

## Elective Service Access Policy

Version:	Version 2.0 December 2015
Ratified by:	TEC
Date ratified:	December 2015
Name of originator/author:	Darrien Bold, deputy head of performance
Name of responsible individual:	Kate Slemeck, chief operating officer
Date issued:	December 2015
Review date:	December 2016
Target audience:	All trust staff
Intranet:	TBC
Related policies:	Cancellation policy Cancer operational policy Cerner template management policy Information governance policy Inter-provider transfers policy Overseas visitor policy PoLCE policy
Date equality impact assessment completed.	02/12/2015

### Version Control Sheet

Version	Date	Author	Status	Comment
1	24/07/14	Darrien Bold	FINAL	First signed off version of combined BCF/RF policy
2	02/12/15	Darrien Bold	DRAFT	Revised version incorporating changes to national guidance and standardising of trust procedures

**Contents**

<b>Section</b>		<b>Page</b>
1	Introduction	3
2	Key principles	4
3	Equality statement	4
4	Responsibilities	5
5	General principles of RTT	5
6	Outpatient appointments	7
7	Management of suspected cancer referrals	11
8	Diagnostics	13
9	Management of elective admissions	14
10	Monitoring compliance	18
<b>Appendix</b>		
Appendix 1	Equality analysis	19

## 1.0 Introduction

This policy outlines and clearly describes the ethics and key principles applied by the Royal Free London NHS Foundation Trust when managing patients who are in their elective (planned) patient care pathway. The policy includes the key principles and best practice guidelines to assist staff with the effective management of outpatient, diagnostic, cancer, planned, inpatient and day case waiting lists to achieve the 18 week referral to treatment (RTT) pathway and the 2 week wait, 31 day and 62 day cancer pathways.

Since January 2009 every citizen of this country has the binding NHS Constitutional Right to be treated within 18 weeks. Where a hospital is unable to offer patients treatment within 18 weeks the patient has the right to be treated elsewhere. In relation to patient access targets the NHS Operating Framework, *Everyone Counts: Planning for Patients and Monitor's Compliance Framework 2013/14* sets the following headline performance measures:

- 92% of patients with an incomplete pathway to have waited no longer than 18 weeks;
- \*99% of patients to have waited no longer than six weeks from referral for a diagnostic test.

*\*Does not form a part of Monitor's Compliance Framework*

The following are excluded from the 18 week RTT pathway:

- Emergency patients;
- Obstetric patients;
- Elective patients undergoing planned procedures, (removal of metalwork, procedures related to age/growth, check cystoscopies etc.) unless the due date has been exceeded at which point an RTT clock will recommence;
- Patients receiving ongoing care where the first definitive treatment for that condition has already occurred;
- Patients who have previously had a clock stop for active monitoring and are awaiting follow-up;
- Non NHS patients, including overseas visitors, who are not covered by this policy and are not entitled to treatment within 18 weeks. They should be managed by the overseas visitor policy and treated according to clinical priority;
- Referrals to a non-consultant led service (excluding audiology);
- Tertiary referrals into a non-consultant led service where the patient has already received first definitive treatment (opinion only);
- Private patients who should be treated in additional designated capacity.

This policy details how patients will be managed administratively at all points of contact within the trust.

## **2.0 Key principles**

This policy covers the processes used by the trust to manage patients who are referred for treatment on admitted, non-admitted or diagnostic pathways. It covers the management of patients at all sites where the trust operates, including outreach and community clinics.

Patients should only be added to waiting lists if they are clinically fit for assessment, ready and willing to attend throughout their pathway and there is an expectation of treating them within the relevant timeframe.

Patients will be treated in order of their clinical need. Patients with the same clinical need will be treated in chronological order.

The order of treatment will be supported by the production and operational use of referral to treatment patient tracking lists for admitted, non-admitted and incomplete pathways. This will be underpinned by accurate and timely recording of all patient activity on the trust's patient administration system (PAS).

All processes that underpin the management of patients waiting for treatment will be transparent both to the individual patient and to partner organisations and will be open to inspection, monitoring and audit.

## **3.0 Equality statement**

The Royal Free London NHS Foundation Trust is committed to creating a positive culture of respect for all individuals, including job applicants, employees, patients, their families and carers as well as community partners. The intention is, as required by the Equality Act 2010, to identify, remove or minimise discriminatory practice in the nine named protected characteristics of age, disability (including HIV status), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex or sexual orientation. It is also intended to use the Human Rights Act 1998 to treat fairly and value equality of opportunity regardless of socio-economic status, domestic circumstances, employment status, political affiliation or trade union membership, and to promote positive practice and value the diversity of all individuals and communities.

This document forms part of the trust's commitment to ensuring that the policies, procedures and obligation in respect of promoting equality and diversity are adhered to in relation to both staff and service delivery.

This policy reflects this commitment by ensuring that access to the trust's services is governed by a clear set of principles that are applied equitably to all patients. No negative impact on equality and diversity has been identified.

The equality analysis for this policy is attached as appendix 1.

#### **4.0 Responsibilities**

This policy has been agreed by the Royal Free London NHS Foundation Trust, in consultation with its clinical commissioning groups. The trust will review and update the policy on an annual basis, or earlier if significant changes are introduced to national patient access targets. Any changes will be ratified by the trust executive committee.

This policy sets out or advises on the overall expectations of the trust and local commissioners on the management of referrals and admissions into and within the organisation, and defines the principles on which the policy is based.

A comprehensive e-learning module covering the principles of RTT can be found on the trust learning and organisational development portal. Further information regarding rules and tolerances can also be obtained via the elective access portal on frenet. Any queries relating to RTT may also be communicated to [rf.rttmailbox@nhs.net](mailto:rf.rttmailbox@nhs.net).

#### **5.0 General principles of RTT**

The maximum length of time that a patient should wait from referral to medical or surgical consultant-led care, until treatment commences, is 18 weeks unless the patient chooses to wait longer. The exceptions to this are suspected cancer patients and diagnostic only patients. The 18 week RTT pathway is based on a clock start when a referral is received and a clock stop when the patient begins first definitive treatment, a clinical decision is made that treatment is not required or the patient chooses to decline treatment.

##### **5.1 Clock start**

A waiting time 'clock' starts when a referral is received from any care professional or service permitted by an English NHS commissioner.

In circumstances where the referral is received directly from the referrer by the trust the clock start date is the date the referral is received by the trust. Referrals are stamped on receipt and inputted into the trust PAS system within 48 hours.

For any patient referred via the NHS e-Referral service the clock start date is the date the patient converts their unique booking reference number (UBRN), including where the referral is rejected by the chosen provider and subsequently re-referred. This also includes conversion of the first UBRN when referred by a referral management service. The party attempting to book the appointment in these circumstances may be the GP, patient, referral management service or The Appointments Line (TAL).

A waiting time clock also starts upon a self-referral by a patient to the above services, where these pathways have been agreed locally by commissioners and providers once the referral is ratified by a care professional permitted to do so.

Upon completion of a consultant-led referral to treatment period, a new waiting time clock starts only when:

- a patient is fit and ready for the second stage of a consultant-led bilateral procedure;
- a decision is made to start a substantively new or different treatment that does not already form part of that patient's agreed care plan;
- a patient is re-referred into a consultant-led interface, referral management or assessment service as a new referral;
- a decision to treat is made following a period of active monitoring;
- a patient rebooks their appointment following a first appointment DNA which nullifies their original clock.

## **5.2 Clock stops for treatment**

The 18 week RTT clock stops when the first definitive treatment begins.

First definitive treatment is a matter for clinical judgement in consultation with others as appropriate, including the patient. It could be:

- treatment provided by a consultant-led service;
- treatment in an interface service;
- therapy beginning in secondary care;
- a clinical decision is made and communicated to the patient, their GP and/or other referring practitioner without undue delay, to add a patient to a transplant list.

## **5.3 Clock stops for non-treatment**

An 18-week clock stops when it is communicated to the patient, and subsequently their GP and/or other referring practitioner without undue delay that:

- it is clinically appropriate to return the patient to primary care for any non- consultant led treatment;
- a clinical decision is made to start a period of active monitoring;
- a patient declines treatment having been offered it;
- a clinical decision is made not to treat;
- a patient fails to attend their first appointment following the initial referral that started their 18 week clock, or any subsequent outpatient appointment, provided that:
  - the trust can demonstrate that the appointment was clearly communicated to the patient and reasonable notice was provided;
  - discharging the patient is not contrary to their best clinical interests;
  - discharging the patient is carried out according to local, publicly available, published policies on DNAs;
  - these local policies are clearly defined and specifically protect the clinical interests of vulnerable patients (e.g. children) and are agreed with clinicians, commissioners, patients and other relevant stakeholders.

#### **5.4 Active monitoring (*watchful waiting*)**

The trust will stop a patient's 18 week clock if the clinical decision is to actively monitor their condition (also known as *watchful waiting*) and not to treat at this stage. Active monitoring therefore constitutes a clock stop on the patient pathway. Following a period of active monitoring, a new waiting time clock will start (at zero weeks) if and when a decision to treat is made. A patient may also initiate active monitoring.

Patients should not be left with "open" pathways, with the opportunity to contact the trust for a future appointment at a later date. If there is no clinical requirement to actively monitor their condition then the patient's clock should be stopped and they should be discharged back to the care of their GP.

### **6.0 Outpatient appointments**

All outpatients will be monitored via the PTL (*patient tracking list*) which will be used to identify any new appointments required, as well as ensuring that a future follow-up appointment has been arranged for all open pathways.

#### **6.1 Referrals**

All referral letters should be managed via the identified outpatient appointment teams.

Patients who are referred on a *Dear Doctor* basis will be allocated to the consultant within the speciality able to see the patient at the earliest opportunity, taking into

consideration subspecialisation. This will provide a faster and more efficient service to the patient without compromising clinical quality.

All paper referrals will be date stamped upon receipt. This date stamp will represent the clock start, and will be documented on the trust PAS system. A copy of the letter will also be scanned and stored in the patient's electronic records.

All referrals will be forwarded to the respective consultant or those responsible for allocating referrals in the speciality within one working day of receipt.

To ensure the effective management of patients, the consultant should clearly state the priority status for treatment, indicate any investigations required and return the referral to the appointments office within two working days.

If a referral is clinically appropriate and the trust provides the relevant service then the referral must be accepted. Where a referral is received without the minimum data set (MDS) necessary to record a clock start the referrer will be contacted for additional information. However, the RTT clock will remain running.

A centralised process is in place for the management of all PoLCEs (*Procedures of Limited Clinical Effectiveness*) entering the organisation either as paper referrals or via the NHS e-Referral service.

## **6.2 Booking new appointments**

Where, upon referral, a patient makes themselves unavailable for a prolonged period of time, this will be regarded as patient choice.

Appointment staff will aim to give the patients the shortest wait based on the clinical prioritisation indicated and the internal milestones or stages of treatment within a total 18 week RTT pathway.

Each specialty will have an agreed time-frame, signed off by senior operations managers and service line leads, in which non-urgent first outpatient appointments should be scheduled.

If a non-urgent appointment cannot be made within this agreed time-frame due to a lack of capacity, a request will be sent to the relevant operational manager to authorise overbooking. If this request is not answered within 36 hours the patient will be overbooked into clinic in accordance with the clinical priority identified at triage.

In circumstances where outpatient capacity constraints are generating extended waits for first outpatient appointments the issue should be escalated to the appropriate divisional director of operations and the head of performance.

### 6.3 Patient choice

For an appointment to be considered 'booked' an appointment must be allocated on PAS and the patient notified of the appointment time and date. The appointment letter advises the patient of the relevant telephone number to use in order to contact the trust should the date and time of the allocated appointment be inconvenient.

In circumstances where a patient declines a first outpatient appointment on the basis that they are not available due to personal circumstances, they will be offered a further appointment within a six week period. Should the patient be unable to accept such reasonable offers then they should be notified of their discharge to the GP, to whom they should return once they are in a position to accept hospital treatment.

A reasonable offer is an offer of a time and date three or more weeks (21 days) from the time the offer was made.

Patients may request a maximum of two changes to their appointment and alternative dates within the subsequent six week period will be provided at the time of their request. However, the administration team will make the patient aware that they may be discharged from the speciality if they request any further changes or cancellations. In this instance, the patient will be referred back to the GP following a clinical review (unless they are a vulnerable patient, a suspected cancer or a paediatric patient), provided that:

- the trust can demonstrate that the appointment was clearly communicated;
- the patient was given a reasonable offer as defined above;
- discharging the patient is not contrary to their best clinical interests.

Where a patient cancels or changes their appointment at short notice (i.e. less than 24 hours) on more than one occasion, for reasons other than ill health, the administration team will make the patient aware that they may be discharged from the speciality if they request any further changes or cancellations.

### 6.4 Failing to attend an outpatient appointment

In line with national 18-week rules, patients who fail to attend a clearly communicated and agreed first appointment booked with reasonable notice will be returned to the care of the GP and their clock nullified with the agreement of the clinician.

If the patient fails to attend a subsequent appointment they may have their clock stopped and be discharged to the care of the GP with the agreement of the clinician.

Trust guidance is that further appointments will not be routinely offered and patients will be discharged to the care of their GP. The following safeguards however apply:

- Clinical discretion: another appointment may be offered where the clinician feels it appropriate based on clinical history.
- Children and vulnerable adults, including those with cancer, will not be discharged without a case review.

### **6.5 Arranging follow up appointments**

Follow up appointments should be scheduled based upon the current treatment status of patients, ensuring that the next event is in keeping with the overall 18 week pathway.

### **6.6 Clinic cancellations**

Six weeks' notice must be given of all planned leave affecting clinics. The only acceptable reason for any clinic to be cancelled or reduced is due to the planned absence of medical or specialist nursing/AHP staff. If less than six weeks' notice is given, the clinic cancellation team will refer the request to the relevant divisional director and divisional director of operations for authorisation.

Patients that have been previously cancelled should not be cancelled a second time.

### **6.7 Clinic outcomes**

All patients attending clinic should be accurately recorded on the trust PAS system. Having been "*checked in*" to the virtual clinic environment, the correct RTT treatment status should be used to reconcile and "*check out*" their appointment. This will help maintain accuracy along each individual patient's 18 week pathway.

This process is administered using an outpatient outcome form. This form is completed by the clinician in order to articulate the status of the patient's pathway and any future appointment to be scheduled.

## 7.0 Management of suspected cancer referrals

The cancer standards are currently as follows:

Service Standard	Operational Standard
<b>Maximum 2 weeks from:</b>	
Urgent GP referral for suspected cancer to first outpatient attendance	93%
Referral of any patient with breast symptoms (where cancer is not suspected) to first hospital assessment	93%
<b>Maximum 31 days from:</b>	
Decision to treat to first definitive treatment	96%
Decision to treat/earliest clinically appropriate date to start of second or subsequent treatment(s) for all cancer patients including those diagnosed with a recurrence where the subsequent treatment is:	
Surgery	94%
Drug treatment	98%
Radiotherapy	94%
<b>Maximum 62 days from:</b>	
Urgent GP referral for suspected cancer to first treatment	85%
Urgent referral from NHS Cancer Screening Programmes (breast, cervical and bowel) for suspected cancer to first treatment	90%
Consultant upgrade of urgency of a referral to first treatment	Not Set

### **7.1 Guidelines on pauses applicable along patient pathways:**

- No medical pauses at any point on the patient pathway;
- No pauses between first seen and Decision to Treat date (DTT);
- No pauses for outpatients between DTT and First Definitive Treatment date (FDT);
- Pause is allowed for DNA of the first outpatient appointment;
- Pause is allowed if a patient declines an offer of admission for treatment.

### **7.2 Consultant upgrades to 62 day pathways**

Patients can be upgraded at any point during their routine pathway if cancer is suspected. This includes, but is not exhaustive to, triage of referral, following an outpatient appointment and following a diagnostic test.

Where a consultant considers it clinically appropriate to upgrade a routine referral to a 62-day cancer pathway this will be communicated by the relevant consultant to the cancer MDT team.

Where a routine referral is upgraded this should be communicated back to the referring clinician (GP) so that they are aware of the elevated priority of the referral.

Communicating with the GP will be the responsibility of the cancer MDT team.

### **7.3 2 week wait target referrals**

Patients referred on a target cancer pathway or with breast symptoms must be seen by a specialist within 14 days of the date the referral was received.

Potential suspected cancer referrals will be registered and booked immediately into the next available target slots. Where there are no available slots within 14 days the appointments office will use their automatic overbooking rights to book an appointment.

Upon contacting a patient the first appointment will be offered within the first block of 5 working days with the second provided in the second block of 5 working days, or an appointment offered within 14 days that is convenient and acceptable to the patient.

In the event of a patient declining both appointment dates, for social or ill health reasons, every attempt should be made to complete the booking within the 14-day period. However if this is not possible, an alternative appointment should be offered outside the 14-day period.

#### 7.4 Failure to attend first 2 week wait target appointment

In the event of a first appointment DNA the patient's 14-day clock may be paused. The pause is from the date the referral is received (day zero of the 14-day pathway) to the date the patient rebooks their appointment. A pause may also be applied for all subsequent first appointment DNAs.

Patients will be discharged to the care of their GP following a second appointment DNA but only when the responsible consultant has reviewed the case and confirmed that discharge is clinically appropriate.

A patient's 14-day clock cannot be adjusted following multiple patient initiated rescheduling of appointments.

### 8.0 Diagnostics

The maximum waiting time for a routine diagnostic test is 6 weeks. Diagnostics may be broken down as follows:

***Pure diagnostic*** – a test or procedure used to identify a person's disease or condition which allows a medical diagnosis to be made. This is a 6 week diagnostic pathway. This may then become therapeutic at the time of the diagnostic;

***Therapeutic*** – defined as a procedure that involves actual treatment of a person's disease, condition or injury which will stop the 18 week clock. The 6 week target does not apply to these patients.

#### 8.1 Diagnostic clock starts

The diagnostic clock starts:

- when the clinical request was made;
- the date the referral was made if the patient is waiting as an outpatient;
- the date the decision to admit is made if the patient is waiting as an inpatient or day case.

#### 8.2 Diagnostic clock stops

The date the patient receives the diagnostic/procedure stops the diagnostic pathway. This is not an RTT pathway stop, unless the diagnostic is a therapeutic diagnostic.

### 8.3 Direct access diagnostics

Direct access diagnostics are requested by the GP directly to the conducting diagnostic modality. Upon completion of the test, the patient is discharged back to the care of their GP. The 18 week standard does not apply to direct access diagnostics.

### 8.4 Straight to test diagnostics

A specific type of direct access diagnostic service whereby a patient will be assessed and might, if appropriate, be treated by a medical or surgical consultant-led service before responsibility is transferred back to the referring health professional.

### 8.5 Cancer diagnostic referrals

It is expected that all target diagnostic procedures requested via the cancer referral process are carried out and reported within one week.

## 9.0 Management of elective admissions

Waiting lists for both inpatients and day cases are divided into the following:

**Elective referral to treatment patient tracking list (RTT PTL)** - The patient has been assessed as requiring a procedure and a decision to admit has been made.

**Planned patient tracking list (Planned PTL)** - Patients in this category are given a date which is part of a planned sequence of clinical care and the date is determined on clinical grounds. The most frequently quoted examples of planned admissions are check cystoscopies or a series of chemotherapy.

Patients on planned lists should be booked in for an appointment at the clinically appropriate time and they should not have to wait a further period after this time has elapsed. For example, a patient due to have a surveillance test in six months' time should be booked in around six months later and should not have to wait longer for non-clinical reasons.

Any planned patient whose wait exceeds their due date should have either an 18 week or 6 week diagnostic clock start immediately after their due date has passed.

Where patients are undergoing a bilateral procedure - i.e. a procedure that is performed on both sides of the body, at matching anatomical sites (for example, removal of cataracts from both eyes) - the initial 18 week clock will stop at the first definitive treatment for the first procedure. Once the patient is fit and ready for the second procedure then a new 18-week clock should start from the date that it is clinically

appropriate for the patient to undergo that procedure, and from when the patient says they are available (not from the date that the provider has the capacity to admit/treat them).

### **9.1 Adding patients to an inpatient or day case waiting list**

Patients will be added to a waiting list within 24 hours, or the next working day, following a decision to admit. Patients must only be added to the waiting list when they have agreed to the proposed surgical procedure / treatment, and are available to come in within the 18 week limit of their pathway.

Patients must not be added to the waiting list unless they are clinically fit for the procedure. For example, a patient who needs to lose weight before a procedure is clinically advisable should be referred back to their GP or put on a period of watchful waiting until the desired body weight is achieved. The patient can then be added to the waiting list.

The chronological order of patients waiting should be managed first by clinical priority, then by the current RTT waiting time to ensure compliance with national standards.

### **9.2 Arranging admission**

Patients should be invited to agree an admission date in advance rather than being told by the hospital when they are expected to attend. This provides certainty and choice.

Patients who require elective admission should be made a reasonable offer for the date of their admission. A reasonable offer is an admission date three or more weeks (21 days) from the time the offer was made for routine cases.

At least three weeks prior to the intended date of their procedure patients will be contacted to agree an admission date. Usually this is undertaken via telephone with contact being attempted at different times of the working day. Further information on the booking process is available in the admissions standard operating procedure.

For urgent cases, patients will be contacted by telephone or by letter if telephone contact cannot be made. If less than 21 days' notice is given and the patient declines the appointment, the admission date cannot be recorded as an earliest reasonable offer and the cancellation cannot be deemed to be patient-initiated.

When a patient declines a reasonable offer of admission, then this date should be recorded on PAS as a patient-initiated cancellation and the reason for the cancellation should be clearly documented.

Should a patient decline a second reasonable offer, their records will be reviewed by the clinical team to ensure that there is no clinical risk involved in discharging the patient.

Subject to confirmation that there is no clinical risk, the patient will be discharged from the speciality back to the care of their GP. All changes and actions must be communicated to the GP and to the patient by letter.

### **9.3 Pre-operative assessment**

If required, the patient will have an appointment made for pre-operative assessment (POA) ideally at least two weeks before their date of admission. Appointment letters will state that patients must attend their POA in order for their procedure / treatment to take place.

Where a patient cancels or changes their POA appointment on more than one occasion, for reasons other than ill health, the admissions team will make the patient aware that their admission will be cancelled should they request any further changes or cancellations.

If a patient fails to attend their POA appointment they will be offered one further appointment and advised that a subsequent DNA may result in a discharge back to the care of their GP.

### **9.4 Patient cancellations and rescheduling of admission dates**

Patients may request one change to their admission date and a new date should be arranged within a six week period of their request. However, the admissions team will make the patient aware that they will be discharged from the speciality if they request any further changes or cancellations. In this instance, the patient will be referred back to the GP following a clinical review (unless they are a vulnerable patient, a suspected cancer or a paediatric patient), provided that:

- the trust can demonstrate that the appointment was clearly communicated;
- the patient was given reasonable notice of their admission date;
- discharging the patient is not contrary to their best clinical interests.

Where a patient cancels or changes their appointment at short notice (i.e. less than 24 hours) for reasons other than ill health, the admissions team will make the patient aware that they will be discharged from the speciality if they request any further changes or cancellations.

If, on admission, the patient is found to be unfit for the procedure they should be removed from the waiting list and either returned to outpatients for a clinical review or discharged to the care of their GP. If a patient is unwell on the day of admission but is otherwise fit to proceed then this will be recorded as a patient cancellation.

### **9.5 Patient admission DNA**

If a patient fails to attend an admission, it is important to note that this DNA will not stop their 18-week clock.

If the patient cannot be contacted by phone, a letter is issued requesting that contact is made with the admissions team. If no further contact is received within 10 working days, the patient is removed from the waiting list following a clinical review. In this circumstance the patient will be discharged back to the care of their GP and the RTT clock will be stopped from the date of the original DNA of admission.

If a patient fails to attend an admission a second time, they will also be removed from the waiting list provided there is no clinical risk.

### **9.6 Cancellation by hospital**

If a patient's operation is cancelled by the hospital on the day of admission for non-clinical reasons, a new binding booking must be arranged within a maximum of 28 days.

Non-clinical reasons include cancellations due to lack of a bed, equipment/technical failure, theatre list overruns or lack of a surgeon / anaesthetist.

An operation which is rescheduled to a time within 24 hours of the original scheduled procedure will count as a postponement and not a cancellation.

### **9.7 Pausing a patient pathway**

With effect from October 2015, the RTT rules suite has been updated to reflect the removal of the provision to apply adjustments to RTT pathways for patient-initiated delays. There is no longer any provision to report pauses in waiting time clocks in monthly RTT returns to NHS England under any circumstances.

The trust, however, wishes to maintain a local record of all patient-initiated delays, to aid good waiting list management and to ensure patients are treated in order of clinical priority.

When two patients have been waiting the same amount of time for a procedure, outside of clinical urgency, the patient with the single longest continuous wait will be scheduled first. This ensures patients who are actively waiting for treatment are seen ahead of those who have exercised their right of patient choice.

## **10.0 Monitoring compliance**

The senior operations manager for each service will be responsible for ensuring that waiting list data is available to all clinical and administrative teams, as well as agreeing the type of information and frequency of distribution of waiting list data, and monitoring reports for their consultants and divisional director.

The reporting and analytics team produce a weekly suite of waiting list reports for each speciality that allows managers to understand the dynamics of their waiting lists. The reports will cover trends in bookings and DNAs; as well as patterns in the overall size of the waiting list and different cohorts of waiters. Similar analysis at individual consultant or clinical team level, or at procedure level, is also available.

A waiting list capacity group (waiting list action group) takes place on a weekly basis to support this process.

The trust board and trust executive committee will receive monthly performance reports including progress towards meeting waiting list targets, with any areas for concern highlighted.

**Appendix 1 – Equality analysis**

Equality Group	Identify negative impacts	What evidence, engagement or audit has been used?	How will you address the issues identified?	Identifies who will lead the work for the changes required and when?	Please list positive impacts and existing support structures
Age	Possible negative impact - communication and understanding would have been assessed at initial consultation, at pre-assessment, and also upon admission if necessary	Booking team expertise and patient management training. Clear guidelines in standard operating procedures.	Booking teams have the knowledge, experience and training to contact the GP or referrer to identify if there is an access or communication difficulty with patients who DNA or do not respond to attempt to contact them.	Deputy head of performance/ Service managers	The trust has communication and support structures in place to support patients at initial consultation, pre-assessment and upon admission, in order to ensure communication structures are fit for purpose.  In cases where patients DNA or fail to confirm appointment dates, booking teams can contact the GP or other referrer to confirm the patient's ability to respond before acting according to the guidance in the access policy.
Disability					
Race					
Religion or Belief					
Carer					

<b>Gender Reassignment</b>	None identified	
<b>Marriage and Civil Partnership</b>		
<b>Pregnancy and maternity</b>		
<b>Sex</b>		
<b>Sexual Orientation</b>		

<b>Equality analysis completed by:</b>	<b>Role</b>	<b>Date</b>
Darrien Bold	Deputy head of performance	Oct-15
Ricky McCullough	Deputy head of performance	Oct-15
Scott Wilson	Analyst	Oct-15
Sheila Hill	Validation manager	Oct-15