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Mr Simon Stevens
Chief Executive
NHS England

4th June 2015

Dear Simon,

Making waiting time standards work for patients

You have asked me to review some of our current waiting time measures to ensure they make sense for patients and are operationally well designed. There is concern that, in a small number of instances, some targets are provoking perverse behaviours and the complexity of others is obscuring their purpose and meaning.

18 weeks Referral to Treatment Times (RTT)

The NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment. That is an important commitment which must be maintained. However, we currently measure this in three potentially conflicting ways – through the admitted, non-admitted and incomplete standards.

It has become increasingly clear that within this confusing set of standards there are in-built perverse incentives. The admitted and non-admitted standards penalise hospitals for treating patients that have waited longer than 18 weeks. As soon as a patient has crossed this threshold, a hospital will effectively receive a black mark for treating them. While hospitals may be the ones penalised directly, the true penalty is for the patient. This cannot be right.

To tackle this situation, the incomplete standard was introduced in 2012, incentivising hospitals to treat patients who have been waiting the longest. The "incomplete" standard measures all patients still waiting at the end of each month – so it includes every patient on the waiting list, not just those treated in that particular month.

The positive effect of the incomplete standard was clear: the number of patients waiting longer than 18 weeks reduced by almost 100,000 in the year following its announcement. In the last year, we announced a temporary suspension of the admitted and non-admitted standards to encourage hospitals to treat long-wait patients. The results were compelling with record numbers of long-wait patients treated. It is absurd, however, to find ourselves in a situation where we had to suspend our own waiting time targets to do what is right for patients

So my advice is that we abolish the admitted and non-admitted measures as soon as practically possible, using the so-called incomplete standard – the only measure which captures the experience of *every patient* waiting – as our main measure. This would reduce tick-box bureaucracy and expose hidden waits. We should update our system of fines for those hospitals with long wait times in line with this change, and also ensure those patients who choose to wait longer have their wishes accommodated without penalising the hospital. This approach will be simpler; more focused, and most importantly will ensure the NHS concentrates on treating all patients as quickly as possible.

Ambulances

The current NHS Constitution standards for ambulances encourage the service to respond to urgent calls (Red 1 and Red 2) within eight minutes. The intention is to ensure that the most urgent cases are dealt with as quickly as is possible. Calls are triaged by the ambulance service and allocated to one of a number of "Red" or "Green" categories. Those patients within categories Red 1 and Red 2 are then to be responded to within eight minutes, with less urgent cases having longer times for response.

There is some evidence that the standards are not being as effective as they could be, particularly because in haste to meet the target many non-urgent calls are incorrectly classified as Red 2. As a result, ambulances are dispatched unnecessarily and are then unavailable when more urgent, life-threatening calls arrive.

To explore whether adjustments to the standard could prevent this problem, a pilot was conducted in the South West where the ambulance service spent up to an additional 120 seconds assessing each call's urgency prior to assigning it to a category and responding. The pilot's initial results have been encouraging. The proportion of calls resolved over the telephone increased and, as a result, vehicles spent less time on the road so that more vehicles were available to dispatch to genuinely urgent calls.

Therefore I recommend we expand the current ambulance pilot, based on emerging findings from the Urgent and Emergency Care Review. New pilots must be founded on hard evidence and analytical rigour with a sharp focus on safety. I will work with the ambulance services to set out details of the proposed changes and geographies in summer 2015 and I will make a definitive recommendation on national standards by autumn 2016.

Accident & Emergency (A&E)

The A&E standard has been an important means of ensuring people who need it get rapid access to urgent and emergency care and we must not lose this focus. I do not consider that there is a case for changing the 4 hour standard at this time. However, my recent Urgent and Emergency Care Review has suggested we need to look at a wider range of measures if we are to drive improved outcomes across the system.

For a hospital to pass the 95% standard, it must admit or discharge 19 out of 20 patients within four hours. In practice, more than half of those 19 patients can be discharged home fairly quickly. What the NHS is currently trying to do is offer better services, closer to home for those patients – rapid access to a GP appointment or clinical advice over the telephone, for example. This is good for patients and also good for hospitals – freeing them up to focus on those patients most in need of specialist care. But it also means that hospitals will be left with a higher proportion of complex patients, and therefore their performance will seem worse. So, the way the target is calculated means that hospitals in communities with good out of hospital and community services, such as primary care or urgent care centres, could perversely be penalised because they see fewer minor complaints.

As we begin implementation of redesigned urgent and emergency care services in various parts of the country later this year, **we should consider how to include these broader services within our access standards, alongside a wider range of clinical measures.**

Other areas

We continue to see large increases in referrals for diagnostics and cancer tests. This is a good thing, but it does mean waiting time targets will come under increasing pressure. Despite this, they are an important means of focusing on providing high quality care and I think they remain appropriate. The cancer targets will also be addressed more holistically by the independent cancer taskforce under the chairmanship of the CEO of Cancer Research UK.

In relation to mental health, NHS England has been leading the world in its pursuit of equal emphasis on mental and physical health. A key part of securing parity has been to commit to the introduction of waiting times standards for mental health services, to match those that have been in place for physical health for 15 years. In 2015/16 we are starting with some psychological therapies and early intervention in psychosis, and over five years we will have introduced standards for a range of services. This is a hugely important step.

Reporting arrangements

Current arrangements for reporting performance are extremely uncoordinated. Standards report with different frequencies (weekly, monthly and quarterly) and on different days of the week. This makes no sense - it creates distraction and confusion. We receive feedback that this makes it difficult for people to have one transparent, coherent picture of performance at any one time.

My recommendation is therefore that we standardise reporting arrangements so that performance statistics for A&E, RTT, cancer, diagnostics, ambulances, 111 and delayed transfers of care are all published on one day each month. Mental health waiting times statistics will follow the same pattern once available, and we will consider whether other data collections can be similarly aligned.

To conclude, I would like to emphasise that the NHS has made massive progress over the last two decades – reducing waits for treatment from several years to only a few months. I would like our NHS to be evidence based, outcomes focussed and driven by values. Where there is strong evidence that changing standards will improve services for patients, we should have no hesitation in adapting our approach. If we abide by this principle, I am confident that waiting time standards will continue to make an important contribution to overall quality of care in the NHS.

Yours sincerely,

Sir Bruce Keogh
National Medical Director
NHS England