

18 Week Patient Pathway Delivery Resource Pack

To be read in conjunction with the
Implementation Framework

10 May 2006



The Prime Minister's
DELIVERY
UNIT

What is the 18 week patient pathway?

By the end of December 2008 no one will have to wait more than 18 weeks from referral to the start of hospital treatment. For the first time this includes all the stages that lead up to treatment, including outpatient consultations, diagnostic tests and procedures.

What will the 18 week pathway mean for patients and the NHS by the end of December 2008?

- Patients will receive the most appropriate treatment with far shorter waits.
- In a patient led NHS, commissioners will be accountable for performance through their contracts with providers.
- Providers will be managing an integrated patient pathway.

Consequently we believe the 18 week patient pathway is different to previous access targets because:

- It involves a shift from focussing on stages of treatment to managing a patient's whole pathway or journey.
- More comprehensive clinical leadership is required, to re-design patient pathways and determine when treatment starts.
- It will be the first commissioner led access target.
- There are substantive systemic risks to be addressed, including the financial environment, System Reform and organisational change.
- It involves a significant reduction in average waits, tackling long waits alone will not be enough.

To understand the 18 week patient pathway an initial assessment identified four key operational challenges the NHS needs to address to achieve an 18 week patient pathway by the end of December 2008. These are:

- Reducing long waits and long clearance times within certain specialties and diagnostic tests – specifically orthopaedics, endoscopy, and echocardiography.
- Thinking in and measuring whole pathways – shifting the focus from stages of treatment to measuring the whole pathway from referral to treatment and managing patients along their entire journey. Health economies will need to put in place their own systems to measure referral to treatment as a matter of urgency, and work is underway at a number of sites to develop measurement models.
- Bridging potential shortfalls in outpatient and diagnostic activity, that are required to reduce waits to 18 weeks, although this could also have an impact on inpatients. These shortfalls and the current financial position of the NHS make finding cost-effective solutions for reducing waiting times critical.
- Health reform and the changing NHS environment – System Reform is changing the NHS and it is important to ensure that the 18 week pathway is a key feature of the new health service. Work is required to ensure the 18 week patient pathway and System Reform work together.

The delivery resource pack

This delivery resource pack sets out the way the Department of Health will be organised to support the NHS in achieving the 18 week pathway. It also identifies the priorities for NHS action and in doing so addresses the key operational challenges isolated by the initial assessment. There are four key areas to the implementation framework, underpinning a single principle of supporting patients along their care pathways, from referral to start of treatment without delay. This resource pack provides the evidence base upon which the 18 week patient pathway implementation framework has been developed.

- Engage the NHS to in solving the new challenges created by the 18 week pathway
- Enable the NHS to deliver by providing clear responsibilities, aligned incentives and proven solutions
- Develop performance measurement and management systems to assure delivery
- Support the NHS by sharing good practice and introducing a tailored support programme

Systemic risks

In addition to the risks managed within the 18 week pathway programme, working with the Prime Ministers Delivery Unit, we have identified a number of external systemic risks.

These will need to be addressed and work to mitigate them will be a key part of this work going forward.

- Financial Environment – Delivery of the 18 week pathway requires significant investment in capacity and process improvement. This has been incorporated into spending plans. The risk is that current financial pressures in the NHS and conflicting priorities mean that funds are diverted to other priorities
- Links to System Reform – The incentives arising from system reform are key to delivering the 18 week pathway. Delays, for example to development of payment by results (PbR) and practice based commissioning (PBC) will impact on delivery
- Commissioners not enabled due to organisational change – commissioners have a key role to plan the delivery of the 18 week pathway and sustainably manage demand. In the short term, reorganisation could create a hiatus which will mean that the right capabilities are not applied to the issues.

Next steps

Immediate action is required to develop measurement systems, communicate the message of the 18 week pathway and start 18 weeks pathway data collection, develop the performance management regime, initiate national projects for focused actions, and work on delivering the stages of treatment milestones and Choice of Scan initiative.

Delivery Resource Pack Evidence

Section 1

What is the 18 week pathway?

By the end of December 2008 there will be a maximum of 18 weeks from referral to the start of hospital treatment. This includes all the stages that lead up to treatment, including outpatient consultations and diagnostic tests and procedures. It covers some elements that are currently measured (inpatient and outpatient waits), but crucially, other elements that were not historically measured – particularly diagnostics.

There have been a number of preconceptions about the 18 week pathway including:

The 18 week pathway could be delivered by reducing waits for each stage of the patient's pathway individually.

The 18 week pathway can be achieved by simple process improvements in existing stages of a patients' pathway.

Solving diagnostic waits alone will deliver the 18 week pathway.

MRI & CT have the longest waits and will be the most significant challenge.

The initial assessment was structured around five work streams to examine these preconceptions, collect evidence of the current position and assess the challenges to be addressed to achieve the 18 week pathway:

Pre-referral

Understanding and influencing the impact of primary care on the delivery of the 18 week pathway.

Pathway Reform

Examining the patient pathway including outpatients, surgical and medical treatment.

Diagnostics

Reviewing the existing situation in imaging, physiological measurement, endoscopy and pathology.

Performance Measurement

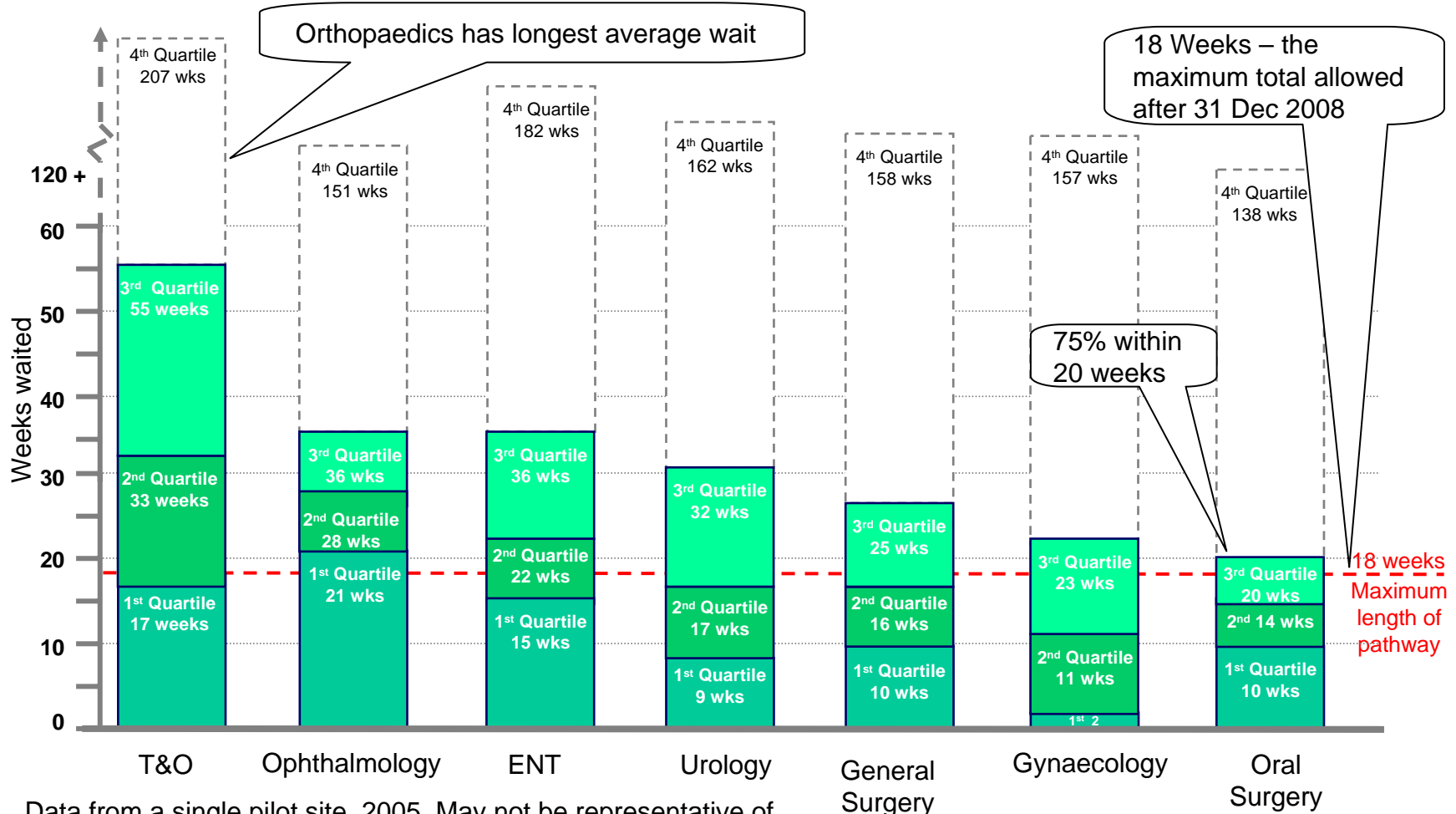
Developing methods of accurately capturing the whole patient journey rather than monitoring stages of treatment as now.

Support Mechanism

Exploring options for hands-on, tailored support for health communities, building on the successful models used for A&E and Orthopaedics.

It is estimated that around half (six million) of all patients (twelve million), are treated inside 18 weeks now. There is a sizeable difference in median and maximum waiting times across all specialties, and all specialties have long tails. Within this the orthopaedics median referral to treatment pathway is five weeks longer than other specialties in this health economy. This is a common trend among health economies around the country.

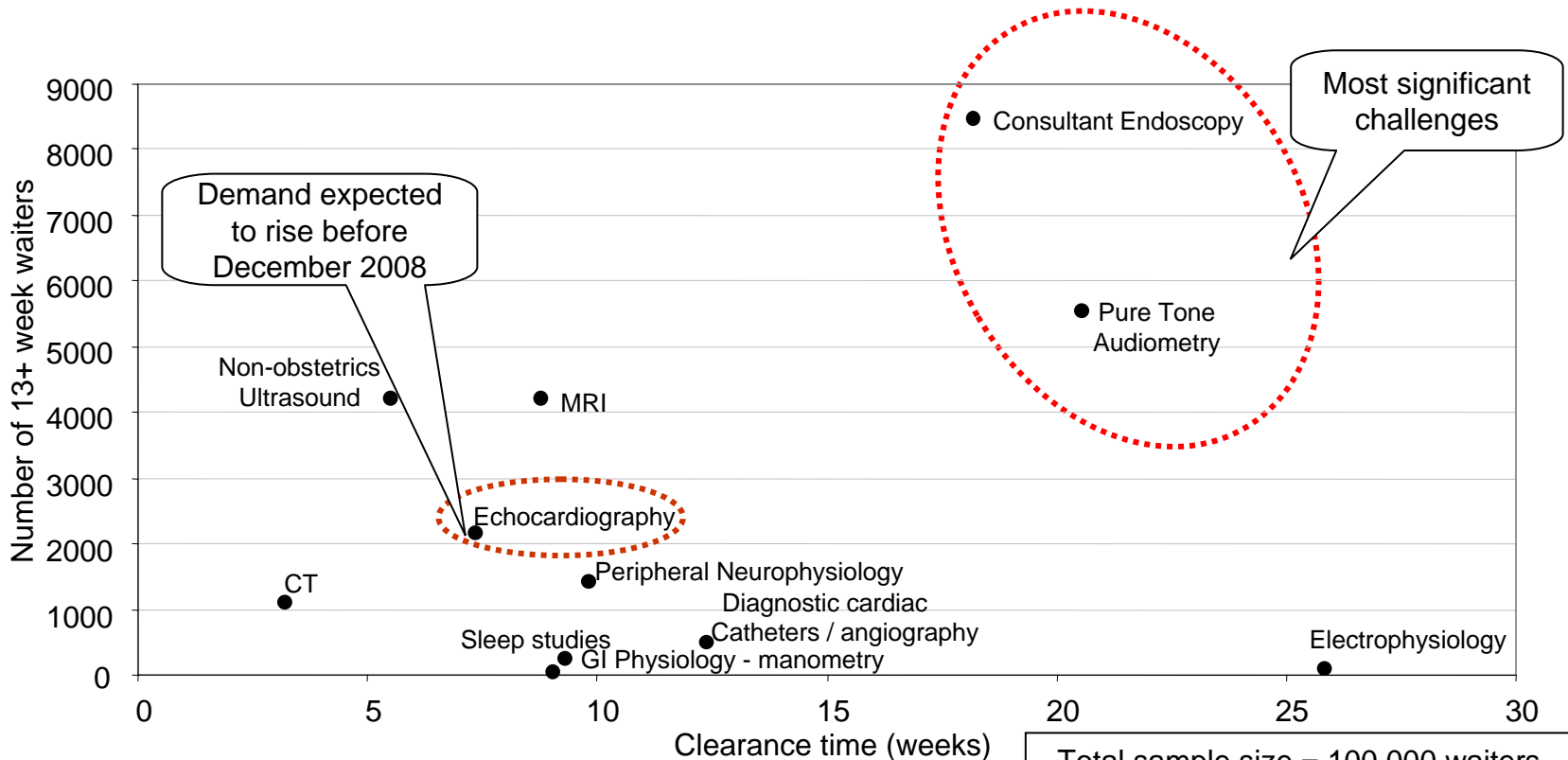
Percentile split for key specialties



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

Data collected from the pilot sites in Q1 of 2005/06 identified that there are long waits for diagnostics which will need to be addressed to achieve the 18 week pathway but that these were not predominantly in the expected areas of MRI and CT. Endoscopy and Pure Tone Audiometry face particularly long waits coupled with large numbers of patients waiting and are therefore a particular challenge.

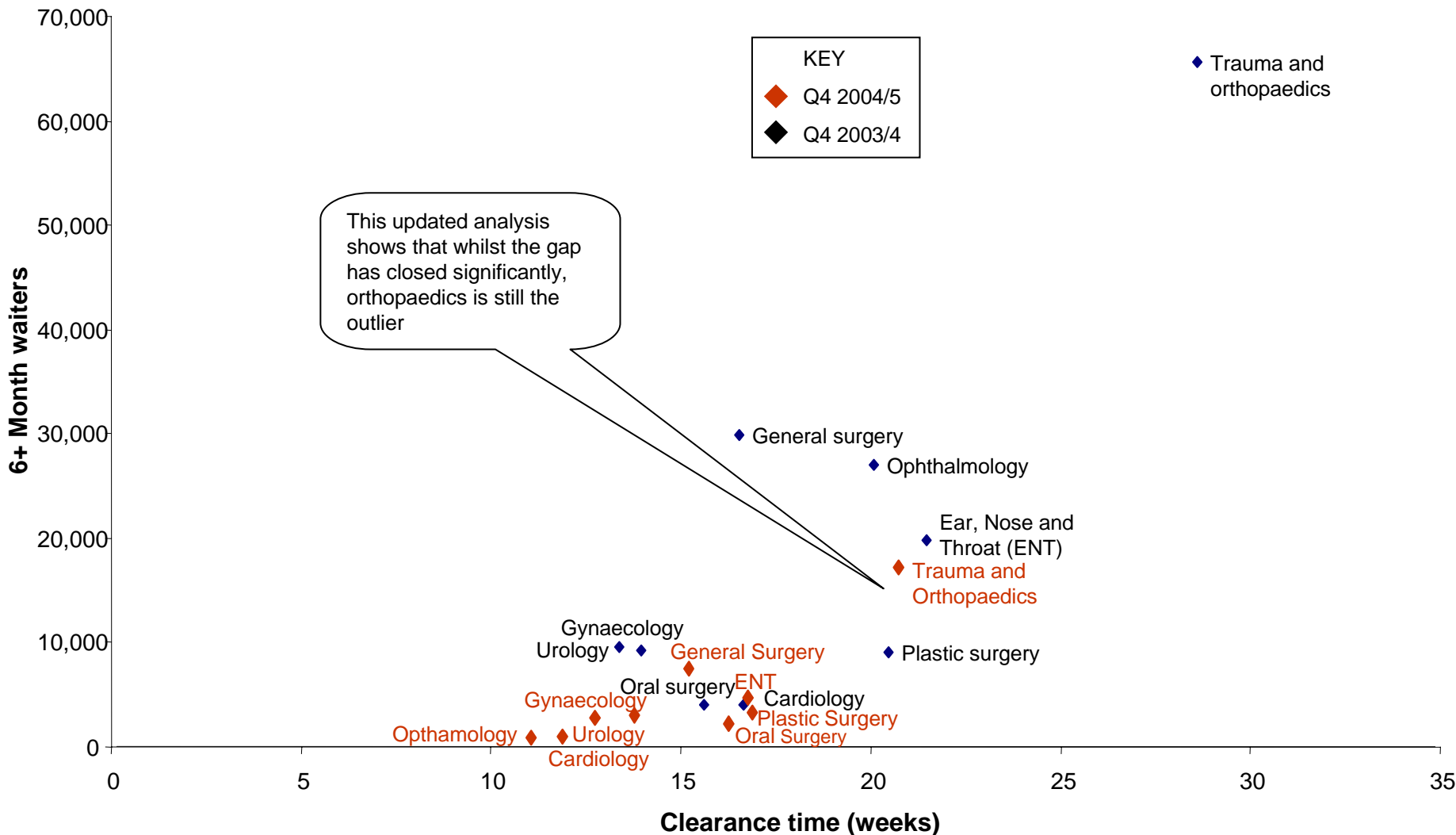
Diagnostic test clearance times



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

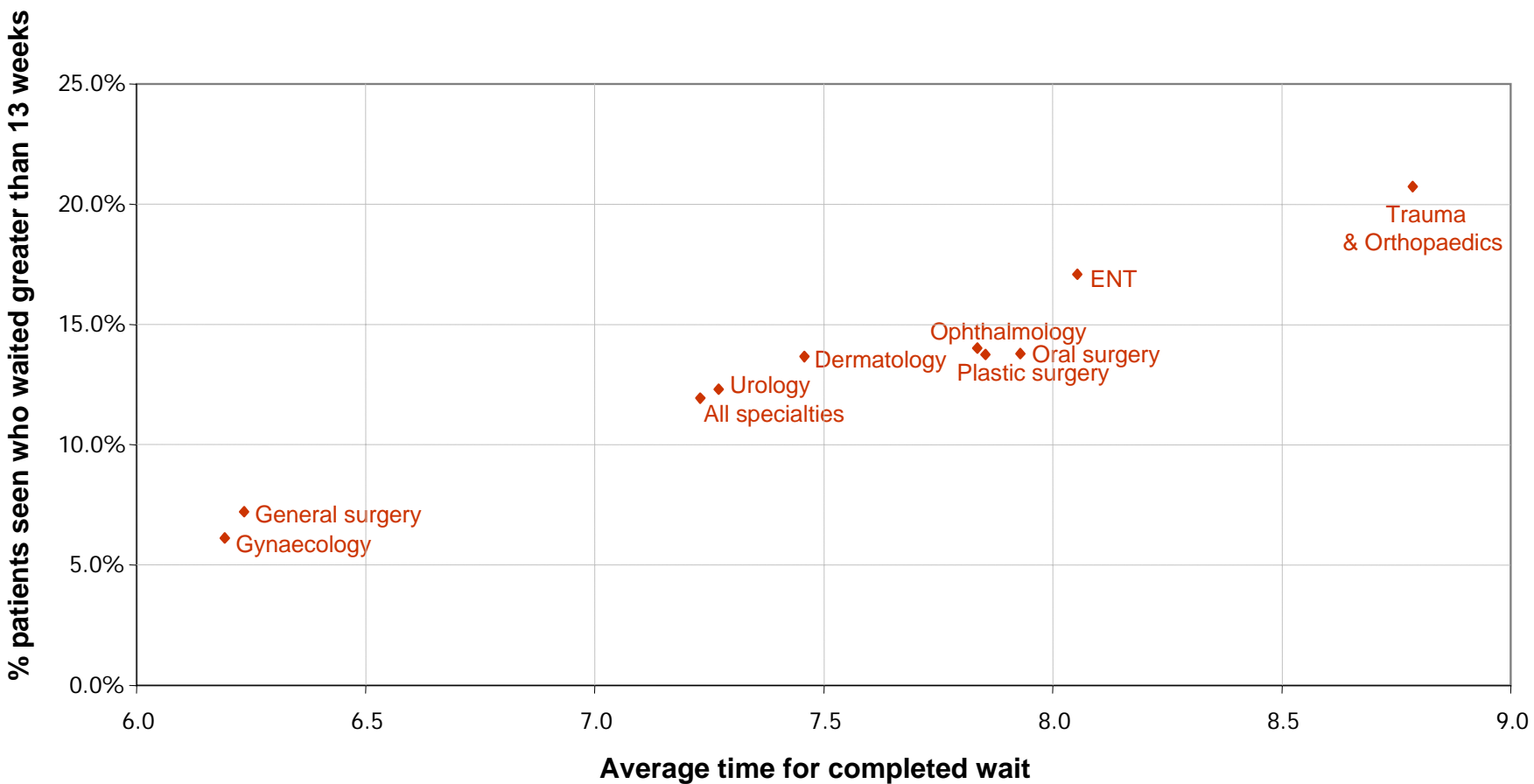
Total sample size = 100,000 waiters

There has been significant progress in reducing clearance times for inpatient waits with progress being made in all specialties. The 6-month operational standard came into effect across the NHS from 1 January 2006. Further reductions in all specialties are required to ensure the total patient journey is within 18 weeks and orthopaedics remains the biggest challenge.



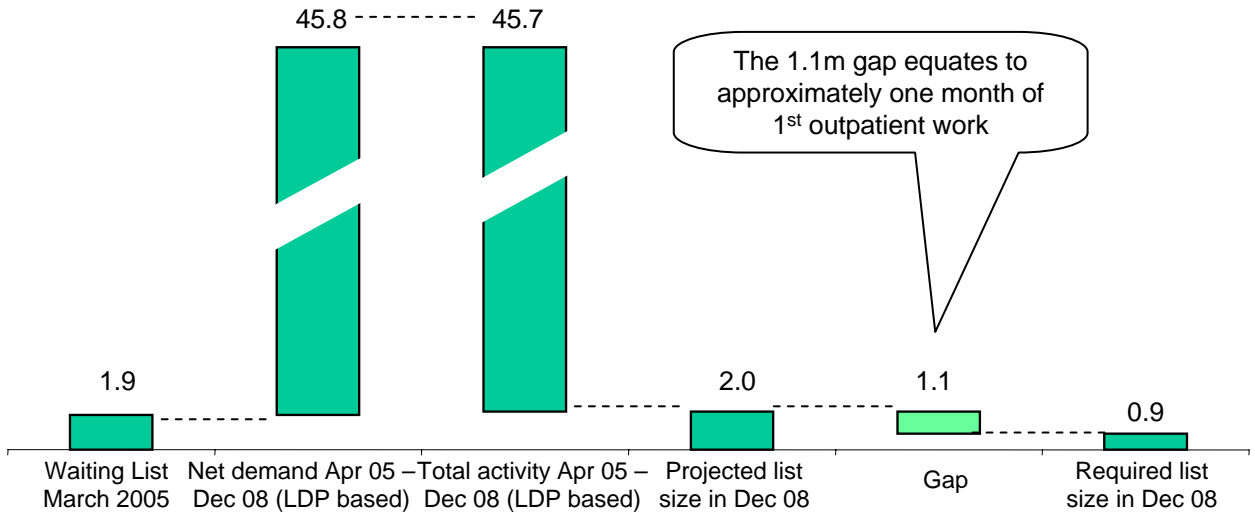
Data collected from the pilot sites in Q2 of 2005/06 shows that, although not as marked as the inpatient data, trauma and orthopaedics has the longest waits for completed outpatient appointments. The chart also reflects that dermatology is the medical specialty with most significant waits. Despite the achievement of 13 weeks by the end of December 2005, considerably more work will need to be completed to support delivery of the 18 week pathway – it is expected that a significant change in the organisation of many outpatient clinics will be required.

Specialty: Outpatient average time for completed wait vs. percent of patients seen who waited greater than 13 weeks



Modelling based on the Local Delivery Plans (pre April 2006 refresh) suggests that there may be a shortfall in planned outpatient activity equal to one month's work over the three year period between 2005 and 2008.

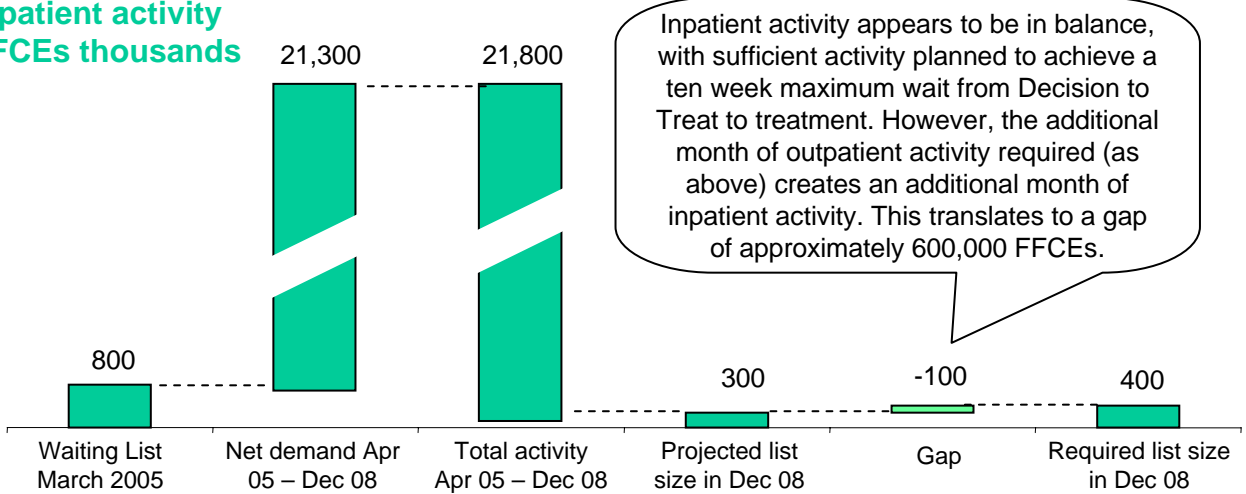
All first Outpatient appointments (millions)



The gap is based on first outpatient appointments and therefore may be greater when the impact of activity required for any subsequent outpatient appointments is included. Initial modelling suggests this could increase the gap by 300,000 appointments to 1.4m. This will require further analysis. The potential activity gap should be considered when refreshing LDPs.

Planned inpatient activity would be sufficient were it not for the knock-on impact of the outpatient shortfall

Inpatient activity FFCEs thousands



The impact of the additional outpatient work, increasing levels of other referrals and the levels of absolute capacity compared to planned activity needs to be further explored.



Workforce will be a key issue to address for the NHS to successfully achieve the 18 week pathway and the pace of change will be a significant challenge.

Delivery of the 18 week pathway requires significant increases in activity and redesign of processes, with consequent required growth and realignment of workforce.

The workforce for the clinical specialties, nurses, and AHPs has been modelled and planned to deliver the resourcing levels required. For these categories, workforce development plans have been built over a number of years and are relatively robust. Current plans indicate that, with the contribution from the independent sector, there should be sufficient workforce in these areas to meet the activity levels required for the 18 week pathway.

However using this workforce to full effect requires skills to be realigned to meet the required roles and responsibilities. Whilst this realignment has been an ongoing reform for a number of years, the pace of realignment of workforce will need to accelerate radically over the next three years – a significant challenge.

This challenge will need to be effectively addressed for the 18 week pathway to be delivered.

The workforce for diagnostics has not received the same level of planning as other areas and there are particular pressures in imaging, endoscopy, physiological measurement and pathology.

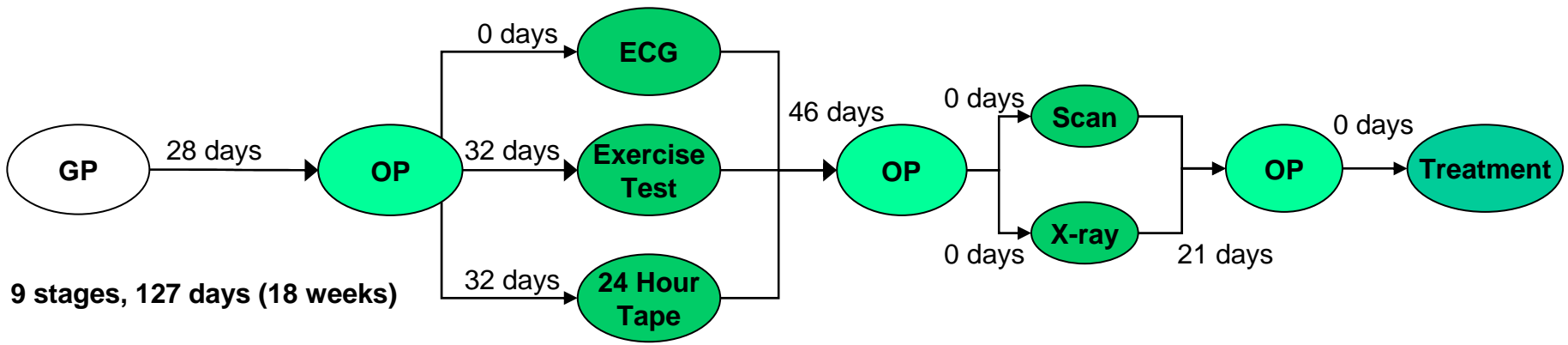
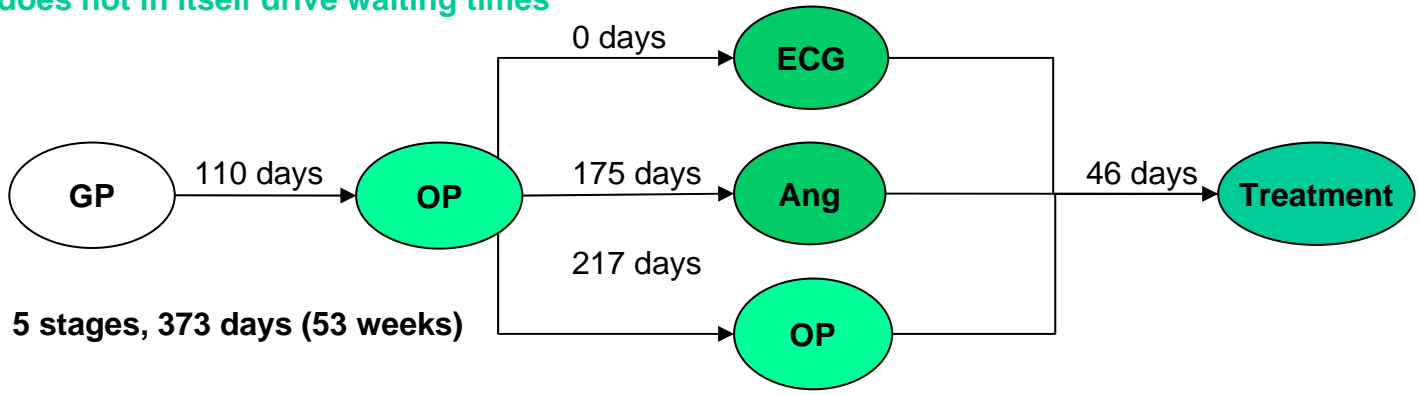
The initial need is to develop workforce planning for diagnostics to the same level as for the rest of the workforce.

Current indications are that these plans will identify two key issues:

- Addressing short term shortages to support delivery of the 18 week pathway, whilst additional workforce is undergoing training
- Ensuring sufficient workforce is under development to meet the longer term need from 2009 onwards to sustain the 18 weeks standard

For the 18 week pathway it is not just the stages of treatment that are important – it is the patient journey from referral to start of hospital treatment that needs to be achieved within 18 weeks. From the initial assessment it was also clear that there is no single attributable cause for the length of pathways – complexity (number of stages and/or handovers and clinical complexities) in itself is not a key determining factor for long waiting times.

Two complex cardiology pathways – one short, one long illustrate that complexity does not in itself drive waiting times



Source: Pilot site data, 2005

Four key operational challenges were identified that the NHS needs to address to achieve the 18 week pathway.

1. Long waits & long clearance times

- Certain specialties and tests have large numbers of patients waiting and long waits. This is especially true for orthopaedics, endoscopy, & audiology
- Echocardiography may fall into this category in time
- However, there is no single simple explanation for long waits

2. Thinking in and measuring whole pathways

- Understanding the diagnostic and outpatient loops in the patient pathway is crucial
- Shifting focus from measuring stages of treatment to whole patient pathways involves changing mindsets to change the way the NHS manages patients in its care
- Put in place systems to measure referral to treatment as a matter of urgency

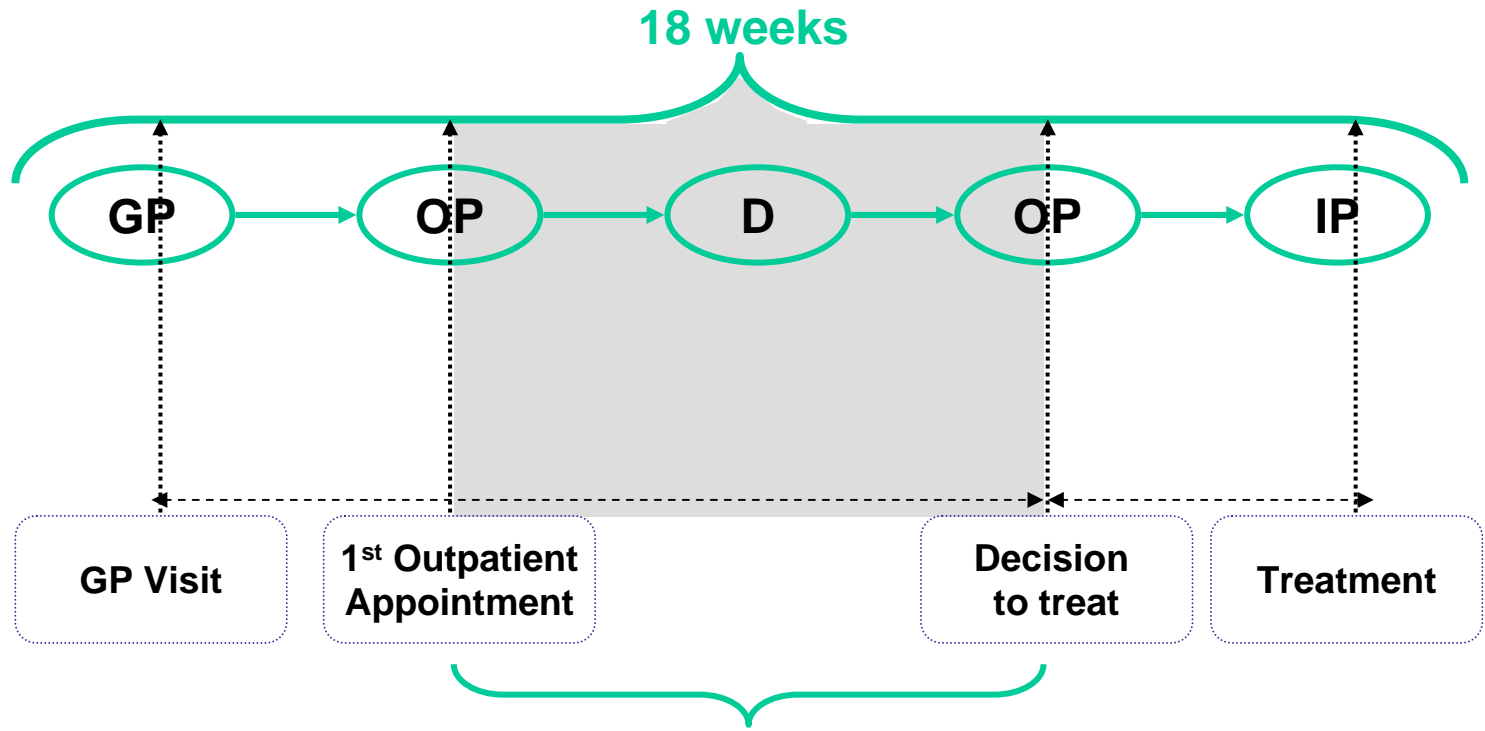
3. Planning the right activity levels

- Meeting potential shortfalls in some outpatient, and diagnostic test activity and addressing any consequent impact on inpatient activity
- Achieving the 18 week pathway within the more challenging financial environment

4. The changing NHS environment

- Aligning the 18 week pathway and System Reform initiatives
- Ensuring that the NHS focuses on the 18 week pathway amidst reform & change

To deliver the 18 week pathway the NHS needs to continue to reduce waits to first outpatient consultation and from decision to treat to treatment. This will require more activity and reform than ever before. However, the NHS also needs to focus real effort on the time from first outpatient consultation to the decision to treat, which historically has not been a major focus.



The time from the first outpatient consultation to decision to treat (or not to treat) includes the most significant challenges including all diagnostics and subsequent outpatient appointments.

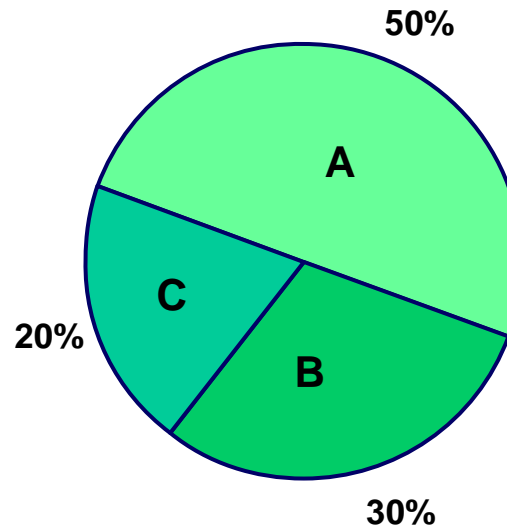
Straightforward pathways can be shortened by working efficiently whilst patients on very complex and urgent pathways are already often individually managed. The greatest challenge lies with the remaining complex patients who do not receive special management attention. Initial work suggests medical pathways may have a greater percentage of patients in this category than surgical pathways.

(A). Patients on straightforward pathways that are relatively short and do not require special efforts to achieve the 18 week pathway. No additional case management is required.

(B). Patients on more complex pathways but not in category C so currently no individual case management / planning.

(C). Difficult / complex / clinically urgent patients who will probably already have an individual case manager.

All pathways*



Three methods for allocating patients to the categories have been used: the number of stages in a pathway as a proxy for pathway complexity, a specific analysis of outpatient and diagnostic loops and the length of the overall pathway.

*The data sample used in these charts represents a small fraction of total NHS pathways. In addition, the pathways represented may be biased towards those pathways on which data was easier to collect.

The initial assessment and subsequent preparatory work for the implementation framework have set out the key operational challenges and identified that some of the preconceptions held did not stand up to further scrutiny in terms of delivering the 18 week pathway.

The outcome of this work is that specifically the NHS will need to:

- Ensure that patients are managed across the whole pathway of care and not in separate stages as now.
- Collect data on the referral to treatment pathways to support performance measurement and management – currently this measurement appears to be the biggest challenge to the successful achievement of the 18 week pathway.
- Resolve any potential activity gaps made more challenging by the current financial position by ensuring that refreshes of LDPs take these activity shortfalls into account.

In addition the Department needs to:

- Ensure the plan for delivery is developed and is fit for purpose for the NHS of 2008 onwards, taking into account the major changes planned through the System Reform programme.

The implementation framework

The implementation framework and this delivery resource pack set out how the Department of Health will be organised to support the NHS achieve the 18 week pathway. It also clarifies the NHS priorities for the next three years. The four elements of the plan are:

- Engage the NHS
- Enable the NHS
- Develop performance measurement and management systems
- Support the NHS

The remainder of the delivery resource pack sets out these items in more detail.

The Delivery Plan

Section 2

Delivering the 18 week Patient Pathway

1. Engage the NHS in solving the new challenges created by the 18 week pathway

2. Enable the NHS to deliver by providing clear responsibilities, aligned incentives and proven solutions

3. Develop performance measurement and management systems to assure delivery

4. Support the NHS by collecting and sharing good practice and introducing a delivery support programme

The roadmap shows the key themes for delivery in each year up to December 2008. Building on the preparatory work in 2005, measurement and developing solutions will be the focus of 2006. In 2007 we will concentrate on rolling out the solutions and begin to deliver the 18 week pathway. 2008 will be about securing delivery and providing support to the most challenged organisations.

2006	2007	2008
<p>Define principles and definitions</p>		
<p>Engage the NHS to deliver 18 weeks</p>		
<p>Deliver stage of treatment milestones</p>	<p>Deliver stage of treatment milestones</p>	<p>Deliver stage of treatment milestones</p>
<p>Implement RTT measurement & plan trajectory</p>	<p>Performance Manage to RTT trajectory</p>	<p>Deliver 18 week standard</p>
<p>Develop solutions in pioneers & focused projects</p>	<p>Rollout solutions across the NHS</p>	
<p>Tailored support for referral to treatment measurement and milestones</p>	<p>Tailored support to ensure NHS has infrastructure in place to deliver</p>	<p>Tailored support to support most challenged trusts</p>
	<p>Begin Rollout of CfH RTT systems</p>	<p>Complete Rollout of CfH RTT systems To 2009</p>

1. Engage the NHS in solving the new challenges created by 18 weeks

Engaging clinicians and managers is crucial so they embrace the challenge and opportunity the 18 week pathway affords.

1.1 Agree and deliver the consistent message for clinicians by clinicians that the 18 week pathway provides the opportunity to address the whole patient pathway and improve quality of care, including speed of access for patients.

1.2 Engage managers and other health professionals, with the support of ISIP, to ensure the patient perspective is adopted, new ways of working are introduced and mainstreamed and that transformed pathways are established.

1.3 Use the publication of the Implementation Framework document and launch of the 18 week website to set the overall context of the 18 week patient pathway.

2. Enable the NHS to deliver by providing clear responsibilities, aligned incentives and proven solutions

By providing clarity, joined up policy and potential solutions, the NHS is enabled to achieve the 18 week pathway.

2.1 Introduce national specialty and diagnostic projects where further focused attention is required to support delivery, and NHS pioneers to develop 'proof-of-concepts' for system change solutions.

2.2 Develop, through the pioneers, techniques and tools to create a system that proactively moves patients through the pathway, utilising ISIP process products and field support to help the NHS implement proven solutions.

2.3 Through System Reform, set commissioner and provider responsibilities and incentives for the 18 week pathway.

3. Develop performance measurement and management systems to assure delivery

Measurement is potentially the biggest challenge to successfully achieving 18 weeks

3.1 Deliver the stage of treatment milestones for March 2006 and March 2007, and the Choice of Scan initiative.

3.2 Set the objectives for the 18 week pathway through the development of a referral-to-treatment trajectory supported by milestones and linked to the Healthcare Commission assessment framework.

3.3 Use pioneers to develop and test referral to treatment measurement systems that will provide the information to drive service change and complete national returns to assess progress.

3.4 Support phased introduction work of the 18 week pathway performance monitoring building on pioneers with an NHS-wide baselining exercise or 'census' and a new data collection for universal referral to treatment measurement.

3.5 Introduce a referral to treatment performance management regime to support the commissioner based target.

3.6 Develop a 'strategic' IT system with Connecting for Health to include the ability to measure from referral to treatment, and provide prospective real-time data.

4. Support the NHS by sharing good practice and introducing a delivery support programme

All NHS organisations will require support to achieve 18 weeks – some will require very focused action.

4.1 With the NHS Institute, NHS Elect and other organisations, collect and disseminate lessons learnt from the Pioneers' proof-of-concept work, and good practice from other NHS organisations and international healthcare systems.

4.2 Support the NHS in delivering the 18 week pathway, through the activities of the Workforce Review Team and the National Workforce Projects Team in workforce planning and development.

4.3 Introduce a delivery support programme for the most challenged organisations building on the experience in the National Orthopaedic Project and A&E.

1. Engage the NHS in solving the new challenges created by the 18 week pathway

Engaging clinicians and managers is crucial so they embrace the challenge and opportunity 18 Weeks affords.

1.1 Agree and deliver the consistent message for clinicians by clinicians that 18 weeks provides the opportunity to address the whole patient pathway and improve quality of care, including speed of access for patients.

1.2 Engage managers and other health professionals, with the support of ISIP, to ensure the patient perspective is adopted, new ways of working are introduced and mainstreamed and that transformed pathways are established.

1.3 Use the publication of the Implementation Framework document and launch of the 18 week website to set the overall context of the 18 week patient pathway.

1. Engage the NHS in solving the new challenges created by the 18 week pathway

Action: 1.1 Agree and deliver the consistent message for clinicians by clinicians that the 18 week pathway provides the opportunity to address the whole patient pathway and improve the quality of patient care including speed of access for patients

Talk directly to clinicians through clinicians to build a consensus that the 18 week pathway is an opportunity to manage the patient pathway in a way that addresses quality and access together and engages clinicians in a way not achieved to date. Develop a set of key messages that support this process and a set of mechanisms to engage directly with clinicians as a priority for this aspect of the work.

The messages will include the opportunity afforded by the 18 week pathway to manage a patient's whole pathway and to therefore engage with clinicians more easily than is possible with the current stage of treatment targets. The messages will be developed by working with senior national and front line clinicians to ensure a cross section of the community has its say. The national clinical lead for the 18 week pathway, Dr. David Colin-Thome, will lead this work.

Plans to support the publication of the implementation framework and principles and definitions will be developed. They will maximise the opportunity to engage clinicians and front line practitioners and clearly explain what the 18 week pathway means for them and their patients and how they are need to start to think and act differently.

Discussions with Royal Colleges and sub-specialty groups as well as more formal meetings in the Department will provide opportunities to embed the messages and truly engage with clinicians, building on the success of projects such as the A&E 4 hour target and 6 month maximum wait. An 18 week pathway stakeholder group is being established to advise on implementation of the 18 week pathway. The group will include senior clinicians, managers, representatives of a range of organisations, and clinical leads.

Underpinning this will be an engagement and communications strategy to ensure the launch momentum is sustained by involving clinicians in running both individual projects as well as the overall programme. The engagement and communications strategy will be developed in consultation with the existing 18 week pathway clinical leads to ensure that the approach and focus is suited to clinicians.

Key milestones:

- Discuss the 18 week pathway with clinical leads regarding communications and engagement strategy in spring 2006
- Agree key messages by spring 2006
- Publish 18 weeks Implementation Framework in spring 2006
- Identify an overall 18 week pathway clinical lead in spring 2006

1. Engage the NHS in solving the new challenges created by 18 week pathway

Action: 1.2 Engage managers and other health professionals, with the support of ISIP, to ensure the patient perspective is adopted, new ways of working are introduced and mainstreamed and that a more structured approach rather than 'more of the same faster' is adopted for some specialties.

This action is about engaging managers and changing hearts and minds so the new issues for 18 weeks are fully embedded.

Working with managers directly and through the NHS Institute and other organisations to ensure they understand the new challenges facing the service including the scale of the change, the size of potential gaps in service and the style of change required to deliver 18 weeks. This will include engaging patients, clinicians and the whole system in managing pathways.

Local NHS managers supported by the central team will use the 18 week website to create an 18 week delivery community supporting each other and problem solving by sharing good practice and experiences of both success and failure. Creating links to build upon Integrated Service Improvement planning is already underway.

The Department of Health will support links to other initiatives such as the 'Do once and share' project, Connecting for Health's Service Improvement work and the NHS Institute's 'no delays' project to further embed the 18 week pathway. This will require a national steer but also strong local linkages with these agendas.

The 18 week team will work with the public and patient involvement team to engage with the wider population and ensure that plans will have the desired effect of taking waiting off the table and that success is acknowledged by the patients themselves.

Focussing on physiological measurement for example, by running a campaign to highlight physiological measurement challenges, including the 'What is Physiological Measurement?' document, and using the information gained from initial diagnostic data returns to highlight any new issues identified.

Create additional focus on the 18 week pathway and referral to treatment including diagnostics by giving notice in early 2006 to the NHS that it will be included as a line item in the 2007 LDP process.

Establish a stakeholder group including among others Royal Colleges, clinical leads, SHA, PCT and acute provider representation, to create a forum for engagement with the NHS.

Key milestones:

- Governance arrangements and stakeholder support to be established in March 2006
- Run a campaign to highlight specific challenges from May 2006
- Flag the 18 week pathway and referral to treatment measured in the LDP process in March 2006
- Release initial products from the NHS Institute in September 2006
- Workforce support material published in April 2006
- Stakeholder Group established June 2006

1. Engage the NHS in solving the new challenges created by the 18 week pathway

Action: 1.3 Use the Implementation Framework document and launch of the 18 week website to set the context of the overall patient pathway.

The draft 18 weeks principles and definitions document published in October 2005 with a six week listening exercise was conducted to:

- Engage the NHS and heighten awareness of the 18 week patient pathway
- Set the context of what was included and excluded, what starts and stops the clock and how the patient is managed along their pathway

Taken together these factors were used to help create a focus on the 18 week pathway. In addition to this the 18 weeks website (www.18weeks.nhs.uk) was used to support the listening exercise but also to provide an ongoing mechanism for engaging the NHS and wider community in the 18 weeks work in order to support delivery.

The initial review of feedback from the listening exercise identified a number of key issues which were reviewed ahead of the final principles and definitions being published in the Implementation Framework.

The 18 week website will continue to be used as the main vehicle to promote the 18 week pathway and through the community forums will be a tool to share issues and ideas for achieving the patient pathway.

Key milestones:

- 18 weeks website and listening exercise launched in October 2005.
- Coverage and tolerances work to be finalised as part of the further guidance on the principles and definitions in autumn 2006.
- 18 week pathway Implementation Framework published spring 2006.
- 18 weeks website to provide community forums as active sharing mechanism for 18 weeks by February 2006

2. Enable the NHS to deliver by providing clear responsibilities, aligned incentives and proven solutions

By providing clarity, joined up policy and potential solutions, the NHS is enabled to achieve the 18 week pathway.

2.1 Introduce national specialty and diagnostic projects where further focused attention is required to support delivery, and NHS pioneers to develop 'proof-of-concept' for system change solutions.

2.2 Develop, through the pioneers, techniques and tools to create a system that proactively moves patients through the pathway, utilising ISIP process products and field support to help the NHS implement proven solutions.

2.3 Through System Reform, set commissioner and provider responsibilities and incentives for the 18 week pathway.

2. Enable the NHS to deliver by providing clear responsibilities, aligned incentives and proven solutions

Action: 2.1 Introduce national specialty and diagnostic projects where further focused attention is required to support delivery and NHS 'pioneers' to develop 'proof-of-concept' for system change solutions.

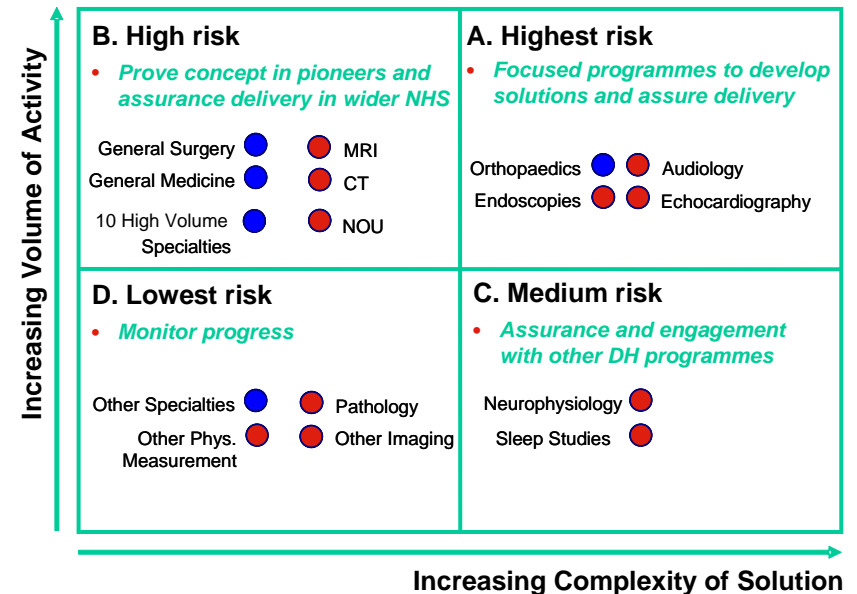
Achieving the 18 week pathway requires a new approach to managing the patient pathway from referral to a decision to treat. An integrated 'referral to treatment' process is needed, in conjunction with reduced clearance times in each component of the pathway - including diagnostics. Endoscopy, imaging, and physiological measurement are all key challenges in this respect. In combination with the other components of the implementation framework, four strategies are defined to address the key constraints to delivery. These are described below and detailed on the following pages. The diagram below shows the strategy to be adopted for each identified constraint. Their positioning will be monitored throughout the programme to ensure that the most appropriate strategy is being applied.

A. Highest risk: Specific high volume specialty or diagnostic test where a focused project is needed to develop solutions. Outcome: achieving 18 weeks or agreed alternative solution in specific specialty or test.

B. High Risk: Speciality or diagnostic test with high referral volumes and large waiting lists, where key issue is developing integrated processes and measurement of the 'referral to treatment' pathway. Outcome: solutions are proved in pioneer communities and learning shared, to assure progress.

C. Medium Risk: Specific complex issues but volume is low and is being addressed by existing programmes. Outcome: assurance that existing programmes deliver the necessary solutions.

D. Low Risk: Speciality or diagnostic where no specific risk has been identified and where no intervention should be needed. Outcome: high level monitoring will ensure that if the speciality or diagnostic appears to be a greater risk, it can be escalated to receive appropriate intervention.



Key milestones:

- Pioneer sites to commence in spring 2006.
- Category A projects initiated in spring 2006.

2. Enable the NHS to deliver by providing clear responsibilities, aligned incentives and proven solutions

Action: 2.1 Introduce national specialty and diagnostic projects where further focused attention is required to support delivery and NHS ‘pioneers’ to develop ‘proof-of-concept’ for system change solutions.

Category A. Highest risk category – focused projects will be initiated to address three specific constraints that represent a major risk to delivery

A number of specific constraints have been identified where new solutions need to be developed. Where these issues pose a major hurdle to reducing unnecessary waits, the strategy is that there should be a focused project or action plan, managed by the 18 weeks programme, to deliver solutions and assure their implementation across the NHS. Where other related programmes already exist, for example the Physiological Measurement Programme, the 18 weeks Programme will liaise closely with it to agree clear lines of accountability, to ensure that all resources are effectively used, and stakeholder engagement maintained. As work progresses, further issues may be identified that require focused Category A projects. This will be kept under review and further projects will be initiated if necessary.

Initially three focused projects will be set up, further detail is given on the following slides:

- **Orthopaedics** – 13 high volume specialties potentially fall into Category A, with orthopaedics at the top of the list. Whilst, for the other specialties, the key issues are delivering on capacity plans and developing integrated pathway processes; orthopaedics poses a different level of challenge: inpatient clearance times are very high, pathways are complex, and primary care has a key role. Sustained effort on orthopaedics is necessary from 2006 as 2007 will be too late to reduce clearance times.
- **Endoscopies** – very high volumes and current long waits, combined with the need to develop effective tools and techniques to proactively move patients between endoscopy and other parts of the pathway, make this very high risk. Whilst solutions have been developed for upper and lower gastrointestinal (GI) endoscopies, similar solutions are needed for non-GI endoscopies, colposcopy, hysteroscopy, cystoscopy and bronchoscopy.
- **Echocardiography** – developing clinical practice is driving a major increase in intervention rates that potentially creates a major problem. Required level of intervention is uncertain, further work is needed to define robust planning assumptions and potentially develop radical capacity solutions.

Key milestones:

- Existing orthopaedic and endoscopy projects to transition to a specific 18 week pathway focus from January 2006
- Further work in understanding the echocardiography issues during spring 2006

2. Enable the NHS to deliver by providing clear responsibilities, aligned incentives and proven solutions

Action: 2.1 Introduce national specialty and diagnostic projects where further focused attention is required to support delivery and NHS ‘pioneers’ to develop ‘proof-of-concept’ for system change solutions.

Category A: Orthopaedics – highest risk specialty for the inpatient part of the pathway, combined with high complexity up to decision to treat, make orthopaedics a major risk to delivery

Orthopaedics, with over two million referrals per annum, was the highest risk specialty in delivering the six months inpatient target.

Good progress has been made and the six month operational standard came into effect across the NHS from 1 January 2006. This represents a significant achievement, but there is still be much to be done to achieve an 18 week pathway.

There is still a sizeable challenge to achieve the inpatient waits required for the 18 week pathway; in addition, typical pathways require multiple outpatient appointments and often diagnostics, including MRI and neurophysiology. Implementing integrated management of the pathway will be difficult in orthopaedics. Improving demand management and referral paths are also major issues for primary care.

The previous National Orthopaedic Project, focused on delivering six months, has built up significant momentum and effectiveness. Maintaining this momentum is essential. The previous project has continued after delivery of the six months target, but will now be refocused on the whole pathway.

About 30% of primary care consultations are for musculoskeletal complaints: about ten million people in the UK have arthritis. The Musculoskeletal Framework (MSF) has been developed to improve services for the millions of people with musculoskeletal conditions and will be published in spring 2006.

NB. Pathway information is based on the sample of patient pathways provided by the Pilot Sites. This is important information, but some caution is required when generalising this information to the many millions of patient pathways that typically take place annually in the NHS.

Key Facts		Trauma and Orthopaedics	Average of other specialties
Length of total pathway *		33 weeks	20 weeks**
Median wait for:	Out patients In patients Diagnostics ***	8 weeks 11 weeks 20 weeks	7 weeks 9 weeks 5 weeks
Percentage of pathways with four or more stages ****		35%	26%
Use of available capacity in diagnostics	MRI Neurophysiology	20% 34%	--

* Based on data from Bedfordshire and Hertfordshire average ‘referral to treatment’ waiting times for key procedures

** Key specialties only

*** Calculated from comparison of the Bedfordshire and Hertfordshire ‘referral to treatment’ data and national out patient and inpatient wait data

**** Data from 18 weeks pilot sites

2. Enable the NHS to deliver by providing clear responsibilities, aligned incentives and proven solutions

Action: 2.1 Introduce national specialty and diagnostic projects where further focused attention is required to support delivery and NHS ‘pioneers’ to develop ‘proof-of-concept’ for system change solutions.

Category A: Endoscopy – very high volumes and current long waits, combined with the need to develop effective tools and techniques to proactively move patients between endoscopy and other parts of the pathway, making this a major risk to delivery.

Endoscopy covers a range of high volume diagnostic tests. Currently there are long waits for most endoscopies and outpatient activity is not fully measured. The charts illustrate the scale of current waits. To deliver the 18 week pathway, all gastrointestinal (GI) endoscopy departments need to attain grade A on the timeliness domain of the Global Rating Scale – currently only twelve percent do so. Whilst arthroscopies and laparoscopies will be addressed through the surgical specialties, the equivalent to the rating scale needs to be developed for other non-GI diagnostic endoscopies. GRS will then be used for endoscopies in the specialities Urology, Gynaecology and Respiratory medicine.

Two specific problems need to be addressed:

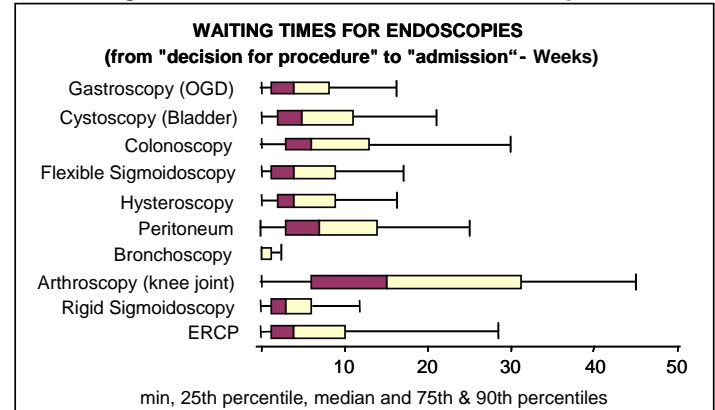
- Improving the clearance time in endoscopy departments is essential to enable 18 week pathways, and
- Developing pathway management processes that ensure that delay is avoided in proactively moving patients between endoscopy and other clinical departments – endoscopy has an impact on many high volume problem pathways

The previous Endoscopy Project made good progress with GI endoscopies, however the same now needs to be done with non-GI endoscopies, including gynaecology (colposcopy and hysteroscopy), urology (cystoscopy), and respiratory medicine (bronchoscopy).

The required outcome is that both GI and non-GI endoscopy departments achieve the necessary clearance times and have developed efficient ‘proactive movement’ processes to enable the rest of the pathway to deliver.

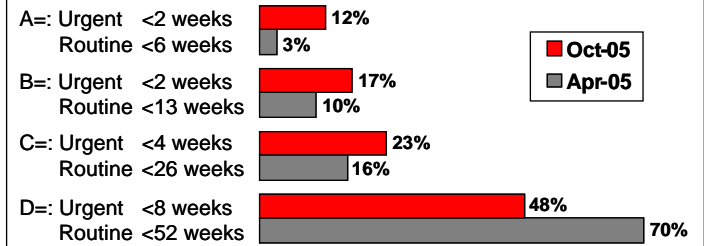
The existing project will be brought within the 18 weeks programme remit and strengthened with additional management input to support the clinical lead and address the non-GI diagnostic endoscopies, as described above.

Significant reduction of maximum waits is required



Top 10 (by volume) Inpatient Diagnostic Endoscopy Procedures for NHS Hospitals in England 2003/04. The top 10 account for 96% of Finished Consultant Episodes for main operations. Source: Hospital Episode Statistics

GLOBAL RATING SCALE
Timeliness Domain for Gastrointestinal Endoscopy Services



Percentage of Endoscopy Units
Data cover over 85% of Endoscopy Units in England returns were web based (www.grs.nhs.uk). All waiting times refer to the longest wait within the department for any new or recall procedure. They do not include delays occurring as a result of patient choice.

2. Enable the NHS to deliver by providing clear responsibilities, aligned incentives and proven solutions

Action: 2.1 Introduce national specialty and diagnostic projects where further focused attention is required to support delivery and NHS ‘pioneers’ to develop ‘proof-of-concept’ for system change solutions.

Category A: Echocardiography – a forecast increase in the intervention rate potentially creates a very large increase in demand – making this a major risk to delivery.

Evidence from pilots and anecdotally is that long waits for ‘echos’ are common, but clearance times are not excessive. The implication is that, at current intervention rates, capacity is not a major issue, but improvement is needed to waiting list management.

They have an impact on emergency as well as a very wide range of elective pathways.

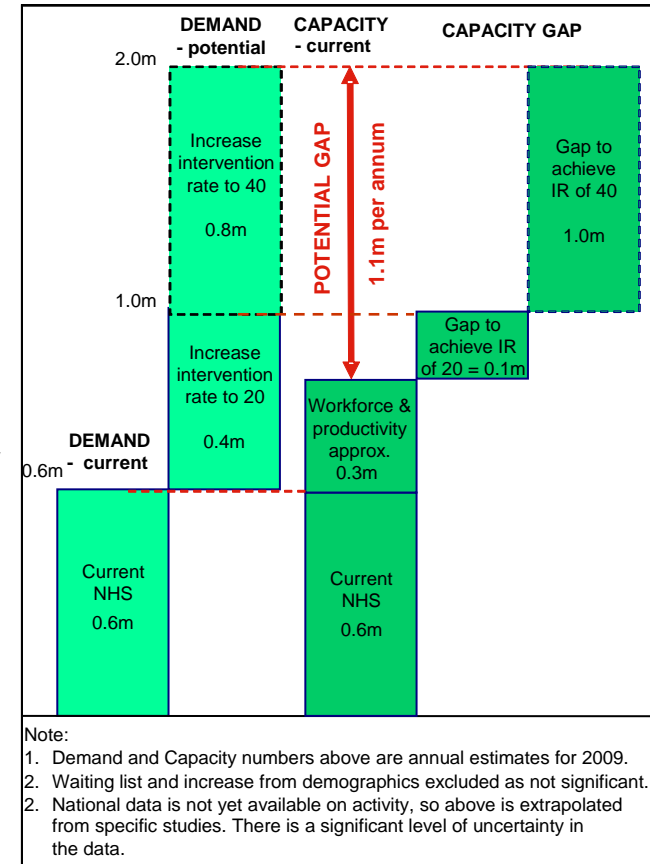
In addition to current problems, demand is forecast to increase dramatically due to changes in clinical practice.

The NHS currently does an estimated 600,000 ‘echos’ per year - an intervention rate of around 11 per 1,000. There is consensus that the intervention rate needs to increase. Department of Health analysis estimates that 20/1000 is required to address good clinical practice. The British Society for Echocardiography estimate an intervention rate of 42.8-47.7 per 1,000, based on similar methodology, but they forecast a very much higher use for hypertension. The implication is a rate between 20 and 40 in 2009.

The chart shows the impact on increasing the intervention rate to 20 or 40. If a 50% increase from current resources is assumed by 2009, there is only a small gap in capacity at 20 per 1,000. However, at 40 the gap is over 1m per year. This is clearly a significant risk to 18 weeks.

The first outcome required is a robust planning assumption for the 2009 intervention rate, based on further consultation with key stakeholders. If this intervention rate is at the higher end of current estimates, radical solutions will needed to develop the additional capacity

A focused project will be initiated, within the 18 weeks programme, to refine the planning assumption for 2009 and to develop capacity solutions. This project will have close links to the Department’s physiological measurement programme and the Department’s Heart Team.



Action: 2.1 Introduce national specialty and diagnostic projects where further focused attention is required to support delivery and NHS ‘pioneers’ to develop ‘proof-of-concept’ for system change solutions.

Category A: Audiology - unmet need and conversion to digital hearing aids creates a major risk to ENT departments.

Historically long waits for hearing tests and the subsequent fitting of hearing aids have been the norm across the NHS. Currently it is estimated some 250,000 patients are waiting for either a first assessment or a reassessment of hearing loss. However progress has been made in that all audiology departments are now able to routinely fit digital hearing aids with enhanced benefits for the recipients.

In addition to the waiting lists, there is also a significant reservoir of unmet need that currently does not present for treatment; a proportion of these patients are expected to present as waits are reduced and as hearing aids further improve. This further increases the challenge of reducing waits for adult hearing services.

It is estimated some 80% of referrals to adult hearing services from GPs are direct to audiology departments. These services are not medical consultant led and as such do not currently fall within the scope of the 18 week target, which is for medical consultant led hospital based services only.

There is a significant risk that there will be pressure to redirect these existing direct referrals to ENT consultants in secondary care, as this way patients would be covered by the 18 weeks target. If this were to happen, it would be likely to overwhelm ENT departments and make it extremely challenging for them to deliver on the 18 week pathway. In addition it would reverse years of progress on modernising audiology services to promote direct referrals.

This risk will be managed in two ways:

- Practice based Commissioning (PbC) has the potential to help manage the risk of redirection of direct referrals and to promote the modernised of the service specification required. Further work will be initiated to review how PbC can be used to manage the risks to ENT departments on 18 weeks.
- Work to underpin the development of the 18 week pathway Principles and Definitions identified that Adult Hearing Services needs more specific action to address these long standing problems. This work has identified options to significantly reduce the unit cost of assessment and fit of digital aids through a redesigned service specification.
- The intention is to work closely with stakeholders, including the NHS and the 8 National Physiological Measurement Development Sites, the Independent Sector, and the RNID, to develop a set of actions leading towards a sustainable low wait solutions for Adult Hearing Services.

2. Enable the NHS to deliver by providing clear responsibilities, aligned incentives and proven solutions

Action: 2.1 Introduce national specialty and diagnostic projects where further focused attention is required to support delivery and NHS 'pioneers' to develop 'proof-of-concept' for system change solutions.

Category B: General surgery, general medicine, ten high volume specialities have high referral volumes and large waiting lists. The key issue is developing integrated processes and measurement of the 'referral to treatment' pathway. Solutions will be proved in pioneer communities and learning shared, to assure progress.

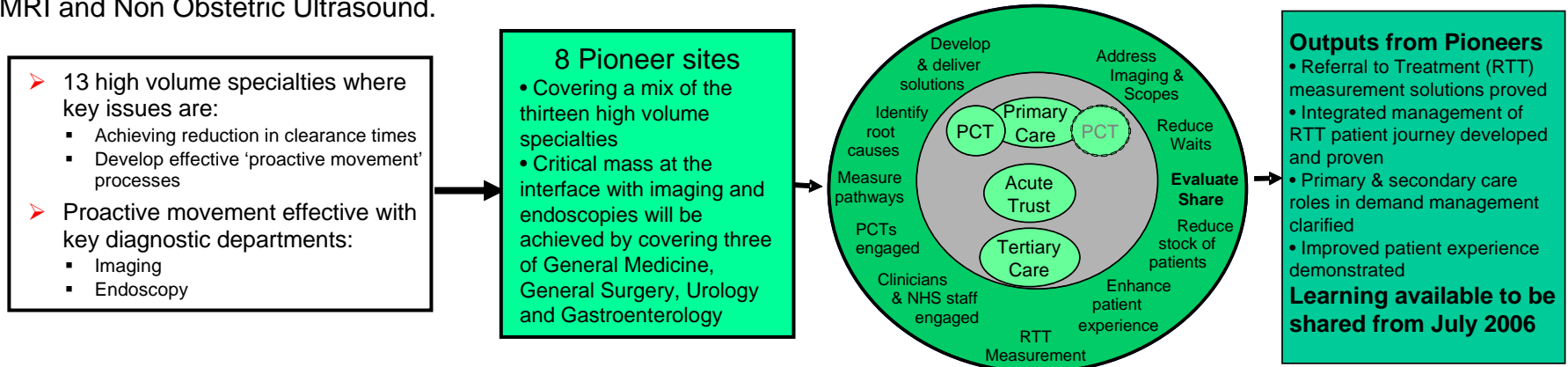
Over 80% of referrals and 95% of the current inpatient waiting list are in 13 specialties (including orthopaedics). These specialties are also dominant users of the high volume constrained diagnostics (including imaging and endoscopy). They represent the critical specialties for sorting the constraints to the 18 week pathway between referral and decision to treat. The key issues are:

- Development of referral to treatment measurement and management information systems
- Development of integrated management processes of the patient pathway - effective proactive movement processes
- Delivery of planned increase in capacity and productivity improvements to achieve the required clearance times.

We have a three stage plan to address these areas:

- Develop and prove solutions in pioneer communities building on measurement - see diagram below showing scope
- Share learning across the NHS and robustly assure progress in these areas
- Support where specific implementation challenges are identified

In addition we will liaise closely with the wider Department of Health Imaging Programme, providing focus on the issues in CT, MRI and Non Obstetric Ultrasound.



2. Enable the NHS to deliver by providing clear responsibilities, aligned incentives and proven solutions

Action: 2.1 Introduce national specialty and diagnostic projects where further focused attention is required to support delivery and NHS ‘pioneers’ to develop ‘proof-of-concept’ for system change solutions.

Category B: MRI, CT and non-obstetric ultrasound (NOU) are all high risk high volume diagnostic tests. Adequate capacity is planned to deliver 18 weeks, however effective commissioning of capacity, utilisation of existing capacity, and proactive movement are critical

Imaging, and in particular MRI, CT, and NOU, are critical to the delivery of 18 week pathways. The balance of capacity to demand is driven by clinical practice impacting intervention rates, rather than reduction in numbers waiting.

Significant capacity increase is required by 2008, with planned increases in intervention rates in MRI, CT and NOU. This has been factored into LDPs.

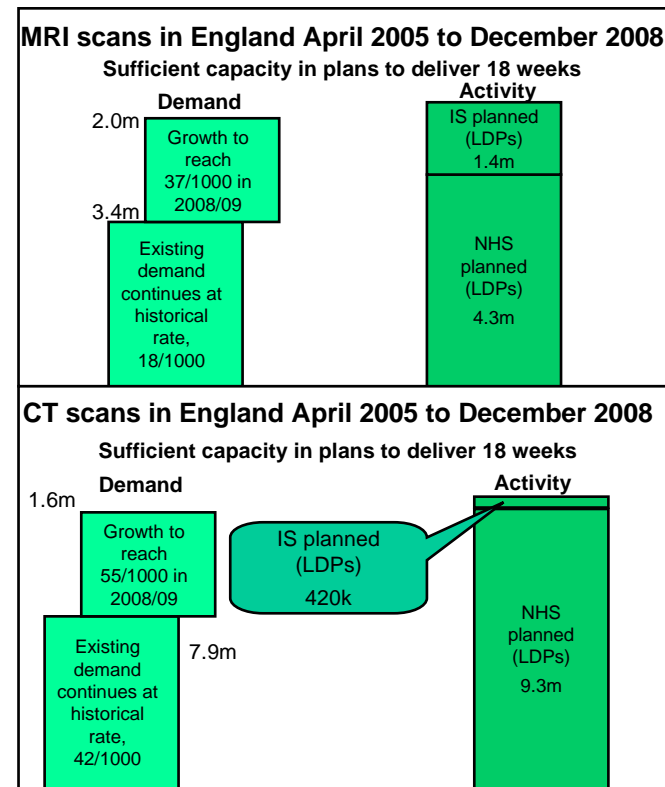
However, the delivery of this and ensuring capacity is made available to match local demand are still very significant challenges.

As no new solutions are needed to deliver capacity and the NHS is already planning to deliver sufficient capacity, imaging does not warrant being a Category A issue.

However the integration of imaging into the 18 week pathway is also a critical issue for delivery of 18 weeks – effective proactive movement processes need to be developed between imaging and imaging and specialties. Development and dissemination of good practice solutions for proactive movement is critical for the 18 week pathway.

This will be achieved through the pioneer communities. At least three of these will address the mix of specialties that represent a critical mass of demand for imaging. This will provide the opportunity to address both specialty and imaging issues.

The outcome from these pioneers will be proven ways of implementing proactive movement processes between imaging and key specialties and confirmation that the planned capacity in these diagnostics is sufficient to deliver the 18 week pathway.



Notes:

1. Waiting list not included as change is small compared with demand.
2. LDPs end in 2007/08. Relative activity growth in 2008/09 assumed to be same as that in 2007/08. LDP plans are assumed fully delivered.
3. Growth in demand to reach target level is assumed to be constant across the period.
4. Current waiting time distribution based on pilot group; this may underestimate current waiting list.

Action: 2.1 Introduce national specialty and diagnostic projects where further focused attention is required to support delivery and NHS ‘pioneers’ to develop ‘proof-of-concept’ for system change solutions.

Category C: Currently sleep studies and peripheral neurophysiology have been identified as medium risk

This category contains issues where there is a significant constraint and where new solutions are required, but where the volumes are relatively low. To date two areas of physiological measurement have been identified in this category:

Sleep Studies

- Key issue is diagnostics to test for sleep apnoea. A variety of treatments are used, including surgery
- Current activity is estimated at 16,000 per year with total potential demand of 40,000 per year - indicating a significant increase in referrals over the next few years
- Approximately 50% currently wait longer than 13 weeks for tests - indicating a need for significant reduction

Peripheral neurophysiology

- Peripheral Neurophysiology is one element of clinical neurophysiology and is concerned with the peripheral nervous system only
- Current estimates are that some 150,000 tests are done a year and that some 25,000 patients are on the waiting list at any time, with approximately 50% waiting more than 13 weeks

In both these the volumes are not high enough to warrant a focused project under category A.

The outcome required is confidence that these issues will be addressed through the existing Physiological Measurement programme, which was set up under the banner of the 18 week pathway, but which is also tasked with addressing longer term diagnostic issues.

The 18 weeks pathway programme will interface with this programme to assure progress against plans and to review whether escalation into category A is appropriate, particularly once robust data from the NHS becomes available in 2006.

Key milestones:

- Physiological measurement programme underway but specific focus on medium risk projects needed from spring 2006

Action: 2.1 Introduce national specialty and diagnostic projects where further focused attention is required to support delivery and NHS ‘pioneers’ to develop ‘proof-of-concept’ for system change solutions.

Category D – Low risk activities in this category will be monitored by the 18 weeks programme

This category represents the areas of activity where no specific risk has been identified or where volumes are low. The same process improvement issues apply to activity in this category as to Category C - robust integrated referral to treatment measurement and management processes will be required to deliver 18 weeks.

Areas of activity in this category include:

- Specialties outside the top 13 defined in Categories A and B
- Pathology
- Imaging - except for MRI, NOU, CT
- Physiological measurement - except for tests included in Categories B and C.

The 18 week pathway programme is focusing its attention on the high volume areas which account for over 80% of patient pathways and over 90% of elective admissions.

The strategy assumes that the NHS will apply the systems and processes they have developed for the high volume activities in Category B to these lower volume activities.

For activities in this category, the 18 week pathway programme will monitor progress, once referral to treatment measurement and diagnostic data collection are in place.

If a particular specialty or diagnostic test is identified as a significant risk, it will be escalated into category A, B, or C.

Key milestones:

- Assessment of category D activities using results from new diagnostic data collection from June 2006

2. Enable the NHS to deliver by providing clear responsibilities, aligned incentives and proven solutions

Action: 2.2 Develop, through the pioneers, techniques and tools to create a system that proactively moves patients through the pathway. Utilising ISIP process products and field support to help the NHS implement proven solutions.

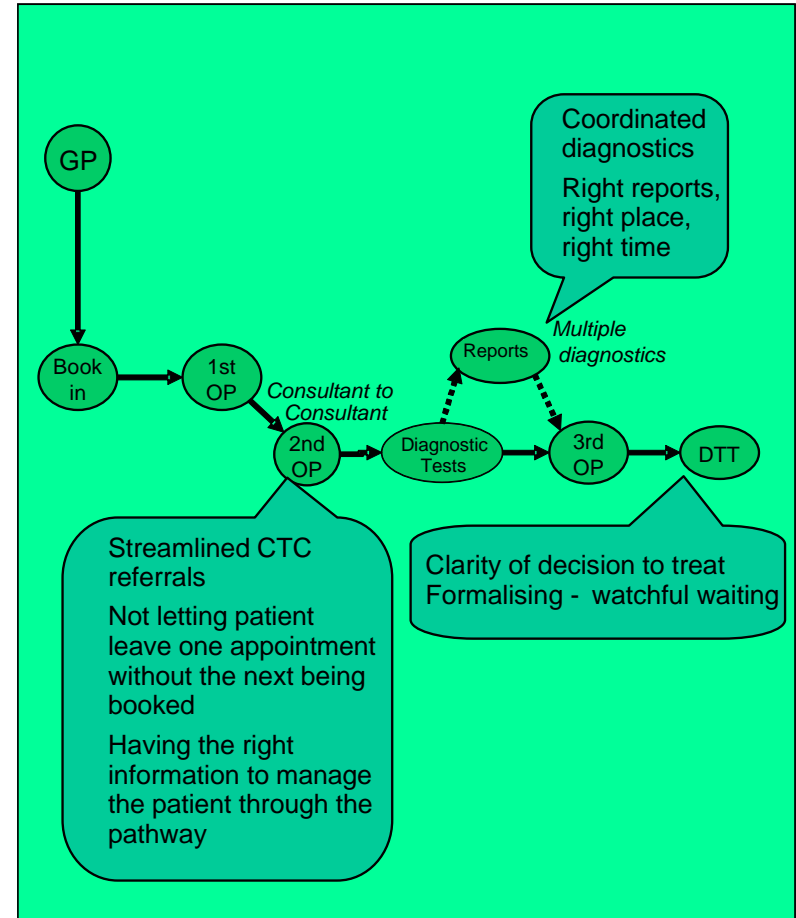
The part of the pathway from referral to a decision to treat is currently managed as a series of separate events. To achieve the required timescales with pathways that involve multiple outpatient appointment and diagnostics, a new integrated approach will be required. This process will have to ensure that proactive movement takes place between departments securely and without loss of time.

It is particularly critical that robust processes are developed to manage patients through an integrated pathway in the high volume specialties – poor processes will rapidly lead to large numbers of patients breaching 18 weeks.

Good practice model techniques and toolkits need to be developed and the effectiveness of these proven in typical hospitals. The successes, and the related techniques and toolkits, will then need to be shared with the whole NHS, via the 18 weeks website and NHS Institute.

A set of pioneer communities was established in February 2006 and in addition to measurement work will develop these solutions and share the learning from July 2006.

The outcome from these Pioneers will be that they will have proven effective proactive movement techniques and tools in managing the pathway from referral to decision to treat in all the 13 high volume specialties.



Key milestones:

- Good practice tools and techniques will start to be shared by the summer of 2006.

2. Enable the NHS to deliver by providing clear responsibilities, aligned incentives and proven solutions

Action: 2.3 Through System Reform, set commissioner and provider responsibilities and incentives for the 18 week pathway.

Traditionally the Department of Health has performance managed acute NHS trusts through SHAs to deliver on the access targets. PCTs have been responsible for commissioning and finances, but not directly for the performance of providers.

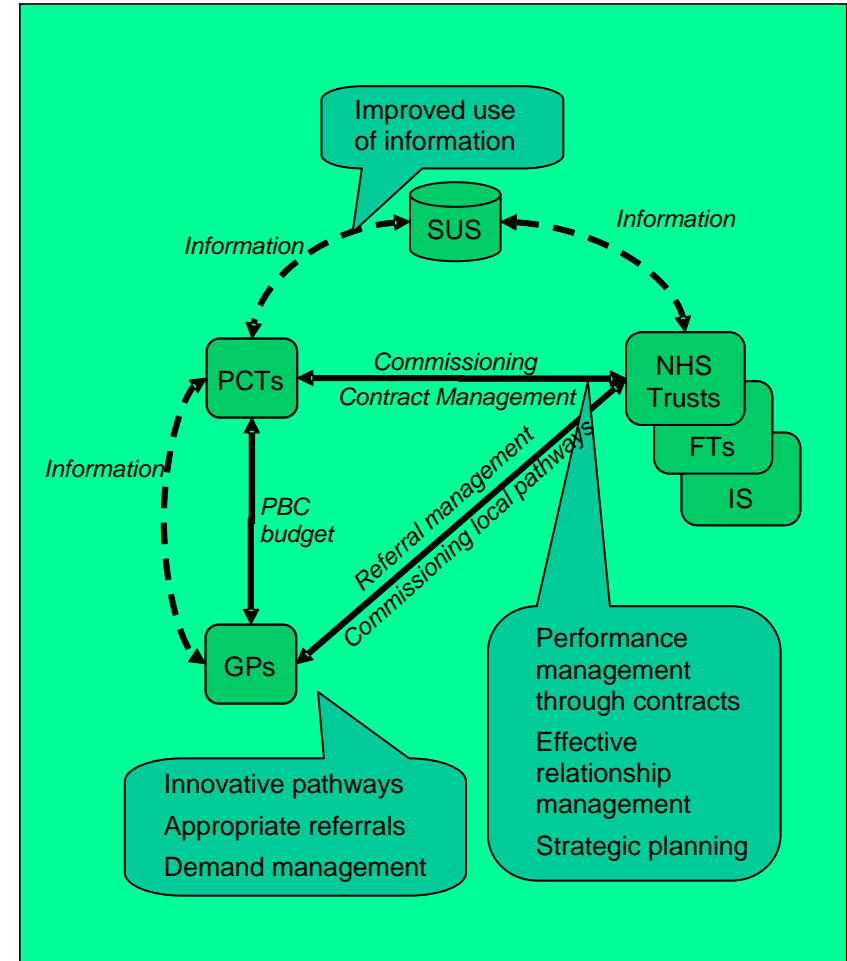
In the future, where the majority of trusts are expected to be Foundation Trusts and with participation of the independent sector, PCTs will be required to performance manage providers through their contracts to deliver the 18 weeks standard.

In addition, Practice based Commissioning (PBC) is designed to engage GPs in the development of innovative pathways of care, improving the appropriateness of referrals and responsibility for managing demand.

Both require improved information, which needs to flow from the new Secondary User Service (SUS)

Achievement of both effective contract management and PBC is essential for sustainable delivery of the 18 week pathway.

SHAs and PCTs are currently undergoing their reorganisation, which creates both threat and opportunity. The threat is that attention is diverted from the 18 week pathway, but the opportunity is to ensure that contract management and commissioning capabilities are at the forefront in the new PCTs.



Key milestones:

- Good practice tools and techniques will start to be shared by the summer of 2006.

Action: 2.3 Through System Reform, set commissioner and provider responsibilities and incentives for the 18 week pathway. Support commissioners through the development of a toolkit for 18 weeks.

The model contract and rules underpinning System Reform will play a key part in underpinning the movement to a commissioner based target as it will outline the specific responsibilities for both commissioners as well as providers within the new NHS.

A commissioner led target does not mean providers will be unaccountable for working to an 18 week pathway. Once the approach is set nationally, it will be interpreted and implemented locally by commissioners setting out the responsibilities for providers who they will contract with. In this way the contract will help to build ownership of the target across the health economy.

In advance of the model contract, initiatives linked to the Local Delivery Planning (LDP) process and Healthcare Commission assessment framework will reinforce the commissioner and provider responsibilities. This will remain a key driver throughout the three years of delivery.

System Reform also provides an opportunity to introduce incentives to support delivery of 18 weeks. Work on payment by results and practice based commissioning are two examples. Using PbR to increase the level of activity undertaken, potentially using the tariff to potentially incentivise delivery of the pathway. Work on these will continue as part of the emerging system reform work and will enable delivery of the 18 week pathway.

To take forward this work the Department of Health's 18 weeks Delivery Programme will maintain strong links with the System Reform leads to keep 18 Weeks at the top of the reform agenda. The 18 weeks policy lead will coordinate this work and will be on the System Reform Board. One critical factor of this work will be the ongoing monitoring of System Reform interdependencies and horizon scanning for any possible negative impacts on the 18 week pathway target. In particular probable perverse incentives created by System Reform will need to be managed to ensure the NHS is best able to deliver the target.

Key milestones:

- End of March 2006 – PbR system rules (technical guidance) for 2006/07
- End of March 2008 – PbR for non-electives / PbR fully operational
- Model contract to be developed during 2006/7.
- LDP refresh to run from January – April 2006.

3. Develop performance measurement and management systems to assure delivery

Measurement is potentially the biggest challenge to successfully achieving the 18 week pathway

3.1 Deliver the Stage of Treatment milestones for March 2006 and March 2007, and the Choice of Scan initiative.

3.2 Set the objectives for 18 weeks through the development of a referral to treatment trajectory supported by milestones and linked to the Healthcare Commission assessment framework.

3.3 Use Pioneers to develop and test referral to treatment measurement systems that will provide the information to drive service change and complete national returns to assess progress.

3.4 Support phased introduction of 18 Weeks performance monitoring building on Pioneers with an NHS-wide baselining exercise or 'census' and a new data collection for universal referral to treatment measurement.

3.5 Introduce a referral to treatment performance management regime to support the commissioner based target.

3.6 Develop a 'strategic' IT system with Connecting for Health to include the ability to measure from referral to treatment, and provide prospective real-time data.

3. Develop performance measurement and management systems to assure delivery

Action: 3.1 Deliver the Stage of Treatment milestones for March 2006 and March 2007, and the Choice of Scan initiative.

The 18 weeks patient pathway builds on existing access targets which are a high priority for the NHS. It is imperative that these targets are met, and the NHS continues to reduce waiting times in individual stages of treatment as per the referral to treatment milestones. Although the current stages of treatment together do not cover the entire referral to treatment pathway, success in reducing waiting times in these areas is indicative of progress against the overarching 18 Weeks target. The Department of Health will continue to support and monitor the existing stages of treatment targets in addition to the referral to treatment trajectory that is being developed.

Stage of treatment milestones				
	Mar 06	Mar 07	Mar 08	Dec 08
<i>Outpatients</i>	13	11	5	18 weeks in total
<i>Diagnostics</i>	26	13	6	
<i>Inpatients</i>	26	20	11	

Choice of Scan initiative

The first phase of the Choice of Scan programme began in November 2005. This offered patients waiting more than 26 weeks for a non-urgent MRI or CT scan the choice of faster treatment at an alternative hospital. A new more ambitious stage of the 'Choice of Scan' programme began in April 2006, offering a choice of hospital to patients waiting longer than 20 weeks for all imaging scans.

Choice of Scan will contribute to delivering 18 weeks; specifically by informing patients that they are entitled to the offer of one alternative diagnostic provider, the patient is empowered and his/her experience is more in line with that envisaged under 18 Weeks.

Key milestones:

- November 2005: Phase 1 of Choice of Scan initiative goes live – 26 weeks maximum wait
- April 2006: Choice of Scan extended to other imaging scans – 20 weeks maximum wait

3. Develop performance measurement and management systems to assure delivery

Action: 3.2 Set the objectives for 18 weeks through the development of a referral to treatment trajectory supported by milestones and linked to the Healthcare Commission assessment framework.

To support delivery of the 18 week referral to treatment pathway it has been agreed to start the referral to treatment trajectory from April 2007 rather than remain as now with a single target of 18 weeks in December 2008. As part of the LDP (Local Delivery Plan) process, the Department will ask the NHS to submit referral to treatment trajectories for 2007/8 during Autumn 2006, to allow the results of the first sampling exercise to be used as the baseline for the plans for 2007/8.

The current milestones as at March 2008 are stage of treatment only (5 weeks for outpatients, 6 weeks for diagnostics and, 11 weeks for inpatients), are essential to provide a step towards the long term goal but will be augmented with a referral to treatment milestone of 22 weeks in total. Further work is required to agree this and decide how long to double run the stage of treatment and referral to treatment trajectory and associated reporting.

The March 2008 point is currently a planning milestone and a view will be taken in the near future about whether this should become a hard target to further underpin delivery – this will be discussed and agreed within the Department Delivery group. From April to December 2008 a further referral to treatment trajectory will be required to set and then track performance from 22 to 18 weeks.

Work will also be undertaken to include the referral to treatment trajectory within the Healthcare Commission assessment framework for commissioners and providers.

The 18 Weeks trajectory will exist along side, and complement, the existing stages of treatment planning milestones. The NHS will continue to be measured against the agreed milestones for 2006, 2007 and 2008.

Key milestones:

- Trajectory to commence April 2007
- Planning milestone or hard target for March 2008 to be agreed by autumn 2006
- Input to Healthcare Commission assessment framework from April 2006 for 2007/8

3. Develop performance measurement and management systems to assure delivery

Action: 3.3 Use Pioneers to develop and test referral to treatment measurement systems that will provide the information to drive service change and complete national returns to assess progress of 18 weeks delivery

Early measurement of RTT is critical for the successful delivery of 18 weeks. An NHS wide solution to RTT measurement will be developed through an interim tactical solution and incremental releases of a long-term strategic solution delivered through Connecting for Health (CfH).

The purpose of the tactical solution is to mitigate the risk of a delay in implementation of the strategic solution, and to develop in 2006 the necessary operational processes – including clinical involvement in pathway stage definition – to measure RTT and track the patient through their pathway.

The initial goal of the interim tactical solution is to develop a ‘proof of concept’ to enable the NHS to produce performance reports that show real-time data on waiting times and not just retrospective waits. This work will include developing appropriate reports, guidance and templates.

The tactical solution will start by covering a wide range of existing PAS systems, but only initially a select few specialties. The rollout of the solution across the NHS will be driven by the implementation of the 18 weeks performance management regime and national data collection. The tactical solution will evolve over the first half of 2006 to cover all specialties.

The growth of the pilot scheme will ensure timely adoption of RTT measurement solutions across the NHS. It is hoped that the visibility of RTT pathways will shine a light on problem areas, and by focusing efforts, lead to the development of solutions to long waits.

Successful rollout of the tactical solution across the NHS in 2006 is predicated by the availability of solutions in the summer of 2006. After a period of parallel running, the tactical solution will be replaced by a long-term strategic solution provided through Connecting for Health. The tactical solution is not a long-term solution to the measurement of RTT pathways and there is a requirement for a uniform national monitoring system for 18 weeks interlinked with CfH’s National IT Programme.

Key milestones:

- RTT measurement pioneers launched and Diagnostic Data Collection commenced January 2006
- National Data Returns process for RTT pathways commences January 2007
- Deliver a tactical solution proof of concept for all existing PAS systems by June 2006
- Deliver specifications for Release 1, Release 2 and Release 3 of Strategic solution by March / April 2006, June 2006 and spring 2007 respectively
- Develop all guidance and tools necessary to rollout all tactical solutions across the NHS for all pathways by autumn 2006

Action: 3.4 Support the phased introduction of 18 Weeks performance monitoring, building on work by the pioneers with an NHS wide baselining exercise or 'census' and a new data collection for universal referral to treatment (RTT) measurement

Solutions for key PAS systems will be developed by the Pioneers. Building on this measurement work by the Pioneers, we will start national data returns to build a national picture of RTT waits and the trajectories needed to deliver 18 weeks. The first step will be a national census of RTT performance in Autumn 2006. This will be followed by shadow RTT monitoring from October 2006, full RTT measurement from 1 January 2007 and RTT trajectories from 1 April 2007.

Work to set the scope and style of the census will be completed using the experience of the pilot sites and work undertaken by the Department analysts. For the census, it will be up to individual trusts to decide how to estimate their baseline performance on RTT times although we will provide some national standards and guidance. The census will be instrumental in informing plans to implement the 18 Weeks trajectory. These plans will be updated and baselined with the introduction of a new national data collection for 18 Weeks.

The rollout of the measurement solutions from the pioneers will enable trusts to measure RTT times. Shadow running of RTT measurement will begin from October 2006. This means beginning to measure RTT pathways for some consultants in each specialty. The coverage of RTT consultants and specialties should be increased during November and December to ensure that each trust is able to report RTT times for all specialties by 1 January 2007.

Early data collection through the census will also provide the Department with important data for performance management and will mitigate some of the risk of delivering 18 Weeks. This data collection will be enabled by including a flag for 18 week referral in current PASs. This will be explored with CfH as a key priority.

RTT performance management will commence from April 2007. Initially we will also continue with the stage of treatment returns and a decision about turning off these returns will be made in 2007. Building on the experience of the census, work on LDP in 2006/7 will commence in Autumn 2006.

Key milestones:

- RTT census to commence in autumn 2006
- Exploring inclusion of mandatory flag in existing PAS systems for 18 week patients by December 2006
- Start of base lining exercise for LDPs in September 2006
- Formal national data collection to commence January 2007, with shadow running from October 2006
- Full performance management commences in April 2007

Action: 3.5 Introduce a referral to treatment performance management regime to support the commissioner based target.

The move to managing pathways operationally and the introduction of RTT data returns and trajectories will not fully support delivery of 18 weeks unless reinforced by a change in the performance management regime.

Performance management will need to focus on the stage of treatment milestones until the RTT data is available. Management to the stage of treatment milestones will be crucial in maintaining progress and achieving the reductions in outpatients, diagnostics and inpatients as set out in the LDP guidance.

The Recovery and Support Unit (RSU) will also play a key part in reinforcing the message that the move to RTT is crucial and will, once it is introduced, performance manage to the new trajectory from April 2007.

Ownership of the target by commissioners will mean that national performance management will focus on PCTs. Locally the chain will be from commissioners to providers, through the new contractual framework.

The Commissioner 'route' will be used to effectively manage Foundation Trusts, and additionally the model contract will provide the necessary levers and incentives to ensure that FTs meet the target.

Key milestones:

- New performance management regime focused on referral to treatment from April 2007

Action: 3.6 Develop a 'strategic' IT system with Connecting for Health to include the ability to measure from referral to treatment, and provide prospective real-time data

The strategic solution in March 2007 will build and improve on the interim tactical measurement solution planned for 2006. Specifications for the strategic solution will be developed with the NHS and strategic partners, such as the Information Standards Board. The rollout of the strategic solution will also be supported by the implementation of the performance management regime – the introduction of formal reporting requirement for 18 weeks in January 2007 will be a powerful incentive for a timely rollout of Release 1 of the strategic solution between March and September 2007.

Release 1 of the strategic solution will provide the ability to measure RTT pathways from start to finish, but not in-between stages, and provide reports detailing prospective, real-time data. It will be a uniform solution accessible across the health service and integrated into CfH systems (such as Choose and Book). The system will enable the production of standard management information to support required national returns. The reports it will produce will support Commissioner based targets – i.e. allow data to be split by PCT, with provider and commissioner both identified.

Release 2 of the strategic solution will build on this functionality providing the ability to see an individual patient's position in the pathway in relation to a defined stage of treatment marker. It will have the ability to drill down and query records to show status of individual episodes and provide prospective real-time reporting capability: a monthly report detailing all pathways by cohort and detailing relative position of patient in pathway.

Release 3 will provide additionally functionality to cope with changes in scope and to facilitate better managerial decision-making. The features of this final release are likely to include: flags and alerts (and exception reports) to indicate patients waiting beyond defined periods, and links between PAS measurement system to diagnostics booking systems to enable automatic update of PAS with bookings.

Key milestones:

- Release 1: specifications available March/April 2006; system available in March 2007; system implementation complete Autumn 2007
- Release 2: specifications available June 2006; system available in March 2008; system implementation complete Autumn 2008
- Release 3: specifications available Spring 2007; system available in January 2009; system implementation complete late Summer 2009

4. Support the NHS by sharing good practice and introducing a tailored support programme

All NHS organisations with require support to achieve 18 weeks – some will require very focused action.

4.1 With the NHS Institute, NHS Elect and other organisations, collect and disseminate lessons learnt from the Pioneers' proof-of-concept work, and good practice from other NHS organisations and international healthcare systems.

4.2 Support the NHS in delivering 18 weeks, through the activities of the Workforce Review Team and the National Workforce Projects Team in workforce planning and development.

4.3 Introduce a delivery support programme for the most challenged organisations building on the experience in the National Orthopaedic Project and A&E.

4. Support the NHS by sharing good practice and introducing a tailored support programme

Action: 4.1 With the NHS Institute, NHS Elect and other organisations, collect and disseminate lessons learnt from the pioneers' proof-of-concept work, and good practice from other NHS organisations and international healthcare systems.

The 18 Weeks Delivery Programme – encompassing work from the Pioneers will work closely with the NHS Institute and NHS Elect amongst others, to test, prove and share good practice.

For example, the work of the NHS Institute will be fundamental in spreading and replicating best working practices and protocols to resolve long waits and meet the 18 weeks target. Drawing on existing NHS networks and through the development of additional pilot schemes and test beds, the NHS Institute will assemble qualitative evidence to prove the efficacy of analytical models and process redesign tools to facilitate a 'no delays service' in the NHS.

The 18 weeks Delivery Programme will, through the Pioneers use the NHS Institute tools and models and provide further testing based on quantitative data on RTT pathway waits and qualitative information.

In addition, the 18 weeks website will develop as both a conduit for the dissemination of good practice, and a fertile breeding ground for the development of new ideas and techniques for streamlining patient pathways in the shape of the 18 weeks discussion forum.

The 18 weeks targeted initiatives in Orthopaedics, Endoscopy and Echocardiography and measurement pioneers will have close links with parallel initiatives within the NHS Institute's programme. Road shows, specific events and tailored communications materials will be amongst the outputs of the NHS Institute to support the health service meet the 2008 target. This will be information provided for and used by all organisations as they work towards 18 weeks – it will enable all organisation to 'get fit' for 18 weeks.

Key milestones:

- Institute tools available from September 2006
- 2006/7 programme to be agreed by end spring 2006.

4. Support the NHS by sharing good practice and introducing a tailored support programme

Action: 4.2 Support the NHS in delivering 18 Weeks, through the activities of the Workforce Review Team and the National Workforce Projects Team in workforce planning and development.

Support the development of the right size and type of workforce

Whilst current workforce plans for the clinical specialties, nurses, and AHPs indicate that, with the contribution from the independent sector, workforce in these areas should not be a constraint for 18 weeks; the workforce for diagnostics has not received the same level of planning and there are particular pressures in imaging, endoscopy, physiological measurement and pathology. There are two issues:

- Addressing short term shortages to support delivery of 18 weeks, whilst additional workforce is undergoing training
- Ensuring sufficient workforce is under development to meet the longer term need from 2009 onwards to sustain the 18 week pathway standard

The Workforce Review Team will support the NHS by developing detailed workforce plans - 'Christmas trees' - for these four areas. This will provide a robust basis to develop both short-term and long-term solutions to delivering the capacity in these diagnostic areas required by 18 weeks.

Supporting the effective use of this workforce

The planned workforce will only be sufficient to deliver 18 weeks if skills are realigned to meet the required roles and responsibilities to enable it to be used more effectively. The pace of realignment of workforce needs to accelerate radically over the next three years - a significant challenge.

In addition, the National Workforce Projects Team will produce an Elective Care Workforce Resource Pack, which will provide good practice guidance to health communities on the local development and realignment of workforce to address the challenges of the 18 week pathway. Workforce planning information, advice and support will be available in the Workforce section of the 18 week website.

Key milestones:

- Elective Care Work Force Resource Pack released in spring 2006
- Christmas Trees for Imaging and Endoscopy by July 2006
- Christmas Trees for Physiological Measurement by December 2006

4. Support the NHS by sharing good practice and introducing a tailored support programme

Action: 4.3 Introduce a delivery support programme for the most challenged organisations building on the experience in NOP and A&E.

With the benefit of the enabling activities described in box 3 of this plan, and the dissemination across the NHS of good practice as described, most organisations will be on track to deliver 18 Weeks.

However, we will also develop whole systems tailored support for 18 weeks over the three years of the programme:

- In 2006/7 the focus will be on Choice of Scan, stages of treatment milestones and RTT measurement.
- In 2007/8 the focus will be on ensuring the NHS have the infrastructure in place to deliver the March 2008 milestone.
- In 2008/9 the focus will be on supporting the most challenged communities.

Following on from this and the sharing good practice workstream a number of more challenged health systems will be identified, and they will receive further tailored support to underpin achievement. This will be in addition to the support provided through the National Projects. This aspect of the programme will be built on the successful experience of A&E and the National Orthopaedic Project. The whole systems approach will be used to solve problems within health economies, e.g. new governance arrangements will be set up to ensure representation across the Trust (clinical and managerial) and PCTs. Support teams will be populated with credible managerial and clinical professionals, and backed up by strong analytical expertise.

The design and implementation of the 18 week pathway Tailored Support Programme (TSP) will be carried out in conjunction with RSU and the NHS Institute. This will ensure a joined-up approach when it comes to sharing good practice and the performance management of the target so that messages given by the TSP team will be reinforced by the RSU in messages to SHAs.

Key milestones:

- Sharing good practice to commence from May 2006
- Detailed TSP strategy to be developed by June 2006 including how to identify the most challenged sites
- TSP intervention programme to commence December 2006

Systemic Risks

Section 3



The preceding part of this delivery plan is focused on addressing the delivery risks that can be directly managed by the 18 week programme. In addition to these risks, there are systemic risks that threaten delivery of the 18 week pathway and cannot be directly controlled by the 18 week programme. Management of these risks will require action by the 18 week team, but also from outside the programme. These have been identified by the PMDU in discussion with the 18 weeks team

The 18 weeks programme will ensure that the criticality of managing these risks is recognised at all levels within DH and that focus is maintained to ensure that they do not threaten delivery.

Financial Environment

Delivery of the 18 week pathway requires significant investment in capacity and process improvement. This has been incorporated into spending plans. The risk is that current financial pressures in the NHS and conflicting priorities mean that funds are diverted to other priorities

Action: 18 week programme to ensure that 18 weeks is given the necessary priority within the NHS and the Department to help secure the necessary funding

Delays or change to System Reform

The incentives arising from system reform are key to delivering the 18 week pathway. Delays, for example to development of PbR (tariffs) and PBC, will impact on delivery.

Action: 18 week programme to ensure implications of delays to system reform are visible at the highest level in the Department and that focus is given to address key issues

Commissioners not enabled due to organisational change

Commissioners have a key role to play in the delivery of the 18 week pathway not least in commissioning care and sustainably managing demand. In the short term, reorganisation could create a hiatus which will mean that the right capabilities are not applied to the issues.

Action: 18 week programme to closely monitor reorganisation plans and identify where tailored support is needed to address problems

Financial Environment

Delivery of the 18 week pathway requires significant investment in capacity and process improvement. This has been incorporated into spending plans. The risk is that current financial pressures in the NHS and conflicting priorities mean that funds are diverted to other priorities

Action: 18 week programme to ensure that the 18 week pathway is given the necessary priority within the NHS and the Department to help secure the necessary funding

Description:

Indications are that the next comprehensive spending review will provide for much slower budget growth for the period after March 2008. The risk is that insufficient funding is available to deliver required reform and increased capacity needed to achieve an 18 week pathway.

Additionally:

1. Current budget pressures on the NHS and competition for limited funds
2. Uncertainty about financial situation post March 2008
3. Increase in unmet demand accompanies service improvement resulting in high running costs

Delays or change to System Reform

The incentives arising from system reform are key to delivering the 18 week pathway. Delays, for example to development of PbR (tariffs) and PBC will impact on delivery.

Action: 18 week programme to ensure implications of delays to system reform are visible at the highest level in the Department and that focus is given to address key issues

Tolerance levels & Patient Choice

The decision to include patients choosing to wait longer than 18 weeks within the target tolerance may mean that the tolerance has to be unrealistically low. If this is the case, it risks not being credible with the public. A review of the methodology for the tolerance will take place in autumn 2006 and a final decision to set the tolerance will be made in April 2007.

Diagnostic independent sector wave two activity

Risk that the diagnostic independent sector capacity in wave two of the independent procurement slips and capacity is not available in time to reduce the stock of patients currently waiting sufficiently by 2008. Mitigation will be to include interim schemes.

Wave two elective procurement

Risk that wave two elective procurement does not deliver in time. Elective procurement will not deliver in time to allow stock to be reduced as planned to achieve 18 weeks. Mitigation will be to include interim schemes.

Demand Management through Practice based Commissioning

Risk that the model of Practice based Commissioning implemented in some health communities will not be sufficient to manage demand effectively or the information to enable practices to manage effectively will not be available in time. Mitigation is to monitor progress closely and to identify issues early enough for further support and intervention.

Commissioners not enabled due to organisational change

Commissioners have a key role to plan in the delivery of the 18 week pathway and sustainably managing demand. In the short term, reorganisation could create a hiatus which will mean that the right capabilities are not applied to the issues.

Action: 18 week programme to closely monitor reorganisation plans and identify where tailored support is needed to address problems

Restructuring of SHAs / PCTs

With System Reform and the work required to restructure SHAs / PCTs there are many other pressing priorities. Focus may move off the 18 week pathway and / or resources are not available to concentrate on reducing waits. Mitigation through monitoring.

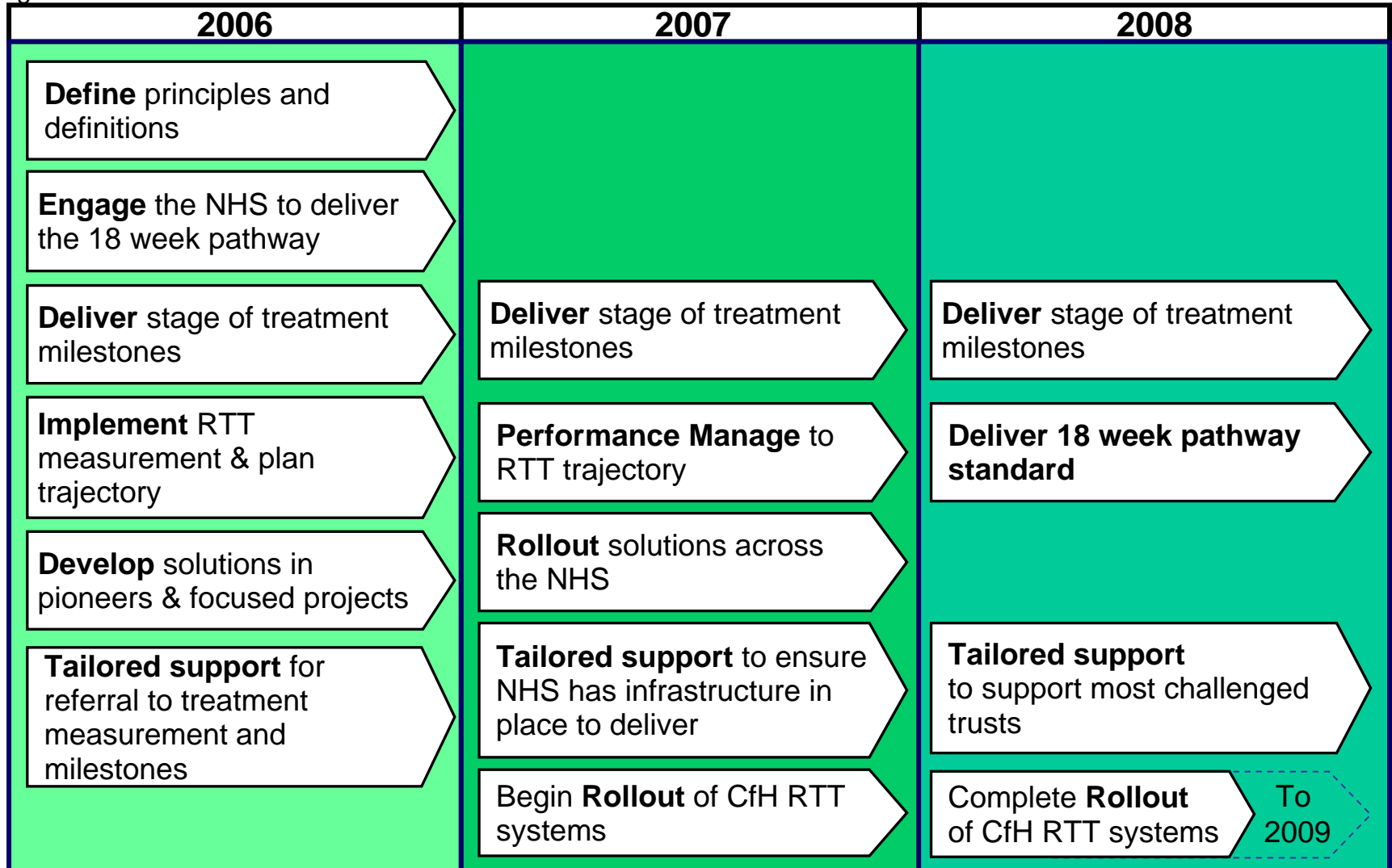
PCT / provider contracts & financial penalties for missing the target

Risk that by 2008 the mechanisms are not in place to sustain the standard of the 18 week pathway. At present there are two mechanisms envisaged for sustaining targets: the Healthcare Commission review of performance and the contracts between PCTs and Trusts. The RSU route should no longer be relied on for sustaining targets. At present the plan is for contracts between PCTs and providers to include financial penalties for not achieving the required standards. The 18 week pathway may not be achieved as financial penalties and contractual arrangements are insufficient and the performance management levers are too weak, taking into account the level of change required in trusts to achieve the 18 week pathway standard. Mitigation to be developed as part of the System Reform / 18 week pathway joint policy work for inclusion in rules for 2006/7 and beyond.

Next steps

Section 4

The roadmap shows the key themes for delivery in each year up to December 2008. Building on the preparatory work in 2005, measurement and developing solutions will be the focus of 2006. In 2007 we will concentrate on rolling out the solutions and begin to deliver the 18 week pathway. 2008 will be about securing delivery and providing support to the most challenged organisations.



① Referral to treatment measurement

Early measurement of referral to treatment is critical for the successful delivery of the 18 weeks pathway target. Failure to provide early visibility of referral to treatment pathways is emerging as the greatest risk to delivering the 18 week pathway.

① Clinical engagement

To effectively communicate the message of the 18 week pathway, and the 18 week pathway principles and definitions, a robust and inclusive engagement strategy is required to build on the existing momentum created by work on the principles, implementation framework and website, and focus clinicians on the challenges ahead.

① 18 week pathway data collection

Activity is required immediately to prepare for and implement an 18 week pathway baselining exercise, and start the groundwork required to refresh Local Delivery Plans to introduce national data reporting for referral to treatment pathways.

① Developing the performance management regime and setting the trajectory

Current efforts to define the 18 week pathway trajectory and develop an appropriate performance management regime must be continued; in particular, work is required to understand what levers and incentives are required to support a Commissioner-led target – this will include work as part of the developing model contract.

① National Projects for focused initiatives

Develop national projects for Endoscopy and Orthopaedics; begin further analysis work for Echocardiography.

① Service change pioneers

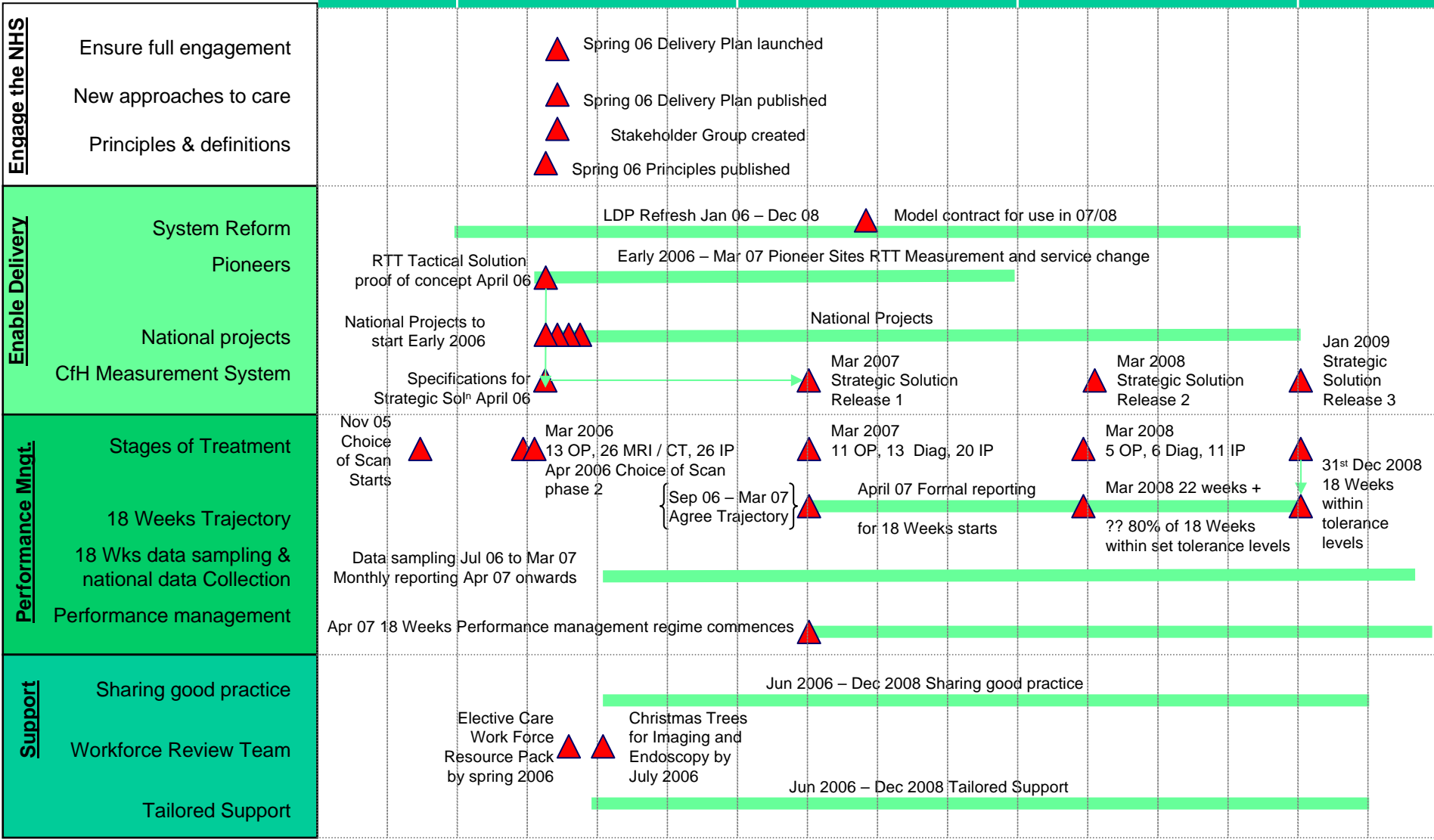
Building on the measurement work the scope of the pioneers will need to expand to cover service transformation. This will be in addition to work on measurement and not a replacement for it.

① Meeting the Choice of Scan and stages of treatment milestones

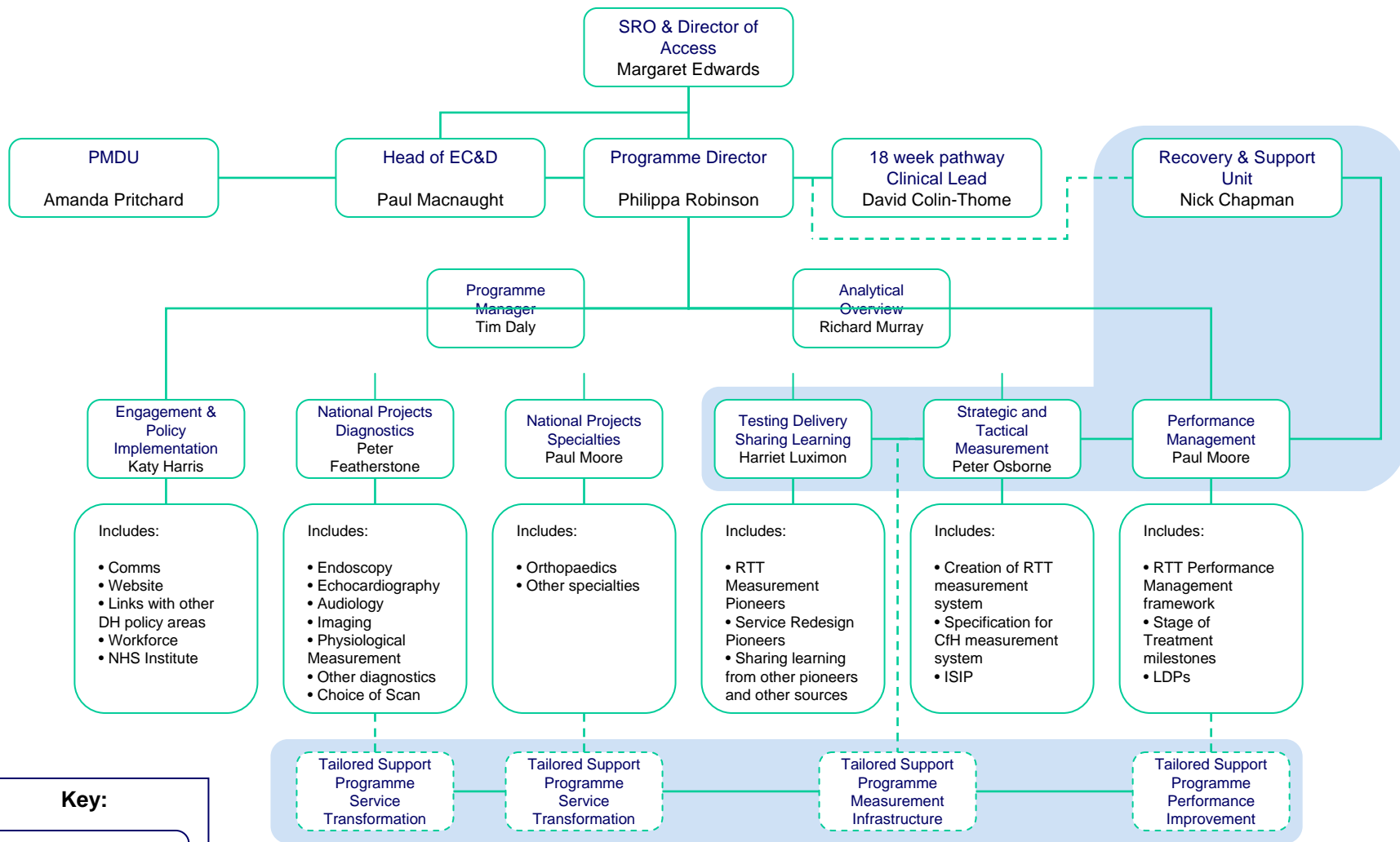
In the next period the NHS must focus on achieving the existing Choice of Scan and stages of treatment milestones. The Department needs to continue in its work to performance manage these targets.

Timeline

Task Milestone



18 week pathway programme governance & organisation



Key:

Role, Department or Project Lead

Projects grouped together

What the 18 week pathway will mean for patients and NHS in 2009?

Patients will receive the most appropriate treatment without any clinically unnecessary waits:

Waiting time will no longer be a significant issue for patients – there will be far shorter waits

Patient safety will be enhanced by managing pathways as an integrated process, with effective proactive movement between hospital departments, with clinicians and managers supported by real time pathway management information for their patients

Patient experience will be enhanced by a coherent pathway that ensures that patients never leave one part of their pathway without a booking for the next

Patient uncertainty will be reduced by faster access to diagnostic tests and quicker assessment of the required treatment

In a patient led NHS, commissioners will be accountable for performance through their contracts with providers:

Practice based commissioners will focus on ensuring patients are treated through the most appropriate pathways, with more activity close to home, reducing demand for secondary care

Commissioners will contract manage their providers to ensure that the right level of service is delivered to their patients

Providers will focus on being 'first choice' for patients, identifying and removing constraints in the pathways, rather than problem chasing individual patients

Costs in these providers will be reduced as inefficiencies and constraints are removed from the pathways