

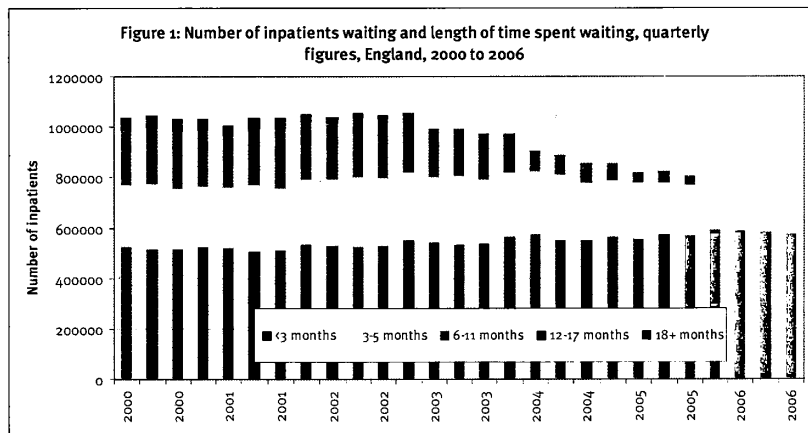
18-week waiting times target

AN UPDATE

The War on Waiting for Hospital Treatment (Harrison and Appleby 2005) examined the government's record on reducing the number of people on waiting lists for elective care in England, and the time they had to wait. This briefing provides an update on that analysis.

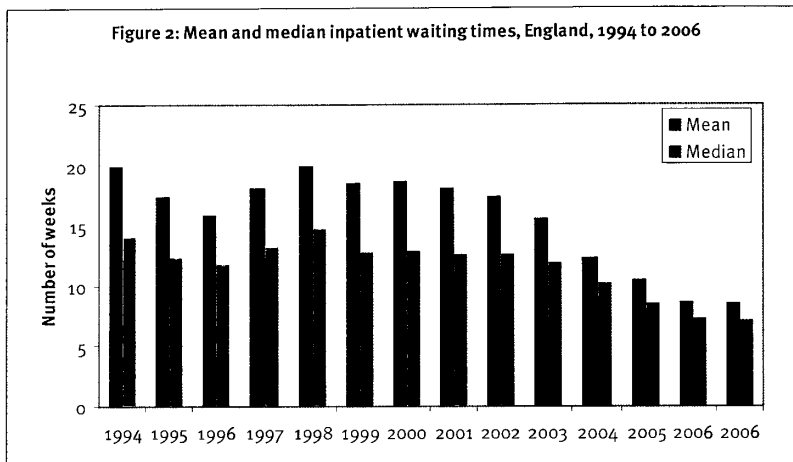
The waiting times targets currently in place were first set in 2000 in the NHS Plan (Department of Health 2000). By 2005, when *The War on Waiting for Hospital Treatment* was published, the total number of people waiting to be treated in hospital, and the maximum time they had to wait, had dropped below levels seen in 2000.

Since 2005, this progress has been maintained. The number of people waiting is now at 674,222: the lowest figure since records were first collected on the current basis (Department of Health 2007e). The number of people waiting for more than six months to be treated – the current maximum wait – has been reduced to less than 436 at the end of May 2007, and waits of more than 18 months have been eliminated entirely (see Figure 1).

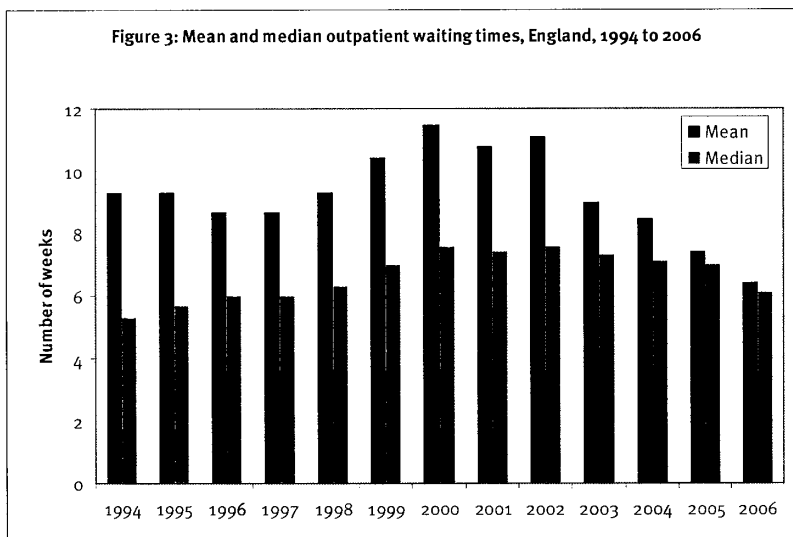


Source: King's Fund analysis of data from Department of Health 2007e

Waiting times fell steadily from 2000 onwards and, by the middle of 2006, median waiting times for inpatient treatment were at their lowest ever, despite a small rise in the first quarter (see Figure 2). Average outpatient waiting times also fell steadily from 2002 onwards (see Figure 3). The latest Department of Health figures (2007e) suggest that the decline is continuing.



Source: King's Fund analysis of data from Department of Health 2007e

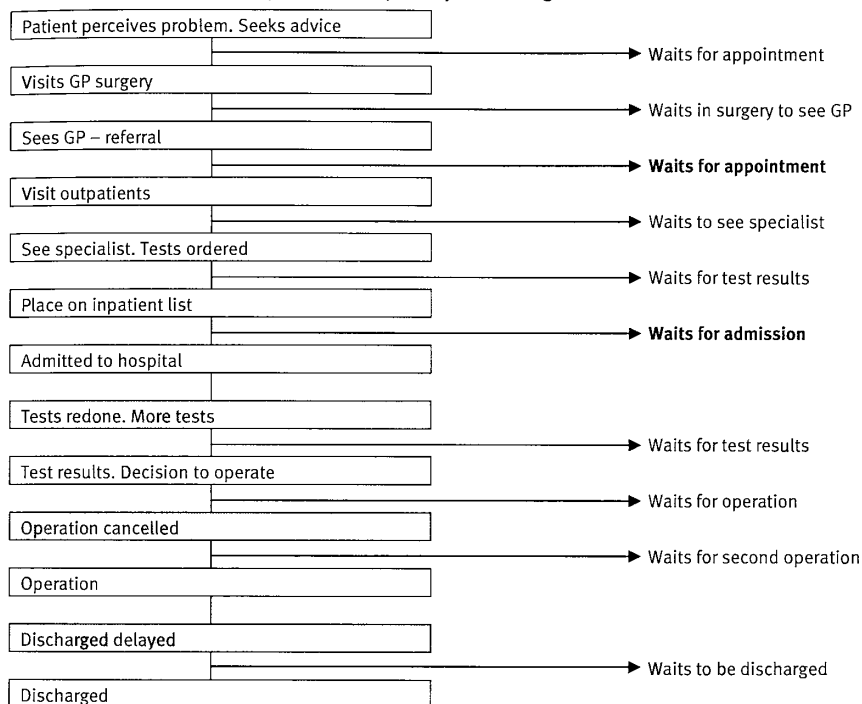


Source: King's Fund analysis of data from Department of Health 2007e

When the NHS Plan targets were in force, but were some way from being met, the government set a new waiting-time target in the NHS Improvement Plan (Department of Health 2004b). This target set a maximum wait of 18 weeks from the time of referral to a hospital consultant, to the start of treatment. This period has come to be known as RTT (referral to treatment). Unlike the previous targets, which measured only two stages along the patient pathway (see Figure 4), the new target takes into account the total period of waiting from the initial referral to the start of treatment, including delays in waiting

for tests and receiving the results. Up until now, these delays have been ignored in the waiting times statistics published by the Department of Health.

Figure 4: Patient pathway and waiting time recorded



The NHS was initially given until the end of 2008 to achieve this new target. The NHS's Operating Framework for 2007–08 (Department of Health 2007h) set two further milestones to be achieved by the end of March 2008:

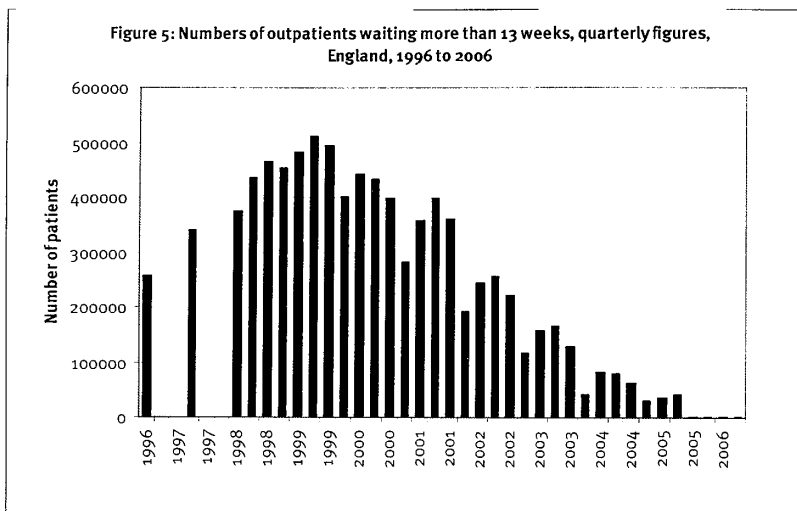
- 85 per cent of pathways where patients are admitted for hospital treatment should be completed within 18 weeks.
- 90 per cent of pathways that do not end in an admission should be completed within 18 weeks.

In addition, from March 2007 onwards, all diagnostic tests should be carried out within 13 weeks of referral.

From the patient's viewpoint, the new form of target represented a significant improvement. Although there was no systematic information about the scale of 'hidden delays' when the target was set, available data suggested that, for some people, they were very long indeed, stretching for months, if not years.

From the NHS's perspective, the new target presented a significant challenge. The lack of data about diagnostic and transfer delays meant that neither the government nor anyone else had a clear notion of how challenging it was. However, even if these delays were negligible, the 18-week target was still demanding. In 2004, at the time the target was set, nearly 300,000 people waited for more than 13 weeks after seeing a consultant, and over 80,000 waited more than 13 weeks for an initial appointment

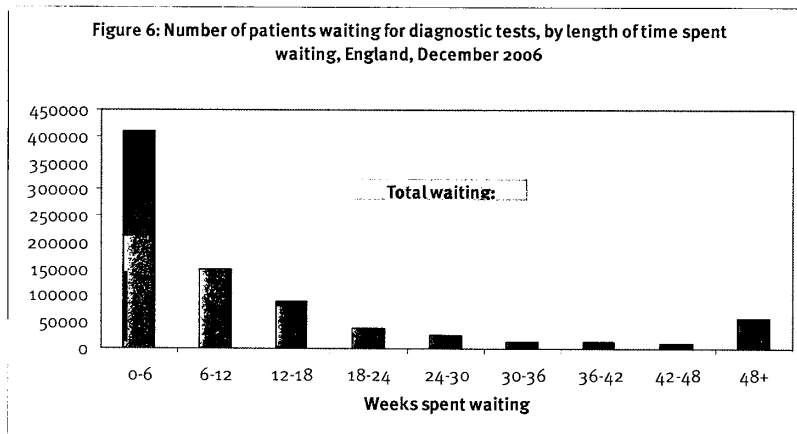
(see Figure 5). It is not possible to combine the data from these two series (inpatient and outpatient data) to derive a total measure of the waits that particular individuals experienced. However, it is clear from these numbers that a major improvement in performance was required at these two stages alone.



Source: King's Fund analysis of data from Department of Health 2007e

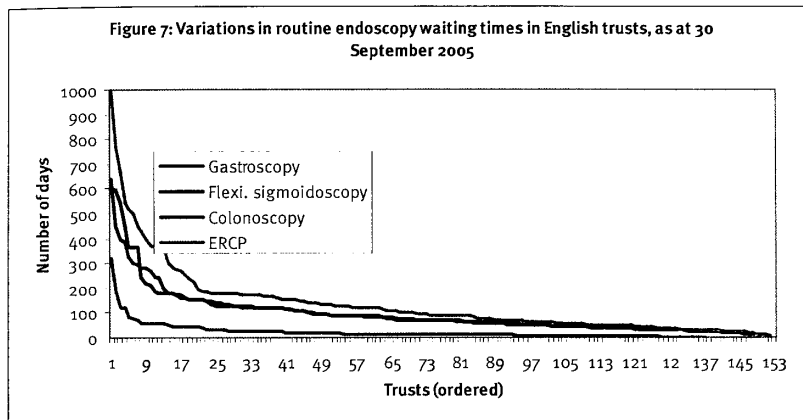
The scale of the new challenge

From July 2006, for the first time, data (on a monthly basis for January 2006 onwards) became available at a national level on waiting times for diagnosis (see Figure 6). This showed that three out of four tests were carried out within 13 weeks (the average was seven weeks), but some people were still waiting for very long periods. Most of these long waits were in audiology and orthopaedics. Since then, there has been some improvement: the total numbers waiting have fallen steadily at the rate of about 10,000 a month (after allowing for changes in definitions) to just over 600,000, and the number of people waiting more than 13 weeks reduced by over a quarter between January and December 2006.



Source: Department of Health 2007e

This data also showed that, although all trusts had some patients waiting for long periods, the situation in some trusts was much worse than others. This picture was confirmed in 2007 in reports published by the Healthcare Commission (Healthcare Commission 2007a; 2007b) that identified considerable variations between trusts in waiting times for imaging and endoscopies (see Figure 7). In 2005/06, waiting times for imaging in over one third of trusts were, for some patients, longer than 26 weeks, well in excess of the time allowed for all stages of the patient journey under the 18-week target. The data below shows that patients in some trusts were waiting over a year.



Source: Healthcare Commission 2007a, 2007b

In December 2006, the results of a national survey of all sources of waiting were published. For the first time, this survey measured delays in all trusts on a full RTT basis, including both diagnostic delays and those arising from referrals from one consultant to another (Department of Health 2006g). This so-called baseline exercise found that, in Autumn 2006, only 35 per cent of patients admitted (day case or inpatient) were seen within 18 weeks. The proportion of non-admitted patients seen in this period was more than twice this, but these pathways were typically shorter than for admitted patients, since they terminated at the first outpatient appointment or after a subsequent diagnostic test.

Orthopaedics emerged as the main problem area: only one in five pathways ended in under 18 weeks. However, all specialties were found to have a significant number of patients waiting over a year. Improvement therefore had to be 'across the board'.

This new data confirmed what was already suspected: that achievement of the 18-week target represented a major challenge. Data released in July 2007 suggested that the NHS was responding (Department of Health 2007f). Of the patients starting treatment in April 2007, 51 per cent had waited less than 18 weeks, an improvement of 13 per cent over the earlier figure. Only three out of four patients treated in April were included in these figures; however, the face value of these statistics suggests that the NHS is rising to the challenge. However, the data also revealed that some patients had waited much longer than 18 weeks: one out of nine had waited over a year. Furthermore, while a small number were shown to be treating nearly all of their patients within 18 weeks, others were treating less than one in three (Department of Health 2007f).

The policy response

When the target was set, the government recognised that meeting the target required a wide-ranging response. The measures taken fell into five groups:

- increasing the availability of, and improving access to, diagnostic services
- increasing the level of technical support available to NHS trusts

- reducing the workload of the hospital
- increasing the funds available
- system reform management.

INCREASING AVAILABILITY AND ACCESS

By the time that the new target was set, the government had already commissioned extra treatment and diagnostic capacity from the private sector after projections made by the NHS in 2002 suggested that it would not be able to carry out enough operations to meet the current targets (Department of Health 2002). From 2005 onwards, the Department of Health procured this extra capacity from providers new to the NHS in the areas where it was considered lacking. A second round is currently being negotiated.

The main emphasis in 2002 was on extra capacity to carry out operations. However, a mobile diagnostic unit was commissioned as part of the first wave of independent treatment centres and, in 2004, the Department of Health (Department of Health 2004a) invited bids for extra mobile capacity of 80,000 MRI scans. In the following year, the Department sought expressions of interest for the procurement of diagnostics to a value of £1 billion over five years (Department of Health 2005d). In 2005, contracts began to be let for this additional capacity. In December 2006, for example, a contract was signed with an international IT provider, Atos Origin, to provide a diagnostic service for the South West and North West Regions.

INCREASING THE LEVEL OF TECHNICAL SUPPORT

The War on Waiting for Hospital Treatment noted the technical support that the Modernisation Agency had offered to trusts seeking to reduce waiting times. During the past 18 months, the scale of the support offered to trusts by the Modernisation Agency's successor, the NHS Institute for Innovation and Improvement, and by the Department of Health through its 18-week programme, has greatly expanded.

At the outset, it was necessary to define precisely how the 18-week pathway was to be measured. In October 2005, the Department issued *Commissioning an 18 Week Patient Pathway* (Department of Health 2005b), which solicited views from the NHS and others on the broad approach to be taken. For example, it asked exactly how the 18 weeks should be defined, what range of pathways should be included in it and the scale of the challenge involved in meeting the target.

In December 2005, the Department of Health requested expressions of interest from local health economies to act as 'pioneers' of the 18-week target (Department of Health 2005c). At the same time, the Department established the 18 weeks delivery programme, with its own website: www.18weeks.nhs.uk (accessed on 16 July 2007). The programme was set up to act as a 'comprehensive source of information and resources' to support the achievement of the target.

In April 2006, the Department published *Tackling Hospital Waiting: The 18 week patient pathway* (Department of Health 2006h), drawing on the experience of 21 pilot sites. It also drew on experience relating to the targets for diagnosis and treatment of cancer patients, which had already implemented an 'end -to-end' or RTT approach. While identifying a small number of particularly difficult areas – consultant endoscopy and pure tone audiometry – the Department argued that improvements had to take place across all specialities. This message was reinforced later in the year by the baseline exercise referred to above. Parts of this guidance have subsequently been modified and clarified, particularly those relating to the precise definition of the 18-week target (Department of Health 2006i).

At the same time, a further paper entitled *18 Week Patient Pathway Delivery Resource Pack* (Department of Health 2006a) was published. This identified that the period from the first outpatient appointment to the decision to treat (or not to treat) presented the most significant challenges. During this stage of

the care pathway, a patient may have to wait for a test, then wait for the results of that test, and the outpatient appointment made to discuss its implications; in some cases, a patient may then need further tests or be transferred to another consultant.

As explained above, data for this stage of the patient pathway had been very limited in the past. From the data that became available in 2006, the Department of Health concluded that reducing delays during this period was likely to require change in the way that services were organised and delivered. The resource pack contains detailed guidance on how to approach this task, making it clear that 'more of the same' would not be adequate; in other words, carrying out more operations alone would not reduce the longest delays. This could only be achieved by tackling the waits between initial consultation and treatment.

Since then, a large volume of additional guidance has been issued. For example, the NHS Institute for Innovation and Improvement has established a 'No Delays' programme (available at: www.nodelaysachiever.nhs.uk/ [accessed on 15 July 2007]) to support trusts in their attempts to shorten care pathways. In addition, a series of programmes has been established, targeted at critical areas, including the workforce and diagnostics. These aim to show providers how professional roles can be changed and the patient pathway redesigned. For example, if tests are carried out and the results assessed in a 'one-stop shop', months of potential delay can be cut out. The Department of Health has also published the specification of more than 30 pathways to show how delays can be designed out.

Some of the recommendations made by the NHS Institute for Innovation and Improvement, such as greater use of day surgery, have been made many times before (Audit Commission 2001), and there are plenty of operational examples. However, in other areas, such as audiology, delivery of the services used along the patient pathway have to be rethought and then redesigned on the ground (Department of Health 2007b).

In the past, changes of this kind have proved difficult to introduce as they may involve new professional roles (which may need regulatory approval), shifts of activity between organisations (which may clearly be resisted), and new technology. Also, as the Operating Framework for 2007–08 states:

Genuine clinical engagement, the development of new alternatives to existing services and the effective use of information management and technology will be the key to successfully delivering the 18 week objective. (para 2.8)

None of these can be taken for granted. However, now more than ever before, those seeking to redesign services can draw on examples of changes made in other areas, through the work of the Department of Health and the NHS Institute, as well as on other supporting material, to help them to see the process through.

The 18 weeks website demonstrates the scale and range of this activity. However, its very extent suggests that the NHS as a whole is not yet prepared (in terms of data and skills) to make the changes necessary to reach the 18-week target. In February 2007, however, 13 local health economies committed themselves to meeting the target by the end of the year: that is, a year early (Department of Health 2007c). This suggests that the target is feasible, if not universally so.

REDUCING HOSPITAL WORKLOAD

Initiatives have been taken to divert demand from hospital to community settings: in other words, to shift the location of care and also to reduce the need for hospital care through preventive measures.

Shift of location

In the White Paper *Our Health, Our Care, our Say* (Department of Health 2006e), published in January 2006, the government set out a range of policy initiatives designed to move care out of the large acute hospitals into community or residential settings. Subsequently, it announced a series of pilots covering a number of specialties, including orthopaedics, as well as ENT, dermatology, gynaecology and urology (Department of Health 2006f). In November 2006, the Department of Health launched the Musculoskeletal Services Framework (Department of Health 2006c), with the aim of providing faster access to care closer to home. This is to be achieved by increasing the number of referral routes open to GPs: for example, by including GPs with special interests, nurses, physiotherapists and pharmacists, which will therefore reduce the number of patients referred to a hospital-based consultant. Similarly, in March 2007, the Department published a plan for audiology (Department of Health 2007b). Some very long waits for audiology had been identified in the base line exercise. To help reduce these the plan also proposed the creation of a new pathway not involving visits to an acute hospital

Reduction

Care and Resource Utilisation: Ensuring appropriateness of care (Department of Health 2006b), published in December 2006, describes a number of ways in which the workload of the hospital sector can be reduced. The two main techniques – utilisation management and prior approval – have been widely used in the US with limited success (King's Fund 2007b). The guidance also discusses clinical assessment services and referral management centres, and promises further guidance in relation to both of these.

It is too soon to say what the impact of these reduction techniques has been. However, the NHS has already had some success in reducing the volume of hospital work. In 2004, the Department of Health had set a target for reducing the number of hospital bed-days arising from the admission of emergency patients by 2008. At the beginning of 2007, it reported that this target had already been met by the end of 2006 (Department of Health 2007d).

It is not clear how this reduction has been achieved. The NHS Improvement Plan (Department of Health 2004b) announced an initiative designed to improve the care of people with complex conditions who were at risk of frequent emergency admissions to hospital. 'Case management' involved the creation between 2005 and 2008 of 3,000 community matrons, who were tasked with giving intensive community support to an estimated 250,000 patients.

Since 2004, there have been a series of technical developments to allow primary care trusts (PCTs) to identify the minority of patients who need this intensive support. The King's Fund, New York University, Health Dialog (an American company) and the Department itself have developed tools (available at: www.kingsfund.org.uk/current_projects/predictive_risk/patients_at_risk.html [accessed on 15 July 2007]). These focused initially on hospital admission data but, by the end of 2006, the technique had been developed to include community and A&E data, as well as data from GP systems. Other independent sector organisations, notably Dr Foster and United Healthcare, have also developed similar tools.

These developments came too late to contribute much to the decline in emergency bed days achieved by the end 2006. In principle, therefore, there should be scope for further reductions in emergency bed days as these techniques are applied. However, other sources of emergency demand – particularly A&E attendances – have continued to rise.

FINANCE

The 2004 Spending Review (HM Treasury 2004) allowed for £1 billion to be spent in 2006/07 on extra operations to help to achieve further reductions in waiting times, and a further £400 million on improving access to diagnostics in 2006/7. For 2007/8, the combined cost was estimated to be £2,700

million. These sums provided for extra activity estimated using the Department of Health's Waiting Times model (used to estimate the number of extra operations required for a given reduction in waiting times) and estimated unit costs of £1,500 for each admitted patient and £80 for each outpatient (personal communication, Department of Health 2006). An allowance was made for switching activity to primary care and also a growth in underlying demand.

These sums represent a significant proportion of the extra money becoming available to the NHS during this period. However, they do not represent a dedicated elective care budget, so there is nothing to prevent the extra finance being used for other purposes. For many NHS and PCTs, the main call on any additional funding is deficit reduction, one of the four priorities set out in the Operating Framework for 2007–08 (Department of Health 2007h). However, across the board, all parts of the NHS continue to have to deal with strong cost pressures arising from increases in staff numbers and higher salaries. The 2007 pay settlement at levels below the expected rate of inflation will, however, make it easier for trusts to contain costs. In addition, the decision to withdraw the Resources Accounting and Budgeting framework announced in March 2007 (Department of Health 2007g) will make it easier for trusts in deficit to recover financial balance.

Payment by Results is now in place for nearly all elective activity. In principle, it creates an incentive for trusts to try to carry out more operations. However, this is only true for those trusts where costs are below the tariff. Furthermore, PCTs cannot provide an open-ended commitment to finance all the activity that a trust seeks to carry out. There have been signs in recent months that PCTs have had to limit the number of operations carried out to the minimum that are required to meet the current six-month maximum waiting target.

A review of the most recent, publicly available PCT board papers, carried out in March 2007 by the King's Fund, shows that 78 per cent of PCTs referred to 'over-performance' by their local acute hospital trusts as a financial risk or cost pressure (King's Fund 2007a). Several points emerge from these documents. First, the data on the real 'referral to treatment time' is only just becoming available for analysis. Second, where it is available, PCTs and trusts are only now beginning to identify the 'challenging specialties, such as orthopaedics in their local areas. Where PCTs do refer to strategies to meet the target, some involve service 'redesign' (for example, streamlining diagnostic tests to avoid repeat visits by patients). However, some also include reducing the number of patients who get into the 'system', by maintaining pressure on GPs to reduce their referrals to outpatients, and by 'capping' the number of consultant-to-consultant referrals.

A common thread running through these board documents was concern about the cost of meeting the 18-week target (with estimates of a 10–11 per cent increase in inpatient and outpatient activity). A minority of trusts (14) also referred to having saved money by requiring their provider trusts to limit their activity to the level required to meet the existing waiting-time targets. This then created a potential conflict with the 18-week requirement to speed up activity.

In the 'old' NHS, elective activity was often cut back towards the end of the financial year as trusts ran out money and, also in some years, to make room for higher winter levels of emergency admissions. Therefore, the phenomenon is not new. It seems, however, that the inflexibility of the Payment-by-Results tariff – which rules out trusts offering extra operations at marginal costs – has made it harder, at least in some cases, for trusts to maintain activity at levels that would use all of their capacity.

Similarly, spare capacity exists outside the NHS in the private sector, as financial pressure on PCTs has also meant that the number of operations purchased from the private sector is much less than the new Independent Sector Treatment Centres (ISTCs) are capable of delivering. However, the NHS is contractually bound to pay for it. Accordingly, it represents a drain in PCT resources in those areas where ISTCs continue to be underutilised.

SYSTEM REFORM AND MANAGEMENT

The War on Waiting for Hospital Treatment identified strong central direction as a key factor explaining the government's success. The central pressure remains: the Operating Framework for 2007–08 sets out nationally determined priorities that include further reductions in waiting times.

Over the past two years, however, the government has taken a number of steps designed to give localities greater control over the way that local resources are used. The main emphasis has been on making the purchasing function more effective. The number of PCTs has been reduced, as there is an expectation that large organisations will have more expertise at their disposal. At the same time, the introduction of practice-based commissioning is expected to increase clinical engagement and encourage new ways of providing services.

The 18 Week Patient Pathway Delivery Resource Pack (Department of Health 2006a) clearly puts the onus on PCTs to be the performance managers. This task was re-emphasised in the *Guidance on the NHS Contract for Acute Hospital Services for 2007/08* (Department of Health 2007a), which made it clear that PCTs should use the contracting framework to keep trusts in budget and, at the same time, to ensure that progress towards targets is maintained. The guidance states that the contract should embody mechanisms such as utilisation review or prior approval in order to keep activity in line with the levels agreed. It also provides for purchasers to 'fine' trusts for failure to meet the milestones on the way to achieving the 18-week target.

Pressure on trusts may also result from the exercise of choice on the part of patients. From 2002, choice of place of treatment has been offered to some patients and is now universally available, albeit on a still-limited basis. In July 2005, the Secretary of State announced that the choice programme would be extended to diagnostics (Department of Health 2005d). As from November 2005, those who were not offered an appointment for a CT or MRI scan within 20 weeks were offered an appointment at another hospital within six weeks: that is, the maximum wait was set at 26 weeks. By that time, however, the numbers waiting longer than 20 weeks for these two diagnostic procedures was already very low. In April 2006, the maximum limit was set at 20 weeks and was further reduced to 13 weeks from April 2007.

Assessment: can the new targets be met?

Since publication of our earlier analysis in 2005, the main indicators of waiting time performance have moved in the 'right' direction. To recap:

- The numbers waiting for treatment is at the lowest level since records began on the current basis (1988).
- Average waiting times for treatment have continued to fall during 2006).
- The numbers waiting more than six months for treatment have remained very low.
- The numbers waiting more than 13 weeks for a first outpatient appointment continue to fall.
- The total number of people waiting for diagnostics rose slightly during the first nine months of 2006, but that was due to a change in recording of audiology tests. Otherwise, numbers fell and the number waiting over six months also fell slightly.
- The latest figures suggest that the proportion of patients treated within 18 weeks from referral has risen from just over a third to nearly a half.

The critical question is: can this progress be maintained?

The War on Waiting for Hospital Treatment distinguished between demand- and supply- side risks. On the demand side, we noted that demand for treatment might rise more rapidly than had been assumed. The data is too sparse to reach a clear conclusion as to whether or not this risk has

materialised and whether it has been managed effectively. However, available data suggests that demand (as reflected in the number of decisions to treat made by hospital consultants) is rising: a reversal of the trend apparent in the first three years of the decade. The numbers accepted for treatment fell rapidly in that period: a decline that went a long way to explain why the number of people waiting fell. That decline levelled out from 2003 onwards, and the most recent figures suggest a slight rise. There is no satisfactory explanation for these changes: therefore, forecasting how numbers accepted for treatment will change in the near future is extremely difficult (Harrison and Appleby 2005).

On the supply side, our earlier analysis noted a number of issues, including changes in the workforce, the impact of Payment by Results, other claims on hospital resources and the scope for improvements in efficiency. As the NHS as a whole has slid into deficit, the government has increasingly emphasised the last of these issues. During 2006, the Department of Health issued a number of statements on the scope for greater operational efficiency in NHS trusts, following up on the previous advice issued by the then Modernisation Agency (Department of Health 2006d). The numbers put forward for attainable cost reductions have varied from the modest but useful to the significant: up to £2 billion a year.

The pressure to reduce costs has also been reflected in the level of the Payment-by-Results tariff, which implies a real-terms average reduction in the cost of elective care of 2.5 per cent during 2007/08. This is more challenging than it may seem for two reasons. First, a simple way of reducing costs is to increase activity while overheads are held constant; however, that option may not, as explained above, be available for some trusts. Second, for some years, the average cost of elective care procedures has been rising: the main reason has been the general cost of inflation experienced by the NHS, which individual trusts have little control over. Finally, for a number of trusts, the kind of changes required in patient pathways and service delivery will be hard to achieve because their management – and clinical resources – will be absorbed in responding to plans to reconfigure services locally.

Across the NHS as a whole, the most serious threat to the new target comes from the overall financial situation, which has worsened since 2004. The government is determined that the NHS should get back into surplus (which has been achieved according to the latest figures) and be able to maintain surpluses in the future. NHS trusts or PCTs with persistent deficits may have little option but to cut back on services, including – in some cases – elective care. In many instances, this will mean that they have started the financial year 2007/08 without having made any progress towards the level required to meet the 18-week target.

Conclusion

In 2005, *The War on Waiting for Hospital Treatment* concluded that the government could be reasonably confident that the new target was achievable, despite the substantial downside risks. The government took the March 2007 figures, which revealed a rapid improvement in the proportion of patients treated within 18 weeks, as confirmation that it could be met. However, the figures also reveal that some parts of the NHS are still a long way from doing so.

The improvement in the overall financial situation in the NHS will allow some commissioners to pay for more activity. However, by itself, that will not be enough to ensure that the 18-week target is met for all patients. The length of some waits for diagnosis, and the other unmeasured delays revealed in the baseline exercise, mean that changes in service organisation and management will still be required: extra activity will not remove those waits that arise when patients are passed through several diagnostic phases. Whether the required changes will happen fast enough is very hard to assess. The advice issued to trusts from the NHS Institute for Innovation and Improvement and the Department of Health's 18 weeks website confirm that there is great potential for introducing improvements that will cut delays for diagnostics and other elements of the patient pathway. However, whether that potential is realised by the end of next year throughout the NHS remains uncertain.

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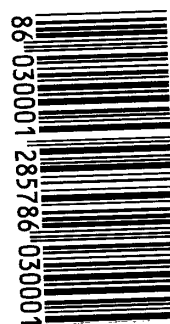
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