Commissioning an 18 week patient pathway

Proposed principles and definitions:
A discussion document

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Title: Commissioning an 18 week patient pathway – Proposed principles and definitions: A discussion document

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Target audience: PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs, Medical Directors, Directors of Finance, Allied Health Professionals, GPs, Communications Leads, SHA Directors of Performance, Trust Directors of Operations

Description: This document takes you through the patient journey from the point of referral to the start of hospital treatment. It sets out the proposed principles and definitions that will underpin the 18 week patient pathway.

Action required: Please use the feedback form provided on the 18 weeks website at www.18weeks.nhs.uk to send us your views

Timing: Please send us your views by 8th December 2005.

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In recent years, the NHS has received unprecedented investment and has made significant improvements to the services offered to patients.

Delivering an 18 week pathway from referral to treatment will build on this success and further improve the patient experience as well as putting the NHS at the forefront of best practice internationally. It would be unrealistic to think that delivering this will be without challenge and the scale of these challenges must not be underestimated. For example, the way elective pathways are managed both operationally and strategically will need to change radically. The measurement systems underpinning this will have to change accordingly. This is complex and is only one among a number of challenges that will need addressing over the coming three years. Despite this, I am confident the NHS will be able to deliver this based on the history of success in this area over many years.

I am keen to enable the NHS to begin the work as soon as possible. To support this work the Department of Health is developing a set of principles and definitions that will underpin 18 weeks and transform patients’ experience of the NHS. To help us with this we are running a listening exercise to engage the NHS and other stakeholders.

This listening exercise will run for six weeks from 27 October – 8 December 2005, enabling us to finalise the principles and definitions ready for publication in early 2006. I very much welcome your views on any of the aspects covered in this paper and would like to take this opportunity to thank you for all you do to ensure that NHS patients receive high standards of clinical and personal care.

Patricia Hewitt
Secretary of State for Health
Introduction

1. The NHS Improvement Plan gave a commitment that by December 2008 no one will have to wait longer than 18 weeks from GP referral to hospital treatment. This has since been reflected in the Department of Health’s Public Service Agreement.

2. This document takes you through the patient journey from the point of referral to the start of hospital treatment. It sets out the principles and definitions that we propose should apply at the different stages of the journey to ensure that the 18 week commitment is applied fairly and consistently – and in ways that deliver the intended benefits for NHS patients and NHS organisations.

3. Colleagues in the NHS have already been involved in developing this paper by taking part in discussions at pilot site meetings and at stakeholder events. Further stakeholder events will take place over the coming weeks. We are keen to enable the NHS to begin working on 18 weeks operationally from early 2006 and as such, we are working to a tight timetable for developing the final set of principles and definitions underpinning 18 weeks. The listening exercise will run for six weeks from 27 October – 8 December 2005, enabling us to finalise the principles and definitions ready for publication in early 2006.

4. We would welcome your views on the proposals in this document. Please use the feedback form provided on the 18 weeks website at www.18weeks.nhs.uk to let us know your views.
5. In recent years, the NHS has come a huge way in reducing hospital waiting times for NHS patients. In 1997, there were over 280,000 patients waiting more than six months for inpatient or day case treatment and over 335,000 patients waiting more than three months for outpatient consultations. Some patients waited 18 months or more for surgery. By December 2005 there will be no patients waiting more than six months for inpatient or day case treatment or more than three months for an initial outpatient consultation.

6. This success provides the platform for setting the much more ambitious and ground-breaking commitment that by December 2008 no one will have to wait more than 18 weeks from GP referral to the start of hospital treatment. This includes all the stages that lead up to treatment, including outpatient consultations and diagnostic tests and procedures. It covers some elements that are currently measured (inpatient and outpatient waits) but, crucially, other elements that are not currently measured (particularly diagnostics). Delivering the 18 week patient pathway will put the NHS at the forefront of best practice internationally.

7. While 18 weeks will be the maximum, most patient journeys will be much shorter than this. The NHS Improvement Plan indicated that initial outpatient consultations will normally take place within six weeks of referral and that access will be even quicker for patients whose conditions require faster treatment. 18 weeks does not replace other waiting times targets or standards where these are tighter than 18 weeks e.g. waiting times for patients with suspected cancer or waiting times for Rapid Access Chest Pain Clinics.

8. The implementation of 18 weeks coincides with the development of a range of system reforms including payment by results, practice based commissioning and patient choice. The Department of Health will continue to work with the NHS to ensure that these reforms are implemented and developed in ways that support the move to a maximum 18 week patient journey. In line with the vision set out in 'Commissioning a Patient Led NHS', delivery of 18 weeks will be a commissioner based responsibility and commissioning low waits will be a key element of the implementation programme.
This document outlines the underlying principles and definitions for 18 weeks as currently proposed by the Department of Health. The document follows the patient through the 18 week journey and specifically covers the following areas:

- Start of the pathway – clock start
- Referrals for therapies, healthcare science and mental health services
- Along the pathway – clinically complex cases, patient choice, consultant to consultant referrals and multi-organisation pathways
- End of the pathway (start of treatment) – clock stop

We are sharing this document with SHAs, Acute Trusts, PCTs and with a range of organisations representing patients, clinical stakeholders and other NHS interests. We would very much welcome your views on any or all of the issues covered.

Once we have finalised these principles and definitions, there will need to be further discussion with the NHS, the Healthcare Commission and other interests about how performance responsibilities are shared between PCTs and acute providers, how we create a focus on commissioning low wait, high quality services, and what this means for performance reporting systems.
12. In developing the proposed principles and definitions, we have taken into account the following criteria:

- **Patient experience** – ensuring that the 18 week patient pathway drives sustained improvements in patient experience and that patients do not experience ‘hidden waits’

- **Simplicity, clarity and transparency** – ensuring that the 18 week patient pathway is easy to understand, both for patients and the public and for the NHS staff responsible for ensuring that patients are able to start their treatment within 18 weeks

- **Consistency with the pledge given in the NHS Improvement Plan** – and with the outline technical guidance issued to the NHS in autumn 2004 as part of the Local Delivery Planning process

- **Reinforcing positive behaviours** – ensuring that the principles and definitions encourage the right behaviours amongst NHS staff, NHS provider organisations and NHS commissioners

- **Resilience** – the need to have a set of principles that will remain workable and robust in the changed environment of 2008 and beyond, as we move to an ever more patient-led NHS with increasing choice and plurality

- **Data burden on NHS** – avoiding any unnecessary increase in NHS data collection requirements.

13. Although initially some areas might not be specifically included within 18 weeks, we would expect the principle of shorter waits and sustained improvements for all patients to be implemented across the service.
14. The diagram below outlines the overall 18 week pathway. The rest of this document discusses each heading in more detail.
Start of the pathway – clock start

Referral routes in

15. For most patients the start of the elective pathway begins at GP referral to a consultant in secondary care. We propose to include also referrals to medical consultants who work in a community setting (either in outreach clinics, directly employed by a PCT or working in a community hospital).

16. By December 2008, we would expect all referrals covered by 18 weeks to be made through Choose and Book. In this ‘full booking’ environment the start of the waiting period will be the point of booking by the patient rather than the point at which the GP makes the decision to refer or the point at which the referral letter is received. This will typically be the point at which the patient makes an appointment for their first outpatient attendance, either in the GP practice or through the Choose and Book Appointments Line (i.e. in technical terms when the patient converts their Unique Booking Reference Number). In the unfortunate event that a patient is booked into the wrong clinic (wrong specialty) and needs to be re-referred to the right specialty the clock would still start from the time the first appointment was booked as the patient is continuing on the same pathway.

17. 18 weeks will also cover referrals from:

- General Dental Practitioners (GDPs) – these referrals are currently treated in the same way as GP referrals and as such are included in 18 weeks.
- Optometrists – changing pathways for eye care have enhanced the role of the optometrist. Referrals by optometrists to hospital consultants will therefore also be counted as the start of the 18 week pathway.

Referrals from other Primary Care Professionals

18. The NHS Improvement Plan stated that 18 weeks would apply to GP referrals rather than to other Primary Care Professionals. However, we would aim for referrals from other Primary Care Professionals to be included from a later date. We will be developing a timetable and we would welcome views on how challenging this extension would be and what an appropriate timetable might be.
Accident and Emergency

19. Any patient that receives a Decision to Admit (DTA) is covered by the current inpatient waiting times target, irrespective of referral route (excluding planned admissions). This means that patients who begin their pathway by attending A&E are covered by the inpatient access target once they receive a DTA.

20. In order to ensure that 18 weeks continues to provide a guarantee for these patients we propose to include referrals to hospital consultants following attendance at an A&E, Minor Injuries Unit, Walk in Centre or GUM clinic. These will be treated in the same way as a GP referral in terms of being the start point for the 18 week clock.

National screening programmes

21. We propose that, where the outcome of a national screening programme results in needing further diagnostics or treatment in secondary care the clock should start from the point of the result being known (and therefore the patient being ‘referred’ to secondary care albeit not always through a GP referral). For example where the outcome of cervical screening is that the smear is abnormal and a colposcopy is needed 18 weeks would be applicable (unless the cancer waiting times targets are applicable). The point at which the patient is referred for the colposcopy would start the clock. Other examples of screening programmes are neonatal hearing and diabetic retinopathy.

Consultant to consultant referrals

22. Where a consultant makes a referral to another consultant for treatment of a condition other than the one identified in the original GP referral, we propose that this should not be covered (consultant to consultant referrals for the same condition are discussed later on in this document). An example of this would be a patient who sees an orthopaedic surgeon and who is referred by the orthopaedic surgeon to a dermatologist for a different condition unrelated to the orthopaedic pathway.

23. It is generally better practice for these cross-condition patients to be referred back to their GP, so that the GP can decide (in consultation with the patient) whether a new hospital referral is appropriate – and, if so, give the patient a choice of provider. It should be stressed that we do not anticipate patients having to physically visit their GP in all cases but primary and secondary care clinicians should communicate using existing methods and new technology such as Connecting for Health’s e-mail facility for this referral to be discussed. The GP’s acceptance of this second referral would start another 18 week pathway.
Intermediate services

24. Referrals to intermediate services include referrals to professionals in primary care such as GPs with a Special Interest (GPSIs), Clinical Assessment Services (CASs) and Referral Management Centres (RMCs).

25. As outlined in the letter from Margaret Edwards to Chief Executives on 5 July 2005, there are some cases where good clinical practice may support patients being referred to community-based CASs or referral management centres, e.g. for mental health services (where this is the agreed service model) and for specific presenting conditions such as musculo-skeletal conditions. Choice at Referral should then be offered by clinicians in the CAS if a referral to secondary care is required. However, referrals to CASs should happen only where this adds genuine clinical value for patients. In all other cases, the referring clinician should initiate the choice offer and discuss the clinical aspects of that choice with the patient.

26. In these circumstances, the 18 week pathway could start either at the point of referral from primary to secondary care (e.g. at the point of onward referral from a CAS), or when the GP refers to the intermediate service. We would welcome your views on these two options.

27. Starting the 18 week pathway at the point of onward referral to secondary care (Option A) would reflect developments in the organisation and provision of services and align with the point at which the patient is offered choice and the ability to book their outpatient appointment (through Choose and Book).

28. On the other hand, we would not want to see waits build up in primary care and whilst other primary care policies should reduce this risk, we would welcome views on whether to reinforce these policies by starting the 18 week clock from the initial point of referral in the GP surgery (Option B). To avoid having to start very significant numbers of patient clocks only to stop them at the point of leaving the intermediate service (if there is no onward referral to secondary care), we would propose (if Option B were adopted) to set the clock only when the patient is referred on to secondary care but with the clock starting retrospectively at the date of the referring GP consultation.

29. We would be interested in your views on whether this retrospective count is possible from a practical perspective as well as whether it is appropriate and how this might impact on delivering the overall 18 week patient pathway.

30. As part of this listening exercise, we will be holding a workshop involving key stakeholders from across the service to discuss these options further.
Direct access diagnostics

31. The issues set out above for intermediate services apply similarly to direct access diagnostics, whether they are provided in primary or secondary care. We would welcome your views on the following options:

A. Start the clock at the point of onward referral to secondary care after the patient has received diagnostic tests. We would clearly not want waits for direct access diagnostics to develop and, if it became apparent over time that waits for these services were creating unmeasured queues for secondary care, there would need to be action at local or national level to remedy this.

B. Where a patient is referred on to secondary care following a diagnostic test, retrospectively set the clock so that it starts at the point of the original GP referral for diagnostics.

C. We would also welcome input on the appropriate performance standard for the turn around time for direct access diagnostics where the test does not, or was never expected to, lead to a referral to secondary care.

Follow-up outpatient appointment

32. There will be a group of patients on long-term treatment pathways, typically patients with long term conditions, whose care is being led and undertaken in secondary care. The initial GP referral or A&E attendance that began the pathway may have been many weeks, months or even years before and may have involved multiple outpatient attendances and diagnostic procedures.

33. Where a decision to treat is made at a follow-up outpatient appointment for these patient groups, we would generally expect the GP to have the opportunity to agree that further hospital treatment is the best way of proceeding and we would want the patient to be able to exercise choice of provider. To avoid patients necessarily having to physically return to their GP, this could be done via communication between primary and secondary care.

34. We propose that in these circumstances a new 18 week clock should normally only be started through confirmation by primary care that treatment is appropriate. This would clearly not prevent a decision to treat in cases of clinical urgency, although the consultant would need to communicate this decision to the GP to ensure all those involved are appropriately informed.
35. The description of 18 weeks in the NHS Improvement Plan included the vast majority of patients but, for the time being, excluded referrals to professionals other than consultants. However, the NHS Improvement Plan also signalled (paragraph 2.7) that;

In the longer term the NHS will also aim to bring waiting times to see other professionals, such as physiotherapists and speech and language therapists, into this target. In the meantime, the NHS will make particular improvements in reducing waiting times for speech and language therapy and child and adolescent mental health services.

36. Therapies (such as physiotherapy, occupational therapy, speech & language therapy and podiatry) or healthcare science interventions (e.g. an audiologist fitting a hearing aid) may in some cases form part of the 18 week pathway and are therefore included. An example would be the consultant to whom the patient is referred deciding that the main treatment should be a physiotherapy treatment, or that a therapy assessment should be part of the assessment which leads up to the start of treatment.

37. However, 18 weeks does not currently include direct referrals or direct patient access to therapies, healthcare scientists or mental health teams that are not led by a medical consultant. Direct referrals may come from GPs or from other clinicians and agencies (e.g. from Schools for Speech and Language Therapy).

38. The overall objective of 18 weeks is to take waiting off the table and shift public perception so that waiting ceases to be an issue for NHS patients and the public. Based on the original clarification of 18 weeks, we therefore propose to set reduced access times for the following areas but possibly over a longer timeframe;

- direct access physiotherapy
- direct access occupational therapy
- direct access speech and language therapy
- referrals to non-consultant clinicians for mental health
- podiatry/chiropody
- audiology.
39. Each of these services is managed on different pathways and will need to overcome different challenges before they can successfully achieve better access times. In particular some of these services deal mainly with long term conditions and the first referral represents the beginning of a long term care pathway. The current waiting times for access to these services are variable and it is difficult to be specific about the waits and assess the challenges to be addressed until further work on data collection is completed. The White Paper consultation (‘Your Health, Your Care, Your Say’) may also have implications for the handling of the future development of these services and may present opportunities to trial some of the emerging ideas.

40. To support this work, we are inviting the NHS to comment separately on each of the services of interest set out in paragraph 38 above. We would particularly welcome comments on:

- the likely scale of the current and future challenge involved in achieving reduced access times, either by 2008 or as part of the period covered by the next planning period (2008-2011)
- whether there are likely to be any exceptions to the general principle of ultimately having a maximum 18 week patient journey for these services
- if there are any likely exceptions, whether there should instead be local standards or whether local health systems should focus on publishing waiting times to focus clinicians and managers on reducing those waits
- the practicalities involved in including these services within 18 weeks
- the deliverability of these services within shorter waiting times
- whether a local or nationally set standard would be appropriate
- how far publication of waits by the local health system would also help to focus clinicians and managers on reducing those waits.

41. Once we have received comments from the NHS and have completed the modelling work centrally, we will outline a timeframe and practical challenges for including the relevant services within a waiting time guarantee (whether national or local).
Along the pathway

Patient exclusions

42. There will be two groups of patients for whom it would be inappropriate to expect treatment to begin within 18 weeks. First, those patients with genuinely complex diagnoses or for whom the appropriate treatment is unclear; second, those who wish to choose later appointments. To allow for these two groups, we propose to set an operational standard that the number of patients waiting more than 18 weeks – either for clinical reasons or for reasons of personal choice – should not exceed a fixed percentage of total referrals (i.e. a tolerance level).

Clinically complex cases

43. There will be occasions where it is not clinically appropriate for treatment to begin within 18 weeks of referral, for instance where a series of tests needs to be done in sequence, or where the patient and consultant have agreed that the patient should receive a second opinion. We propose that clinically complex cases such as these should be covered by an operational standard, rather than allowing a suspension facility. This approach follows the principle of the A&E operational standard.

44. PCTs and Trusts would need to be able to demonstrate (where asked by an auditor or the Healthcare Commission or in the event of a patient complaint) that cases within this margin of tolerance were genuine clinical exceptions, but we would not be prescriptive about the precise form of audit trail needed for this purpose. To ensure transparency, PCTs and Trusts would have to report the length of all waits (i.e. including the longer waits covered by the tolerance). This would enable the Department and SHAs to identify quickly if patients waiting more than 18 weeks were left waiting for an unacceptably long further period. We would welcome your comments on this.

Patient choice

45. From the end of 2008, when 18 weeks becomes operational, patients will also have a free choice of providers at the point of referral to secondary care. The NHS Improvement Plan made clear (paragraph 2.11) that:

*If a patient chooses to be treated by a provider which cannot offer a waiting time of 18 weeks or less the patient will be able to choose another provider or choose to wait longer for their first choice.*
46. In those circumstances where demand for a particular provider/clinician starts to exceed capacity, this should be identified as soon as possible and it would be the joint responsibility of the provider and the PCT(s) to agree a management plan. Generally, it will be the provider’s responsibility to ensure that they expand or reduce capacity to reflect demand. The payment by results regime should support this.

47. Patient choice raises wider issues for 18 weeks. Even where the provider has offered earlier appointments, patients may choose a late first outpatient appointment, or a late appointment for subsequent outpatient appointments, subsequent diagnostics or the start of their treatment. These later appointments may be more convenient for the patient for personal or social reasons, but could mean that the provider cannot then guarantee a maximum 18 week wait.

48. To ensure that patients can exercise these choices, we propose that the operational standard should allow a margin of tolerance for patients waiting more than 18 weeks for reasons of personal choice. As with clinical exceptions, PCTs and Trusts would have to be able to demonstrate (if asked or challenged) that cases within this margin of tolerance were genuine instances of patient choice. This would enable individual patients to be assured that they should not have to wait more than 18 weeks unless they choose later dates than those being offered or that they fall within the small group of patients where there are clinical reasons for deferring start of treatment.

49. Setting an operational standard for patient choice and clinically complex cases would mean the end of suspensions as social suspensions would all fall under the tolerance level for patient choice and medical suspensions would fall under the tolerance for clinically complex cases.

50. Similarly, patient cancellations would also fall under the tolerance level for patient choice. However, in cases where the provider cancels an appointment the clock would continue ticking and 18 weeks remains binding.

51. Based upon high level modelling, we believe the combined tolerance for clinical exclusions and patient choice should be no more than 5%. We would welcome your views on the appropriate level of tolerance, including any evidence you have to support your view. We will then set the figure when we publish the final rules and definitions. We are also keen to hear your views about the principle of having a tolerance rather than a suspension system and about the practicalities of either option.
Diagnostics

52. The NHS Improvement Plan set out that no one will have to wait longer than 18 weeks from GP referral to hospital treatment by December 2008, which means that waiting for diagnostic procedures as part of the 18 week pathway or as the start of treatment is included. The definition of diagnostics is as follows: ‘a test or procedure used to identify a person’s disease or condition and which allows a medical diagnosis to be made’.

53. Current waiting times guidance states that endoscopies should be recorded as day cases or outpatients depending on the setting in which the procedure takes place. If the patient is admitted to hospital then the procedure will be a day case. 18 weeks will ensure that the discussions around the classification of endoscopies will become a thing of the past as the focus of 18 weeks is on the patient journey from referral to hospital treatment regardless of the setting in which the procedure takes place. Endoscopies undertaken in outpatients or as a day case will both be part of 18 weeks.

Therapies

54. Similar to diagnostics, therapies (such as physiotherapy, occupational therapy, speech & language therapy and podiatry) may in some cases form part of the 18 week pathway. This will be the case where the consultant to whom the patient is referred decides that the main treatment should be for instance a physiotherapy treatment, or where a therapy assessment is part of the assessment that leads up to the start of treatment.

Consultant to consultant referrals for the same condition

55. Consultant to consultant referrals for patients with the same underlying condition are likely to be follow-on referrals after the first outpatient appointment and should be included within 18 weeks (with the clock starting at the point of the original GP referral). For example a referral from a physician to a surgeon or vice versa i.e. a GI physician to a GI surgeon for a colorectal condition. In cases of clinical complexity and uncertainty different rules will apply (please see the section on clinically complex cases for further guidance).
**Tertiary referrals**

56. Standard tertiary referrals, i.e. where the referral is a standard element of the elective pathway, are included within 18 weeks (clock starting at GP referral). For example, this would apply to many CHD patients and will include a range of procedures including angioplasty, cardiac valve repair, heart bypass surgery and electrophysiology procedures. Other tertiary referrals will occur in cases of clinical complexity and uncertainty and in such cases the tolerance principle would apply. Please see the section on clinically complex cases for further guidance.

**Multi-organisation pathways**

57. For pathways that include multiple organisations, we propose the following. In cases where a patient is referred from one provider to another (whether NHS or Independent Sector) and where the patient cannot be treated at that provider and consequently needs treatment at the referring provider the patient should still start treatment within 18 weeks. This would not just apply between Treatment Centres and providers but between providers of all sorts.

58. With regard to specialised services, there might be occasions where initial diagnostic processes eliminate the more common diagnoses but then more complex diagnostic tests (possibly in another unit) are needed before treatment can begin. In cases of clinical complexity and uncertainty, the rules for clinically complex cases will apply. However, where patient pathways involve multiple organisations but are not clinically complex 18 weeks still applies.

59. Further work will be done on developing the performance assessment system supporting 18 weeks. Performance assessment arrangements for multi-organisation pathways will play a key part in this process.

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1 Tertiary referrals are referrals from a consultant in one provider to a consultant in a tertiary centre (this could be within the same provider organisation).

2 Specialised services are those with low patient numbers but which need a critical mass of patients to make providing services cost effective. Particular challenges for these services include training specialist staff, supporting high quality research programmes, and making the best use of scarce resources like expertise, high tech equipment and donated organs. 36 specialised services are covered by the Specialised Services National Definitions Set which can be found at: http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/SpecialisedServicesDefinition/fs/en
End of the pathway – clock stop

60. The end of the pathway and the clock stopping for 18 weeks will be at the start of definitive treatment. Start of definitive treatment can be defined as the start of the first treatment that is intended to cure a person's disease or injury. For the purpose of 18 weeks, the start of treatment, and therefore clock stopping, includes the following actions and decisions.

Treatment as inpatient or day case

61. The patient is admitted as a day case or inpatient for treatment. The date of the clock stopping will be the date of admission as now and if patients are then cancelled the clock will restart from the point of the earlier stop.

Treatment in outpatients

62. Treatment undertaken in an outpatient setting (surgical, medical or treatment provided by an Allied Health Professional (AHP) or mental health and learning disability professional), where no further inpatient episode is expected can stop the clock. Undertaking a procedure is not necessarily in itself the end of a pathway i.e. outpatient or day case diagnostic episodes prior to admission for treatment do not represent the end of the pathway for purposes of 18 weeks and in these cases are part of the diagnostic process rather than the start of treatment.

63. Where treatment starts in parallel with diagnostic testing and in advance of a definitive surgical procedure the start of this particular treatment does not count as the end of the pathway and therefore the clock does not stop. Examples would include treating skin lesions with topical cytotoxic in advance of a surgical procedure; an orthopaedic surgeon prescribing pain control/anti-inflammatory drugs or steroids to manage the condition whilst the patient waits for the actual operation; a psychiatrist prescribing drug treatment whilst the patient waits for the start of Cognitive Behaviour Therapy. The key issue is that the clock will continue ticking whilst the clinician is managing the condition ahead of definitive treatment starting.

64. The date of the clock stopping will be the date of attendance in outpatients for those patients whose treatment starts in outpatients.
Fitting of a medical device

65. Where a consultant decides that treatment consists of fitting of a medical device (i.e. a hearing aid) we propose that the clock stops at the point of the actual fitting of the device instead of the point at which the patient is being measured for the device. We propose that the clock should stop when fitting is complete, on the assumption that most fittings will be relatively simple and can almost always be done in one or two visits (e.g. hearing aids). More complex fittings (e.g. for prosthetic limbs) are much less likely to come at the start of a treatment pathway. If they are the start of treatment they are likely to be among the cases covered by the proposed tolerance for clinically complex cases.

Therapeutic treatment

66. Some procedures will include both a diagnostic\(^3\) test and a therapeutic\(^4\) treatment. There are also some procedures that are intended as diagnostic but the healthcare professional makes a decision to undertake a therapeutic treatment at the same time. Both these examples could count as an initiation of definitive treatment and as such the clock would stop. Many endoscopies could fall into this category i.e. a colonoscopy having been started as an investigative/diagnostic procedure could result in being a therapeutic treatment if during the investigation the cause of the problem (such as a polyp) can be removed.

First-line treatment

67. In some pathways less intensive treatments and medical management may be attempted before moving on to more invasive procedures and treatment. In such cases, the initiation of the first treatment would count as the initiation of treatment and therefore the end of that particular 18 week pathway. Should the patient at some later stage require more aggressive treatment then this subsequent treatment would not fall within 18 weeks, unless primary care confirms the treatment through another referral (also see the section on follow-up outpatient appointment – paragraphs 32-34).

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3 Diagnostic means a test or procedure used to identify a person's disease or condition and which allows a medical diagnosis to be made.

4 Therapeutic is defined as a procedure which involves actual treatment of a person's disease, condition or injury.
68. This scenario would for example apply to IVF treatment. A typical patient journey would begin with the GP referring the woman/couple to an obstetrics and gynaecology consultant/infertility treatment service. In many cases, the consultant will only decide that IVF is appropriate after other forms of infertility treatment such as Intra Uterine Insanmination (IUI) have been tried. In this situation, 18 weeks would apply to the IUI treatment. However, in this case the patient can return to the GP and get a new referral specifically for IVF, which would mean the start of a new 18 week clock. Alternatively, the patient can be referred without returning to the GP as long as there is appropriate communication between primary and secondary care with primary care agreeing to the required funding.

Follow-up inpatient treatment

69. Some patients require follow-up inpatient treatment sometime after the original admission (i.e. removal of metalwork following an orthopaedic procedure, removal of grommets, second cataracts). Patients waiting for an admission of this kind are usually described as being on a planned list.

70. For follow-up operations such as second cataracts, removal of metalwork following orthopaedic procedure or removal of grommets, it is proposed that these would be planned cases which will however be subject to the 18 week maximum wait. In this scenario, the clock would start from the point of the decision to treat being made for the follow-up operation, either at an outpatient appointment or directly following the first inpatient treatment.

Other clock stop points

71. The patient is returned to primary care either after outpatient attendance or after diagnostic testing. It is decided not to treat and no further action in secondary care is undertaken at this time (start of non-treatment). The date of this decision being communicated to the patient should be used as the clock stop date.

72. A decision to treat is made but the patient declines treatment. The date the patient declines treatment should be used as the clock stop date.

73. There will be patients for whom a period of watchful waiting or active monitoring is appropriate. On this occasion, the clock would stop at the point where the decision is made (and communicated to the patient) that treatment will not start but that a period of watchful waiting/active monitoring is appropriate – in essence, this will be the start of non-treatment. If a patient subsequently requires further treatment this would follow on from the period of watchful waiting and the decision to treat would start a new 18 week clock. The patient would not necessarily need to return to
primary care although the consultant would be expected to keep the GP updated with the progress of their patient (please see the section on follow-up outpatient appointment for further guidance).

74. Where patients repeatedly fail to respond to attempts to agree a date for an appointment (at any stage of the pathway) the patient can be returned to primary care and the clock would stop. The provider can write to the GP to indicate that the patient would need to be referred again if treatment was still needed.

75. Patients who have not kept their appointment for admission and have failed to tell the hospital in advance that they will not be coming are identified as ‘Did Not Attend (DNA)’. If the patient does not attend for a second time the clock stops and the patient should be returned to their GP. If the GP re-refers the patient a new 18 week clock would start.
Performance reporting and performance management

76. This paper outlines the principles and definitions for 18 weeks and sets out the plan for this to become a commissioner based target. We will do further work on this in due course which will involve further discussions with the NHS, Healthcare Commission and Monitor but the concept of a commissioner based target will be a key element of this work.

77. Commissioners should be looking to put in place a range of choices for patients, all of which allow the patient to reach the start of treatment within 18 weeks. This means that commissioners will need to manage the maximum waits at each stage of the pathway and the hand-offs between organisations.

78. We will also do further work on how performance is measured and reported. At present, we use a snapshot approach for reporting inpatient and outpatient waiting times. For inpatients, for example, the NHS reports the stock of patients waiting for admission on the final day of each month and the proportion of these patients who have been waiting more than six (or nine) months at that point in time. We also collect annual data on the actual waits for each patient who has completed treatment, but it is the snapshot approach that is currently used for national performance reporting and management. We propose to move to reporting based on actual completed waits and will do further work on when this would become operational. This is also a key issue to address linked to the patient’s experience. We would welcome your comments on this.
Conclusion

79. As outlined in the introduction, the NHS has come a long way in reducing waiting times for patients. The December 2008 GP referral to hospital treatment commitment builds on this success and was developed with the objective of reducing both measured and unmeasured waits and to take waiting of the table. This objective has underpinned the development of the draft principles and definitions outlined in this paper and should be maintained when interpreting 18 weeks.

80. In the case of uncertainty, the NHS should always follow the spirit of the rules, which is about reasonableness to patients and honesty to the public.

Next steps

81. This listening exercise runs from 27 October to 8 December 2005. Please use the feedback form provided on the 18 weeks website at www.18weeks.nhs.uk to let us know your views by no later than 5pm on 8 December 2005.

82. We will then consider all feedback and redraft the principles and definitions to take account of your views. We are aiming to get an agreed final set of principles and definitions in December 2005 with a view to publishing the final document to the NHS in early 2006.
Circulation list

83. This paper is being shared with the following organisations. We would welcome your suggestions as to anyone else we could share this with.

18 weeks clinical leads and champions
18 weeks pilot sites
Allied Health Professions Federation (AHPF)
Association of Professional Music Therapists
British and Irish Orthoptic Society
British Association of Art Therapists
British Association of Drama Therapists
British Association of Prosthetists and Orthotists
British Dietetic Association
Chartered Society of Physiotherapy
College of Occupational Therapists
Connecting for Health
Diagnostics National Leadership Group
Foundation Trust Chief Executives
General Practitioner’s Committee (BMA subgroup)
GPs
Healthcare Commission
Independent Healthcare Forum
Long Term Medical Conditions Alliance
Monitor
NHS Alliance
NHS Confederation
NICE
PCT Chief Executives
Royal College of Anaesthetists
Royal College of General Practitioners
Royal College of Obstetricians and Gynaecologists
Royal College of Ophthalmologists
Royal College of Paediatrics and Child Health
Royal College of Pathologists
Royal College of Physicians of London
Royal College of Psychiatrists
Royal College of Radiologists
Royal College of Speech and Language Therapists
Royal College of Surgeons of England
SHA Chief Executives
SHA Directors of Performance
Society and College of Radiographers
Society of Chiropodists and Podiatrists
The Patients Association
The Patients Forum
Trust Chief Executives
Trust Directors of Finance
Trust Directors of Operations
Trust Medical Directors
Trust Nursing staff
Trust Scientific staff