Waiting List Management Procedure

The key messages the reader should note about this document are:

* This procedure contains the operating principles for the management of waiting lists, to ensure service users receive timely, equitable access to treatment in line with national access standards and the NHS Constitution.
* Referrals to the Trust will clearly include:
* Date/time of referral
* Details of the referrer
* Details of the person referred
* Pathway for referral
* Reason for referral
* Goal or outcome of the proposed treatment pathway
* Working diagnosis.
* Cases of non-attendance by people assessed as at risk should be escalated immediately.

This policy/procedure may refer to staff as qualified/registered/professional or other such term to describe their role. These terms have traditionally referred to individuals in a clinical role at band 5 or above. Please note that the use of these terms **may or may not** include nursing associates or associate practitioners (band 4). For clarification on whether a nursing associate or associate practitioner is an appropriate person to take on the identified roles or tasks in this policy/procedure please refer to the job description and job plan for the individual, or local risk assessment.

**DOCUMENT SUMMARY SHEET**

ALL sections of this form must be completed.

|  |  |
| --- | --- |
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**Amendment detail**

|  |  |  |
| --- | --- | --- |
| **Version** | **Amendment** | **Reason** |
| 1 | New procedure | This procedure is required to set out the arrangements for the management of waiting lists |

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# THE PROCEDURE

# Introduction

This procedure outlines the waiting standards and processes for referrals into the Trust’s services, where the services operate waiting lists. This procedure is not applicable to inpatient services, where processes are defined in the [Bed Management](https://www.dpt.nhs.uk/resources/policies-and-procedures/clinical/bed-management) and [Inpatient Admission, Transfer and Discharge Policies.](https://www.dpt.nhs.uk/resources/policies-and-procedures/clinical/admissions-transfer-and-discharge)

This procedure provides a set of overarching principles for the management of referrals and waiting lists. However, it is recognised that all services which operate waiting lists will do so in different ways, therefore, each service will develop its own Standard Operating Procedure (SOP) by which it will operate. Nothing in the Service Line SOPs will contradict the principles set out in this procedure.

* 1. **Purpose**

The purpose of this procedure is to state the arrangements for the management of waiting lists and to ensure service users receive timely, equitable access to treatment in line with national access standards and the NHS Constitution. The procedure also includes the guidelines and procedures to ensure that waiting lists are managed effectively and that the offer of a high quality of care to service users is maintained.

* 1. **Definitions**
  + **Referral to Assessment [RTA]** – Applies where a referral is made to the Trust for assessment of a person’s potential for requirement of secondary Mental Health Services.
  + **Referral to Treatment [RTT]** – Applies where a referral is made to a medical consultant-led mental health service, regardless of setting. It also applies where a GP (or other referrer) makes known their intention to refer to a mental health medical consultant (for example, a consultant psychiatrist), even though they may refer through a mental health interface service. Referrals from primary care to mental health services that are not consultant-led (which may include multi-disciplinary teams and community teams run by mental health trusts) irrespective of setting, do not start an RTT clock.
    - Decisions about which services are medical consultant-led are ones that must be made locally, in line with the national definition of consultant-led, that is where a consultant retains overall clinical responsibility for the service, team or treatment.
    - Mental health trusts that provide services/pathways that fall within the scope of RTT should submit a return.
* **First definitive treatment for mental health** is defined as with all other specialties, that is ‘an intervention intended to manage a patient’s disease, condition or injury and avoid further intervention’. It is recognised that sometimes it is difficult to identify the start of first definitive treatment in mental health pathways. However, ultimately this must be a local clinical decision and it would not be appropriate to issue prescriptive national guidelines defining the start of treatment in the context of mental health. [NHS England 2015]
  1. **Duties**

The **Trust Board** will define the Trust’s policy in respect of Waiting Times, taking into account legal and NHS requirements. The Board is also responsible for ensuring that sufficient resources are provided to support the requirements of the policy.

**Managers** within the Trust are responsible for ensuring the procedure and supporting standards and guidelines are built into local processes and there is on-going compliance.

**All staff**, whether permanent, temporary or contracted, and contractors are responsible for ensuring they are aware of the requirements incumbent upon them and for ensuring they comply with these on a day-to-day basis.

**General Practitioners** (GP’s). The doctor of a person using the Trust’s services can play a pivotal role in the care of those people who have a history of not engaging with services. If there is an expectation that their GPs will have a role in notifying the Trust of non-attendance or concerns regarding non-attendance then this should be incorporated in the individual’s recovery plan. This will be documented and agreed with the individual’s GP who should be named in the service user’s CareDirector record along with their surgery contact details.

* 1. **General standards applied across Trust services**

The Trust aims to provide a range of services that are delivered in the right place, at the right time, are personalised to the needs of the individual and promote the greatest possible ease of access; for first time users and those who are re-referred.

The Trust is committed to ensuring equality of access to our services and will endeavour to ensure that arrangements are made to support those individuals who have a communication or support need, for example for those who communicate through British Sign Language or for where English is not their first language. We recognise that we may need to make reasonable adjustments for those who have a disability in order that they are able to access the services we provide.

* 1. **Referrals**

The referral will clearly include:

* Date/time of referral
* Details of the referrer
* Details of the person referred
* Pathway for referral [where possible]
* Reason for referral
* Goal or outcome of the proposed treatment pathway [where possible]
* Working diagnosis [excluding self-referrals]
* Any current risks identified
* Any risk history
* Known safety network contact details.

Where the referral contains insufficient information, this should be returned by the team within the timescales of the Service SOP, clearly identifying what further information is required and what timescale the referrer is working to, before a subsequent new referral will be required.

The level of risk of harm to themselves or others, where indicated, must be ascertained, and plans made to see the person based on the risk assessment, information received and good practice. This will mean making a clinical judgement on referral information provided (if comprehensive) or phoning the referrer to gather more information.

The self-referral process should be clearly outlined in the Service SOP for services that allow self-referral.

* 1. **Referral management**

The referrer will assume the referral is accepted unless a clear explanation of why the referral is not accepted within the timescales as defined in the Services SOP is made to the referrer and documented in the Service User’s CareDirector Record.

Requests for more information for the referral will be requested and expected within the timescales as defined in the Services SOP.

With regard to assessment and treatment, the ‘clock’ will not begin until sufficient information is received from the referrer by the assessment/treatment team.

Priority referrals are defined in the service specific SOPs.

* 1. **Breaching of waiting times for assessment or treatment**

Breaches will be monitored and reported in line with the Service SOPs.

* 1. **Booking Appointments**

It is good practice that appointments should, wherever possible, be arranged in person with individuals. In addition, a minimum offer of two appointments on different days, with at least three weeks’ notice, should be provided. However, clinical needs may dictate that such a notice period may not be appropriate even for routine referrals, with assessments commenced within days of referral, not weeks.

The ‘three week rule’ and ‘offer of appointment choices’ are tests of reasonableness to avoid situations where individuals feel they have been offered an appointment that is too soon, or difficult to attend due to existing commitments. While these specific tests may not always be achievable, it is for all staff and managers to ensure that this spirit of fairness is observed in how appointments are offered and booked.

Where a service user lacks capacity or requires support to attend appointments, wherever possible or applicable, appointment discussions should include family members, carers or other circles of support, to ensure appointment attendance is supported appropriately.

Where a service user does not lack capacity, it is good practice to offer the service user the opportunity to invite someone from their wider network, who can support them through the process.

After the appointment confirmation has been sent to the person to be seen by the service, other contact methods such as telephone or text message should be utilised to encourage attendance.

All correspondence and records of telephone calls made to the person using the Trust’s services in respect of setting up the appointment must be recorded in the service user’s CareDirector Record even in the event of them declining the service. Actions taken at the time of non-attendance and rationale for any decision-making should be clearly documented in the person’s Electronic Care Record together with details of the risk assessment and further plans to engage with the individual.

* 1. **Internal Service Transfer**

Occasionally people move between geographic areas or between service specialties (e.g. where the balance of care indicates care coordination would be more effectively managed by an alternative service).

Once indicated for transfer, this will take place within 2 weeks unless otherwise agreed for specific clinical or service user considerations.

Where this is the case, transfer will be planned and managed in a sensitive way taking into account individual service user needs. The existing service care coordinator or person identified in the Service SOP, will be responsible for the management of the transfer and ensuring all communication is clear to the service user, referrer and receiving service to ensure that the person receives a seamless service.

**1.11 Monitoring**

The Trust has in place monitoring reports, via the ECHO reporting dashboard, that allows managers to view in real time their compliance with the various standards of their service. This information is reported bi-monthly to both the Trust Board and Commissioners and will be monitored at service level via the bi-monthly Quality, Delivery and Performance (QDaP) meeting.

Non-attendance varies across the Trust from service-line to service-line. In Specialist Services such as Addiction, non-attendance is commonplace and as such DNA is monitored by teams via their ECHO dashboard, through clinical supervision, team clinical meetings and is reviewed on a higher level at the bi-monthly QDaP meetings.

# APPENDICES

**Appendix A**

Services operating waiting lists which will be covered by a local Standard Operating Procedure (SOP):

|  |  |
| --- | --- |
| **Service** | **Service Line** |
| Deaf CAMHS | Children and Young Peoples Services |
| WAA CMHT | Community and Wellbeing Services |
| CONNECT | Eating Disorders, Rehab and Gender Services |
| Gender Identity Service | Eating Disorders, Rehab and Gender Services |
| Assertive Outreach team | Eating Disorders, Rehab and Gender Services |
| Recovery Centre | Eating Disorders, Rehab and Gender Services |
| CREST | Eating Disorders, Rehab and Gender Services |
| Forensic Outreach Team (Leeds) | Forensic Services |
| Forensic Outreach Team (York) | Forensic Services |
| Community LD Service | Learning Disability Services |
| Liaison Psychiatry Out-Patient Service | Liaison and Perinatal Service |
| Psychosexual Medicine | Liaison and Perinatal Service |
| Chronic Fatigue Service | Liaison and Perinatal Service |
| Perinatal Community Service | Liaison and Perinatal Service |
| OPS CMHT | Older Peoples Services |
| Memory Assessment Service | Older Peoples Services |
| Young People with Dementia | Older Peoples Services |
| Emerge | Regional and Specialist Services |
| Leeds Autism Diagnostic Service | Regional and Specialist Services |
| ADHD Service | Regional and Specialist Services |
| Northern Gambling Service | Regional and Specialist Services |
| Forward Leeds | Regional and Specialist Services |
| Veterans (Op Courage) | Regional and Specialist Services |

**PART B**

**3 IDENTIFICATION OF STAKEHOLDERS**

The table below should be used as a summary. List those involved in development, consultation, approval and ratification processes.

|  |  |
| --- | --- |
| **Stakeholder** | **Level of involvement** |
| Deputy Director of Operations | Development |
| Heads of Operations in Care Services | Consultation |
| Deputy Director of Service Development | Consultation |
| Head of Operational Governance | Consultation |
| Operational Delivery Group | Approval |
| Policy and Procedure Group | Ratification |

**4 REFERENCES, EVIDENCE BASE**

* The NHS Constitution
* National access standards

**5 ASSOCIATED DOCUMENTATION (if relevant)**

* Individual Service Line Standard Operating Procedures
* Admission and Discharge Procedure

**6 STANDARDS/KEY PERFORMANCE INDICATORS (if relevant)**

The monitoring of performance is set out in section 1.11

**7 EQUALITY IMPACT**

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. Consideration must be given to any potential impacts that the application of this policy/procedure might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

Declaration: The potential impacts on the application of this policy/procedure have been fully considered for all nine protected groups. Through this process I have not identified any potential negative impacts for any of the nine protected groups.

**Print name**: Mark Dodd

**Job title**: Deputy Director of Operations

**Date**: 21 November 2023

If any potential negative impacts are identified the Diversity Team must be contacted for advice and guidance: email; [diversity.lypft@nhs.net](mailto:diversity.lypft@nhs.net).

\*delete as appropriate

**8 CHECKLIST**

To be completed and attached to any draft version of a procedural document when submitted to the appropriate group/committee to support its consideration and approval/ratification of the procedural document. This is a checklist and is part of the working papers.

|  | **Title of document being newly created / reviewed:** | **Yes / No/** |
| --- | --- | --- |
| **1.** | **Title** |  |
|  | Is the title clear and unambiguous? | Yes |
|  | Is the procedural document in the correct format and style? | Yes |
| **2.** | **Development Process** |  |
|  | Is there evidence of reasonable attempts to ensure relevant expertise has been used? | Yes |
| **3.** | **Content** |  |
|  | Is the Purpose of the document clear? | Yes |
| **5.** | **Approval** |  |
|  | Does the document identify which committee/group will approve it? | Yes |
| **6.** | **Equality Impact Assessment** |  |
|  | Has the declaration been completed? | Yes |
| **7.** | **Review Date** |  |
|  | Is the review date identified? | Yes |
|  | Is the frequency of review identified and acceptable? | Yes |
| **8.** | **Overall Responsibility for the Document** |  |
|  | Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document? | Yes |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of the Chair of the Committee / Group approving** | | | |
| If you are assured this document meets requirements and that it will provide an essential element in ensuring a safe and effective workforce, please sign and date below and forward to the chair of the committee/group where it will be ratified. | | | |
| Name | Joanna Forster Adams | Date | 21 November 2023 |
| **Name of the chair of the Group/Committee ratifying** | | | |
| If you are assured that the group or committee approving this procedural document have fulfilled its obligation please sign and date it and return to the procedural document author who will ensure the document is disseminated and uploaded onto Staffnet. | | | |
| Name | Clare Edwards | Date | 12 December 2023 |