Referral to treatment consultant-led waiting times

Reviewing the pathways of patients who have waited longer than 18 weeks before starting their treatment

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Description	As set out in the NHS Operating Framework and NHS Constitution patients have a right to start consultant-led treatment within a maximum of 18 weeks. To minimise unnecessary waits, commissioners need to understand and act upon the reasons for any unnecessary waits over 18 weeks. this guidance suggests methods for reviewing and reporting waits longer than 18 weeks in order to understand the causes and drive further improvements in patient experience.
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Reviewing the pathways of patients who have waited longer than 18 weeks before starting their treatment

Aims

1. This good practice guidance sets out the benefits of reviewing and reporting on waits longer than 18 weeks - which include understanding the causes of any unnecessary waits and driving further improvement in patients' experience of 18 weeks pathways.

2. The 18 weeks commitment is a universal right, as set out in the NHS Constitution and the NHS Operating Framework. This commitment should be delivered for every patient, in every specialty and in every organisation unless the patient chooses otherwise or it is not in their best clinical interest. The tolerances provided by the national 18 weeks operational standards (a minimum of 90 percent for admitted patients and 95 percent for non-admitted patients to start treatment within 18 weeks) are for patients who choose to wait longer or for whom this is clinically appropriate.

3. The aim of reviewing waits longer than 18 weeks is to differentiate between legitimately longer waits (where it is not in the patient's clinical interest or the patient chooses to wait along the pathway) and unnecessary waits longer than 18 weeks.

4. Reviewing waits longer than 18 weeks will identify systemic problems which need to be rectified in order to deliver the universal right. Ultimately, when no unnecessary waits are being reported it will confirm that all waits longer than 18 weeks are for legitimate reasons.

5. A better understanding of any waits longer than 18 weeks should allow local health communities (LHCs) to agree local access policies which meet the needs of patients and deliver the 18 weeks standard for all patients. It is good practice to agree local access policies with clinicians and patients – and to publish these.

6. The overarching aim of reviews of waits longer than 18 weeks is to identify systemic problems in an organisation or a local health community so that these can be tackled. Organisations will want to satisfy themselves that local procedures take full account of equalities and that there is no evidence of disproportionate waits for any particular population group or groups. Organisations will also need to have sufficient information to be able to explain the reasons for waits longer than 18 weeks when asked to do so by patients and the public.

Responsibilities

7. It is recommended therefore that responsibilities for reviewing waits longer than 18 weeks locally are:

    - Providers to review waits longer than the 18 week standards on a monthly basis in a way that differentiates between legitimately longer waits and unnecessary waits at specialty level and to report this information to their Board and their commissioner(s).

- Commissioners to report the results of reviews of waits over 18 weeks to their Board and as part of the ongoing commissioning processes to eliminate all unnecessary waits over 18 weeks;

- SHAs to assure themselves at their regular performance meetings that their local commissioners are reviewing waits over 18 weeks and acting to tackle any unnecessary waits;

- SHAs to raise any substantial issues arising from reviews of waits longer than 18 weeks with the DH at their regular performance meetings. This will include raising issues about disproportionate waits for any particular population group or groups.

How to carry out a review

8. It is not intended that these reviews should add to the burden of reporting. Indeed, rather than a superficial assessment of all waits longer than 18 weeks it is recommended that there is more value in undertaking a detailed review of a small cohort of waits longer than 18 weeks on a monthly basis to ensure the root-cause(s) are identified and understood.

9. The guidance at Annex 1 suggests ways in which the selection of waits longer than 18 weeks could be carried out. These focus initially on high volumes of waits longer than 18 weeks and areas with the longest waits.

10. It is recommended that reviews should record the *primary* reason why patients waited longer than 18 weeks. This requires an assessment of the total pathway by staff who understand the Trust processes, systems and local access policy. Locally agreed milestones by specialty or clinical pathway will help with this process in most instances (see 'Tips for Implementation' at Annex 2).

11. In declaring that the primary reason for a wait longer than 18 weeks is legitimately the result of patient choice or patient co-operation, Trusts must demonstrate that:

    - either the patient generated the delay by asking to wait longer;

    - or that the wait was a clinical exception (i.e. that waiting longer than 18 weeks was in the best clinical interest of the patient).

12. It should be emphasised that reviewing waits longer than 18 weeks is not a substitute for effective demand and capacity planning and proactive management of services to prevent unnecessary waits.

13. We recommend that monthly review reports should include:

    - the total number of unnecessary waits in the month and the distribution of their Referral to Treatment (RTT) waiting times at specialty level - and where possible, separating those specialities reported in national returns under the 'Other' category to ensure greater visibility of those specialities at local level. It may also be helpful to report at sub-specialty level where appropriate (e.g. spinal surgery,

bariatric surgery, etc);

- a breakdown of waits longer than 18 weeks for legitimate reasons (choice and complexity) unnecessary waits;
- for unnecessary waits, details of the systemic reasons identified, the total length of RTT waiting time and an estimate of the excess wait caused by the reason;
- a commentary and action plan for resolving unnecessary waits.

Annexes:

Annex 1: Selection Guidance

Annex 2: Tips for Implementation

Annex 3: Example Descriptors for waits longer than 18 weeks

Selection Guidance Annex 1

Overview

Analysing all waits over 18 weeks could be prohibitively labour intensive, and therefore some audit selection may be required.

A sample-based approach is recommended, therefore, which involves selecting patients that are representative of the population as a whole and which will identify systemic problems which make the greatest contribution to unnecessary waits.

Examples of sample selection

Trusts may find it helpful to use two stages during the selection process.

- The first is a high level assessment of a broad range of patients to identify the proportion of patients who have waited longer than 18 weeks for legitimate reasons compared with the proportion who have waited unnecessarily and through this identify an area for further investigation.

- The second stage will produce a more detailed understanding of the causes of unnecessary waits and will identify actions to rectify the situation.

Trusts should start their reviews in those service areas which are anticipated to have the largest systemic problems and over time need to step back and undertake periodic reviews to confirm that all services in the organisation are being addressed. There are many ways in which trusts might want to undertake reviews:

Example 1

Trusts may decide to undertake a detailed analysis of **all waits longer than 18 weeks** in **all** specialties if they have a low volume of waits longer than 18 weeks and this is not considered to be too labour intensive.

Example 2

Trusts with a large number of waits longer than 18 weeks may find it helpful to take the 2 phased approach to audit selection:

Phase 1 would involve selecting a diverse cohort of patients covering a variety of treatment functions and length of wait and to identify the proportion of patients who have waited longer than 18 weeks for legitimate reasons and those who have waited unnecessarily. It is suggested that Trusts should investigate approximately 5-10% of patients who have waited longer than 18 weeks.

Phase 2 will undertake a deeper investigation into a particular area identified in phase 1 by selecting 12-24 patients from the target area to produce a more detailed understanding of the primary reasons for systemic delays and identify the actions required to rectify this.

Example 3

Trusts may already have established weekly reporting on patients waiting longer than 18 weeks as part of operational performance monitoring that is able to identify legitimate waits longer than 18 weeks as well as unnecessary waits. This information can be used as a starting point for the monthly review report. However, as recommended above, the monthly report also needs to draw together key areas of systemic delays and provide an action plan which will tackle the root causes of these delays.

Example 4

Trusts may decide to undertake a more detailed audit by treatment function on a rotating basis, e.g. March – Orthopaedics, April - General Surgery. Trusts need to have a clear rationale for their selection process which could include a variety of existing reports e.g. RTT performance reports and existing local validation processes.

Tips for Implementation

Annex 2

It is recommended that wherever possible Trusts should:

- Identify and record reasons for delays in real time as any delay could contribute to more patients having an unnecessary wait in the future. Trusts should use any available PAS fields to record reasons for delays when they occur.

- Consider modifying existing validation sheets and RTT reporting spreadsheets to record delays identified at validation and/or the outcome of the monthly audit of waits longer than 18 weeks using local descriptors and a free text explanation.

- Ask a senior manager to lead reviews, and take responsibility for identifying the cohort of patients to be reviewed (see Annex 1) and for producing the report.

- Ensure reviews are an assessment of the total pathway by individual(s) who understand the pathway, other Trust standards and the Trust access policy, processes and systems. Trusts may find it helpful to involve staff working in the areas to be audited. The process needs to include: analysis of PAS data; the RTT data base; 18 week validation records; other data bases e.g. RIS and the patients' medical records.

- Analyse the locally agreed process and standards set for the specialty, sub-specialty or large volume pathway to identify the primary reason for waits longer than 18 weeks. Locally agreed milestones can be very helpful to assist in this process. For example, the maximum waiting time set for:

  - time from clock start to date the patient was added to the waiting list for admission

  - the time from referral for diagnostic test to the result being available to the specialty

- Identify the primary reason for a wait longer than 18 weeks. This is the most significant delay found in the pathway and/or which was not delivered within the local standards.

- Share data on waits longer than 18 weeks for inter-provider patient pathways with referring organisations on a regular basis and for both organisations to work together to agree processes that will eliminate delays. Tertiary centres with high volumes of inter-provider transfers from a large number of organisations may not have been able to achieve this with all referring organisations yet. However, reviews of waits longer than 18 weeks will assist tertiary centres to identify those referring organisations or those pathways which need to be their priority for further detailed work.

- Appropriately account for any clock nullification at 1st DNA and/or patient initiated clock pause along the admitted phase of patient pathways. For more information on clock pauses see the Referral to Treatment consultant-led waiting times rules suite at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/ReferraltoTreatmentstatistics/DH_089757

- Include reviews of waits longer than 18 weeks as a regular agenda item at appropriate executive director led meeting(s) e.g. a board or performance meeting. This will ensure action plans are ratified and the findings of audits lead to improvements in patient pathways.

- include reports of waits longer than 18 weeks in all key reports to the Trust Board.

Example Descriptors for Waits Longer Than 18 Weeks

Annex 3

The following provides an example list of descriptors for legitimate reasons and common reasons of unnecessary delays which providers and local health communities could use, or adapt to suit local circumstances.

This is not an exhaustive list. In addition, further drill down will be required in some areas to identify the root causes.

Example descriptors		
Legitimate waits longer than 18 weeks	Patient chooses to wait longer than 18 weeks	See national Referral to Treatment consultant-led waiting times rules Also refer to your own published access policy
	Patient non-cooperation (e.g. DNAs) *N.B. Providers must ascertain communications with patients were effective and received and in good time*	
	Not in the patient's best clinical interest	
Unnecessary wait	Insufficient capacity	Capacity – first appointment
		Capacity – Post-diagnostic follow up
		Capacity – Theatre
		Capacity – beds
		Capacity – specialist staff
		Capacity – ICU
		Capacity – preassessment
		Capacity – other
	Hospital cancellation	Hospital cancellation of Clinic
		Hospital cancellation – no theatre
		Hospital cancellation – no beds
		Hospital cancellation – staff absence
	Diagnostic delay	Insufficient diagnostic capacity to deliver local standards for diagnostic tests
		Reporting delay
	Medically not fit	Medically not fit at pre-assessment
		Not fit while awaiting admission
	Process delay	Paper process delay
		Incorrect patient demographics
		Referral vetting delay
		Postal delay
	Late transfer from another provider	
	Other local issues	