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To NHS Chief Executives

Cc NHS Foundation Trust Chief Executives
NHS Medical Directors
Monitor

Gateway reference: 16994

25 November 2011

Dear Colleague

Patients waiting on 'Planned' Waiting Lists

A recent review by the Department of Health of patients who had been waiting for hospital appointments has found examples of patients waiting inappropriately which has impacted on clinical outcomes.

Many of the patients required structured follow-up to detect the need for further treatment at appropriate follow-up intervals for individual clinical conditions. Examples are patients with diabetic eye disease, or other eye conditions, who need eye examination to detect progression requiring urgent treatment to prevent blindness, or planned monitoring in patients with long term conditions and those patients on disease-modifying drugs (such as in rheumatoid arthritis) where both potential side-effects of the drugs and response to treatment must be assessed.

There are strong clinical governance and safety reasons why patients' planned care *should not be deferred* and all organisations should treat patients at the right time and in order of clinical priority. A significant proportion of 'planned' activity is associated with surveillance of high risk groups of patients who are at risk of significant clinical deterioration if not managed correctly.

A service that allows 'planned' activity to be deferred because of pressure on active waiting lists is not in control of its total demand. This is not sustainable and such services risk building up backlogs of long waits and failing to deliver patients' right to maximum waiting times under the NHS Constitution and a maximum 6 week wait for diagnostic tests

Patients should only be added to a 'planned' list when it is clinically appropriate for them to wait for a period of time. This includes patients waiting for a planned diagnostic test or treatment or a series of procedures carried out

as part of a treatment plan - which are required for clinical reasons to be carried out at a specific time or repeated at a specific frequency. Patients on these 'planned' lists should be booked for an appointment at the clinically appropriate time and should not wait for a further period after this time has elapsed. This is not an acceptable use of a 'planned' list. Where patients' treatment can be started immediately, then they should start treatment or be added to an active waiting list.

It is for trusts locally to determine the appropriate arrangements for each individual patient but these arrangements must take into account achieving the best clinical outcomes for the patient complying where appropriate with NICE Quality Standards and evidence based guidelines.

Therefore, we:

- draw your urgent attention to the attached policy statement on this issue; and,

- ask you to review all 'planned' waiting lists for all specialties and diagnostic services by no later than the end of December 2011.

We have asked SHAs to assure themselves that this is done and where needed, the appropriate action taken.

Yours faithfully,

Professor Sir Bruce Keogh
NHS Medical Director

David Flory
Deputy NHS Chief Executive

Policy for patients who require appointments for assessment, review and/or treatment - use of planned (pending or review) lists

Commissioners and providers need to plan and manage their services so that new and planned patients are treated at the right time and in order of clinical priority. Patients requiring initial or follow-up appointments for clinical assessment, review, monitoring, procedures, or treatment must be given a specific date and time, as required by best clinical evidence.

Patients should only be added to a planned list where clinically they need to wait for a period of time. This includes planned diagnostic tests or treatments or a series of procedures carried out as part of a treatment plan - which are required for clinical reasons to be carried out at a specific time or repeated at a specific frequency. 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 re-test in six months time should be booked in around six months later and they should not get to six months, then have to wait again for non-clinical reasons. This is not an acceptable use of a planned list.

When patients on planned lists are clinically ready for their care to commence and reach the date for their planned appointment, they should either receive that appointment or be transferred to an active waiting list and a waiting time clock should start (and be reported in the relevant waiting time return). The key principle is that where patients' treatment can be started immediately, then they should start treatment or be added to an active waiting list.

It is for trusts locally to determine the appropriate arrangements for each individual patient case, using the above definitions on a commonsense basis and one where the best possible clinical outcomes can be achieved for the patient.

Trusts should have systems in place to regularly review any planned lists to ensure that patient safety and standards of care are not compromised to the detriment of outcomes for patients. Patients should also be given written confirmation if they are placed on such lists, including the review date. Effective communication removes uncertainty for patients and ongoing review ensures that patients' treatment is not delayed inappropriately.
There are very strong clinical governance and safety reasons why planned care should not be deferred. A significant proportion of this activity is done for surveillance of high risk groups of patients associated with high rates of mortality and poorer outcomes if not managed correctly - and delaying these can increase emergency admissions.

It should also be remembered, that many patients require structured follow-up to detect the need for further treatment at appropriate follow-up intervals for individual clinical conditions. Examples may be patients with diabetic eye disease, or other eye conditions, who need eye examination to detect progression requiring urgent treatment to prevent blindness, or patients with

long term conditions who require planned monitoring including those on disease-modifying drugs (such as for rheumatoid arthritis) where both potential side-effects of the drugs and response to treatment must be assessed.

A service that allows planned activity to be deferred because of pressure on active waiting lists is not in control of its total demand. This is not sustainable and such services risk building up backlogs of long waits and failing to deliver patients' right to maximum waiting times under the NHS Constitution and a maximum 6 week wait for diagnostic tests. Long waits may also lead to failure to meet accreditation requirements.