

# Maximum Waiting Times

## Guidance for Commissioners



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## 1. Background

The NHS Constitution sets out statutory rights for all NHS patients. One of the factors taken into account in determining Quality Premium payments for clinical commissioning groups (CCGs) will be discharging their patients' statutory rights on waiting times. Annex A summarises these.

Equality and diversity are at the heart of the NHS strategy. Due regard to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited in under the Equality Act 2010) and those who do not share it, has been given throughout the development of the policies and processes cited in this document

## 2. Implementation Support

How can I plan capacity to ensure that patients' rights to access services within maximum waiting times are met?

When you are reviewing providers' activity plans for the following year, commissioners should review the level of referrals to a provider and waiting times to identify any areas where the level of activity commissioned should be different from current activity levels. If referrals or waiting times are increasing, this could indicate that more activity will be required to stay within maximum waiting times. Equally, it could indicate that waiting list management and processes should be reviewed.

How can I monitor the performance of my providers?

The NHS Standard Contract requires providers to submit information on referrals and waiting times to national systems. You should review this information routinely to understand performance. You may also wish to require the provider, through your Contract, to provide regular summary reports and evidence of validation and management of waiting lists, eg patient tracking lists (PTLs).

How can I take action on under-performance by my providers?

The NHS Standard Contract includes financial adjustments including where providers do not meet the 18 weeks maximum waiting time standard for any specialty.

Where can I find support on validation and management of waiting lists?

Extensive guidance on the measurement and validation of referral to treatment (RTT) waiting times is available at:

<http://www.england.nhs.uk/statistics/rtt-waiting-times/rtt-guidance/>.

The NHS Interim Management and Support Intensive Support Team has also produced some useful material on elective care, available at

<http://www.nhsimas.nhs.uk/what-we-can-offer/intensive-support-team/>

### **3. Referral to Treatment Consultant-led Waiting Times: Patient Tracking List (PTLs)**

Good waiting list management involves treating according to clinical priority, and then treating in turn those patients who have waited the longest.

In order to discharge patients' rights to access services within maximum waiting times from referral to treatment (RTT), every provider organisation needs to know, at least weekly, how long each patient has waited since being referred for treatment. A local weekly PTL can deliver this.

An anonymised summary of the PTL can be provided to commissioners so that they can track patients' real-time waits and play their part in ensuring delivery

#### **What a PTL is and how it can be used**

A PTL is a list of patients who need to be treated by given dates in order to start treatment within maximum waiting times set out in the NHS Constitution.

A Patient Tracking List (PTL) is an established, forward-looking, management tool that can be used by the NHS to help achieve and sustain short Referral to Treatment and diagnostic waits.

The PTL provides a prospective viewpoint, and so can act as a planning tool for managing patient waiting lists in a way that a retrospective data collection cannot. Essentially, a PTL contains the data required to manage patients' pathways, by showing clearly which patients are approaching the maximum waiting time so operational staff (eg staff booking appointments or admissions for patients) can offer dates according to clinical priority and within maximum waiting times.

Other advantages of a PTL include:

- driving up data completeness and quality;
- enabling commissioners to make more informed decisions about future commissioning needs; and
- helping inform the redesign of pathways to support delivery of more efficient and streamlined care.

#### **How providers can structure a PTL**

A model Referral to Treatment Summary Weekly Patient Tracking List has three sections, corresponding to three categories of patients on referral to treatment pathways:

- Patients without a decision to admit for treatment who are still awaiting treatment (including patients where it has not yet been decided whether to admit for treatment or treat in outpatients).
- Patients with a decision to admit for treatment who are still awaiting treatment.
- Patients with a referral to treatment period end date in the last seven days.

This does not cover all the components of a PTL that individual providers and commissioners may wish to develop and share, especially at patient and treatment function level.

## **Lessons learnt by organisations that have used RTT PTLs**

### **i. There is a lead time to setting up a PTL**

- Invest time in training staff about the referral to treatment waiting times standards and the maximum waiting times right.
- Ensure staff who are inputting information understand the importance of accurate RTT data.
- Clinical engagement is essential to facilitate the data required to support an RTT PTL. Clinicians need to understand definitions to capture accurate data on clinical outcome forms (see section iv [data collection]).

### **ii. Develop one PTL for all RTT consultant-led patients**

It is recommended that one PTL is used for all RTT patients, rather than one for admitted and one for non-admitted patients. This is because admitted patients cannot be identified at the point of referral, and running two PTLs can lead to duplication.

### **iii. Consider how to track the diagnostic phase within the pathway**

For example, clinic outcome data can help indicate whether a patient is waiting for a diagnostic test, or a test has taken place and the results are awaited.

### **iv. Generate a PTL that is easy to understand**

Convert field names into easily/widely recognised descriptions when extracting data from the Patient Administration System (PAS), so that PTL reports are understood by staff without analyst support.

### **v. Data collection**

Clinic outcome forms that record what actually happened at an outpatient attendance (eg treatment in outpatients) and any intended next step on the patient pathway are a key step to being able to track RTT pathways.

It is important to ensure that all patients have clock starts, which may require some retrospective data entry into a PAS, to ensure that all incomplete

pathways have a treatment period status assigned to their previous attendances. The status tells whether an activity is part of an RTT pathway or not, and whether that activity has started a clock, stopped a clock or continued an existing ticking RTT clock.

**vi. Inter Provider Transfers (IPTs)**

Ensure that there is an agreed process for transfer of RTT data between organisations for patients whose care transfers from one organisation to another. Think about the interfaces between Referral Management Centres (RMCs) and secondary care, between NHS and independent sector providers, and between secondary care and tertiary services.

Commissioners must ensure that the time taken for patients who are initially referred to a RMC, to be referred onwards, is clearly agreed and that this is closely monitored; the RTT waiting time clock starts when the GP makes the referral to the RMC.

More information on IPTs is available in the Referral to Treatment Consultant-led waiting times guidance on 'How to Measure' available at

<http://www.england.nhs.uk/statistics/rtt-waiting-times/rtt-guidance/>

**vii. Consider the coding of waiting lists**

Consider whether waiting lists can be coded in order to identify whether a future appointment is intended for first definitive treatment or not, so that those pathways where a clock stop is planned can be identified.

**viii. Identify which follow up appointments are relevant for a PTL/to an RTT pathway**

For patients requiring follow-up attendances, subsequent to their initial outpatient or diagnostic appointments, as part of their referral to treatment pathway (for example, in the lead up to first definitive treatment), such follow-up attendances should be captured on the PTL.

Waits for follow-up attendances that are not part of an active referral to treatment pathway - and cannot take place for clinical reasons until a specified time in the future - should be recorded on a separate planned waiting list and should not be captured on a PTL. Guidance on the appropriate use of planned waiting lists is available at

<http://www.england.nhs.uk/statistics/rtt-waiting-times/rtt-guidance/>

**ix. Consider stage of treatment milestone dates along the pathway**

What date is a patient expected to be at key stages on the pathway? eg New Outpatient date, Decision to treat and Treat by date. This can make it easier to identify whether a patient is at risk of waiting longer than the maximum waiting time.

**x. Where is support and advice available?**

Practical help and advice on using a PTL is available from the Intensive Support Team of the NHS Interim Management and Support Service ([nhs.imas@nhs.net](mailto:nhs.imas@nhs.net)).

## **4. How to raise patient awareness, including hard to reach groups**

It is good practice for commissioners and providers to make patients aware of their rights and of the steps patients can take should their rights not be met.

Commissioners can:

- require (through your provider contracts) that all patients are aware of when their clock starts and stops;
- work with your Local Healthwatch to develop ways to support patients in exercising their rights; and
- work with local GP practices and clinical champions to raise awareness of the NHS Constitution and its benefits for patients and staff and display information on the 18-week right, in waiting areas in primary care and hospitals.

Also commissioners can require providers to:

- to include information on waiting time rights in patient appointment confirmation letters ( the NHS Standard Contract requires providers to do this);
- communicate the NHS Constitution maximum waiting time right, including the right to request alternative provision, at the beginning of a patient's referral to treatment pathway; and
- include information in the first appointment letters on how patients can find out more about the right; and official notification of when the 18 week clock started.

## **5. Alternative providers for patients who wish to be treated more quickly**

Where patients are likely to breach, or have breached, their maximum waiting time and wish to be treated more quickly, the commissioner has a duty to take all reasonable steps to identify alternative providers. Commissioners are responsible for ensuring that providers have effective systems in place to manage this process on their behalf.

Commissioners should ensure that providers take all reasonable steps to offer a range of alternative appointments to start the patient's treatment elsewhere.



Commissioners have a duty to act on the patient's behalf to secure alternative provision if the provider has failed to take all reasonable steps to do so or if the patient requests this.

A suitable alternative provider is one that can provide clinically appropriate treatment and has a contract with a CCG or NHS England. The alternative provider must be able to commence the patient's treatment more quickly than the original provider; and able to provide services on the same mandatory terms and conditions as other similar NHS services.

Where this is not possible, the provider (or, where necessary, the commissioner) should explain the reasons to the patient. It is good practice to keep a record of this conversation to inform any subsequent review of the patient's case.

### **Suggested step-by-step good practice**

Commissioners will wish to ensure that providers establish a process that is simple for patients to follow.

Where a patient or someone acting on the patient's behalf (such as a parent, guardian or carer) makes a request to seek an alternative provider, the original provider could take the following steps:

1. The provider discusses with the patient where they would be willing to travel in advance of seeking alternatives.
2. The provider tries to find the patient a quicker appointment to start treatment earlier either at a different site (at the original provider) or with other providers with whom the original provider has local arrangements and to which the patient is willing to travel.
3. The provider works with the patient's commissioner to identify, where possible, a range of alternative providers which can start the patient's treatment more quickly.
4. If suitable alternative providers are identified that can start the patient's treatment more quickly, the patient should be offered appointment dates at the alternative providers, ensuring that they are able to provide appropriate and suitable aftercare for the patient.
5. If more timely offers to commence treatment are not available at any other provider, the original provider should explain this to the patient and offer the patient an apology. The original provider should then treat the patient as soon as possible.

### **Other good practice points to note**

- The patient does not have to accept an alternative offer and may choose to remain at the original provider. This is not, however, classified as 'choosing to wait longer than 18 weeks' for the purpose of performance reporting and the patient's waiting time clock should continue to run until they start their treatment.

- Providers and commissioners should keep records of all conversations with the patient regarding this waiting time right.
- If a patient accepts the offer of an alternative provider, the provider should consider making appropriate arrangements for the patient's travel and accommodation to avoid financial disadvantage.
- When discussing alternative provision options with patients, it is good practice for providers or commissioners to:
  - provide specific information about the consultant/surgeon in charge of the patient's treatment at the alternative provider;
  - explain where to find information on quality and safety at the alternative provider;
  - provide logistical information (for example, will transport to the alternative provider be available?);
  - provide information on facilities at the alternative provider (for example car parking, visiting hours) or an indication of where the patient can find this information;
  - give patients the opportunity to meet the consultant/surgeon at the alternative provider before treatment commences/surgery takes place; and
  - provide information on where the patient's post-operative/follow-up care will take place (i.e. original provider or alternative provider).
- There is no standard amount of time that patients should be given to make decisions, but a good practice principle is that patients should not be expected to make a decision on the same day that the options are presented/received.
- It is good practice for discussions about alternative provision options to take place with clinical departments, rather than centralised booking departments.

#### **Directory of additional information / resources**

<https://www.gov.uk/government/publications/right-to-start-consultant-led-treatment-within-18-weeks>

<http://www.nhs.uk/choiceinthenhs/rightsandpledges/nhsconstitution/pages/yourrightstochoice.aspx>

#### **18 week measurement rules**

<http://www.england.nhs.uk/statistics/rtt-waiting-times/rtt-guidance/>

#### **2 week-wait measurement rules**

<http://www.connectingforhealth.nhs.uk/nhais/cancerwaiting/documentation>

#### **Handbook to the NHS Constitution**

<https://www.gov.uk/government/publications/the-nhs-constitution-for-england>

## Annex A

### The NHS Constitution rights

The NHS Constitution says, “You have the right to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of alternative providers if this is not possible”.

The two waiting times rights are

- Patients should expect to wait no more than two weeks from the time they are urgently referred by their GP with suspected cancer to the time they are seen by a specialist.
- No one should expect to wait more than 18 weeks from the time they are referred to the start of their consultant-led treatment, unless it is clinically appropriate to do so or they choose to wait longer.

### Commissioners’ Legal Duties<sup>1</sup>

To ensure that for patients for whom they are responsible:

- at least 90 per cent of patients admitted for hospital treatment start consultant-led treatment within 18 weeks in all specialties;
- at least 95 per cent of patients who are not admitted to hospital start consultant-led treatment within 18 weeks in all specialties;
- at least 92 per cent of patients still waiting to start consultant-led treatment have been waiting no more than 18 weeks.

To take all reasonable steps to ensure that any patients for whom the 18 week or two week maximum waiting time is not met are offered a quicker appointment to start treatment at a range of clinically appropriate alternative providers, if the patient requests this.

To provide patients on 18 week and two week pathways with a dedicated contact point to approach if the maximum waiting time has been, or will be, breached and if they wish to seek an alternative.

To ensure providers give a contact point for patients to approach if the maximum waiting time has been, or will be, breached and if they wish to seek an alternative.

To follow the Referral to Treatment consultant-led waiting times rules.

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<sup>1</sup> Set out in the NHS England and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 available at [http://www.legislation.gov.uk/uksi/2012/2996/pdfs/uksi\\_20122996\\_en.pdf](http://www.legislation.gov.uk/uksi/2012/2996/pdfs/uksi_20122996_en.pdf)

These duties apply both to CCGs and to NHS England. CCGs also have a duty to let NHS England know if a patient notifies the CCG that they have not or will not start treatment within 18 weeks in a service that NHS England commissions

The NHS Standard Contract does not permit commissioners to set minimum waiting times

### Exclusions

What services are excluded from the right to be treated within 18 weeks?

- Maternity services: referrals of healthy pregnant women are not covered by the 18 week patient right or operational standard. Pregnancy referrals should only start an 18 week clock when there is a separate condition or complication, which does not arise in the ordinary course of pregnancy, requiring medical or surgical consultant-led attention.
- Any healthcare services that are not consultant-led.
- Public health services provided or commissioned by local authorities.

Which patients are excluded from the right to be treated within 18 weeks?

- Patients who are registered with a GP in Northern Ireland, Scotland or Wales.
- Patients who do not attend (DNA) an agreed appointment, or rearranged appointment, without giving prior notice where the date of the original appointment offered was reasonable. Patients who give prior notice when cancelling or rearranging their appointments in advance should not be classed as DNAs;
- Patients who refuse treatment. The reasons for the refusal of treatment by the patient, or someone acting lawfully on their behalf, should be recorded.
- Patients who choose<sup>2</sup> to wait longer than 18 weeks for their treatment, or who are unable to have their treatment within 18 weeks, for social, work or personal reasons, who had been offered a reasonable date to attend an appointment at the provider.
- Patients for whom it is not clinically appropriate to start treatment within 18 weeks.
- Patients who do not require treatment following clinical assessment.
- Patients who are referred back to primary care services to receive treatment.
- Patients who require active monitoring following assessment.
- Patients who are placed on a national transplant waiting list following assessment.

Which patients are excluded from the right to be seen within two weeks for urgent referrals for suspected cancer?

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<sup>2</sup> Where patients on an admitted pathway have chosen to pause their clock for social or personal reasons PCTs should try to ensure that these patients are treated within the maximum waiting times + any clock pause in accordance with 18 weeks guidance

- Patients who are registered with a GP in Northern Ireland, Scotland or Wales.
- Patients who do not attend (DNA) two agreed appointments, without giving prior notice where the date of the original appointment offered was reasonable. Patients who do not attend one appointment should be offered a further appointment within two weeks of the initial DNA.

### **Dedicated points of contact**

Each provider and commissioner should have a dedicated contact point for patients.

Provider contact point:

- should be readily available to patients and included on appointment confirmation letters. You can require this through your provider contract;
- should be able to help the patient with any concerns about the length of their wait and, where necessary, investigate alternative provision if the patient requests it;
- should be available to patients at convenient times with sufficient cover.

Commissioner contact point:

- should be readily available to patients and the provider should share this information where a patient requests it. It should also be listed on the commissioner's website;
- should be able to help the patient if they are unsatisfied with the way the provider has handled their request;
- should be able to act on the patient's behalf to secure them alternative provision if this is available;
- should be available to patients at convenient times with sufficient cover.