Waiting List and Waiting Times Policy (OP-001)

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Author (name & job title)	Claire Jenkinson, Deputy Chief Operating Officer Pauline Antcliff, Access and Performance Manager
Executive Lead (name & job title):	Lynn Parkinson, Chief Operating Office
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Date EMT as approving body notified for information:	

Policies should be accessed via the Trust intranet to ensure the current version is used

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1. INTRODUCTION

This policy outlines arrangements for the management of waiting lists to ensure patients receive timely and equitable access to treatment in line with national access standards and locally defined waiting time standards.

This policy and procedure details out how referrals will be managed to ensure that each patient's journey is managed fairly and consistently. At an operational level this translates into the adoption of the following key principles:

- Patients will be seen according to clinical priority and then in chronological order.
- The policy is in addition to the national policy on RTT waiting times and National Mental Health Access Standards and does not seek to contradict or contravene those policies and guidance, just add to them to provide local context.
- That patient choice will be facilitated where appropriate
- The patient referral to treatment pathway will be defined by the service specification agreed with commissioners. Where a service specification does not exist Humber Teaching NHS Foundation Trust will define the pathway in conjunction with commissioners.
- The management of patients will be fair, consistent and transparent and communication with patients and/or carers will be clear and informative, and decisions taken regarding treatment will be based first and foremost on clinical need.

There are a number of core principles upon which the Trust will base its approach to waiting list management. The right to start treatment may not be appropriate if:

- The patient chooses to wait longer.
- Delay in the start of treatment is in the best clinical interest of the individual.
- Treatment requires completion of a sequence of tests that will take longer than 18 weeks or locally defined waiting times.
- It is clinically appropriate for the individual to be monitored without clinical intervention or diagnostic procedures.

Guiding principles on waiting list management and the 'Rules' relating to waiting lists can be found in Appendices A and B.

Integrated Care Boards (ICBs) have been established and are responsible for performance oversight within their Integrated Care System (ICS). The Trust is accountable to the ICB for improving waiting times by ensuring national and locally defined waiting times are achieved.

The NHS Constitution outlines that patients/service users should wait no longer than 18weeks from Referral to Treatment (RTT). Whilst this has been long referenced in physical health services, Achieving Better Access to Mental Health Services by 2020 was published in October 2014 which introduced the first national waiting time standards for mental health.

The below table lists the current national mental health access standards:

Indicator	Service Area	Description/calculation	Standard
Urgent cases should be seen within 24 hours of referral	Mental Health Front Door Services	For an urgent referral to a community based mental health crisis service, a patient should be seen within 24hours from referral, across all ages	90%

Indicator	Service Area	Description/calculation	Standard
Urgent cases should be seen within 24 hours of referral	Mental Health Front Door Services	For a very urgent referral to a community based mental health crisis service a patient should be seen within 4hours from referral across all age groups	95%
Patients referred from Accident and Emergency should be seen face to face within one hour, by mental health liaison or children and young people's equivalent service	Mental Health Liaison Service	Patients referred from Accident and Emergency should be seen face to face within one hour, by mental health liaison or children and young people's equivalent service	80%
People with a first episode of psychosis begin treatment with a NICE-recommended care package within two weeks of referral (UNIFY2, moving to Mental Health Services Data Set – MHSDS)	Early Intervention in Psychosis	More than 60% of people experiencing a first episode of psychosis will start treatment within a NICE-recommended package of care with a specialist early intervention in psychosis service within two weeks of referral	60%
Improving Access to Psychological Therapies (IAPT)/talking therapies .waiting time to begin treatment (from IAPT minimum dataset): i) within 6 weeks ii) within 18 weeks	IAPT Services	Percentage of people waiting i) six weeks or less from referral to entering a course of talking treatment under Improving Access to Psychological Therapies (IAPT) ii) 18 weeks or less from referral to entering a course of talking treatment under IAPT	i. 75% ii. 95%
Children and young people in need receive treatment within one week for urgent cases (i), and four weeks for routine Cases (ii).	CAMHS Eating Disorders	95% of children and young people referred for assessment or treatment for an eating disorder should receive NICE-approved treatment with a designated healthcare professional within one week for urgent cases and four weeks for every other case	95%

Indicator	Service Area	Description/calculation	Standard
Measuring waiting times in non-urgent community mental health services for adults and older adults	Adult and Older adults Community based mental health services	Adults and older adults presenting to community-based mental health services should start to receive help within four weeks from request for service (referral). This may involve the start of a therapeutic or social intervention, or agreement about a patient care plan.	None set yet.

2. SCOPE

This policy applies to all patients referred to the Trust for assessment and treatment, and for all members of staff employed by the Trust. In particular, it applies to those staff involved in delivering or supporting direct clinical care.

3. POLICY STATEMENT

Humber Teaching NHS Foundation Trust aims to provide the highest quality of care to its service users and minimise the risk of any harm or distress to them in all service areas, both clinical and non-clinical. The Trust recognises the need to specify the principles and responsibilities concerning the management of referral to treatment pathway for our patients.

4. DUTIES & RESPONSIBILITIES

The following are required to instigate appropriate actions to ensure the successful implementation of the policy within their area(s) of control.

Chief Executive
To assure the Board that this policy and associated standard operating procedures are acted on through delegation to the appropriate divisions and committees.

Trust Board
To ensure that this policy is acted on through delegation of responsibility for the implementation of the policy to the appropriate directors and committees.
To ensure that the policy, procedures and guidelines comply with UK law requirements.
To ensure the policy and procedures are monitored and reviewed formally through the appropriate committees.

Chief Operating Officer
The Chief Operating Officer will ensure that this policy is acted on by Directors and Assistant Directors through a process of policy dissemination and implementation in collaboration with Trust Senior Managers.

Divisional General Managers
Responsible for the application of the policy for the Service and the delivery of national and local targets. In addition, they are responsible for the development, quality assurance implementation and

monitoring of each service specific standard operating procedure which is based on the agreed service specification.

It is the responsibility of the General Managers to ensure waiting list validation occurs via appropriate personnel and that there is appropriate representation at the weekly waiting list performance review meetings; designed to provide assurance of validity of waiting lists and effective implementation of Standard Operating Procedures.

Assistant Divisional General Managers, Service Manager, Team Manager and Unit Managers
Responsible for the implementation of policy and adherence to the service specific associated Standing Operating Procedures, including training for relevant staff groups in their areas of responsibility.

Information, Performance Management Teams and Clinical Systems Team
Provide appropriate performance reports, technical advice, systems support and tools to ensure the Trust to manage referral to treatment pathways.

Oversight of waiting list performance, ensure adherence to waiting list policy, support with development of improvement plans and monitoring.

Employees
All employees will comply with this and any other associated policies and procedures.

5. PROCEDURES

Standard operating procedures based on the agreed service specification will be created for each service. This will be carried out in accordance with this policy.

Each procedure will include the following;

- Referral Criteria including Minimum Data Set (MDS)
- Referral Process
- Exceptions
- Triage of New Referrals
- Management of Referrals
- Waiting List Management
- Offering Appointments
- Management of cancelled appointments and operations (patient or Trust caused)
- Management of Do Not Attend (DNA) Appointments
- Management of patient risk and escalation
- Consideration of the safeguarding of vulnerable service users with regard to the management of Do Not Attend Appointments/discharge back to referrer

The standard operating procedures will be critical in the effective management of waiting times. They will be robustly adhered to and monitored via a programme of clinical audit and performance management.

6. EQUALITY & DIVERSITY

An Equality and Diversity Impact Assessment has been carried out on this document using the Trust approved EIA.

7. IMPLEMENTATION

This policy will be disseminated by the method described in the Policy and Procedural Documents Development and Management Policy.

The General Manager for each directorate will be responsible for addressing the implementation of the policy within their services, The General Managers, Service Managers and Matrons will ensure the policy is embedded within the service areas.

The policy will be circulated within the Trust's Global communication ,and will be available on the Trust intranet.

All staff have a responsibility for ensuring that this policy is effectively implemented. This policy does not require additional financial resource.

8. MONITORING & COMPLIANCE

Compliance of this policy will be monitored by:

- Executive meetings by the Chief Operating Officer
- Presentations of the senior operational and clinical teams to the Operational Performance and Risk Meetings.
- All levels of performance management meetings including Divisional Business Meetings
- Performance and Access Manager via weekly waiting list review and validation meetings

Action plans and Standard Operating Procedures required to support the compliance to the waiting list policy will be developed and managed by operational services with support from corporate services. The performance information will be provided by the performance management team on a monthly basis.

Waiting time information will be provided to commissioners on a monthly basis. Exception reports will be provided for any services non-compliant with the national standards or the locally agreed standards.

9. REFERENCE TO ANY SUPPORTING DOCUMENTATION

The NHS Constitution for England, DoHSC

Achieving Better Access to Mental Health Services by 2020, NHSE

Was Not Brought and No Engagement Policy, Trust Intranet

Mental Health Capacity Act

APPENDIX A – WAITING LIST MANAGEMENT

IMPROVING WAITING TIMES

To be effective, plans to improve waiting times should take account of the entire waiting time journey, commencing with the initial outpatient referral and working through assessment and where appropriate diagnostic tests to treatment and discharge.

To effectively develop plans to improve waiting times, each service should:

Manage Demand – Ensuring each referral represents the most appropriate decision for the care of the individual patient.

Manage the Queue – Ensuring waiting lists are well managed and patients are called for treatment in appropriate order.

Manage Capacity – Provide efficient and effective services that meet the level of demand from appropriate referrals. Where capacity is acknowledged to be insufficient to meet demand discussions should be held via Divisional ODG meetings to agree the most appropriate means of addressing the gap in service. This should also be discussed at the Trust level ODG and Performance and Productivity meetings.

Provide Leadership – Ensuring that all internal services work together to achieve waiting time improvements in the best interests of patients.

MANAGEMENT OF DEMAND

- Referral protocols should be utilised as appropriate to identify the most effective referral options for patients and the most effective use of both primary and secondary care resources.
- The number of referrals received is the initial indication of demand for services. The referral process should be actively managed and the number of referrals received should form a basis for calculating the level of services to be provided now and in the future.

MANAGEMENT OF THE QUEUE

- A waiting list is simply a queue of patients waiting for assessment or treatment. Every patient waiting in this queue has a valid expectation of treatment within a reasonable period of time. Waiting lists should be regularly reviewed to ensure they are accurate and it should be possible at any time to access up-to-date information on any individual patient on the list.
- Patients should be called from a waiting list in order of clinical priority and within agreed waiting time standards. Patients with similar clinical priority should be seen predominately in chronological order.
- Capacity for urgent referrals should be kept within the daily plan.
- Regular contact should be made with patients in the queue to ensure that their condition has not deteriorated in accordance with the Standard Operating Procedure for the service.

MISSED APPOINTMENTS, DNA/WNBs and No Engagement

Disengagement by a family/parent/child may be partial, intermittent, or persistent. It is important to be aware that this may be a signal of increased stress within a family and/or potential abuse or neglect of children and or adults at risk. It is important to identify early signs of disengagement so

that any potential risk to a child young person or adult at risk can be assessed. Refer to **Was Not Brought and No Engagement Policy**

MANAGEMENT OF CAPACITY

Waiting time standards should be delivered on the basis of a clear capacity plan. Referrals indicate the level of demand and the waiting list shows clearly how many patients are waiting and how long they are waiting. It should therefore be possible at any time to assess the level of capacity required to maintain a waiting time standard.

Potential pressures on waiting time standards should be identified at an early stage, for instance an increase in the number of outpatient referrals, additions to the waiting list, emergency referrals or reduced team capacity. Regular and effective performance review will identify requirements for management action which should be taken to ensure waiting time standards are maintained.

The number of patients treated is related to the efficiency of services. The effective utilisation of resources, for instance specialists (e.g. psychology) should be ensured through regular management against agreed efficiency targets.

LEADERSHIP

Each service should have a detailed and comprehensive plan setting out the manner by which waiting time standards will be achieved and maintained. This plan should address the requirements of all patient groups who wait for treatment and address services from primary care through assessment and investigation to discharge from the treatment process.

Waiting Time improvement should not be seen as the responsibility of the above team. All of those involved in the care of patients who wait for treatment have a responsibility to ensure that patients are well informed, supported and wait as short a time as possible. Waiting time information for all services will be shared with commissioner via contract meetings.

WAITING LIST INITIATIVES

INCREASING CLINICAL ACTIVITY TO IMPROVE WAITING TIMES

Additional activity to improve waiting times may be provided for two purposes:

- The short-term requirement to treat a “backlog” of patients on a waiting list and achieve an improved waiting time.
- The long-term requirement to close any on-going gap between the number of patients joining a waiting list and the number of patients leaving a waiting list.
- Any additional waiting list initiative activity must be authorised by the Divisional General Manager

CLOSING THE GAP BETWEEN DEMAND AND CAPACITY

Closing a recurrent gap between demand and capacity requires a different approach from treating a non-recurrent backlog of patients from the waiting list. It is necessary to project the expected recurrent difference between the number of patients joining the waiting list and the number of patients leaving the waiting list. Efficiency measures and additional resources should be agreed as appropriate to bring into balance the number of additions to, and removals from, the waiting list.

It should always be understood that the non-recurrent requirement to treat a backlog of patients on the waiting list is not the same as the recurrent requirement to close any gap

between demand and capacity. The first approach may ensure that a waiting time standard is **achieved**; the second approach is designed to ensure that the standard is **maintained**.

THE 10 GOLDEN RULES FOR WAITING TIME MANAGEMENT

1. The patients' interests are paramount.

2. Referrals for health care services should be clinically appropriate and directed towards the most suitable service.

3. Adequate services should be available to meet appropriate referrals for assessment and treatment.

4. Patients should be offered care according to clinical priority and within agreed waiting time standards.

5. Patients should be advised of any waiting time standard that applies to their treatment and kept up-to-date on their expected waiting time.

6. Health care services should maintain accurate and complete information on patients waiting for treatment and provide patients with clear guidance to be followed when notifying any changes in contact details or availability for treatment.

7. Patients should be clearly advised of the action that will be taken if they fail to attend for an appointment and failures to attend should be minimised.

8. Improvements in waiting times should be delivered through an effective partnership between Primary and Secondary Care, with appropriate protocols and documentation in place for referral and discharge.

9. The factors which influence waiting times, such as changes in referral patterns, should be regularly monitored and management action taken in sufficient time to ensure waiting time standards are maintained.

10. Leadership and accountability for the improvement of waiting times should be explicit within each service area and staff should be adequately trained to ensure waiting times are managed and administered effectively.

APPENDIX B – WAITING LIST RULES AND GUIDANCE

What STARTS the clock?

Upon receipt of a referral for an NHS commissioned service from an appropriate and permitted care professional.

Upon receipt of a self-referral by a patient where these pathways have been agreed locally and upon ratification by a care professional permitted to do so

What STARTS a NEW clock?

Upon the decision to start a substantively new or different treatment/care plan that does not already form part of that patient's agreed care plan

When a decision to treat is made following a period of active monitoring

When the patient rebooks their appointment following a first appointment that was DNA'd that may have stopped and nullified their earlier clock

What STOPS the clock?

When first definitive treatment is commenced or in any of the following scenarios:

- First Definitive Treatment – intended to manage a patient's disease, condition or injury
- Start of Active Monitoring initiated by the patient or by the care professional
- Decision Not to Treat – must be communicated to the patient and referrer
- Offer of treatment is declined by the patient
- Commencement of watchful wait / active monitoring
- Patient is discharged back to the referrer
- Start of Assessment – assessment pathway only

What is First Definitive Treatment?

"An intervention intended to manage the patients' disease, condition or injury and avoid further intervention. It is a matter of clinical judgement in consultation with the patient."

What are Active Monitoring and Watchful Wait?

When it is clinically appropriate to start a period of monitoring without clinical intervention or diagnostic procedures.

Note – if a decision to treat is made at a later date then a NEW clock starts.

What can PAUSE the clock?

In line with the NHS Referral to Treatment consultant-led waiting times, there is no provision to pause or suspend an RTT waiting time clock under any circumstances.

APPENDIX C – DOCUMENT CONTROL SHEET

Document Type	Policy – Waiting List and Waiting Times Policy		
Document Purpose	This policy outlines how referral to treatment pathways will be managed to ensure safe and consistent delivery of care		
Consultation/ Peer Review:	Date:	Group / Individual	
list in right hand columns consultation groups and dates ->		Existing Document reviewed and refreshed to ensure alignment with current waiting time standards, references and processes. Mental Capacity Section reviewed by Mental Health Act Clinical Manager	
	20.04.23	Business Intelligence Lead	
	25.04.23	Operational Delivery Group	
Approving Committee:	ODG	Date of Approval:	TBC
Ratified at:		Date of Ratification:	
Training Needs Analysis: *(please indicate training required and the timescale for providing assurance to the approving committee that this has been delivered)*	Refresh of existing document – reflects existing process – no training required	Financial Resource Impact	N/A
Equality Impact Assessment	Yes [x]	No [ ]	N/A [ ] Rationale:
Publication and Dissemination	Intranet [x]	Internet [ ]	Staff Email [ ]
Master version held by:	Author [ ]	HealthAssure [x]	
Implementation:	*Describe implementation plans below - to be delivered by the Author:*		
	Intranet EMT Headlines/Global Communication Direct email to General Managers highlighting key changes		
Monitoring and Compliance:	Monitoring and compliance evidenced via weekly waiting list performance meetings and other performance assurance meetings and methods		

Document Change History:			
Version Number / Name of procedural document this supersedes	*Type of Change i.e. Review / Legislation*	*Date*	*Details of Change and approving group or Executive Lead (if done outside of the formal revision process)*
1.0	*New Policy*	*July 15*	*New policy created. Localisation of policy to reflect mental health and community services. Include structure of the Standard Operating Procedure (SOP) for waiting list management Amendments after review with Service Team Amendments after consultation with Commissioners Amendments to SOP after review with RPIT service Minor amends to job titles and committee names*
1.1	*Minor review*	*Dec 16*	*Review and updated to reflect new national waiting times targets for mental health Guidance for the Standard Operating Procedure strengthened.*
1.2	*Minor review*	*Jan 18*	*Amendments to wording around the 'pause clock' section Review following feedback from Hull & East Riding CCG Signed off by Director 24 Jan 2018*

1.3	*Minor review*	*3 Mar 20*	*Minor review. Approved at ODG.*
2.0	*Review*	*25 April 23*	*Minor amendment of wording to Mental Capacity section* *Introduction section reviewed and rationalised* *Introduction section updated to reflect current performance oversight arrangements and current national mental health access standards* *Scope section rationalised – no changes to scope defined* *Duties and Responsibilities – updated to reflect current titles and new Access and Performance manager role* *Bribery Act Section – discussed with Iain Omand, removed as not relevant to policy* *Monitoring and Compliance Section – addition of Performance & Access Manager role and responsibilities included* *Reference to Supporting Documents – added* *Appendix A – rationalised* *Appendix B – rationalised and refreshed against RTT rule suite* *Document Control Sheet updated* *Equality Impact Assessment Added.* *Approved at ODG (25 April 2023).*

APPENDIX D – EQUALITY IMPACT ASSESSMENT

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document of Process or Service Name: **Waiting List and Waiting Times Policy**
2. EIA Reviewer (name, job title, base and contact details): **Pauline Antcliff, Performance & Access Manager**
3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other? **Policy**

Main Sims of the Document, Process or Service
To set out the process associated with referral and waiting list management to ensure fair and equitable access to services based on clinical priority and need
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the proforma

Equality Target Group	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed? Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	How have you arrived at the equality impact score? f) who have you consulted with g) what have they said h) what information or data haveyou used i) where are the gaps in your analysis j) how will your document/processor service promote equality and diversity good practice
10. Age 11. Disability 12. Sex 13. Marriage/Civil Partnership 14. Pregnancy/Maternity 15. Race 16. Religion/Belief 17. Sexual Orientation 18. Gender re-assignment		

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people, Young people, Children, Early years	Low	Policy will ensure fair and equitable access to services based on clinical need and appropriateness
Disability	Where the impairment has a substantial and long-term adverse effect on the ability of the person to carry out their day-to-day activities: Sensory, Physical, Learning, Mental Health (and including cancer, HIV, multiple sclerosis)	Low	Policy will ensure fair and equitable access to services based on clinical need and appropriateness
Sex	Men/Male, Women/Female	Low	Policy will ensure fair and equitable access to services based on clinical need and appropriateness
Marriage/Civil Partnership		Low	Policy will ensure fair and equitable access to services based on clinical need and appropriateness
Pregnancy/Maternity		Low	Policy will ensure fair and equitable access to services based on clinical need and appropriateness
Race	Colour, Nationality, Ethnic/national origins	Low	Policy will ensure fair and equitable access to services based on clinical need and appropriateness
Religion or Belief	All Religions Including lack of religion or belief and where belief includes any religious or philosophical belief	Low	Policy will ensure fair and equitable access to services based on clinical need and appropriateness
Sexual Orientation	Lesbian, Gay Men, Bisexual	Low	Policy will ensure fair and equitable access to services based on clinical need and appropriateness

Gender Re-assignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Low	Policy will ensure fair and equitable access to services based on clinical need and appropriateness

Summary

Please describe the main points/actions arising from your assessment that supports your decision above	
EIA Reviewer: Pauline Antcliff	
Date Completed: 21/04/23	Signature: P Antcliff