NHS Providers

THE 18 WEEK REFERRAL TO TREATMENT TIME (RTT) TARGET

A debate has been tabled in the House of Lords for Wednesday 6 September[1] on the appropriateness and process of relaxing the requirement for 92% of patients to be treated within 18 weeks of referral (the 18 week referral to treatment [RTT] target).

NHS Providers is the representative body of NHS hospital, ambulance, community and mental health services. Representing 97% of NHS foundation trusts and trusts, we set out in the briefing below:

- Details of the target, including current performance;
- What is happening to the target in 2017/18; and
- The need for an open, honest and realistic conversation about the target, and a managed process for any changes to it.

1) THE CONSTITUTIONAL STANDARD

The basis of the 18 week RTT target

Together, the NHS Constitution and the Handbook to the NHS Constitution establish that patients *"have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible"*, which includes the right to start *"consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions"*.[2]

The statutory basis of this right is contained in Part 9 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012. The regulations state that a relevant body (in this case, NHS England or a clinical commissioning group [CCG]) *"must make arrangements to ensure that at the end of each data collection period, not less than 92% of [relevant patients for which they are responsible] have been waiting to commence treatment for less than 18 weeks"*.[3]

Recent performance against the target

The 18 week RTT target has not been met for the last 16 months, with figures for June 2017 showing 3.8 million people are now on the waiting list and 92% of patients are waiting 19.5 weeks for treatment. This is the largest the list has been since December 2007 with the list growing by two thirds since January 2009. When adjusted for those trusts which did not report their data, the current list grows to an estimated 4 million people.[4]

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[1] House of Lords order paper for 6 September 2017 http://lordsbusiness.parliament.uk/ItemOfBusiness?itemOfBusinessId=35936§ionId=38&businessPaperDate=2017-09-06
[2] Department of Health, *NHS Constitution for England* (March 2012, updated October 2015) https://www.gov.uk/government/publications/the-nhs-constitution-for-england
[3] The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 http://www.legislation.gov.uk/uksi/2012/2996/contents/made
[4] Rob Findlay, *Health Service Journal*, 'Analysis: Waiting list tops 4 million as admission rates slump' (10 August 2017) https://www.hsj.co.uk/quality-and-performance/analysis-waiting-list-tops-4-million-as-admission-rates-slump/7020338.article; NHS England, Consultant-led Referral to Treatment Waiting Times https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/

The impact on patients of under-performance against the target

The patient experience and safety impacts of these delays is well known and is set out in recent commentary from the Royal College of Surgeons and the Patients Association.[5] These include:

- Patients have to live with the consequences of debilitating conditions longer;
- The risk of the condition worsening, requiring more complex, difficult and expensive treatment;
- Mental health and quality of life deteriorating;
- Added anxiety, frustration and distress as a result of treatment cancellations and uncertainty; and
- In the most extreme examples, conditions becoming permanent and untreatable.

The provider view of the 18 week RTT target

NHS trust leaders are committed to providing the best possible care for patients, meeting their NHS constitutional performance standards and achieving financial balance, including an appropriate degree of performance, productivity and financial stretch. Their strong and clear preference is for the NHS to be funded at a level that enables the average trust to deliver that aggregate task.

The constitutional standards were introduced and formally enshrined in legislation because they represent a reasonable and appropriate level of patient care – for example, when compared to standards offered in other advanced Western health systems. However, their delivery requires appropriate funding and, in the absence of that funding, difficult choices need to be made between competing priorities in allocating NHS resources.

2) THE RTT TARGET IN 2017/18

Provider request for 2017/18 prioritisation

Before the start of this financial year, it was clear that NHS foundation trusts and trusts would not be able to deliver all that was being asked of them, given that NHS cost and demand were due to increase by 5.2% but NHS England funding was only due to increase by 1.3%, compared to the 3.6% increase it received in 2016/17. NHS Providers' report, *Mission Impossible?* (https://nhsproviders.org/resource-library/reports/mission-impossible-the-task-for-nhs-providers-in-201718) sets this out in more detail.

Trust leaders argued that the national NHS leadership (the Department of Health, NHS England and NHS Improvement) had to make a decision about how to prioritise the service's resources in 2017/18 and what was deliverable given the gap between cost / demand and funding increases.

The national NHS bodies' view of the RTT target in 2017/18

NHS system leaders have adopted a different approach to the RTT target in 2017/18, as set out in two documents: *Government's mandate to NHS England for 2017-18* (the 2017/18 Mandate) and *Next steps on the five year forward view* (the FYFVNS).

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[5] Royal College of Surgeons, 'Winter pressures - what's happening in surgery?' (12 January 2017) https://www.rcseng.ac.uk/news-and-events/blog/winter-pressures/; The Patients Association, *Feeling the Wait - Annual Report on Elective Surgery Waiting Times* (November 2016) https://www.patients-association.org.uk/wp-content/uploads/2016/11/Waiting-Times-Report-2016-Feeling-the-wait.pdf

For 2016/17, the Mandate had required that NHS England, *"with NHS Improvement, meet the 18-week referral-to-treatment standard, including implementing patient choice in line with the NHS Constitution; and reduce unwarranted variation between CCG referral rates to better manage demand"*.[6] However, a year later, the Mandate for 2017/18 diluted the requirement and set the year's deliverables as including *"with NHS Improvement, meet agreed standards on A&E, ambulances, diagnostics and referral to treatment"*.[7]

Meanwhile, the FYFVNS stated that:

> *Looking out over the next two years we expect to continue to increase the number of NHS-funded elective operations. However given multiple calls on the constrained NHS funding growth over the next couple of years, elective volumes are likely to expand at a slower rate than implied by a 92% RTT incomplete pathway target. While the median wait for routine care may move marginally, this still represents strong performance compared both to the NHS' history and comparable other countries.*[8]

Together, these can be interpreted as recognition that performance against the 92% constitutional standard will not be achieved in 2017/18.

3) RECOVERING PERFORMANCE AGAINST THE TARGET

To restore performance against the 18 week target, the current c4 million waiting list would need to be cleared and performance against new referrals maintained. NHS Providers estimated in *Mission Impossible?* that catching up to an RTT target where 92% of people are seen within 18 weeks would cost a minimum of £2bn to 2.5bn.[9] Once this backlog has been cleared, trusts need to have sufficient capacity in place to maintain performance. It is impossible to predict how long the backlog would take to eliminate but past "elective waiting clearance exercises" have traditionally taken 12 to 18 months to complete, though the size of the list to clear is a key determinant.

Beyond funding, there are two further significant factors affecting the NHS' ability to clear waiting lists. Firstly, staffing levels are key to trusts being able to recover and maintain performance, but the sector is experiencing growing workforce pressures. Providers finding it increasingly difficult to recruit and retain sufficient staff with the skills and experience needed to meet the rising demand for services. Trusts are also struggling to match the staffing levels they require with the finances available.[10] The arm's length bodies would need to work closely with trusts to establish, enable and fund workforce requirements within the timescales required.

Secondly, the competing pressures on trusts in how they manage their finances and their delivery requirements must be reconciled. For example, to support performance against the 18 week target, the care of some elective patients was moved from the NHS to the private sector. However, trusts are now being encouraged to move that care back to the NHS in order to reduce their funding gap. As trusts do not consistently have the capacity to re-

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[6] The Department of Health, *NHS mandate 2016 to 2017* (December 2015, updated March 2017) https://www.gov.uk/government/publications/nhs-mandate-2016-to-2017
[7] The Department of Health, *NHS mandate 2017 to 2018* (March 2017) https://www.gov.uk/government/publications/nhs-mandate-2017-to-2018
[8] NHS England, *Next steps on the NHS five year forward view* (March 2017) https://www.england.nhs.uk/publication/next-steps-on-the-nhs-five-year-forward-view/
[9] See section 4.2.2, pages 17-19: NHS Providers, *Mission impossible: the task for NHS providers in 2017/18* (March 2017) https://nhsproviders.org/media/2727/mission-impossible-report.pdf?utm_source=resourcepage&utm_medium=link&utm_campaign=missionimpossible&utm_content=report%20pdf
[10] NHS Providers, *The state of the NHS provider sector* (July 2017) https://nhsproviders.org/resource-library/reports/the-state-of-the-nhs-provider-sector

absorb those patients, there is a danger that additional scheduled elective care then has to be cancelled. This neither delivers the care that patients need nor improves trusts' financial outlook.

4) HONESTY AND REALISM IN EXPECTATIONS OF NHS PERFORMANCE

We should not maintain a fiction around what the NHS can deliver given current demand increases, workforce shortages and sustained levels of funding increase that are well below historic averages. To do so carries several risks, including:

- Misleading the public as to what is now deliverable on the funding levels available. It also prevents the mature debate that is now needed about how, as a nation, we will meet rapidly growing healthcare needs on an inevitably constrained amount of public expenditure. It also risks undermining public confidence in the NHS;
- Preventing the NHS from properly planning and allocating scarce resources where they could provide maximum benefit. If trusts seek to meet a range of different, impossible-to-deliver targets they are more likely to miss all of them. Delivering a smaller range of priorities should maximise overall benefit for the money spent;
- Placing an unsustainable burden on frontline staff, adversely affecting their morale and engendering a constant sense of failure as they work harder but fail to deliver requirements that NHS system leaders publicly argue are deliverable.

We recognise the sensitivity of this debate. However, it is not in the patient, taxpayer or NHS staff interest to obscure or avoid the reality of NHS performance and funding. The NHS Constitution exists to set the benchmark and ensure public debate if standards are not met.

5) REVIEWING NHS DELIVERY PRIORITIES

NHS Providers has been arguing for some time that the current NHS strategic context means difficult decisions must now be made about NHS priorities. While we welcome the implicit acknowledgement by the national NHS bodies in the FYFVNS that delivery of the 18 week RTT target in 2017/18 is unrealistic, we believe it is important that any decisions on target performance should be made through an open, transparent, formal review and decision making process.

This needs to be done at a national level. Failure to do so just pushes decisions on priorities and compromises to a local level. While it is right that local providers and partnerships are closely involved, the NHS Constitution requires the national NHS bodies to be absolutely clear about the service's priorities. Choices to reduce standards are political, wherever these decisions are made. The NHS Constitution deliberately set out clear expectations on what the public should expect from local NHS services. It should not be altered community by community, but only through a clear, transparent, national decision.

Any review of the RTT target needs to include:

- Establishing a realistic and transparent delivery trajectory, assuring it against both funding and workforce levels for the given timescale. There is performance and delivery risk in privately or informally working on the basis that the target will not be met but then failing to set a clear, lower, performance delivery trajectory;

- Rigour and clarity about the cost, time and staffing required to regain the standard. As outlined above, NHS Providers estimates a minimum £2-2.5 billion cost to clear the backlog to regain the standard. There will be inevitable pressure on national NHS leaders to regain the standard as quickly and as cheaply as possible. Any commitment must be fully assured as deliverable, avoiding any sense of over promising;
- Trust involvement in the review process from end to end to ensure there is appropriate ownership of the delivery task and legitimate input and challenge to NHS arm's length body assumptions;
- If the target is to be missed for an extended period, seeking to amend the regulations, with parliamentary approval gained as appropriate and, in turn, amendment of the NHS Constitution and its Handbook; and
- Providing a clear statement of policy communicated to the NHS and the public.

6) CONCLUSION

There are significant demand, funding and workforce pressures building within the NHS. There needs to be an open and honest debate, informed by frontline trusts, on how these pressures should be managed and how any prioritisation of resources impacts on performance standards including NHS Constitutional standards. While other public services have been able to change service standards and eligibility criteria without significant public debate, the NHS – through the NHS Constitution – operates according to a different standard and process.

Any debate on these issues needs to reach a clear conclusion, establishing how the Government and NHS leadership wishes to prioritise delivery requirements. In turn, to enable that prioritisation, trusts need a realistic funding allocation, sufficient workforce capacity, and an appropriate performance trajectory.

The consequences of delaying this process are building, with patients facing growing uncertainty and an accelerating dissonance between expectations and reality. Without a clearer path to resolving the competing pressures that trusts face, other targets – including the recovery of the four-hour A&E target – are vulnerable and may likewise need to be reassessed.

Contact: Ferelith Gaze, senior public affairs manager, ferelith.gaze@nhsproviders.org