Department of Health

Tackling hospital waiting: the 18 week patient pathway

An implementation framework

NHS

DH Department of Health

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Description	The Implementation Framework provides an overview of the challenges involved in delivering the 18 week pathway. It sets out a high-level implementation plan and timetable, clarifying the different contributions of all involved. It sets out the principles and definitions to underpin the 18 week pathway, and points to additional analysis in a Delivery Resource Pack, available online.
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1: Tackling hospital waiting

1.1 The *NHS Plan* (2000) set out a vision of a service designed around the patient, with a ten year programme of investment and reform to transform the system and put it at the forefront of best practice internationally.

1.2 Patients can now expect faster access to services than ever before. Five years ago, it was not uncommon to wait six months for an outpatient consultation and eighteen months for inpatient treatment. Since December 2005, patients can expect an outpatient consultation within thirteen weeks, and inpatient treatment within six months, and the average wait is much less. These improvements are the result of the hard work of all those working in the NHS, and illustrate that the programme of investment and reform is working (see Figure 1).

1.3 Building on this, the *NHS Improvement Plan* (June 2004) set out an ambitious new aim.

"By 2008 no one will wait longer than 18 weeks from GP referral to hospital treatment."

The principles and definitions in annex A set out what is included in the 18 week pathway. While 18 weeks will become the maximum normal wait for non-urgent patients, most patients will be seen more quickly. As with the six month inpatient target, the average wait on the 18 week pathway will be much less than the maximum, probably around nine weeks.

1.4 This 18 week target is different from previous waiting time targets. Instead of focusing on a single stage of treatment (such as outpatients or inpatients) the 18 week pathway addresses the whole patient pathway from referral up to the start of treatment. In doing so, it is the first to shine a light on so-called 'hidden waits' – the diagnostic and follow-up outpatient stages which historically have taken weeks or months to complete and have never been measured systematically. The 18 week pathway requires the NHS to measure the total period waited by each patient and to manage each patient's journey from referral to treatment in a timely and efficient manner. Also, for the first time, the commissioners – Primary Care Trusts – will be held directly accountable for the achievement of the pathway for their patients.

1.5 The first step in eliminating hidden waits is to be able to measure them. In January 2006, the NHS began the systematic collection of data on waiting times for diagnostic tests, something it has never done before. As with any such data collection, several months' worth of collection and review is required before the data are of sufficient quality to be

published. Publication will focus attention on diagnostic waits as never before and will enable the NHS to press ahead with reform of a key part of the 18 week pathway. Some of the data will show long waits for diagnostics in some areas. Reducing these waits is one of the principal reasons that we have set the 18 week pathway target.

1.6 When the data are published, some people will try to add together figures on outpatients, diagnostics and inpatients in an attempt to estimate the total pathway wait and numbers waiting. In reality, many of the patients involved will be the same across the three lists, and many of the periods waited will overlap. Not until we have proper referral to treatment measurement – for which the collection will begin in January 2007 – will we be in a position to assess pathway waits properly. At the moment, a best guess is that about 50% of patients may be receiving treatment within 18 weeks of referral, with large variation across specialties.

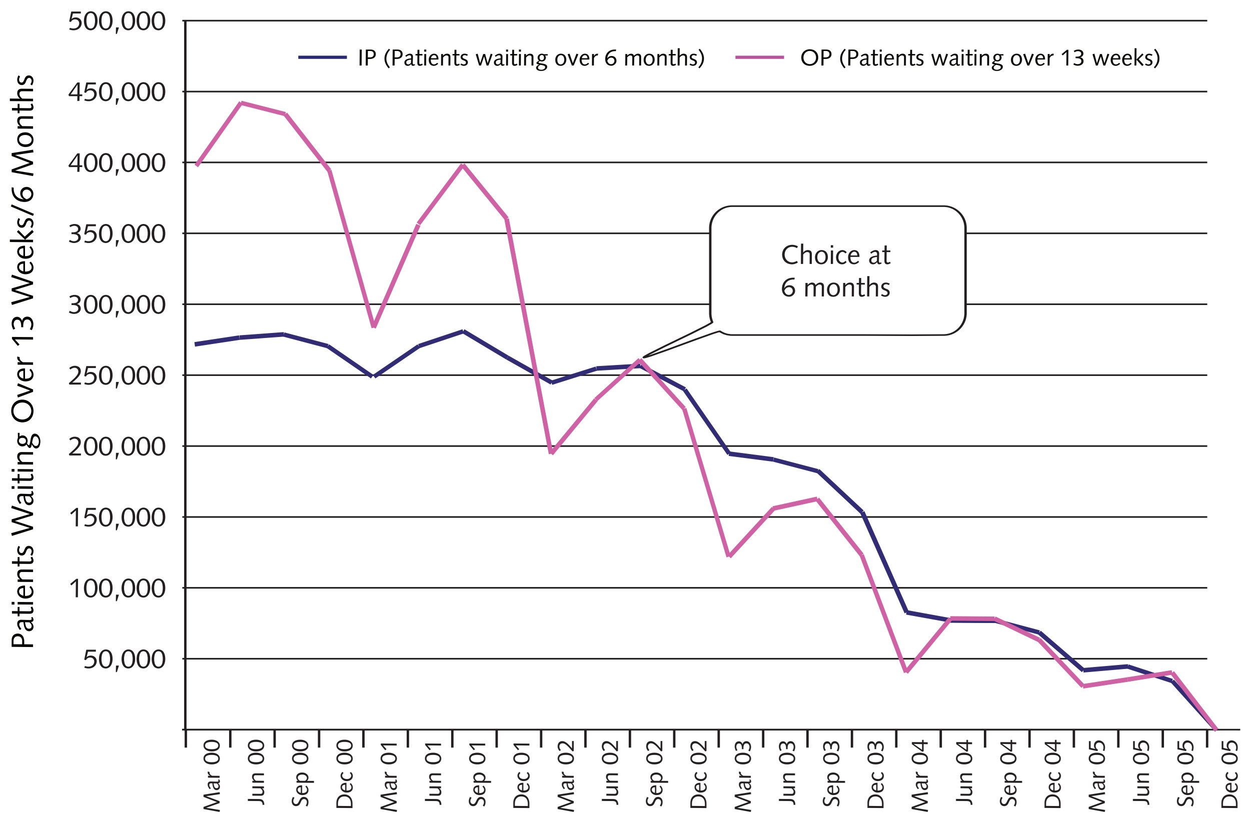
1.7 Achieving an 18 week pathway for all (bar clinical exceptions or those who choose to wait longer) by December 2008 is very ambitious, requiring a contribution from everyone working in the NHS. It will not be enough simply to tackle long waits at the margins. While the extra activity necessary to achieve 18 weeks was fully-funded by the Treasury in the 2004 Spending Review, radical new approaches are required of commissioners and providers throughout the health and social care system.

1.8 This implementation framework explains the nature of the 18 week pathway challenge based on extensive analysis completed during 2005/06. It sets out a high-level implementation plan and timetable to achieve it, clarifying the different contributions required of all those involved.

1.9 The 18 week pathway does not replace existing shorter waiting time guarantees, for example cancer and heart disease. As cancer and heart disease were the first end-to-end pathways, the experience gained in implementing these targets has been and will continue to be applied to the 18 week pathway.

1.10 For queries on this document, please e-mail 18weeks@dh.gsi.gov.uk, or call 020 7633 4025.

Figure 1: Number of patients waiting longer than 13 weeks for outpatients and six months for inpatients



2: The 18 week pathway challenge

2.1 The 18 week patient pathway is the most ambitious access target for the NHS to date. Up to now, reform has focused on outpatients and inpatients. Dramatic improvements have been made, significantly reducing total pathway time for patients. Now it is time to address the remaining parts of the pathway between first outpatients and inpatients which can shape patients' experience of the NHS so significantly, and which are often a source of frustration to staff. By measuring pathways from referral to the start of treatment, the NHS will be able to focus on tracking and managing patients' journeys right the way through.

2.2 To better understand the nature of the 18 weeks challenge, the Department of Health carried out a programme of analysis, working with 21 pilot sites across England during 2005/06. The pilot sites collected data on waiting times for key diagnostic tests and on whole patient pathways, providing for the first time an analysis of the whole patient pathway from referral to treatment. This was brought together with analysis, carried out centrally, of historical data and local health economy plans for the coming years. Lessons were drawn from the NHS' successes in achieving the 13 weeks and six month targets in December 2005, and from the experience of reducing waits for the diagnosis and treatment of cancer, which like the 18 week pathway, takes a whole patient pathway approach.

2.3 The analysis and findings from this work are presented in detail in a 'Delivery Resource Pack', available on the Department of Health website, www.dh.gov.uk and at www.18weeks.nhs.uk.

2.4 The work highlighted a number of key challenges that need to be tackled systematically. The challenges fall into four areas. More detailed documents setting out the programme of work for each area will be developed over the coming months. The immediate focus of work for each area is set out below.

Challenge 1: Long waits and long clearance times

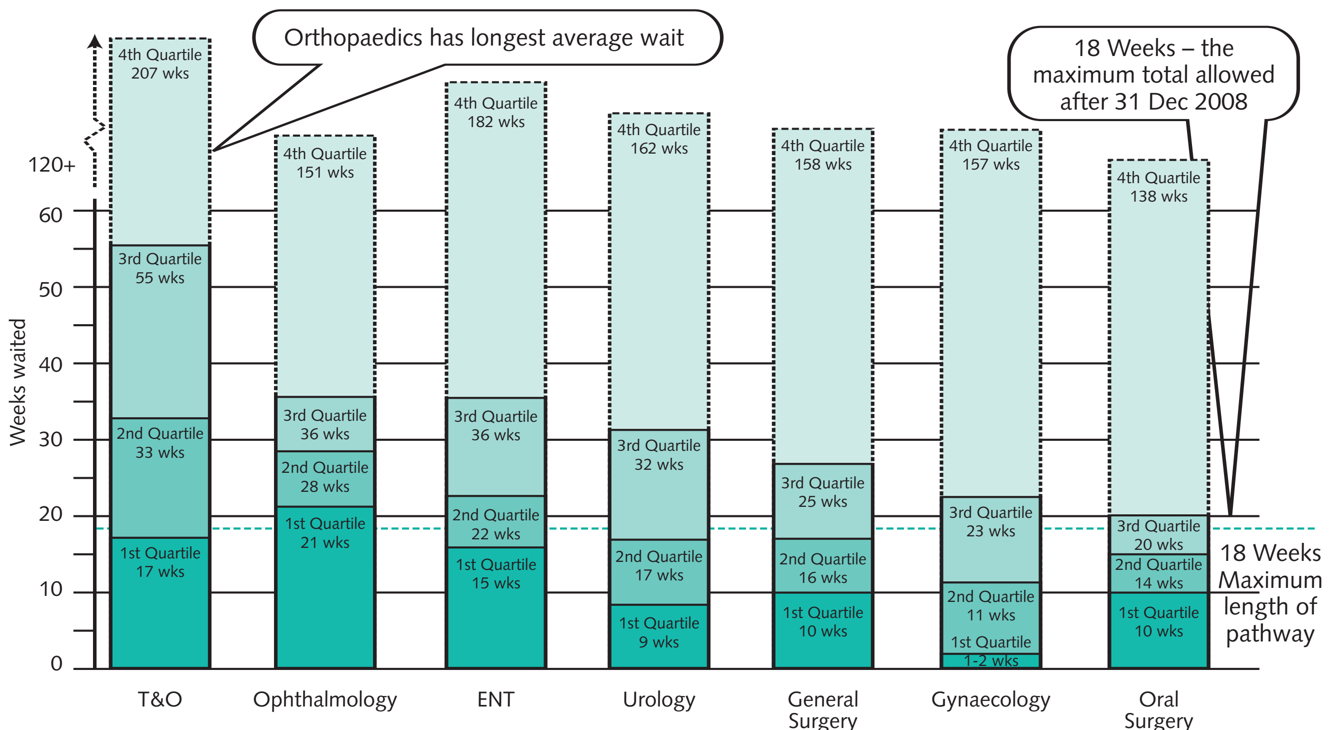
2.5 The pilot sites revealed that there is no single issue that causes long waits and long clearance times across all specialties and diagnostic tests. Waiting times need to be reduced in all areas, but certain specialties and diagnostic tests have particularly long waits coupled with high volumes of patients, and require special attention. The analysis has highlighted orthopaedics, echocardiography endoscopy, and audiology as areas that need focused work to achieve the 18 week pathway. Within the implementation programme for the 18 week pathway, dedicated projects are

being put in place to identify measures in relation to orthopaedics, echocardiography and endoscopy. For audiology, and adult hearing services in particular, which as a result of modernisation programmes are mainly accessed directly by primary care and are therefore outside the scope of the 18 week pathway, which is focused on changing traditional hospital consultant pathways, a separate action plan is being developed on improving access to services, given that they present a significant challenge to providers and commissioners (as outlined in figure 3). This reflects the direction set out in the White Paper *Our health, our care, our say* (January 2006) to move services closer to the patient.

Clearance times

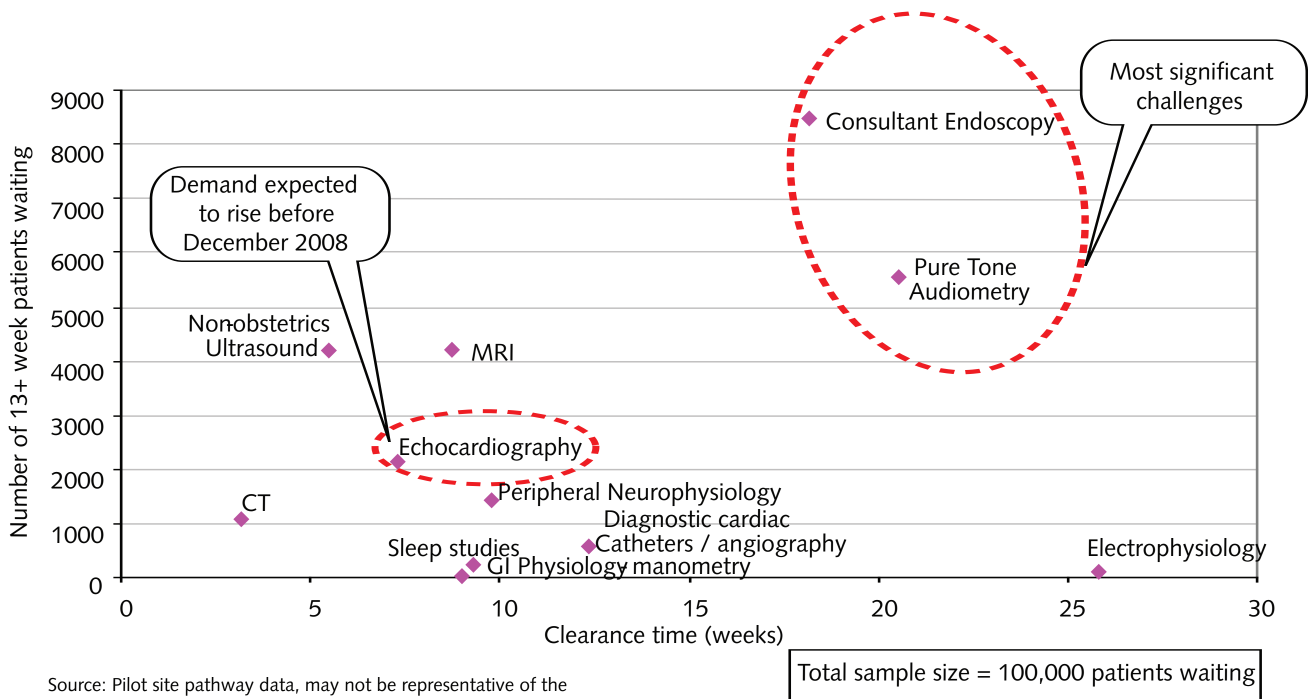
The clearance time is the time required to treat the current stock of patients on the waiting list with the available capacity. As we move into a 'short wait' health economy, clearance time becomes a critical criterion for planning sustainable delivery.

Figure 2: Median and maximum referral to treatment waiting times



Data from a single pilot site, 2005. May not be representative of the national position.

Figure 3: Diagnostic test clearance times



Source: Pilot site pathway data, may not be representative of the national position

2.6 Figures 2 and 3 suggest other specialty areas which may face their own challenges in achieving 18 week pathways. The Department of Health will work with the NHS to identify any particular obstacles and will be prepared to put in place arrangements to help as necessary.

Orthopaedics

2.7 With over two million referrals a year, roughly 14.3% of the national total (Q4 2004/05 – Q3 2005/06), orthopaedics represents perhaps the biggest area of challenge (as it was for the December 2005 six months inpatient target). The project in this area will consider reforming pathways, integrated pathway management, and realising the potential that primary care can contribute to delivering improvements. This includes prevention and self-care, rehabilitation and pain management, and allowing people to be treated closer to home.

2.8 To maintain the momentum of the work of the National Orthopaedic Project, which led at national level the delivery of the six month inpatient waiting time target, we will build on its work, reforming it on the entire patient pathway. It will examine first the 30% of primary care consultations that are

for musculoskeletal conditions. A Musculoskeletal Framework will be published shortly to support this work. It will then develop to support the delivery of orthopaedics services specifically to achieve the 18 week pathway, linking closely with the development of orthopaedic services in primary care in the light of the recent White Paper, *Our health, our care, our say: a new direction for community services*.

Endoscopy

2.9 Endoscopy covers a range of high volume diagnostic tests for which relatively long waiting times were identified. Over 20 different types of endoscopy are performed in the NHS and these are key diagnostics in over 26 clinical specialties, so faster throughput in this area is essential. The endoscopy project covers all the main types of endoscopy: both upper and lower gastrointestinal (GI) and endoscopies in gynaecology (colposcopy and hysteroscopy), urology (cystoscopy), and respiratory medicine (bronchoscopy). The project will incorporate work already in hand to reduce waits for endoscopy for patients suspected of having cancer, who need to be diagnosed and treated much faster.

2.10 The project will build upon the National Endoscopy Team's work, using the successful 'Global Rating Scale', details of which can be found at www.grs.nhs.uk. The project will seek to embed proven, self-sustaining changes in practice and offer intensive support where needed.

The Global Rating Scale

The GRS is a tool for defining and measuring a patient-focused endoscopy service. Its primary aim is to help endoscopy teams identify areas for quality improvement. The GRS has helped the NHS to understand the issues facing endoscopy, identify good practice and reduce waits.

The Global Rating Scale can be found at www.grs.nhs.uk

Echocardiography

2.11 Many elective and emergency care pathways use echocardiography, a diagnostic test using ultrasound to create images of the heart. Intervention rates are forecast to increase over the next few years as technology and clinical practice develop. The NHS will need to plan to match this increased demand with the necessary capacity, while improving waiting list management to reduce waits.

2.12 The project in this area will work closely with stakeholders to reach consensus on an appropriate intervention rate, or range, for planning purposes, and then facilitate the development of pathway solutions.

Audiology

2.13 The analysis also found long waits in audiology – in particular for adult hearing services. These waits present significant challenges which the NHS needs to address. Most such services are accessed directly from primary care and are therefore not subject to the 18 week pathway target which focuses on hospital consultant pathways. But 20% of adult hearing service patients do access the service via hospital consultants (especially through ENT) and so the area as a whole requires attention in order to support the achievement of 18 weeks. It is important that innovation in removing unnecessary steps in the pathway continues, and that direct access referrals are not re-routed to ENT consultants. A plan of action is under separate development and further details will be published in due course.

Diagnostic initiatives linked to the 18 week pathway

2.14 Also linked to the 18 week pathway are separate diagnostic work programmes covering all imaging, physiological measurement and pathology diagnostics.

2.15 The national imaging work programme is developing innovation and good practice by promoting integrated patient pathways across all service providers, and common clinical protocols for referral into imaging services from primary care. It will develop optimum utilisation models across all imaging modalities, supporting practice based commissioning through imaging specific commissioning guides and providing interim solutions for unbundling imaging tariffs.

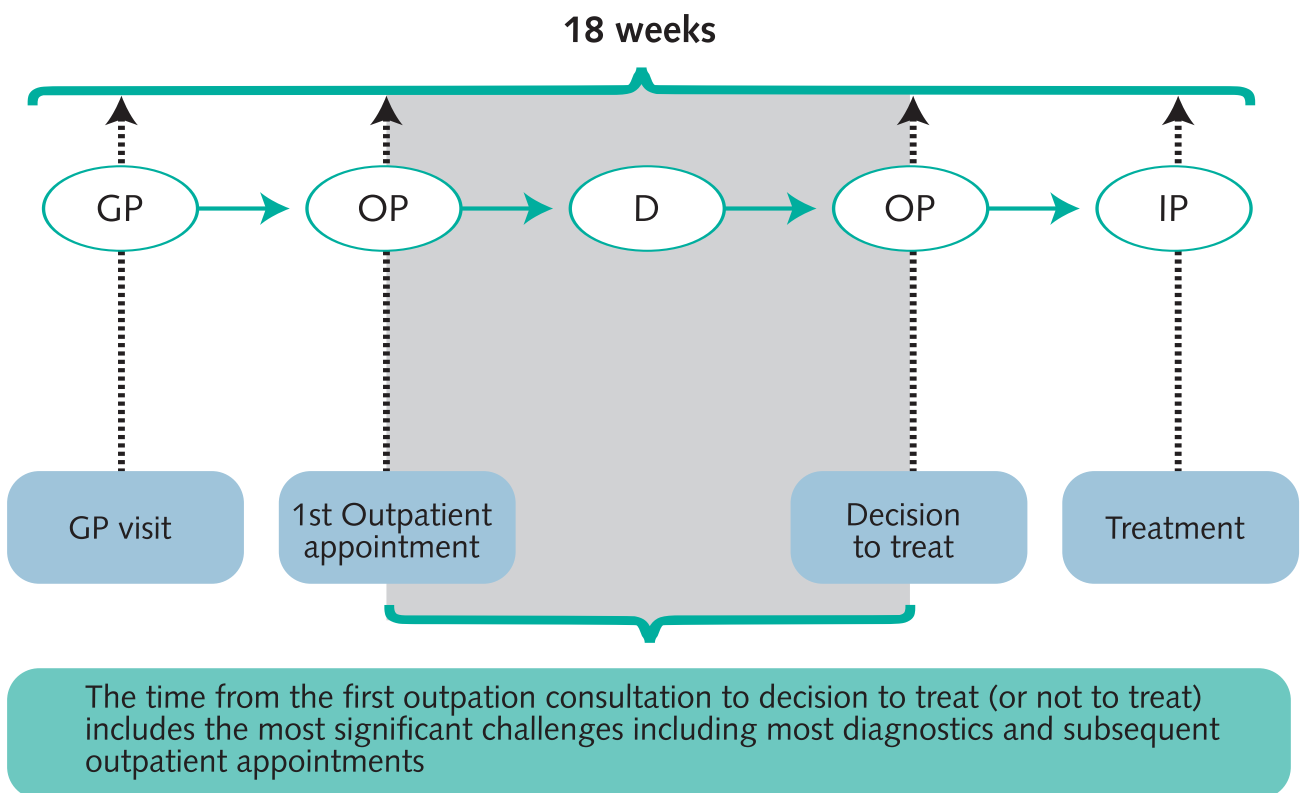
2.16 The first phase of the Choice of Scan programme began in November 2005, offering patients waiting more than 26 weeks for a non-urgent MRI or CT scan the choice of faster treatment at an alternative hospital. Data for publication shortly is expected to show that Choice of Scan may have had a significant impact in reducing waits for MRI and CT. A new, more ambitious stage of the Choice of Scan programme began in April 2006, offering patients waiting longer than 20 weeks for all non-urgent imaging tests the choice of faster treatment at an alternative hospital.

2.17 In addition to work on echocardiography and audiology, there may also need to be specific workstreams in areas where particular challenges to the 18 week pathway exist, such as in peripheral neurophysiology and sleep studies. More widely, the physiological measurement programme covers other diagnostics that are used to assess the function of major organ systems in eight disciplines: cardiac physiology, gastrointestinal physiology, neurophysiology, ophthalmic and vision science, respiratory physiology (including sleep studies), urodynamics, and vascular

technology. The programme will promote service innovation, improving standards, quality of provision and delivering better services for patients across these eight disciplines. Solutions in each area are already being tested at eight physiological measurement development sites across England. Learning from these sites will be rolled out later in 2006.

2.18 A Modernising Pathology Programme has also been running since 1999. Currently, NHS pathology services are the subject of an independent review, led by Lord Carter of Coles. Whilst pathology is not expected to present a major challenge for the 18 week pathway, this programme and the outcome of the review will help to ensure that pathology services support its delivery. The vision is of a pathology service built around the needs of patients and their clinicians, enabling and empowering staff to work across traditional boundaries, offering patients more choice and integrating pathology considerations into wider service developments and improvements.

Figure 4: The whole pathway



Challenge 2: Thinking in and measuring whole pathways

2.19 The pilot sites identified the middle section of the pathway – and lack of understanding about it – as a key problem area for achieving the 18 week pathway. Patients are often involved in a series of diagnostic and outpatient appointments, illustrated in the grey area of figure 4. Focus will need to shift from resolving problems in particular treatment stages to finding solutions for the whole pathway. This will be the first time that the NHS has focused on the whole pathway for all patients.

2.20 We are taking the first step towards understanding the middle of the pathway with the new routine data set on activity and waiting times for diagnostic tests. NHS Trusts and PCTs have been collecting these data since January 2006. These data will identify long waits for some diagnostic tests. For the first time, it will be possible to see the length of first outpatient, diagnostic and inpatient elements of the patient journey. These data are not linked to individual patients however, and will not tell us how long each patient is waiting. The next challenge therefore is to measure entire patient pathways.

2.21 Currently, most patients are not tracked as they move through their pathway. The 18 week pathway means that the NHS needs systems in place to know where every patient is, in relation to their 18 week pathway, and to measure the length of time they have been waiting. The 18 week pioneers are identifying approaches to this based on existing patient administration systems (PASs) to enable referral to treatment measurement from January 2007 so that Local Delivery Plans (LDPs) for 2007/08 can include planned referral to treatment times. For the longer run, a complete measurement system is being agreed with Connecting for Health (CfH).

2.22 To achieve this, eight pioneer health economies across England are developing practical solutions using existing IT systems. They will complete this work by the end of June 2006, when their solutions will be shared across the NHS. From the start of January 2007, the NHS will be required to report the length of time that patients wait. This will be the first time that the NHS and the public have full information on the length of time that NHS patients are waiting from referral to treatment. It will provide the necessary baseline from which NHS organisations will then work to reduce pathway waits to 18 weeks by December 2008.

2.23 As a preliminary step, the NHS will be asked to conduct a referral to treatment baselining exercise or 'census' in autumn 2006. This one off exercise will provide

information on referral to treatment pathways across the 13 major specialties to inform the LDP process and ensure future commissioning of activity is sufficient to meet 18 weeks. Guidance on how the baselining exercise will be carried out will follow shortly, once the methodology has been tested.

Challenge 3: Planning the right activity levels

2.24 Ensuring that LDPs are consistent with making progress towards the 18 week pathway by December 2008 is critically important. The 2004 Spending Review included funding to achieve the 18 week pathway (see box). It appears that there will be sufficient capacity in the system to deliver the 18 week pathway, but it is important that PCTs ensure they have commissioned sufficient activity to meet the stage of treatment milestones, particularly in some diagnostic tests and outpatients.

2.25 Initial work for the Delivery Resource Pack suggests that first outpatient activity will need to increase by the equivalent of one month's work over the three year period between 2005 and 2008, and work to achieve this extra activity must be undertaken immediately in 2006/07. This level of activity may need to be greater still if follow up outpatient appointments are also included in the analysis. Local planning will need to take into account any consequent impact on inpatient activity. Progress towards meeting the capacity gap was made last year with submission of capacity plans by the SHAs, but the results have yet to be realised in extra activity. LDPs are currently being refreshed.

2004 Spending Review

The cost of implementing the 18 week pathway was estimated for the 2004 Spending Review. In financial year 2006/07, the Spending Review estimated that of the general increase in revenue expenditure, 18 weeks would cost £1,400 million, with £1,000 million on reducing waiting times, and £400 million on improving access to diagnostics. For 2007/08, the Spending Review estimated that of the general increase in revenue expenditure, 18 weeks would cost £2,700 million, with £1,900 million on reducing waiting times, and £800 million on improving access to diagnostics.

Challenge 4: The changing NHS environment

2.26 In delivering the 18 week pathway, there is a need to harness to best effect the system reform changes underway.

Commissioning a Patient-led NHS

2.27 The 18 week pathway is a 'commissioner-led' target. Successful implementation requires strong and creative local

commissioning to ensure that all specialities are dealt with and that all parts of the pathway make their contribution. The changes to SHAs and PCTs introduced by *Commissioning a Patient-led NHS*, will create the stronger commissioning function required.

Choice

2.28 A choice at the point of referral of at least four providers has been in place since 1 January 2006. We know that faster access and high quality care are key factors when patients choose where to go. Choice therefore provides an incentive for providers to reduce access times in support of the 18 week pathway. The extension of choice at referral during 2006/07 with the recent introduction of a national menu of choice options for patients provide similar incentives for providers willing to reduce access times.

New providers

2.29 Much of the capacity growth in recent years has been with the 18 week pathway in mind. Further developments, such as the current procurement process to appoint a range of independent sector providers onto the 'extended choice network' increase the options open to patients without committing the NHS to fund set levels of extra capacity. The growing range of providers, and expanding list of NHS Foundation Trusts, tends to promote innovation in practice as providers strive to improve efficiency and access in order to attract patients.

Practice based commissioning

2.30 Practice based commissioning (PBC) gives GPs the tools to shape the patient pathway from start to finish and bring parts of the pathway out of secondary care into primary care where they can be provided more efficiently, quickly and conveniently for patients, and freeing up resources for reinvestment.

Payment by results

2.31 Payment by results (PbR) provides a transparent, rules-based system for paying providers. It rewards efficiency, supports patient choice and diversity, and encourages the increased activity necessary for the 18 week pathway.

Integrated Service Improvement Programme

2.32 The NHS Integrated Service Improvement Programme (ISIP) has been established to help health and social care organisations achieve and sustain transformational change. The ISIP approach enables local commissioners and providers to identify a shared vision and jointly plan the implementation of integrated change programmes. ISIP prioritises those improvements likely to deliver the greatest benefits in each particular locality. This helps to drive efficiency and productivity, contributing to the delivery of the 18 week pathway in a locally relevant way.

3: Implementation strategy

3.1 Delivering the 18 week pathway will require contributions from all parts of the health service, the Department of Health and many other bodies. We need to work in co-operation to ensure that each part of the system is working together to support the 18 week pathway, doing what only that part can do and avoiding duplication of effort. The table below sets out the key actions for different parts of the health service and others involved in the 18 week pathway. The Department of Health's role is outlined below. For up to date information on the Department of Health's delivery strategy, please visit www.18weeks.nhs.uk.

National engagement

3.2 The analysis and Delivery Resource Pack were completed following extensive work with the NHS, including two major stakeholder events in 2005. The Department of Health will continue to engage with all parts of the NHS to steer implementation, ensuring that work at national level focuses effort on the critical areas and ensures 'join-up' of policy areas which have an impact on the 18 week pathway.

3.3 The Department of Health will continue to liaise closely with patient and staff representatives, the Royal Colleges, professional bodies and other stakeholder bodies, as well as regulators including the Healthcare Commission and Monitor, and directly with independent and voluntary sector providers.

3.4 An 18 week pathway stakeholder group is being established to advise the Department of Health on the implementation of the 18 week pathway and to act as champions for the 18 week pathway to other organisations and interested parties. The group will include senior clinicians, managers and representatives of a range of organisations, and will be chaired jointly by the national clinical lead for the 18 week pathway, Dr David Colin-Thome, and the National Implementation Director for the 18 week pathway, Philippa Robinson. Membership of the stakeholder group will be published on www.18weeks.nhs.uk.

3.5 It is intended that everyone should see the 18 weeks website as a key resource and channel for sharing information on the 18 week pathway. It is updated on a regular basis and contains advice on best practice including case studies and other helpful guidance. It also offers community forums for those who wish to communicate with others in the NHS about implementing the 18 week pathway.

3.6 The website will provide an increasing range of workforce and improvement tools. Two workforce tools looking at workforce role redesign and planning in

support of the 18 week pathway were launched at the HR in the NHS conference in April and are available now on the website. The NHS Institute for Innovation and Improvement's 'No Delays' programme, which supports the NHS's work on the 18 week pathway, will release tools in the autumn to support delivery of the 18 week pathway.

Principles and definitions for the 18 week pathway

3.7 Achieving the 18 week pathway is a target against which NHS performance will be assessed. As with any such target it is important to be as clear as possible about what it covers. The principles and definitions in annex A were developed with extensive NHS involvement during 2005/06 and subject to a six-week listening exercise. Responses were extensive, with over 180 organisations, stakeholders and individuals expressing views, all of which were taken into account in finalising the principles and definitions. We will continue to work with the 18 week pioneer sites and others to ensure that the principles and definitions meet the purpose for which they are intended and will issue further clarification if necessary.

National projects focused on high risk specialties and diagnostics

3.8 As outlined in part 2, the analysis done to inform delivery of the pathway has highlighted specialties and diagnostic tests that represent particular challenges to the achievement of the 18 week pathway. The Department of Health is establishing national projects to focus effort on orthopaedics, echocardiography and endoscopy, and developing an action plan for audiology. We will continue to monitor progress in other areas to ensure that risks are managed as appropriate.

18 weeks pioneers

3.9 Over 80% of referrals and 95% of current waiting lists are represented by the thirteen highest-volume specialties (see table). Pathways in these specialties naturally include high volumes of diagnostic tests. To enable the health service as a whole to deliver 18 weeks, the Department of Health is now working with eight pioneer sites to understand the challenges in more detail and develop solutions in four key areas:

- Developing a referral to treatment measurement and management information system (see challenge 2)
- Assess the tolerance and adjustment system options for clinical exceptions and patient choice
- Developing an integrated approach to pathway management
- Developing and testing service improvement approaches

Thirteen high volume specialties

Cardiology	Neurology
Dermatology	Ophthalmology
Ear, Nose, and Throat	Oral Surgery
Gastroenterology	Trauma and Orthopaedics
General Medicine	Plastic Surgery
General Surgery	Urology
Gynaecology	

3.10 The experiences of the pioneers will be shared widely with the NHS and via www.18weeks.nhs.uk, which already includes information on key findings to date. From summer 2006, the Department of Health will run a series of 'roadshows' to spread the pioneers' conclusions on referral to treatment measurement.

Outputs from pioneers

- Referral to treatment measurement solutions proved
- Integrated management of referral to treatment patient journey developed and proven
- Primary & secondary care roles in demand management clarified
- Improved patient experience demonstrated
- Learning available to be shared

3.11 Other useful experience can be drawn from cancer services, including the 'How to' guide to delivering cancer waiting times, on the Cancer Services Collaborative website at www.cancerimprovement.nhs.uk

Performance improvement

3.12 In the absence currently of referral to treatment measurement, stage of treatment milestones are currently in place. Performance management of delivery towards 18 weeks in 2006/07 will be driven by focussing on these, including for the first time performance management of diagnostic waits.

Stage of treatment milestones

	Mar 06	Mar 07	Mar 08	Dec 08
Outpatients	13	11	5	18 weeks in total
Diagnostics	26	13	6	
Inpatients	26	20	11	

3.13 In the summer of 2006 we will start the process of putting in place referral to treatment measurement by conducting with the NHS a referral to treatment baselining exercise or 'census'. This baselining exercise will provide information on referral to treatment pathways across the 13 major specialties and is intended to inform local LDP planning.

3.14 We will request LDP referral to treatment trajectories to be in place from April 2007. We expect to start collecting monthly national data on referral to treatment from January 2007. The details of this monthly requirement will be announced shortly. This, together with agreed LDP trajectories will allow performance management of the referral to treatment pathway to be put in place from April 2007.

3.15 At present for elective access, we use a snapshot approach for reporting inpatient, outpatient and diagnostic waiting times. However, delivery of the 18 week pathway will be measured by the actual time waited by each patient, in line with the way that cancer waits are currently measured. For inpatients, for example, the NHS reports the stock of patients waiting for admission on the final day of each month and the number of these patients who have been waiting more than six months at that point in time. The Health and Social Care Information Centre also collects annual data on the actual waits for each patient who has completed treatment, but the snapshot approach is currently used for national performance reporting and management on elective waiting times. Some health economies are already counting actual waits and other areas are encouraged to move towards this model as quickly as possible. When monthly data collection of referral to treatment starts in January 2007 we expect to collect data on both realised or retrospective waits during the month (the actual time waited for each patient whose clock has stopped during the month) and also on prospective waiting times (the time waited by each patient still waiting at the end of the month). We will announce more details of this soon.

3.16 Within the Department of Health, the Recovery and Support Unit will have a key role to play as the main conduit of performance communication to and from the NHS.

Delivery support programme

3.17 Strategic Health Authorities will have the key role in supporting local transition to the 18 week pathway, both by performance management of PCTs and by supporting local health communities with service improvement. There will be some national resource to support this.
A national programme will be developed, in conjunction with SHAs, to support local health communities in making the transition to 18 weeks where they are unable to manage it themselves. It is expected that the national support will range from the proactive communication of best practice to intensive 'tailored' support.

Contributions from all

3.18 The table outlines some of the key actions anticipated from various parties. They are subdivided into general actions, not exclusive to the 18 week pathway and 18 week pathway specific actions.

18 week pathway key actions

Patients	**General** Keep appointments or advise if not able to **General** Help manage your own health **General** Use the appropriate part of the service for your needs **18 week pathway** Be involved in management of your pathway
PCTs	**General** Commission best practice pathways **General** Implement local Integrated Service Improvement Programme **18 week pathway** Performance manage trusts on delivery of Choice of Scan **18 week pathway** Validate national waiting times data collections **18 week pathway** Achieve local stage of treatment milestones **18 week pathway** Implement referral to treatment measurement systems in collaboration with providers **18 week pathway** Complete baselining exercise of referral to treatment times in second half of 2006 **18 week pathway** Report on progress towards achievement of 18 weeks **18 week pathway** Use the model contract to support delivery **General** Performance manage all providers through the contract **General** Manage local service provision **General** Promote the use of Choose and Book **General** Reduce waits for therapies where possible using service improvement techniques

GPs and referrers	**General** Use Choose and Book **General** Refer according to local protocols and best practice **18 week pathway** Use practice based commissioning to drive 18 week pathway delivery **18 week pathway** Create proactive processes to help patients move quickly through pathways **General** Move appropriate services into primary care
Acute providers: general	**18 week pathway** Manage patient pathways **General** Develop transfer protocols to ensure delays are minimized and good data flows between providers **General** Implement local Integrated Service Improvement Programme **18 week pathway** Implement Choice of Scan for all diagnostic imaging tests **18 week pathway** Report accurate and complete information for data collections **18 week pathway** Achieve local stage of treatment milestones **18 week pathway** Complete baselining exercise of referral to treatment times in second half of 2006 **18 week pathway** Implement referral to treatment measurement systems in collaboration with commissioners **18 week pathway** Reduce waiting and clearance times
Acute providers: Consultants and secondary/tertiary care teams	**18 week pathway** Help redesign patient pathways **18 week pathway** Record the start of treatment and other decision points **18 week pathway** Work with managers to create proactive processes to help patients move quickly through pathways

Acute providers: Managers	**18 week pathway** Help redesign patient pathways Work in partnership with clinicians **18 week pathway** Work with clinicians to create proactive processes to help patients move quickly through pathways **General** Reduce waits for therapies where possible using service improvement techniques
Strategic Health Authorities	**General** Support the transfer of best practice learning/information from national to local level **18 week pathway** Lead implementation of 18 week pathways across sectors **18 week pathway** Ensure LDPs support achievement of stage of treatment milestones **General** Ensure provision of performance improvement mechanisms **18 week pathway** Work in partnership with RSU and 18 week pathway team to provide tailored support to local health communities **General** Provide an integrated approach to benefits management through implementation of ISIPs
NHS Institute for Innovation and Improvement	**General** Develop ways to help organisations identify where they need to focus efforts **General** Provide organisations with the most appropriate intervention tools to improve their service
Social care services	**General** Support pathways with appropriate discharge **General** Help people stay out of hospital

4: Timetable of key deliverables

The timetable that follows sets out the series of waiting times reductions that have been achieved by the NHS since the publication of the NHS Plan. This is followed by the steps to be taken in achieving reduced waiting times.

Summer 2000	• The *NHS Plan* published
Spring 2002	• April: 15 month inpatient target operational 26 week first outpatient target operational • *Delivering the NHS Plan* published
Spring 2003	• April: Twelve month inpatient target operational 21 week first outpatient target operational
Spring 2004	• April: Nine month inpatient target operational 17 week first outpatient target operational
Summer 2004	• *The NHS Improvement Plan* published
Winter 2005–2006	• White Paper *Our health, our care, our say: a new direction for community services* published • January: Six month inpatient target operational 13 week first outpatient target operational • Pioneers' work on referral to treatment measurement started
Spring 2006	• April: new stage of treatment milestones in place: 13 weeks for first outpatient consultation 26 weeks for MRI and CT scans 26 weeks for inpatients • Healthcare Commission indicators in place: Outpatients 11-13 weeks Inpatients 20-26 weeks

Spring 2006 (cont)	• *Tackling hospital waiting: the 18 week patient pathway. An implementation framework* including the 18 week pathway principles and definitions published. Delivery Resource Pack released • 18 week pathway stakeholder group in place • Focused projects in orthopaedics, echocardiography and endoscopy begin • Workforce support material available on the 18 week website • *What is Physiological Measurement?* services guide published • Start of physiological measurement development sites
Summer 2006	• Referral to treatment measurement solutions delivered by pioneers • Referral to treatment measurement roadshows to support national implementation of measurement • Pioneer work on pathway redesign started and roll-out commenced • Workforce planning tools for imaging and endoscopy available on the 18 week website • Baselining exercise of referral to treatment times to inform LDP refresh • Framework for commissioning, practice based commissioning and the national contract published • Master classes on workforce planning launched
Autumn 2006	• NHS Institute 'No Delays' programme tools released • Service redesign started across the NHS • Supplementary guidance to principles and definitions published • NHS to implement measurement solutions to prepare for referral to treatment data collection based on pioneer sites learning
Winter 2006–2007	• Referral to treatment data collection begins – first national information on whole pathways • Imaging *Trends & Assumptions* Guidance document launched • Workforce planning tool for physiological measurement available on the 18 week website • Physiological measurement framework launched

Spring 2007	• Connecting for Health measurement solution, release one available • April: new stage of treatment milestones in place: 11 weeks for first outpatient consultation 13 weeks for all diagnostics 20 weeks for inpatients • Healthcare Commission indicators support the monitoring of the referral to treatment trajectory • Referral to treatment performance measurement started • National Model Contract for 2007/8 in place
Spring 2008	• Connecting for Health measurement solution, release two available • April: new stage of treatment milestones: 5 weeks for first outpatient consultation 6 weeks for diagnostics 11 weeks for inpatients
Winter 2008–2009	• 18 week pathway becomes operational • Connecting for Health measurement solution, release three available

Annex A: Principles and definitions for the 18 week pathway

Part A
Overview of the 18 week pathway

A.1 This guidance outlines the patient journey from the point of referral to the start of hospital treatment. It sets out the principles and definitions that will apply at the different stages of the journey to ensure that the 18 week pathway is applied fairly and consistently – and in ways that deliver the intended benefits for NHS patients and NHS organisations.

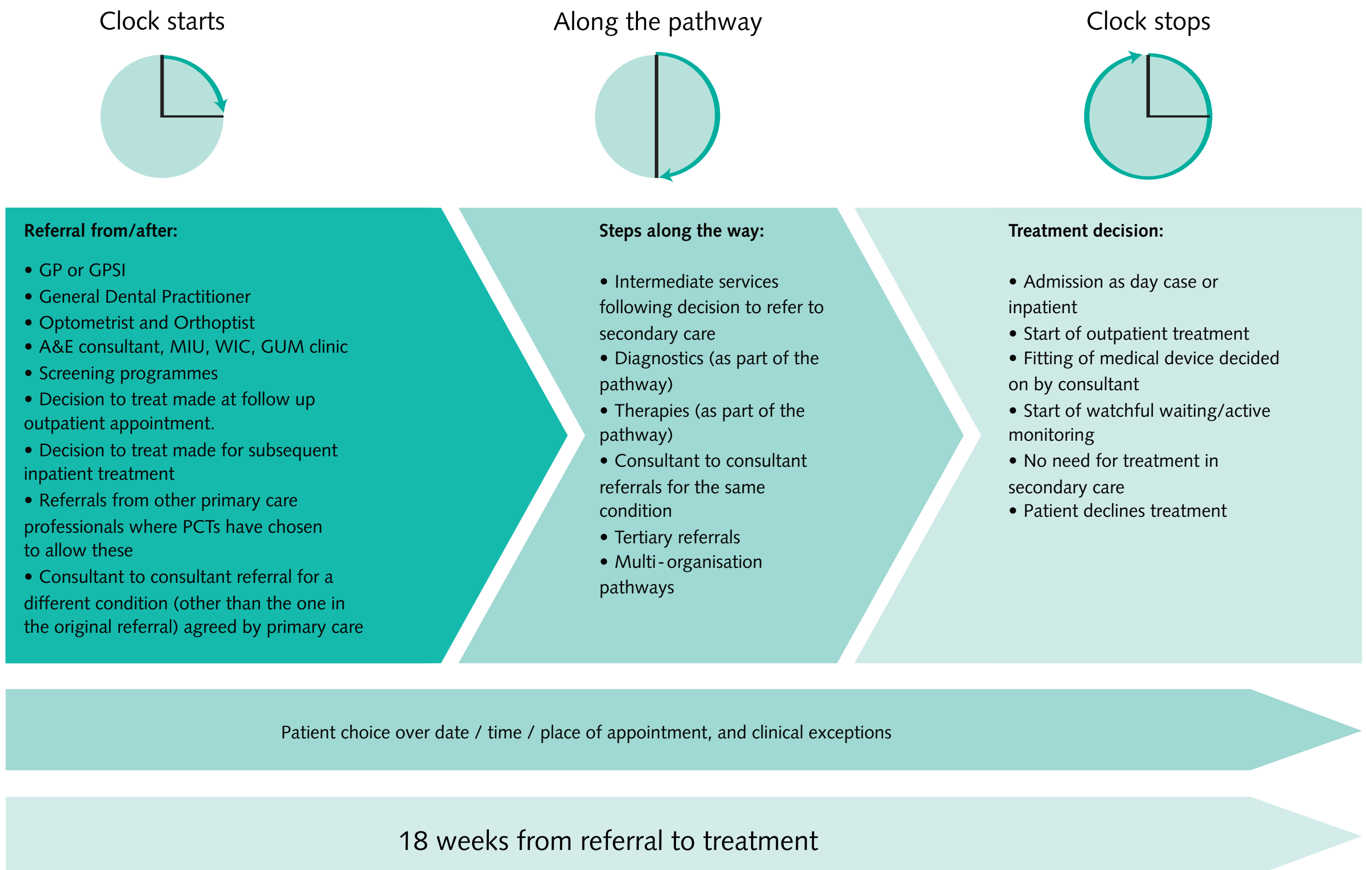
A.2 In autumn 2005 the Department of Health held a listening exercise on the proposed principles and definitions, *Commissioning an 18 week patient pathway: Proposed principles and definitions*. Over 180 NHS organisations, stakeholders and individuals expressed their views and the considerable feedback has been taken into account in producing this guidance.

A.3 While these principles and definitions are essential in providing a guideline for implementation, the spirit of the 18 week pathway commitment is as important. The 18 week patient pathway is about delivering the right care, at the right time, and of the right quality, to all without unnecessary delays. It is this principle that is the basis of this guidance.

A.4 The 18 week pathway does not replace other waiting times targets or standards where these are shorter than 18 weeks such as waiting times for patients with suspected cancer or waiting times for Rapid Access Chest Pain Clinics.

A.5 The diagram below outlines the overall 18 week pathway. The rest of this guidance provides more detail.

18 week patient pathway



Part B
Start of the pathway – clock start

Referral routes in

B.1 For most patients the start of the elective pathway begins at GP referral to a consultant in secondary care.

B.2 Referrals to medical consultants who provide secondary care services in community settings are also included (either in outreach clinics, directly employed by a PCT or working in a community hospital).

B.3 18 weeks also covers referrals to hospital consultants from:

- General Dental Practitioners (GDPs)
- General Practitioners with a Special Interest (GPwSIs)
- Optometrists and Orthoptists
- Accident & Emergency
- Minor injuries units
- Walk in centres (WIC)

} Where patients are transferred to an elective pathway (applies to Accident & Emergency, Minor injuries units and Walk in centres)

- Genito-urinary medicine clinics
- National screening programmes (for non-malignant conditions)
- Specialist nurses or allied health professionals where PCTs have approved these mechanisms locally

B.4 By December 2008, we expect all primary care referrals covered by the 18 week pathway to be made through Choose and Book. In this 'full booking' environment, the start of the waiting period is the point of booking by the patient. This will typically be the point at which **the patient makes an appointment** for their first outpatient attendance either in the clinician's practice or through the Choose and Book Appointments Line (i.e. in technical terms when the patient converts their Unique Booking Reference Number).

Example One: Clock start from the point the patient books their appointment

A patient visits their GP for a back problem. The GP tells the patient they will be referred to the hospital and gives the patient their Unique Booking Reference Number. Two days later the patient phones the Choose and Book Appointments Line and makes the appointment for their outpatient visit. The clock starts when the patient books their appointment.

B.5 In the unfortunate event that a patient is booked into the wrong specialty clinic 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.

B.6 Where Choose and Book is not (yet) in place (for example for referrals from GDPs, A&E, WICs etc) the 18 week clock starts at the point at which the referral letter is received by the secondary care provider, as per the current waiting times guidance.

B.7 Throughout the rest of part B (start of the pathway – clock start) please refer to the guidance in paragraphs B.4-B.6 for actual clock start points for measurement purposes.

Consultant to consultant referrals for a different condition

B.8 If a consultant identifies a condition other than that for which the patient was originally referred and makes a referral to another consultant for treatment of that condition, this will start a new patient pathway with a new 18 week pathway clock. The original referral pathway also continues with its own 18 week pathway clock.

Example Two: Consultant suspects a new condition

A patient sees an orthopaedic surgeon who suspects that the patient has an additional dermatological condition. The orthopaedic surgeon refers the patient to a dermatologist, copying the details of the referral to the patient's GP. A new 18 week pathway clock starts for the dermatological procedure. Both the orthopaedic and dermatology pathways then run separate clocks for the same patient concurrently.

B.9 Because of GPs' new responsibilities under practice based commissioning, the consultant should copy the details of the referral to primary care (as happens now) for possible veto in exceptional circumstances. Consultants can make urgent cross-condition referrals without express GP agreement. Where PCTs/GPs would specifically want to give agreement to new 18 week pathway clock starts, this requirement should be specified in local commissioning arrangements. Where no specification has been made in the contracts secondary care can assume approval by primary care.

Referrals to intermediate services

B.10 Referrals to intermediate services include referrals to professionals in primary care such as GPs with a Special Interest (GPwSIs), Nurses with a Special Interest (NwSIs), or Allied Health Professions with a Special Interest (AHPwSIs). Intermediate services are often called Clinical Assessment Services (CASs) or Referral Management Centres (RMCs). Referrals to intermediate services should happen only where this adds genuine clinical value for patients and causes no unnecessary steps in their pathway.

B.11 Where intermediate services are involved in a patient's pathway, the underlying principle in considering when to start the clock should be the patient's perspective. It will be vital for GPs to communicate effectively with patients about their expectations in relation to their pathway. In practice, where a GP refers a patient onward to an intermediate service or GPwSI, the clock will normally start at this time. The exception is when the GP has the expectation that they may be able to treat the patient on receipt of the investigations carried out in the intermediate service.

Example Three: GP refers patient to CAS for further assessment before decision to refer to secondary care

A patient has a musculoskeletal condition and the GP refers the patient to a primary care CAS in the expectation that the CAS will be able to treat the patient without the need for a referral to a secondary care consultant. However, if in this case, clinicians in the CAS decide that a referral to a consultant is necessary, the patient will perceive that their 18 week pathway started when the GP referred the patient to the CAS. Therefore, the original date of the GP referral will represent the start of the pathway.

Direct access diagnostics

B.12 Increasingly, GPs can refer directly to diagnostic services and this often forms part of referral protocols agreed between primary and secondary care clinicians. As with intermediate services, if the referrer has decided to refer a patient to secondary care and requests diagnostic tests as part of the preparation for the patient's appointment with a consultant, the clock starts when the patient books their secondary care appointment, before they have the diagnostic tests. If however the diagnostic tests are to determine more about the patient's condition before the GP decides to refer or not, the clock does not start until it is decided that he or she should be referred to secondary care.

Example Four: GP refers patient for diagnostic tests after the decision to refer to secondary care

A GP refers a patient using Choose and Book to secondary care for suspected Urinary Tract Infection. The 18 week pathway clock starts when the patient books the appointment with the consultant. The patient then attends for a renal ultrasound and those test results are then available for the first outpatient appointment with the consultant.

Follow-up outpatient appointments

B.13 There are 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 the patient pathway may have involved multiple outpatient attendances, diagnostic procedures and treatment.

B.14 Consultants can make a decision to treat at follow-up outpatient appointments for these patients and as for cross-condition referrals copy the details to primary care.

B.15 In this scenario, a new 18 week pathway clock starts when the decision to treat is made, unless the GP disagrees with the decision.

B.16 It is expected that the number of follow up hospital outpatient appointments will be reduced in line with best practice and to complement the shift in care outlined in chapter six of the recent White Paper *Our health, our care, our say* (January 2006).

Referrals to primary dental services

B.17 Some patients choose to access primary dental services provided by dental students in secondary care settings as an alternative to GDP services in primary care. As these services are substitutes for primary care based provision they are not included within the 18 week pathway. Consultant-led oral surgery and orthodontic treatment which takes place in secondary care is however included in the 18 week pathway.

Referrals to therapies, healthcare science, and mental health services

B.18 We are working to improve direct access, meaning direct referrals from GPs and self-referrals to therapies and mental health services in primary and community settings and direct referrals to healthcare science interventions without a patient needing to go to hospital, as set out in *Our health, our care, our say*.

B.19 These direct access pathways are not covered by the 18 week pathway as the work on the 18 week pathway commitment focuses on hospital consultant pathways as set out in the NHS Improvement Plan. Outside the 18 week pathway programme the wider Department of Health will be working to support innovation and improve productivity in those areas with particular problems in access, such as audiology and speech and language therapy. Direct access to these services will further be improved as part of the changes being implemented through the White Paper. Where possible, local health communities should begin to work on reducing waiting times for these services whether in primary or secondary care settings.

B.20 At this stage, referrals to non-consultant clinicians for mental health (this includes multi-disciplinary teams and community teams run by Mental Health Trusts) are excluded from the 18 week pathway. We will however continue to work towards improving access to mental health services and specifically psychological therapies, where capacity is particularly challenged.

Part C
Along the pathway

Patient exclusions

C.1 There are two groups of patients for whom it would be inappropriate to expect treatment to begin within 18 weeks. Firstly, those patients with genuinely complex diagnoses or for whom the appropriate treatment is unclear; secondly, those who wish to choose a later appointment than offered, which would cause them to fall outside the 18 week pathway timescale.

Clinical exceptions

C.2 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 need to be done in sequence; or where the patient and consultant have agreed that the patient should receive a second opinion; or where the patient is medically unfit to be treated. There are also patients for whom there is genuine clinical uncertainty about the diagnosis and the clinician (in agreement with the patient) elects to observe the patient over a specified period. It is proposed that clinical exceptions such as these will be covered by an operational tolerance, rather than the existing suspension system. This approach follows the principle of the A&E operational requirement.

C.3 PCTs and Trusts need to be able to demonstrate (when asked by an auditor or the Healthcare Commission or in the event of a patient complaint) that cases within this margin of tolerance are genuine clinical exceptions. PCTs and Trusts will therefore be asked to report the length of all waits for patients (i.e. including the longer waits covered by the tolerance). This will enable local health economies, SHAs and the Department of Health to identify quickly why patients are waiting longer, and if patients waiting more than 18 weeks are waiting for an unacceptably long further period.

Patient choice

C.4 Even where the provider has offered earlier appointments, patients may choose a later first outpatient appointment, or a later 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 pathway wait.

C.5 To ensure that patients can exercise these choices, we are investigating with the 18 weeks pioneers (www.18week.nhs.uk/pioneers) whether an operational tolerance or adjustment system should be used to allow 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 that cases within this margin of tolerance were genuine instances of patient choice. This will assure individual patients that they will 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.

C.6 The Department of Health continues to investigate both the tolerance and adjustment system options for dealing with patient choice, and will continue to do so as PCTs and Trusts begin to measure whole patient journeys. The final system and any tolerance level will be confirmed to coincide with the start of national performance management for the 18 week pathway in April 2007.

C.7 From the end of December 2008, when the 18 week pathway becomes operational, patients will also have free choice of provider 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.

Further guidance will be made available to support Free Choice and how it interacts with the 18 week pathway commitment, but providers and commissioners will be expected to work together to flex capacity as necessary to ensure all providers can meet 18 weeks for patients who wish to be treated by them.

Reasonableness of appointments

C.8 As now, patients can only be expected to accept reasonable offers of appointments. Currently, 'reasonableness' is defined as a choice of two dates with at least three weeks' notice. These rules will not work for an 18 weeks pathway. We will draw lessons from the Pioneers as to how to define 'reasonableness' for 18 weeks pathways.

Therapies

C.9 Patients should receive therapies (for example physiotherapy, speech and language therapy and podiatry) and healthcare science interventions within a total 18 week pathway if they form part of a consultant led hospital pathway. For example, a consultant might decide that the definitive treatment for a patient should be physiotherapy (stopping the clock), or that a therapy assessment should form part of the pathway before

the start of definitive treatment (clock continues).

Consultant to consultant referrals for the same condition

C.10 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 the 18 week pathway (with the clock starting at the point of the original GP referral).

Example Five: Referral for the same condition

A patient with knee pain is referred to an orthopaedic consultant. At the first outpatient appointment, the consultant believes that the pain is being caused by a rheumatology problem and refers the patient to the rheumatologist. The same pathway clock continues to tick.

Tertiary referrals

C.11 Standard tertiary referrals i.e. where the referral is a standard element of the elective pathway are included within the 18 week pathway (clock starting at original referral). For example, this would apply to many coronary heart disease (CHD) patients and includes 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 paragraphs C.2 and C.3 for further guidance.

Specialised services

C.12 Where a patient needs to access 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 clinical exceptions will apply. Where patient pathways involve multiple organisations but are not clinically complex the 18 week pathway will still apply.

Multi-organisation pathways

C.13 For pathways that include multiple organisations, for example where a patient is referred to another provider (whether NHS or independent sector) and where for whatever reason the patient cannot be treated at the other provider and subsequently returns to the original provider the patient should still start treatment within the 18 week pathway. This does not just apply between treatment centres and other providers but between providers of all kinds.

C.14 For the 18 week pathway, it will be a requirement on the referring organisation to include the date of the original referral in the onward referral letter (e.g. clock start date). The referring organisation will also be required to provide any further information that informs the receiving organisation of the 18 week pathway status (for example if the patient pathway has been extended due to patient choice or because of clinical exceptions). All organisations involved in a multi-trust patient pathway will be responsible for delivery of treatment within 18 weeks (as per cancer waits).

Part D
End of the pathway – clock stop

D.1 The end of the 18 week pathway and clock stop will be at the start of definitive treatment. Start of first definitive treatment can be described as the start of the first treatment that is intended to manage a person's disease, condition or injury. The clock stops if the treatment that is started is *intended to avoid further intervention*. If the treatment is part of an agreed pathway then the clock does not stop. For the purpose of the 18 week pathway, the start of treatment, and therefore clock stopping, includes the following actions and decisions.

Treatment as inpatient or day case

D.2 If a 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. If a patient's treatment is then cancelled by the hospital, the clock will not stop, but continue, and only stop when treatment has been initiated.

Treatment in outpatients

D.3 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. For example, 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.

D.4 Clinicians often begin to manage a patient's condition in advance of the definitive first treatment taking place, for example by giving pain relief before a surgical procedure takes place. In these cases, the clock does not stop until the first definitive treatment (in this example, surgery) has started.

D.5 For those patients whose treatment starts in outpatients the date of the clock stopping will be the date of attendance in outpatients. Treatment in outpatients can for example be the commencement of medication, if it is intended as the first line treatment.

Fitting of a medical device

D.6 Where a consultant decides that treatment consists of fitting a medical device (eg. leg braces or bespoke footwear), the clock stops at the point of the actual fitting of the device rather than the point at which the patient is measured for the device. The clock will stop when fitting is complete, on the assumption that most fittings will be relatively simple and can usually be done in one or two visits.

Therapeutic procedures

D.7 There are some procedures that are intended as diagnostic but the healthcare professional makes a decision to undertake a therapeutic procedure at the same time. In this example, it may count as an initiation of definitive treatment and as such the clock would stop.

Example Six: Diagnostic becomes treatment

A colonoscopy is being carried out as an investigative/diagnostic procedure. During the investigation, the cause of the problem is found to be a polyp and the clinician is able to remove it during the procedure. This stops the clock.

First line treatment

D.8 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 first treatment will 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 the decision to treat would start a new 18 week pathway clock (see paragraphs B.13 – B.16 for further guidance).

Example Seven: First line treatment

A GP refers a couple for infertility treatment to an Obstetrics and Gynaecology consultant. In many cases, the consultant will only decide that IVF is appropriate after other forms of treatment such as Intra Uterine Insemination (IUI) have been tried. In this situation, the 18 week pathway would apply to the IUI treatment. The patient can be referred for IVF without returning to the GP as long as there is appropriate communication between primary and secondary care. Primary care will have the option to veto the referral if required.

Planned inpatient treatment

D.9 Some procedures are done in two parts separated by a period of time, such as double cataracts, double hip replacements or removal of metalwork.

D.10 Patients who will have the need for a planned procedure identified at the point of decision to treat should stay on their original pathway and expect to receive a date for part two, or for a planned outpatient appointment for review, before they are discharged after part one (clinical best practice will determine the most appropriate time for this). The clock stops at the start of the first part of the treatment.

Watchful waiting/active monitoring

D.11 There will be patients for whom a period of watchful waiting or active monitoring is clinically appropriate. In these cases, the clock stops when a diagnosis has been reached but the clinical decision is made (and agreed with the patient) that treatment will not start but that a period of active monitoring will begin – in essence, this will be the start of non-treatment. If a patient subsequently requires further treatment following active monitoring (watchful waiting) this decision would start a new 18 week pathway clock. The patient would not necessarily be required to return to primary care although the consultant would be expected to keep the GP updated with the progress of their patient (please see paragraph B.9 onwards for further guidance).

Example Eight: Watchful waiting (active monitoring)

A patient presents with a photo dermatological condition in the autumn. This type of condition is seasonal, and at its worst in the summer, requiring treatment in the spring. A patient presenting with this condition in the autumn would start a period of watchful waiting and as such the clock would stop. In the spring, when it will be clinically appropriate to treat the condition a new 18 week pathway clock will start.

Other clock stop points

D.12 There are other situations in which the clock would stop. Examples are:

- The patient returns to primary care either after outpatient attendance or after diagnostic testing. There has been a decision not to treat and no further action in secondary care is undertaken at this time (start of non-treatment). The date on which this decision is communicated to the patient should be used as the clock stop date.
- A secondary care clinician decides that treatment is appropriate but the patient declines treatment. The date the patient declines treatment should be used as the clock stop date.
- Patients who do not attend appointments (at any stage of the pathway) and have failed to tell the hospital in advance that they will not be coming are identified as 'Did Not Attend (DNA)'. The work of the Pioneers will be informing how DNAs and other types of patient-initiated delays should be dealt with and we will publish further guidance in due course.

Conclusion

D.13 We appreciate that this guidance is not exhaustive and that there are other scenarios which have not been covered. If in doubt, the spirit of the guidance should be followed. This is to provide the right care, at the right time, and to the right quality without unnecessary delays. It is also about reasonableness to patients and honesty to the public.

D.14 For queries on this guidance, please e-mail 18weeks@dh.gsi.gov.uk.

Annex B: Glossary

18 weeks pilot sites

From the spring of 2005, 21 NHS Pilot sites worked with the Department of Health in a consultative exercise focusing on the patient and operational implications of the 18 week pathway. Together we identified the challenges to achieving an 18 week pathway. Clinical, managerial and technical specialists in the NHS all participated, providing feedback and collecting data on current waiting times.

18 weeks pioneer sites

In order to support the delivery of the 18 week patient pathway, the programme team is working with eight local health communities pioneers from across England on developing simple and practical short term measurement systems to capture and record referral to treatment times. Details on the 18 weeks pioneer sites can be found at www.18weeks.nhs.uk/pioneers

Acute providers

A hospital/unit which provides a range of clinical services sufficient to meet the needs of a defined population of about 150,000 or more for hospital care but not necessarily including highly specialised services

Choose and Book

Currently being introduced throughout England, Choose and Book is an information system that allows people to make their first outpatient appointment, after discussion with their GP, at a time, date and place that suits them.

Commissioning

The full set of activities that PCTs and local authorities undertake to make sure that services funded by them, on behalf of the public, are used to meet the needs of the individual fairly, efficiently and effectively.

Connecting for Health

An agency of the Department of Health that delivers new, integrated IT systems and services to help modernise the NHS and ensure care is centred on the patient. The website can be found at www.connectingforhealth.nhs.uk.

Genito-urinary Medicine Clinic

Many hospitals have a genito-urinary medicine department or clinic. This is usually called the GUM clinic, but may also be called the sexual health centre or department. Genito-urinary medicine (GUM) is the branch of medicine concerning the male and female sexual organs and the urinary system (that stores and removes urine from the body).

Healthcare Commission

The independent inspectorate in England and Wales that promotes improvement in the quality of the NHS and independent health care. The website can be found at www.healthcarecommission.org.uk

Independent sector

An umbrella term for all non-NHS bodies delivering health care, including a wide range of private companies and voluntary organisations.

Integrated Service Improvement Programme

The Integrated Service Improvement Programme (ISIP) has been established to promote and support the planning and delivery of transformational change across the NHS. It represents a new way of working, whereby NHS organisations within Local Health Communities jointly identify, plan and deliver a series of integrated change programmes which will achieve step changes in service quality and value for money through the realisation of benefits. For further information please visit www.isip.nhs.uk

Local Delivery Plan

A plan that every Primary Care Trust (PCT) prepares and agrees with its Strategic Health Authority (SHA) on how to invest its funds to meet its local and national targets, and improve services. It allows PCTs to plan and budget for delivery of services over a three-year period.

Minor Injuries Units

Minor Injuries Units are for less serious injuries, such as sprains, cuts and grazes. They can provide an alternative to A&E services.

NHS Improvement Plan

A Government publication, published in June 2004 that builds on the NHS plan vision and sets out next steps for reform of the health service.

NHS Plan

The ten year vision for the NHS, published in July 2000 that set out the programme of investment and reform.

Payment by Results

A scheme that sets fixed prices (a tariff) for clinical procedures and activity in the NHS whereby all Trusts are paid the same for equivalent work.

Physiological Measurement Development Sites

The eight physiological measurement development sites will tests a series of improvements to these services, promoting service innovation, improving standards, quality of provision and delivering better services for patients.

Primary Care Trusts

NHS bodies with responsibility for delivering health care and health improvements to their local areas. They commission or directly provide a range of health services.

Practice Based Commissioning

The range of providers in primary care will increase through Practice Based Commissioning (PBC). PBC gives GPs the tools to shape the entire patient pathway to make it more focused and efficient.

Strategic Health Authorities

The local headquarters of the NHS, responsible for ensuring national priorities are integrated into local plans and for ensuring that PCTs are performing well. They are the link between the Department of Health and the NHS.

Walk in Centres

NHS Walk in Centres offer fast and convenient access to a range of NHS services, including health information, advice and treatment for a range of minor illnesses (coughs, colds, infections) and minor injuries (strains, sprains, cuts). Most centres are open from early morning to late evening, seven days a week.

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