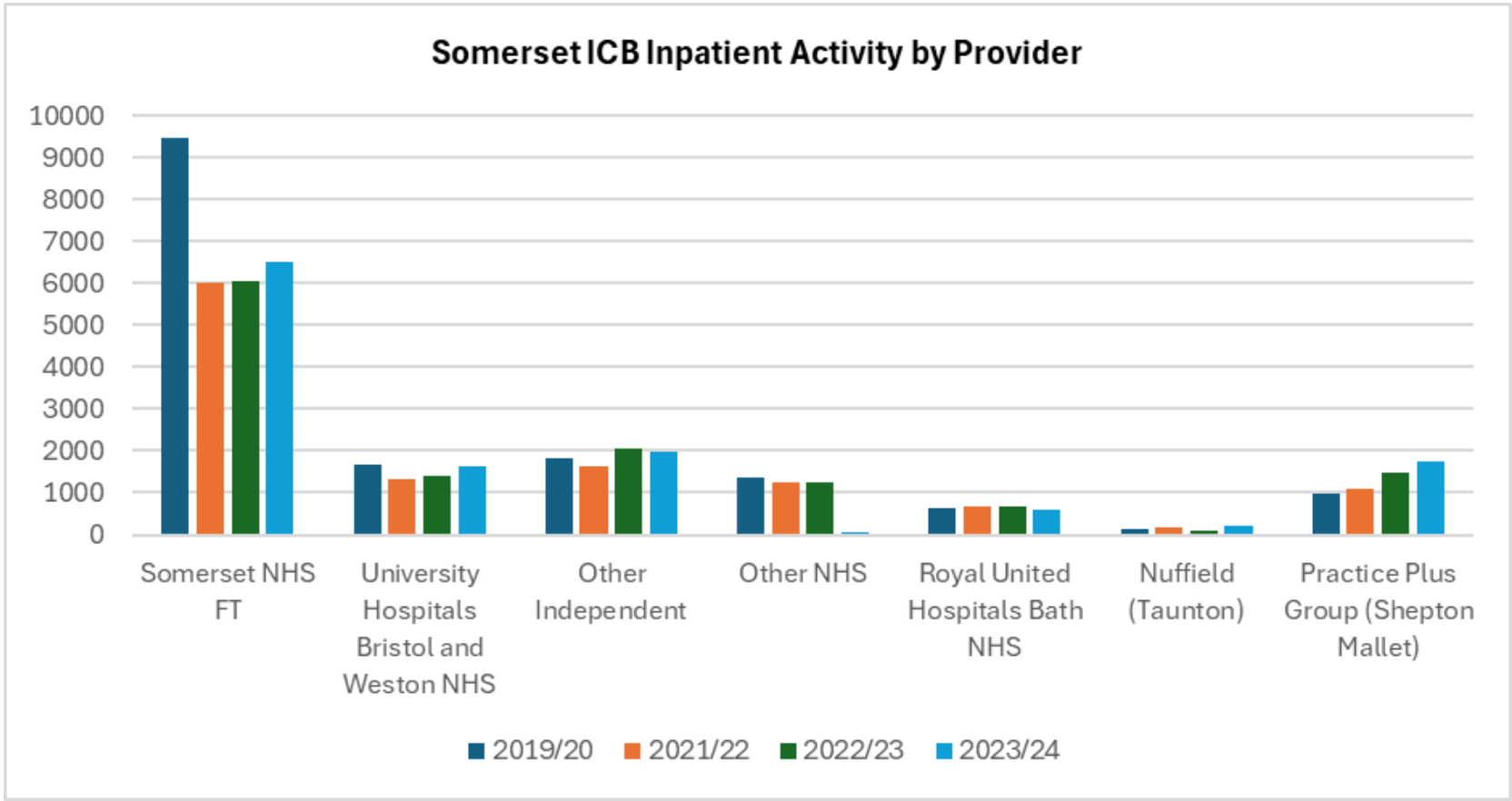

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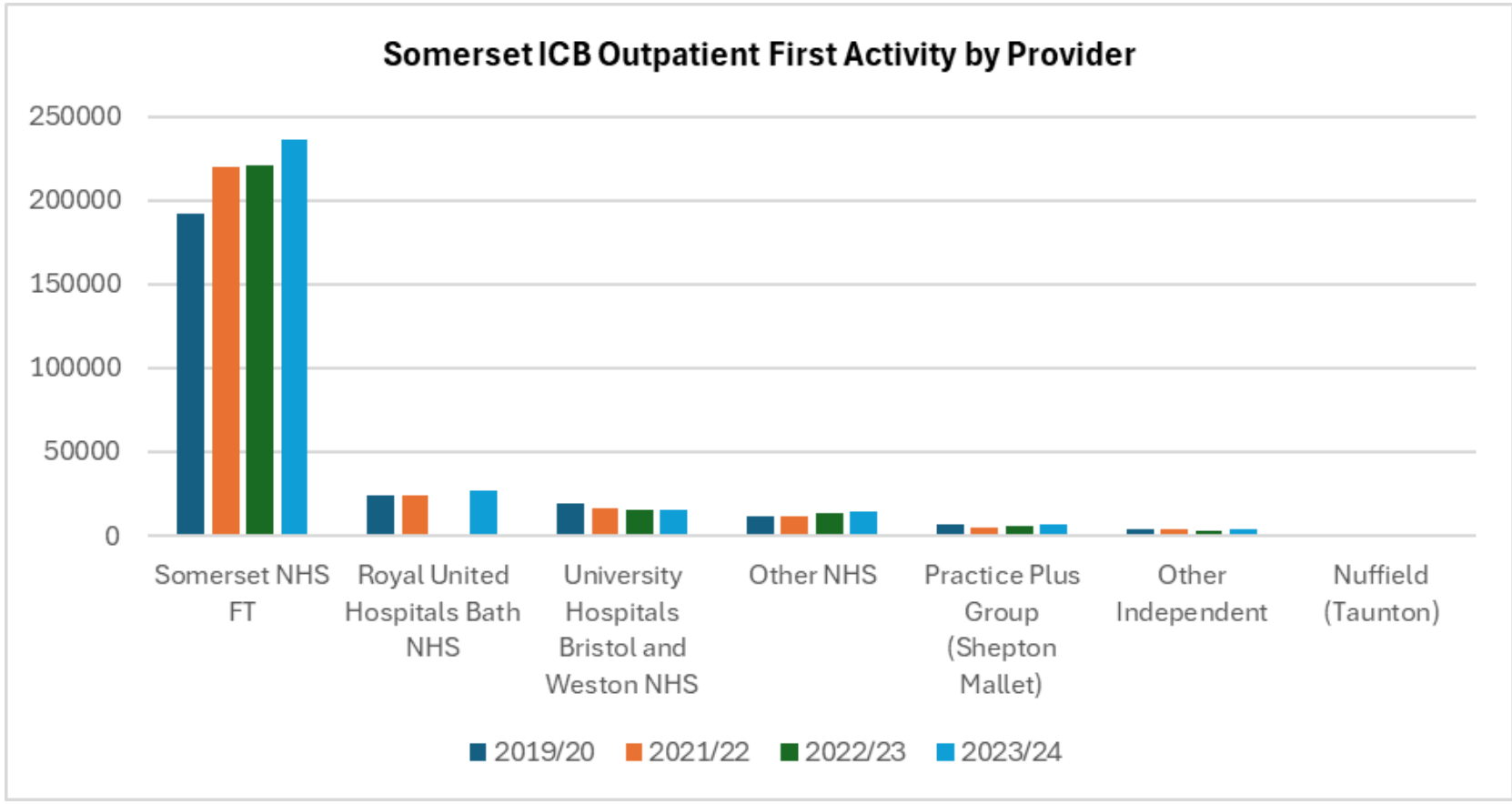

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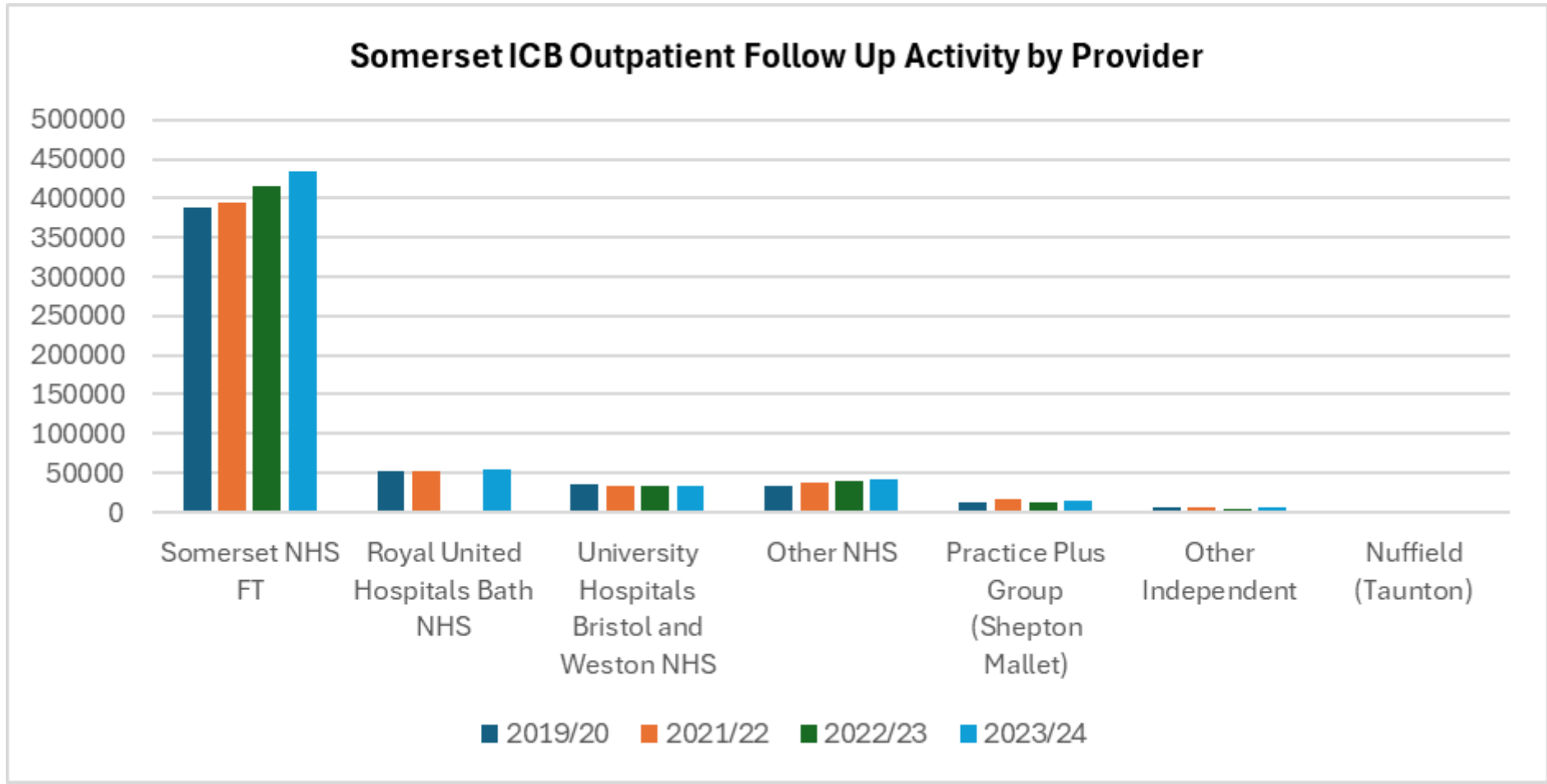
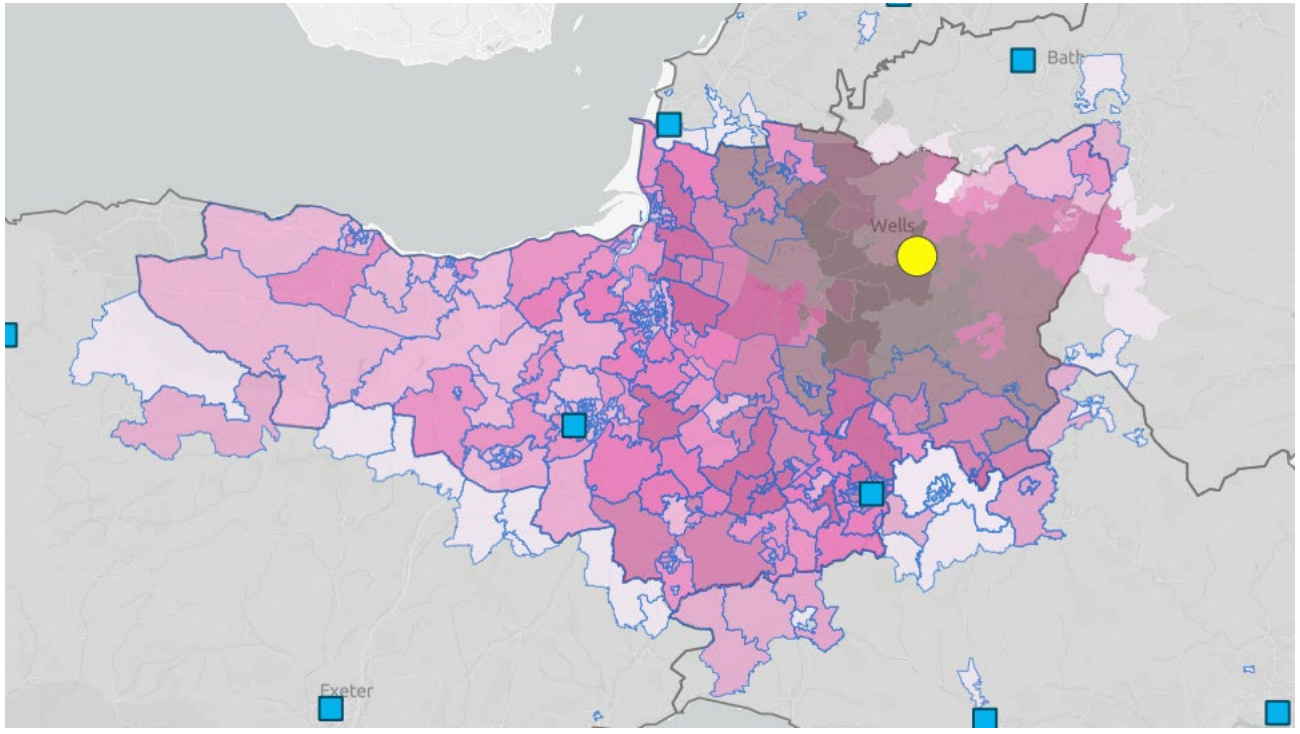
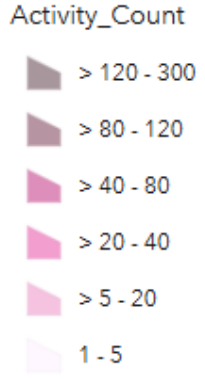


Independent Sector Flows

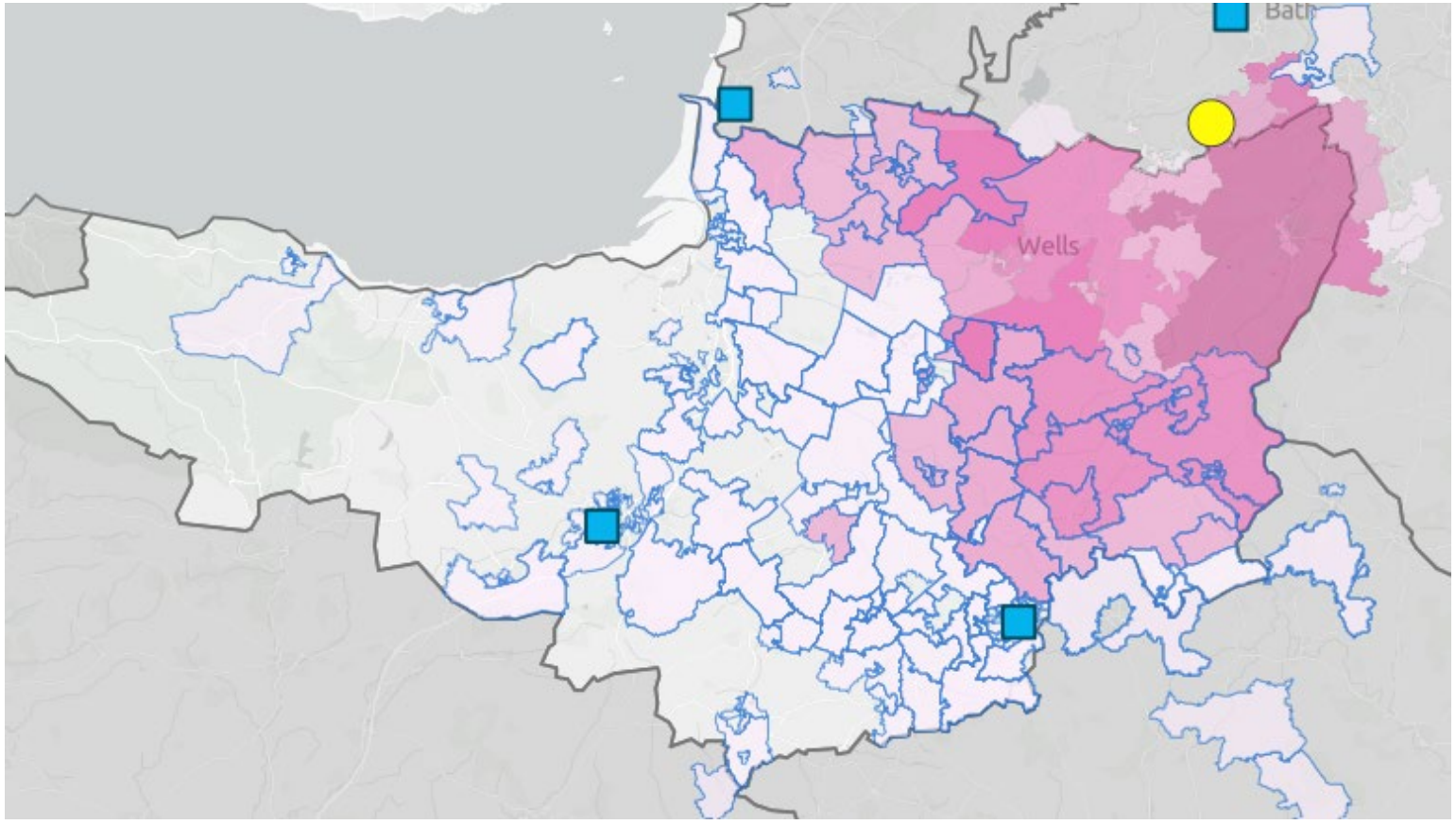
- Current IS utilisation/flows have been analysed by patient flow and by deprivation. Currently limited to biggest providers of NHS activity.



PPG (Yellow): Geographic flows of patients



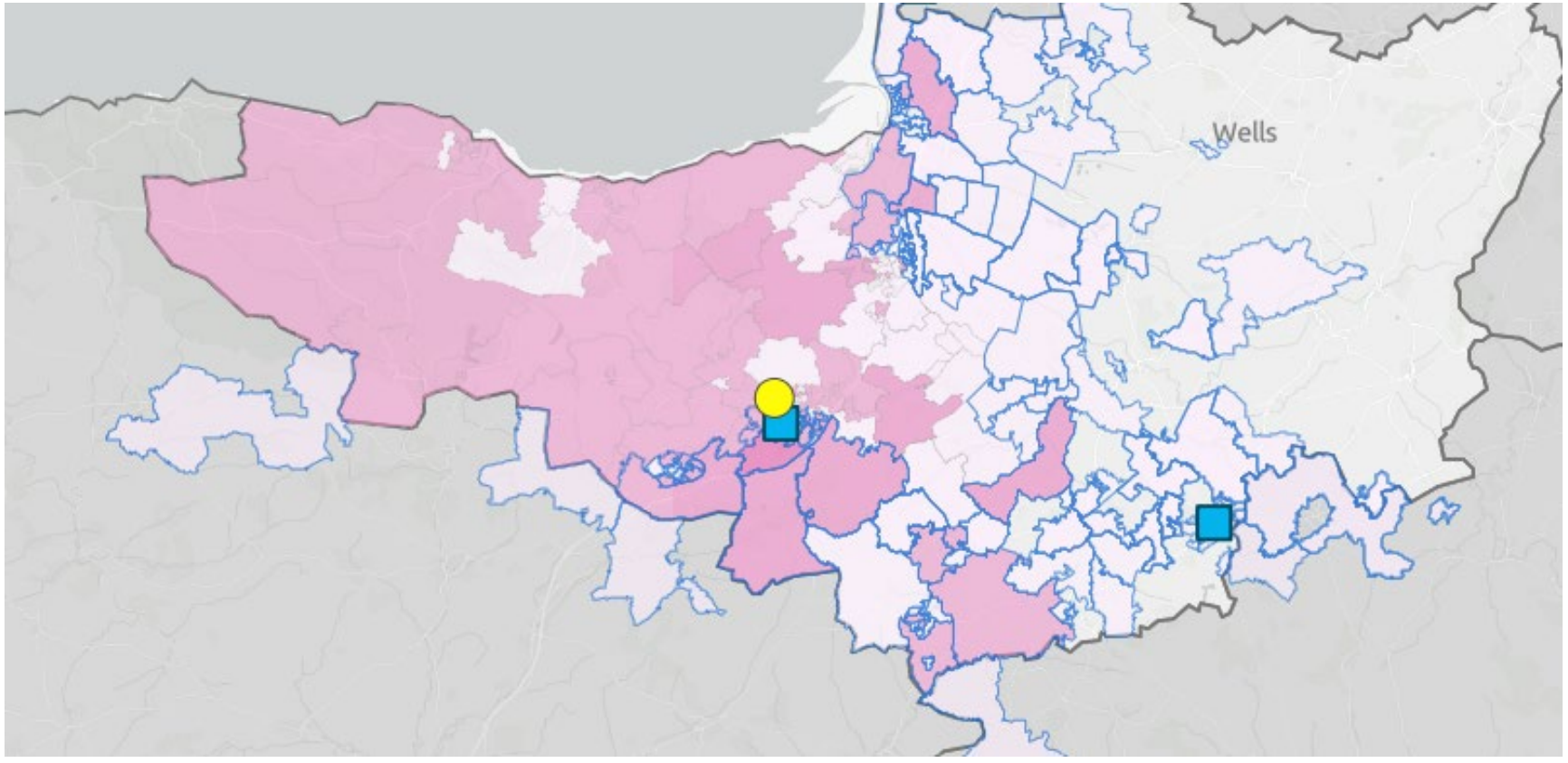
Patient flows: Sulis



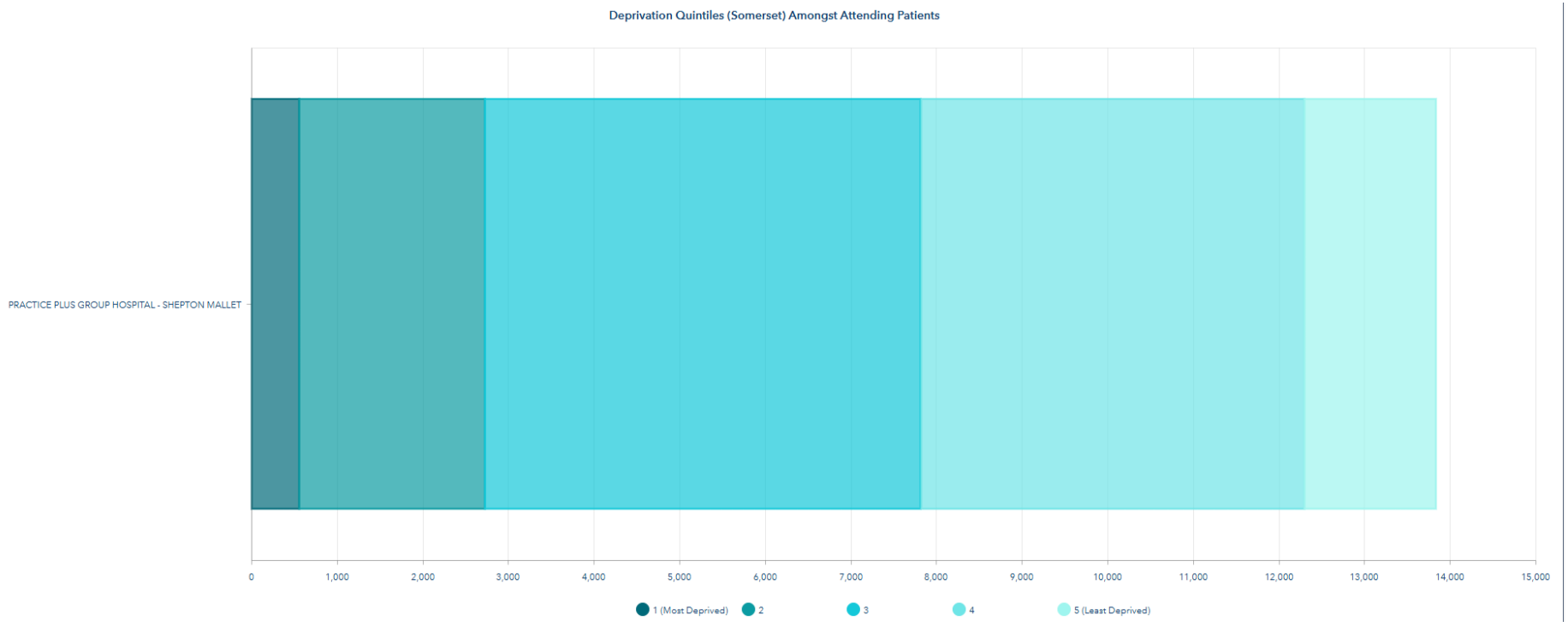
Activity_Count

- > 120 - 300
- > 80 - 120
- > 40 - 80
- > 20 - 40
- > 5 - 20
- 1 - 5

Patient flows: NewMedica Taunton



IS by Deprivation: PPG



Working Together to Improve Health and Wellbeing

Future Modelling

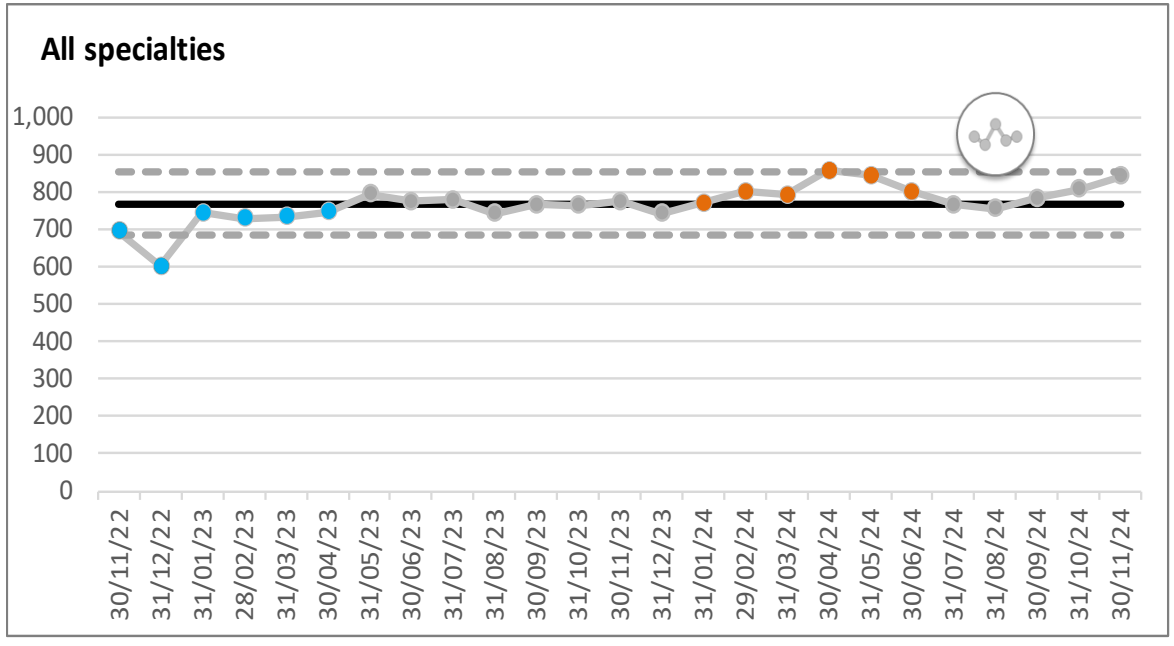
Note: All figures are indicative at this stage and subject to further refinement and validation.

Understanding Current D&C: Modelling Approach

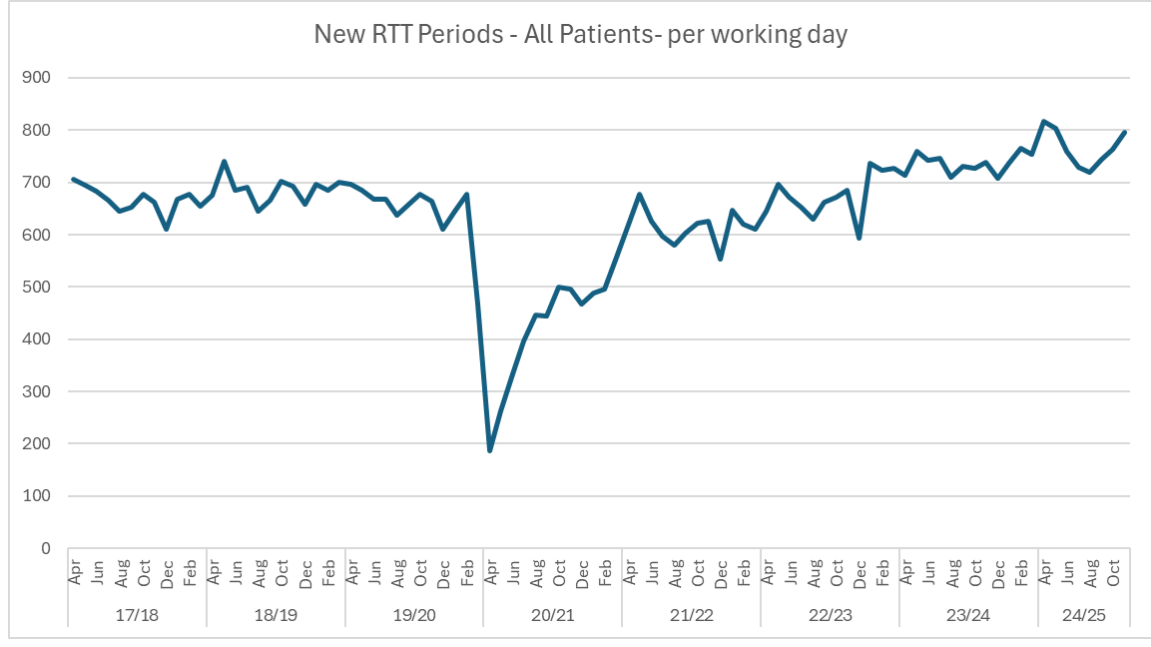
- Data source: Secondary Uses Service (SUS)
- Scope: Somerset registered population
- Baseline period: Dec-23 – Nov-24
- Year 0 (24/25) position = baseline projected forwards with recent historic demand growth at provider/specialty level
- Demand based on average weekly activity (annualised) less waiting list change over baseline period
- Demographic growth: age-weighted at specialty-level based on latest ONS population projections
- Non-demographic growth: 1% p.a, 2.9% p.a. for specialised (in line with 5YFV), historic growth for Oral Surgery

Rationale for demand growth assumptions

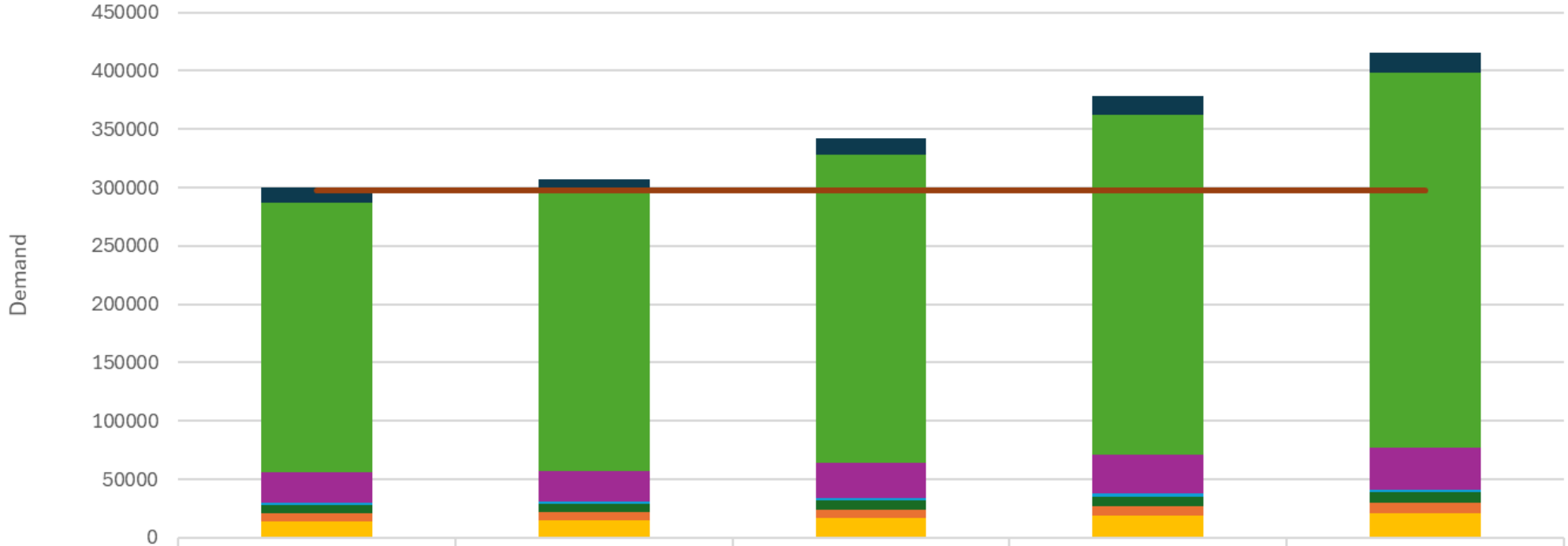
- Recent growth in demand (RTT clock starts) not showing special cause variation (also analysed at specialty-level):



- Recent growth not in line with pre-COVID trends, suggesting unlikely to continue at the same level in the long term (also analysed at specialty-level):



Output summary – Outpatient First



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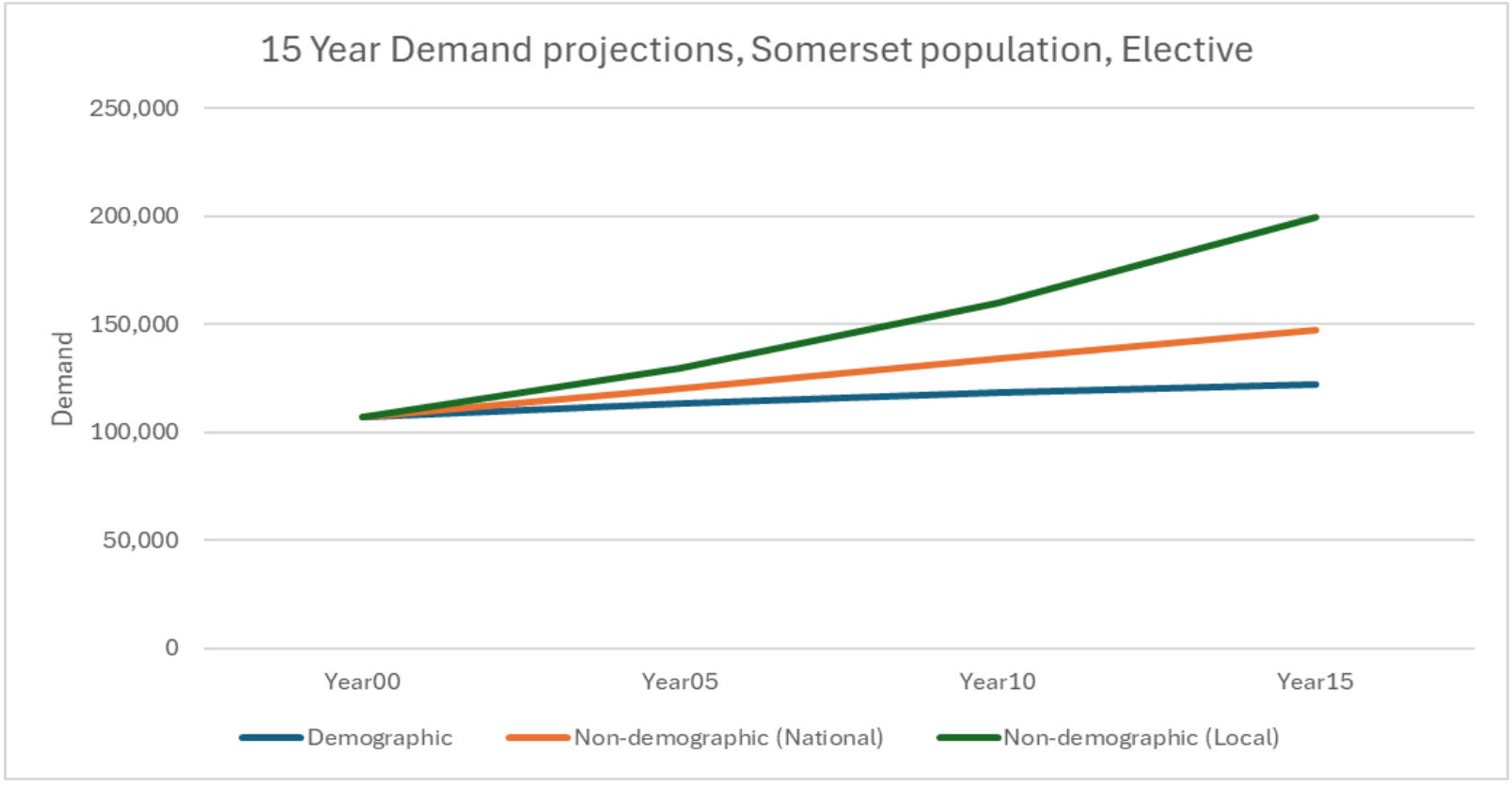
Growth Rate Comparisons

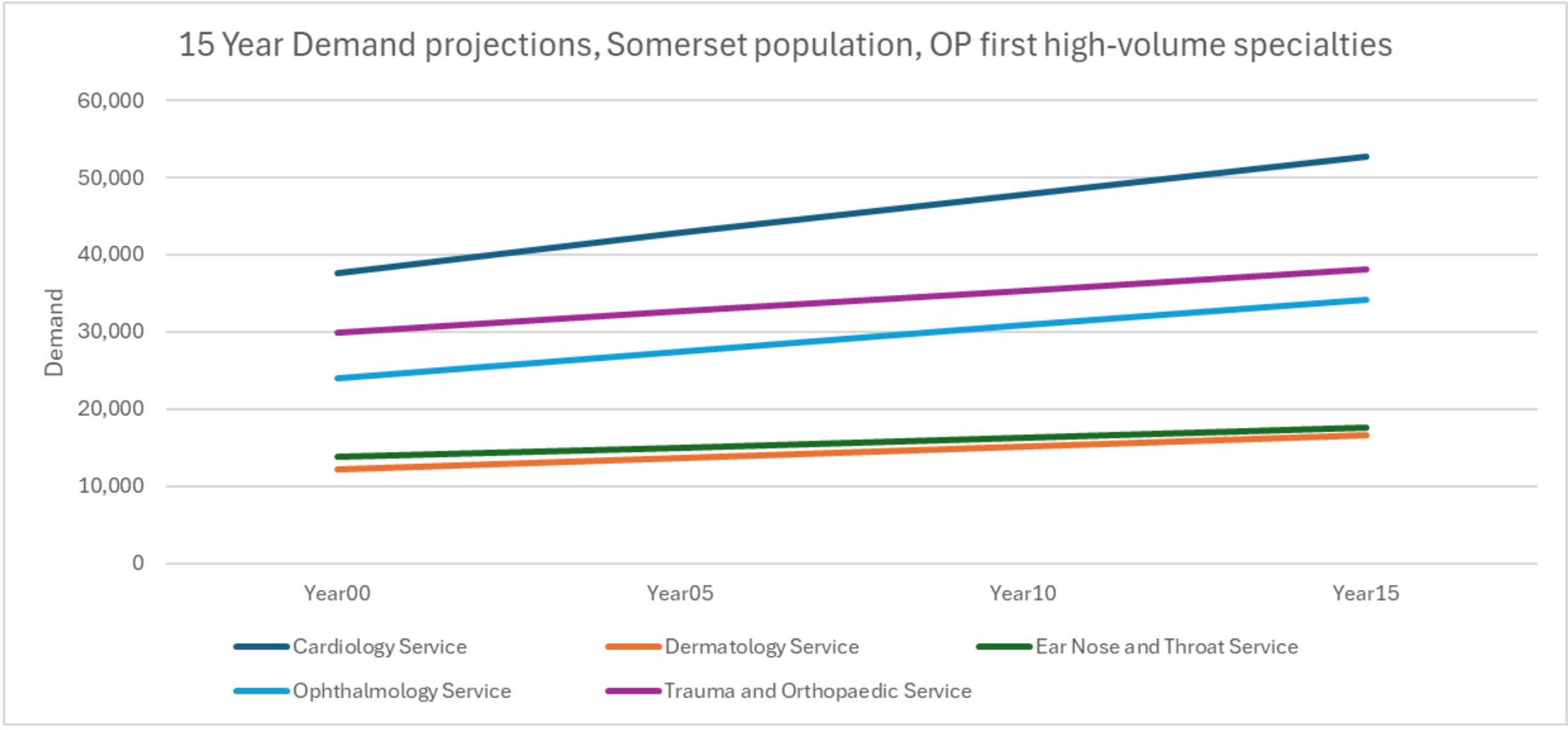


Activity type	Demographic	Non-demographic (National)	Non-demographic (Local)
OP First Attendance	0.8%	2.0%	4.2%
OP Follow Up Attendance	0.8%	2.3%	4.1%
OP Total	**0.8%**	**2.2%**	**4.1%**
Elective DC	0.9%	2.1%	4.3%
Elective IP	0.7%	2.1%	3.7%
Elective Total	**0.9%**	**2.1%**	**4.2%**

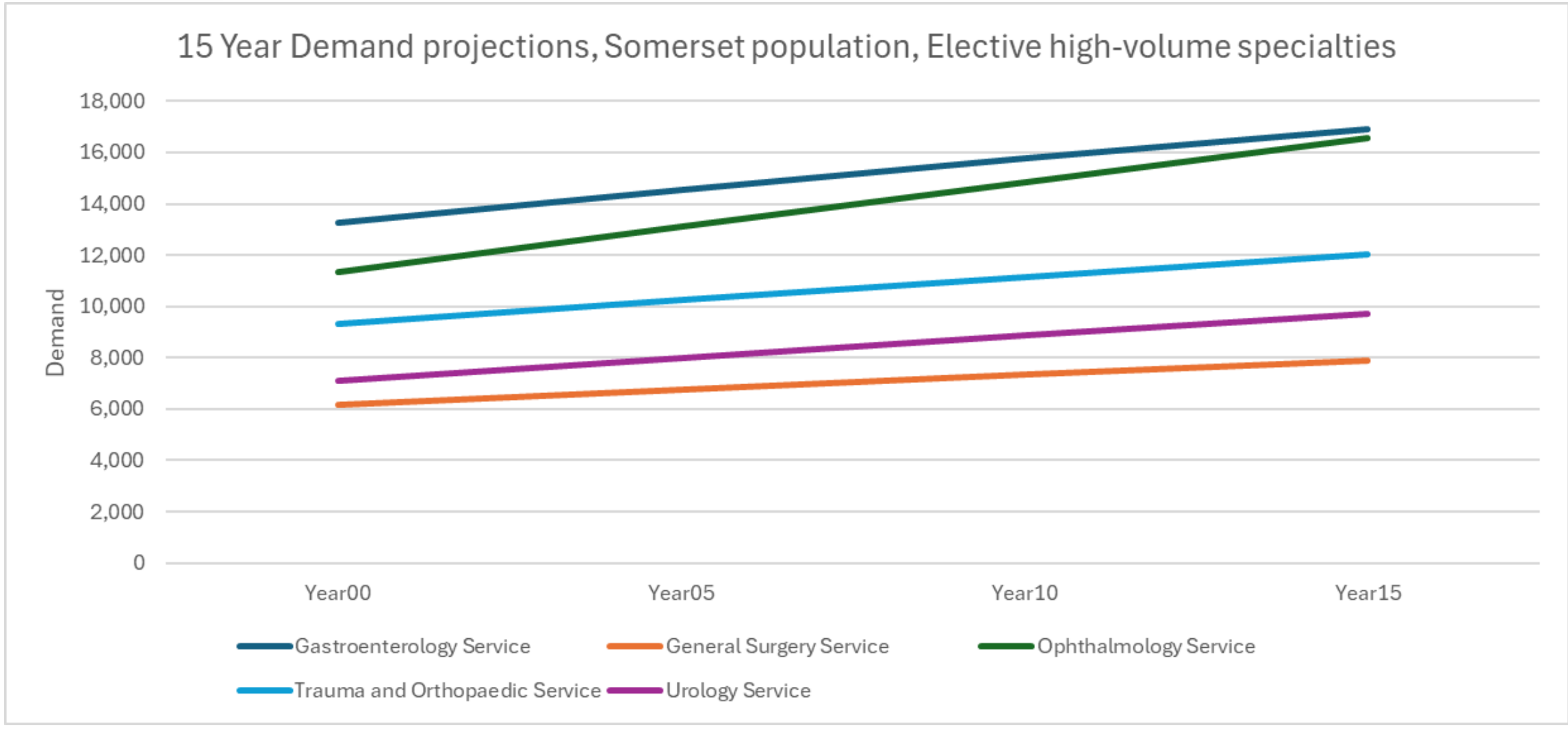
Non-demographic (National) = growth rate used in model, 1% p.a. for acute, 2.9% p.a for specialised activity

Non-demographic (Local) = applying recent growth trend in clock starts (Apr-23 onwards), capped at 5% p.a. at specialty level

High-volume specialties– Outpatient First



High-volume specialties– Elective



Further developing the model

- Update model baseline to 24/25 actuals
  - Currently not possible due to missing outpatient data in latest SFT SUS submissions. Feasibility of updating baseline will depend on SFT's expected resolution timescales.
- Assess impacts of demand mitigation schemes (e.g. A&G) and the impact on capacity of provider initiatives e.g. productivity and service provision changes (e.g. elective hub), and overlay these onto the unmitigated position
- The outputs cover recurrent demand only – the modelling implicitly assumes that there will be non-recurrent demand to recover the RTT position in year 1-4 and will therefore not impact on the current model horizon (5/10/15 year).
  - Consider whether to undertake further work to estimate the non-recurrent demand in year 1-4 and assess possible capacity gaps during this medium-term horizon in addition to the longer-term projections
- Consider using updated non-demographic growth assumptions, from national New Hospitals Programme model