Patient Administration System

Waiting List Procedures

<WL>

Version 2.12

ICT TRAINING has made every effort to ensure that the material in this manual was correct at the time of publication but cannot be held responsible for any errors or inaccuracies. ICT TRAINING reserves the right to change or replace information contained in the manual without notice. For the most up to date version please refer to the ICT Training website. All references made to patient records are fictitious for the purpose of training only.
CONTENTS

1. GENERAL COURSE INFORMATION .................................................................................. 1

2. INFORMATION GOVERNANCE ........................................................................................ 2
   2.1. What can you do to make Information Governance a success? ......................... 2

3. CONFIRMATION OF DETAILS PROCEDURES ............................................................... 4

4. INTRODUCTION ........................................................................................................... 5

5. WAITING LIST ADD, REVISE AND LIST <WLA> .......................................................... 6
   5.1. Adding a Patient to a Waiting List ........................................................................ 6
   5.2. Episode Enquiry View <EPI> .............................................................................12
   5.3. To Revise or List Waiting List Activity <WLA> ..................................................13
   5.4. To Delete Waiting List Activity <DWA> ..............................................................13

6. WAITING LIST NAME ENQUIRY <WNI> .........................................................................14

7. PATIENT PATHWAY FUNCTIONS <PPM> <PPA> .............................................................15
   7.1. Option Select Screen .....................................................................................15
   7.2. Pathway Selection Screen ...............................................................................15
   7.3. Add a New Pathway .......................................................................................16
   7.4. Delete a Pathway ...........................................................................................17
   7.5. View/Revise a Pathway ..................................................................................17
   7.6. View Pathway Episodes ................................................................................19
   7.7. Add Episodes to a Pathway .............................................................................19
   7.8. Delete Episodes from a Pathway .....................................................................20

8. WAITING LIST REMOVAL (CANCEL) <WLC> ...................................................................21
   8.1. To Delete a Waiting List Removal <DWC> ......................................................22

9. WAITING LIST SUSPEND <WLS> .................................................................................. 23
   9.1. Waiting List View (List) or Waiting List Suspension Extension ......................24
   9.2. To Delete a Waiting List Suspension <DWS> .................................................. 25
   9.3. Waiting List Reinstate <WRI> ..........................................................................26

10. PRE – ADMISSION NAME ENQUIRY <PNI> ..................................................................27

11. CANCEL ELECTIVE TREATMENT ADD <CEA> .......................................................... 28

12. SELECT FROM WAITING LIST <SWL> ...........................................................................30

13. WAITING LIST TRANSFER <WTR> ................................................................................32
   13.1. Block Transfer ................................................................................................32
   13.2. Delete Block Transfer Request .......................................................................33
Patient Administration System (P.A.S) Course

1. GENERAL COURSE INFORMATION

<table>
<thead>
<tr>
<th>COURSE TITLE</th>
<th>METHOD OF TRAINING</th>
<th>WAITING LIST PROCEDURES &lt;WL&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Classroom</td>
<td></td>
</tr>
<tr>
<td>DURATION</td>
<td>2 ½ hours</td>
<td></td>
</tr>
<tr>
<td>PRE-REQUISITES</td>
<td>PMI Add/Revise</td>
<td></td>
</tr>
</tbody>
</table>

ABOUT THE COURSE
This course will enable the student to create and manage Waiting List activity and print Waiting List reports.

SUITABLE FOR
Administration and Clerical staff working in an inpatient area who manage Waiting List activity.

OBJECTIVES

This course will enable the student to:

1. Record and manage patients’ Waiting List activity
2. Record and manage a Waiting List suspension
3. Record and manage a Waiting List cancellation
4. Utilise Waiting List enquiry functions
5. Identify and understand Waiting List activity
6. Utilise Waiting List reports
2. INFORMATION GOVERNANCE

Information Governance (IG) sits alongside the other governance initiatives of clinical, research and corporate governance. **Information Governance is to do with the way the NHS handles information about patients/clients and employees, in particular, personal and sensitive information.** It provides a framework to bring together all of the requirements, standards and best practice that apply to the handling of personal information.

Information Governance includes the following standards and requirements:

- Information Quality Assurance
- NHS Codes of Conduct:
  - Confidentiality
  - Records Management
  - Information Security
- The Data Protection Act (1998)

2.1. What can you do to make Information Governance a success?

2.1.1. Keep personal information secure

Ensure confidential information is not unlawfully or inappropriately accessed. Comply with the Trust ICT Security Policy, Confidentiality Code of Conduct and other IG policies. There are basic best practices, such as:

- Do not share your password with others
- Ensure you "log out" once you have finished using the computer
- Do not leave manual records unattended
- Lock rooms and cupboards where personal information is stored
- Ensure information is exchanged in a secure way (e.g. encrypted e-mails, secure postal or fax methods)

2.1.2. Keep personal information confidential

Only disclose personal information to those who legitimately need to know to carry out their role. Do not discuss personal information about your patients/clients/staff in corridors, lifts or the canteen or other public or non-private areas.

2.1.3. Ensure that the information you use is obtained fairly

Inform patients/clients of the reason their information is being collected. Organisational compliance with the Data Protection Act depends on employees acting in accordance with the law. The Act states information is obtained lawfully and fairly if individuals are informed of the reason their information is required, what will generally be done with that information and who the information is likely to be shared with.

2.1.4. Make sure the information you use is accurate

Check personal information with the patient. Information quality is an important part of IG. There is little point putting procedures in place to protect personal information if the information is inaccurate.
2.1.5. **Only use information for the purpose for which it was given**

Use the information in an ethical way. Personal information which was given for one purpose e.g. hospital treatment, should not be used for a totally separate purpose e.g. research, unless the patient consents to the new purpose.

2.1.6. **Share personal information appropriately and lawfully**

Obtain patient consent before sharing their information with others e.g. referral to another agency such as, social services.

2.1.7. **Comply with the law**

The Trust has policies and procedures in place which comply with the law and do not breach patient/client rights. If you comply with these policies and procedures you are unlikely to break the law.

For further Information Governance training refer to: [http://www.igte-learning.connectingforhealth.nhs.uk/igte/index.cfm](http://www.igte-learning.connectingforhealth.nhs.uk/igte/index.cfm)

Written by PHT Information Governance Manager, Sept 2010
3. CONFIRMATION OF DETAILS PROCEDURES

To ensure that the Patient Administration System (PAS) contains up to date particulars of all patients being treated, staff must verify with patients their personal details. This should be undertaken when the patient is arriving at the hospital on admission or when attending for an outpatient clinic or other types of appointment.

The types of details we must verify are those within the Patient Master Index (PMI) function within PAS and covers the following items:

- Patient Forename, Surname and Title
- Date of Birth
- NHS Number (If not one shown on screen)
- Address and Postcode
- Telephone Number – Home and Work numbers
- Name and Practice Address of GP
- Religion
- Marital Status
- Next of Kin
- Ethnic Group
- Military No (If applicable)

By checking the above details with the patient, we are ensuring the following:

* PAS contains the latest details for all our patients.
* Mistakes or “old” details can be amended.
* Information relating to the patient’s well-being, such as Religion and Ethnic Group, can be used in patient care.
* Emergency contact details for relatives are up to date.

In some circumstances it will be difficult to verify the details highlighted above as the patient may not be coherent at time of arrival (eg emergency admission, A&E, etc). However, it is important that at the earliest opportunity, the details are verified and amended accordingly.

**Important – If details are amended**, please remember to print a new set of labels, remove and destroy any incorrect labels from casenotes. We must not retain any labels that do not contain current details.

Many thanks for your cooperation.

Prepared by: ICT Information Manager
Issued: January 2003
Reviewed: July 2011
Version No: V1.2

* To amend patient details you will need to have access to PMI at level 1. Please book the course PMI Add and Revise. In the meantime make sure you ask a colleague with access to amend the patient record.
4. INTRODUCTION

The functionality of Waiting List will enable you to record and manage patients on consultant Inpatient Waiting Lists. The data must be entered in accordance with the current PHT Inpatient/Day Case Waiting List Policy and Good Practice Guide. This document may be accessed through the Policies and Guidelines link on the Trust Intranet.

**WARNING**: All deletion functions should only be used to eradicate incorrect data and will erase any trace that the data was ever recorded. Please use with caution and if you are sure that’s what you want to do.

Please refer to the PMI Manuals for usage of APE, DP, EPI, LIS, MAH, MGH, NI, NID, and PMI.

Waiting List has six-access levels. You will only be given access to those functions that you have been trained.

**Level 0**

APE | Appointment Enquiry  
LIS | PMI LIS  
NID | Inpatient Name Enquiry DW  
PNI | Pre Admission Name Enquiry  
WNI | Waiting List Name Enquiry  

**Level 1**

DP | Document Print

**Level 2**

DWA | Delete Waiting List Add  
PMI | PMI Add/Revise  

**Level 3**

CEA | Cancel Treatment - Elective Add  
DWC | Delete Waiting List Removal  
DWS | Delete Waiting List Suspension  
MGH | Maintain GP History  
RWL | Review Waiting List  
WLR | Waiting List Reports  
WRI | Waiting List Reinstate  

**Level 4**

DWT | Delete Waiting List Transfer  
WTR | Waiting List Transfer  

**Level 6**

TWL | Transfer Waiting List
WAITING LIST ADD, REVISE AND LIST <WLA>

This function will enable you to add a patient to a Waiting List, revise details of a patient already on a Waiting List or view the details of a patient’s Waiting List registration.

NOTE: It is highly recommended that before adding a patient to a Waiting List you familiarise yourself with the patient’s 18 Week Pathway history to confirm if there is an existing pathway for the condition and if it is open or closed. See section on Patient Pathway Function on page 15.

5.1. Adding a Patient to a Waiting List

1. In LIS search for Patient using the recommended search procedure.
2. Check demographics and update if necessary
3. Select WLA and use the command L to recall the patient.
4. Previous episodes are displayed including any existing Waiting List entries. Please ensure that you are not duplicating an existing Waiting List entry.
5. At the Case Note Field use the command L to recall the last patient or use super help to display the Case note Help screen and select the appropriate number.
6. At the first Registration screen check and amend any details if these are not up to date.
7. At the second registration screen you must reflect the original referral source.

**NOTE:** If the patient was referred to an outpatient Consultant from their GP and then referred to the Consultants Waiting List the original referrer is the GP. This screen is also used to record any temporary address, if the patient is an overseas visitor or a temporary resident of the Portsmouth Hospitals.

Waiting List Details 1 Screen

8. Enter the details of the Waiting List that the patient is being added to.

**NOTE:** Once you have selected the Waiting List Code the Diagnosis Group, Hospital, Consultant and Specialty will default for you. You may need to overtype with the correct specialty, use super help to view the specialty codes assigned to your consultant.

**NOTE:** Joint Consultant & Joint Specialty are fields that in general are not used. However, if your department enters data into these fields, then follow your departmental procedures.
Urgency
Use super help to Select Urgent or Routine.

Special Case
Enter Yes or No. This is only an indicator on this screen and can not be viewed anywhere else.

Short Notice
Defaults to No. Enter Yes if the patient could be available within a 24 hour notice period.

In Care
Not currently used, press return to accept default answer of NO.

Contact Phone
Defaults with the telephone number if previously entered. Over-type if a more appropriate number is required i.e. Work Telephone Number, Mobile Number.

Acc Person
Enter YES or No if a friend or relative is staying overnight on the ward.

Comment N/CI
Enter Non clinical detail. This comment will appear on the WL Reports & the Expected Admissions List.

Referral
Mandatory. Use super help, to select appropriate code.

Method of Admission
Mandatory. Use super help, to select appropriate code.

Booking Type
Mandatory. Use super help, to select appropriate code.

Intd Mgmt
Defaults to Ordinary Admission. (A patient staying over night, use super help to reselect if you have a day case or a planned admission).

Category
Defaults to NHS. Use super help if your patient is Military, Private Patient, Overseas visitor, Asylum Seeker/ Refugee.

Trans
Transport, mandatory, default 11 not required. Use super help to amend code if necessary.

OSV Status
Overseas Visitor, mandatory, default 8 not applicable, use super help if necessary.

Ward
Optional; enter the ward code used to show where the patient will attend. Use super help if required.

Waiting List Details 2 Screen

<table>
<thead>
<tr>
<th>Adm Reason</th>
<th>Operation</th>
<th>Comment CI</th>
<th>Prov Diag</th>
<th>Prin I Proc</th>
<th>Sec I Proc</th>
<th>HRG Code</th>
<th>EFG Code</th>
<th>View full HRG details</th>
<th>Exp Op Date</th>
<th>Exp Type Anaest</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AMPUTATION OF LEFT HAND INDEX FINGER</td>
<td></td>
<td>561.0</td>
<td>X08.3</td>
<td>2</td>
<td>:H42</td>
<td>:049H</td>
<td>View full HRG details</td>
<td>:NO</td>
<td>:GENERAL</td>
</tr>
<tr>
<td>Field</td>
<td>Description</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------</td>
<td>-------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admission Reason</td>
<td>Free text (appears on Management Reports).</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operation</td>
<td>Free text (appears on WL &amp; Expected Admission List).</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comment</td>
<td>Clinician comments - Free text (appears on WL reports and Expected Admissions report).</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prov Diag</td>
<td>Use super help for partial search.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prim I Proc</td>
<td>A Primary Intended Procedure Code must be entered for each episode.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sec I Proc</td>
<td>A Secondary Intended Procedure code is optional.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HRG Code</td>
<td>Press &lt;Return&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>View Full HRG details</td>
<td>Press &lt;Return&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exp Op Date</td>
<td>Optional. Bypassed if no operation entered.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Theatre Time</td>
<td>Optional. Bypassed if no operation date entered. Enter in minutes if previous field completed.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exp Type Anaes</td>
<td>Optional. If the Operation field is populated, it is possible to complete the expected type of anaesthetic. F9 for choices.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Waiting List Details 3 Screen

**Dt on List**  
Mandatory. Enter the date that the Consultant decided to add the patient to his Waiting List.

**Original Date on List**  
This will default to the same date as date on list, but may be over typed if appropriate to do so.

**Guaranteed Adm Dt**  
This will default from the master file settings.

**Expected Adm Dt**  
Optional unless the method of Admission is Booked (BK). Waiting List management reports may be sorted by this field. Data also appears on the Expected Admission Lists.

**Expected LOS**  
Optional. Enter expected length of stay if known. (The format is numerical and should indicate the number of nights stayed).

**Cancel Defer Dt**  
Display only.

**Last Reviewed & Response Received**  
Are optional fields. Used to enter dates when validating Waiting Lists.

**Review Result**  
Optional. Used to enter free text information when validating Waiting Lists.

**RTT Wait**  
Displays the number of RTT Waiting Weeks/Days if the patient is on an 18 Week Wait Pathway.

**Enter?**  
Yes to save the Waiting List entry.

**18 Week Monitoring?**  
Yes if the Waiting List entry is to be added to an 18 Week Pathway.

**Await Diagnostic Tests?**  
No. (There is no consequence of answering Yes or No at this prompt.)
NOTE: The Waiting List episode can only be added to an existing Pathway if that Pathway is open i.e. there is no End Date. There may be an End Date on the Pathway if the patient has already received treatment eg: at an Outpatient attendance.

NOTE: If the Waiting List episode is the first referral on PAS for this condition and is to be part of an 18 Week Pathway, it may be appropriate to create a Pathway at this stage. See below.

18 Week Pathway RTT Details Screen

This screen is used to link the Waiting List activity to an existing Pathway, or to create a Pathway if appropriate.

**Linking the Waiting List activity to an existing Pathway:**

**Command**

**Pathway Number**

F9. A list of all existing pathways will appear. The correct pathway should be selected. Unless the user knows the pathway number the choice of pathway will be made depending on the Pathway Description.
Pathway Condition Return. Defaults to current entry.
Start Date Return. Defaults to current date.
RTT Current Status Return. Defaults to current status.
Enter? Yes

NOTE: The current dates and codes would not normally be changed here.

Creating a Pathway:

Command Add
Pathway Number Return. Defaults to the next available Pathway number.
Pathway Condition Freetext. Add a description that will make this pathway identifiable for this episode.
Start Date Date added to Waiting List will default in. The clock will start.
RTT Current Status Return.
Enter? Yes

Select Document Screen
Use super help to select any documents you may wish to print. This option is the same as DP in the PMI menu.

5.2. Episode Enquiry View <EPI>
Episode Status WL ACTV indicates the patient is waiting an offer of a date to come in (TCI) to hospital. Time spans are recorded to indicate a patient’s waiting time. This can be used to manage waiting time so that the Trust does not breach Waiting List wait guidelines.
5.3. To Revise or List Waiting List Activity <WLA>

1. Select <WLA>.

2. Search for and select the patient.

3. Amended Basic Details screen if necessary.

4. Select the Consultant’s Waiting List activity to be revised.

5. At the Command field, use super help to select revise or list.

![Waiting List Add Revise List](image)

5.4. To Delete Waiting List Activity <DWA>

This function should only be used when the activity has been entered in error. By deleting you are removing all records of the activity.

1. Select <DWA>.

2. Search for and select the patient.

3. Select the Waiting List episode of the activity to be deleted.

4. Select the ADDED to WL entry.

5. You will be asked if you are sure that you want to delete. Enter Yes if you are certain that you wish to erase the activity.
6. WAITING LIST NAME ENQUIRY <WNI>

This function allows you to view details of patients who are on a current Waiting List.

1. Select <WNI>.

2. Enter the patient’s partial or full surname.

A list of patients matching the criteria you have entered will be displayed.

<table>
<thead>
<tr>
<th>Casenote No</th>
<th>Name</th>
<th>Wt Code DiaG Grp</th>
<th>Org Contract Id</th>
<th>Ward Cons</th>
<th>Spec Age</th>
<th>Sex</th>
<th>Stat</th>
<th>Sex</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>10000001</td>
<td>SMITH, ALISON</td>
<td>YREC J2S</td>
<td>120</td>
<td>39Y</td>
<td>F</td>
<td>DEF</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10000002</td>
<td>SMITH, ALISON</td>
<td>BI ITA</td>
<td>110</td>
<td>39Y</td>
<td>F</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10000003</td>
<td>SMITH, BRENDA</td>
<td>3WILK</td>
<td>120</td>
<td>85Y</td>
<td>F</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10000004</td>
<td>SMITH, CLAIRE</td>
<td>SHI</td>
<td>100</td>
<td>33Y</td>
<td>F</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10000005</td>
<td>SMITH, GERTRUDE</td>
<td>BG</td>
<td>301</td>
<td>81Y</td>
<td>F</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10000006</td>
<td>SMITH, GERTRUDE</td>
<td>BTM</td>
<td>101</td>
<td>81Y</td>
<td>F</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Either:

Select a patient using the sequence number, you will be asked if you wish to view further details? Enter Yes or No.

**NOTE**: You will only be able to view Waiting List detail if you have booking access to the Waiting List that the patient is on. If you have no access the selected patient will be retained in the computer’s memory for you to recall when using another function.

Or:

If you press return through the entire list, you will be asked if you wish to try again. No, will return you to the Main Waiting List Menu. Yes, will return you to Name field.
7. PATIENT PATHWAY FUNCTIONS <PPM> <PPA>

The functions PPM – Patient Pathway Add/Revise and PPA – Patient Pathway Add/Revise Archive allow the viewing and management of 18 Week Pathways.

The functionality is the same in each function. A closed pathway will only show in PPM for up to 30 days from the date it was closed, thereafter it can be viewed in PPA.

7.1. Option Select Screen

The Option Select Screen lists 6 options for managing Patient Pathways.

Enter the required option number and press Enter.

7.2. Pathway Selection Screen

When selecting options 2, 3, 4, 5 or 6 from the Option Select screen a list of all Pathways will display. Both open and closed Pathways are listed. If a Pathway is closed it will have an End Date. A Pathway may be closed because treatment for that condition has already been given.

Select the required Pathway using the sequence number (SNo) and press Enter.
7.3. Add a New Pathway

It is possible to create a Pathway independent of creating an episode. This may be done if a Pathway has not been created when it should have been eg - when recording a referral or waiting list activity.

The relevant episode(s) should then be linked to the Pathway.

There are two ways of creating a Pathway:

**Either:**
Go back into the function the referral was originally created, ORE WLA PAD, and create the Pathway at the prompt. This automatically links the episode to the Pathway.

**Or:**
1. Select PPM
2. Select Option 1 – Add a new Pathway

```
<table>
<thead>
<tr>
<th>Patient Pathway Add/Revise</th>
<th>26/06/08 17:15 OAH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>PIKE, JANICE</td>
</tr>
<tr>
<td>Command</td>
<td>:ADD</td>
</tr>
<tr>
<td>Pathway Number</td>
<td>:RHU80000000009834</td>
</tr>
<tr>
<td>Pathway Condition</td>
<td>:DERMATOLOGY</td>
</tr>
<tr>
<td>Start Date</td>
<td>:26/06/2000</td>
</tr>
</tbody>
</table>
```

3. **Command:** Defaults to ADD
4. **Pathway Number:** F9 Superhelp and select DOH Code RHU, the Pathway Number will now automatically allocate.
5. **Pathway Condition:** Freetext an appropriate description – Speciality.
6. **Start Date:** Enter appropriate date, present or past dates only (should be referral date)
7. **Enter:** YES

Now the relevant episode(s) need to be linked to the Pathway see page 19.
7.4. Delete a Pathway

Option 2 Delete a Pathway from the Option Select Screen allows you to remove a Pathway if it has been added in error. You will first need to delete all Episodes from the Pathway see page 20.

1. Select the Pathway you wish to delete using the sequence number (SNo) and confirm the action.

```
   Patient Pathway Add/Revise
   --------------------------------------
   Name: SELLER, MICHAELA
   Date: 04/03/98 15:47 QM
   RAS No: 22026704

   PATIENT HAS THE FOLLOWING PATHWAYS
   SNo Pathway Number   Pathway Condition     Start Date    Status     End Date
   1    RH000-0000-0000-0002  DHYRE - UTI

   Select/Continue : Y
   Are you sure you wish to delete? : Y
```

7.5. View/Revise a Pathway

Option 3 View/Revise a Pathway from the Option Select Screen will LIST or REVISE the Pathway details.

1. Select the relevant Pathway from the Pathway selection screen.

```
   Patient Pathway Add/Revise
   --------------------------------------
   Name: SELLER, MICHAELA
   Date: 03/03/00 10:31 QM
   RAS No: 22026704

   Command: REVISE
   Pathway Number: RH000-0000-0000-0002
   Pathway Condition: GYNE - UTI
   Start Date: 05/02/00
   End Date: 05/02/00
   RTT Current Status: GYNECOLOGY
   RTT Current Prov: ADU PORTSMOUTH HOSPITALS NHS TRUST
```

2. Command: LIST or REVISE (default).

6. Pathway Number: Displays the Pathway number.

7. Pathway Condition: Displays the Pathway description. Revise if required.
8. **Start Date:** Revise if appropriate.

9. **RTT Current Status:** No code indicates no activity has been recorded against the Pathway. Enter appropriate code, if required.

10. **Sts Dt:** Enter the date of the RTT Current Status.

11. **End Date:** Displays the end date if the Pathway is closed.

12. **Enter?** Enter Y or N.

### 7.5.1. To manually close a Patient Pathway – example

There will be occasions when a Patient Pathway will need to be ended. For example, a patient contacting the Trust to inform they do not want their treatment to continue. Removing a patient from an Inpatient Waiting List will automatically update a Patient Pathway but there may be other occasions when this process needs to be done manually.

**RTT Current Status:** Enter appropriate code or press F9 (Superhelp) to select.

**Sts Dt:** Enter the date of the RTT Current Status.

**End Date:** Defaults with date.

**Enter?** Enter Y or N.

### 7.5.2. To manually reopen a Patient Pathway – example

**RTT Current Status:** Enter appropriate code or press F9 (Superhelp) to select. A Warning message is displayed at the bottom of the screen: "**Are you sure you want to Re-open this Pathway – Re-enter to confirm**". Re-enter the same code.

**Sts Dt:** Enter the date of the RTT Current Status.

**End Date:** Date is removed.

**Enter?** Enter Y or N.

### 7.5.3. Watchful Waiting/Active Monitoring

At any time after the start of a Pathway, a clinician may decide to ‘Actively Monitor’ the progress of the patient. This could occur during the Outpatient or Waiting List stage.
The code for the start of Watchful Waiting/Active Monitoring is ‘SMH’, once entered on PAS this code will automatically default an End Date on the Pathway. This will be the date of the start of Active Monitoring.

The code for the end of Watchful Waiting/Active Monitoring is ‘EAM’, once entered on PAS this code will automatically remove the End Date on the Pathway and start date must be altered to the date when the Watchful Waiting/Active Monitoring ends.

Outside of Outpatient appointment activity the Pathway should be revised with the codes SMH or EAM following the procedures 7.5.1 and 7.5.2 above.

7.6. View Pathway Episodes

Option 4 – View Pathway Episodes will display all episodes linked to a specific Pathway.

When adding a patient to a Waiting List or Pre-admitting it is advisable to check the Pathway status prior to adding to the Waiting List. This is the best function to use.

7.7. Add Episodes to a Pathway

There will be occasions when it is necessary to link an episode to an existing Pathway. However, episodes can only be linked to an open Pathway, i.e. it has no End Date. Generally, if a patient has received any form of treatment, the Pathway will have an End Date of when the treatment took place. It is only necessary to link episodes to a Pathway, for the same condition, when there is no End Date.

1. Select Option 5 – Add Episodes to a Pathway

2. Select the appropriate Pathway. If the Pathway Number is not known refer to the Pathway Condition for guidance.
Patient episodes will be displayed on screen. Inappropriate episodes or those already linked to the Pathway will have no sequence number.

3. Select the appropriate episode.

The screen will remain on the episode display.

4. F1 to exit the screen once all episodes to link have been selected.

The Pathway start date will display the date of the newly linked episode if it is earlier than the date entered when the Pathway was created.

**7.8. Delete Episodes from a Pathway**

Option 6 **Delete Episode from a Pathway** from the **Option Select Screen** allows you to remove an Episode if it has been incorrectly added to a Pathway.

Select the Episode you wish to delete using the sequence number (**SNo**) and confirm the action.
8. WAITING LIST REMOVAL (CANCEL) <WLC>

This function allows you to remove the patient permanently from the Waiting List. Perhaps the patient has decided against the procedure, died or moved out of the area.

**NOTE:** THIS FUNCTION MUST NOT BE USED TO CORRECT ERRORS.

1. Select <WLC>.
2. Search for & select the patient.
3. Select the Waiting List episode that the patient is being removed from.
4. At Waiting List Removal screen complete the following fields:

   - **Reason**: F9 (Superhelp) for the list.
   - **Removal Date/Time**: Enter date and time.
   - **Comment**: Optional, free text.
   - **RTT Current Status**: Displays if the activity is on a Pathway. The current status of the Pathway will default in. It should be overwritten with the appropriate status code. F9 (Superhelp) for the list.

5. Enter Yes to remove the patient from the Consultant's Waiting List.

**NOTE:** Patient's episode status will be WL CANC. The reason code for removal is also displayed in episode enquiry. The 18 Week Pathway will automatically be closed and the End Date will be the Waiting List Removal Date.
To view Waiting List Removal comment field or to revise WLC entry


7. Search & select the patient.

8. Select the WL CANC episode.

9. At Command, use Superhelp to list (view only) or revise.

9.1. To Delete a Waiting List Removal <DWC>

This function allows you to delete the removal from the Consultant Waiting List. This will remove all traces that the patient was removed from a Waiting List. Only proceed if you are sure that's what you wish to do.

1. Select <DWC>.

2. Search & select patient.

3. Select the WL CANC to be deleted.

4. Select the CANCELLED activity.

5. You will be asked if you are sure that you want to delete. Enter Yes if you are certain that you wish to erase the activity.

**NOTE**: The Episode Status will be returned to WL ACTV.

**NOTE**: The 18 Week Pathway activity will need to be restored by revising the pathway using the function PPM, option 3. See page 17.
9. WAITING LIST SUSPEND <WLS>

This function allows you to suspend the patient from the Consultant's waiting list. A date to reinstate the patient will be required when recording the suspension. The system will automatically reinstate the patient to the Consultant's waiting list on this date. Please refer to Waiting List Policies & Procedure regarding patients not available for surgery.

1. Select <WLS>.
2. Search & select the patient to be suspended.
3. Select the Waiting List episode to be suspended.
4. Press return through the Display Inpatient Events screen.
5. Use super help to assist you whilst completing the suspension screen.
   a. Did the patient or the Consultant initiate the suspension?
   b. What time and date did this happen?
   c. Why the patient was suspended (free text)?
   d. What date is the patient suspended until (Mandatory)?
   e. Reason Code; use Superhelp to select appropriate code.

```
Enhanced Waiting List Suspend
Init By Start Date/Time Reason Code Susp Until
: : : :
```

**NOTE**: The episode status in Episode Enquiry will be WL SUSP. Reason for the suspension cannot be viewed in Episode Enquiry. The suspension reason may be viewed in the function of Waiting List Suspend (WLS). At the command field use Superhelp and select LIST.

**NOTE**: If the patient is on a Pathway, the Pathway will also need to be managed. If the patient is suspended from the Waiting List for Active Monitoring the Pathway needs to be stopped until Active Monitoring has finished. Revise the Pathway status in the function PPM see page 15.
9.1. Waiting List View (List) or Waiting List Suspension Extension

1. Select <WLS>.

2. Search and select the patient.

3. Select the WLS episode to be viewed/revised.

4. Select the SUSPENDED activity.

5. At the command field use super help to list (view) or revise the activity.

**NOTE**: The reason free text and the reason code are on view here.

6. To extend the suspension time period, enter through the data recorded. The additional fields of Extended Until; Extension Reason & By will become visible. Populate fields as necessary.

**NOTE**: The Consultant may make the decision to manage the patient in his Outpatient Clinic or the patient could be returned to the care of their GP. This may result in the patient being removed from the Waiting List until they are suitable for their Inpatient treatment.
9.2. To Delete a Waiting List Suspension <DWS>

**NOTE:** If you are only administrating a partial deletion use WLS and use F2 (Delete Field) to delete the extension part i.e. Weigh Loss as shown in the Enhanced Waiting List Suspend screen shot previously.

Use <DWS> if deleting the whole of the Waiting List Suspension.

1. Select <DWS>.
2. Search & select the patient.
3. Select the WL SUSP episode.
4. Select the SUSPENDED activity.
5. You will be asked if you are sure you want to delete. Enter, Yes if you are certain you wish to delete the activity.

**NOTE:** The episode will be returned to WL ACTV if the whole suspension is deleted. Be mindful of implications on the Pathway status and dates.
9.3. Waiting List Reinstate <WRI>

You may manually reinstate a suspended patient back to the Waiting List before the recorded suspension/deferral date using the function of <WRI>.

1. Select <WRI>.
2. Search and select the patient.
3. Select the appropriate WL SUSP.
4. Press return through the Inpatient Display Screen.
5. Enter the Return Date/Time that the patient was manually reinstated to the Waiting List.
6. At Select Document, print any documents that may be required for your department.

**NOTE**: The episode status in Episode Enquiry will read WL ACTV. The internal episode will display the suspension/deferral & the reinstate details. Be mindful of implications on the Pathway status and dates.
10. **PRE – ADMISSION NAME ENQUIRY <PNI>**

1. Select <PNI>.

2. Enter the patient partial or full surname.

A list of patients matching your criteria will be displayed.

![Pre-admission Name Enquiry Example](image)

Either:

Select a patient. You will be returned the Waiting List Main Menu, the selected patient will be retained in the computer's memory for you to recall when using another function.

Or:

Return through Select Patient, where you will be asked if you wish to try again. No, will return you to the Main Waiting List Menu. Yes, will return you to Name field.
11. CANCEL ELECTIVE TREATMENT ADD <CEA>

This function books the patient back onto a Waiting List and can rebook the patient’s admission date after being admitted and discharged without having had their treatment. The previous Waiting List details are then available without having to re-enter them.

1. Select <CEA>.

2. Search & select the patient.

3. Revise the basic details if required.

4. Select the correct DSCH (discharge) episode. This should be the episode with the correct date criteria, Consultant, Speciality and Waiting list Code.

5. Select the ADDED TO WL activity.

6. You will be asked whether you wish to Retain the patient on the Waiting List or Rebook (offer a new admission date) now. Use super help for options.

7. If you Retain on WL the system will take you through the process of adding the patient onto the Waiting List. The original Waiting List details will be populated.

Canc/Defer Dt 1: This will populate with the date the patient was cancelled or deferred. If the patient has previously been cancelled or deferred “DT 1” will display a different number and the previous details will be listed below.

In Pat. Interest: Answer YES or NO as appropriate.

Self-Deferral: Answer YES or NO as appropriate.

Reason: Use Superhelp to select the Reason for the
8. If you **Rebook now** the system will take you thorough booking a new admission date on the system. You will need to enter the new Expected Admission details.

**NOTE:** The episode status in episode enquiry will display the DSCH INCPT with the *CEA* indicator and the new WL ACTV or PRE ADM TCI episode.

```
1 PREADM TCI 29/06/65 GEH 110 QAH NHS 9257981 GEHWL
2 DSCH INCPT 15/06/65 GEH 110 QAH DSUQ NHS 9257981 GEHWL
  * CEA *
```

**NOTE:** The function CEA will not prompt you to add the new episode to an 18 Week Pathway. If the episode is related to an 18 Week Pathway you must manually link the new WL ACTV or PREADM TCI to the appropriate Pathway.

See page 19 for how to link an episode to a Pathway.
12. SELECT FROM WAITING LIST <SWL>

The function allows you to display on the screen patients on a specified waiting list. This function may help you select a patient who is available at short notice, filling a cancelled Pre Admission slot.

1. Select <SWL>.

2. Enter the Consultant Waiting list Code or use super help to search. The Diag Group & Hospital will default, press return through these fields.

3. At Urgency Either enter thorough to view all urgencies or use super help to define individual urgency.

4. At Select/Continue To move thorough the screens, press return, or select the patient by their sequence number.

5. At Action Use super help to either LIST or TCI.

6. LIST This option will display three screens detailing the patient’s Waiting List activity.

7. TCI This option will display the TCI details screen. These screens are for general validation or updating purposes. If any patients are selected for TCI you will be able to print a report as you exit the function. At WL Code press F1. You will be taken to the Destination field. Enter your printer code to print a list of patients selected for admission.
13. WAITING LIST TRANSFER <WTR>

This function will allow you to transfer patients from one Waiting List to another either on block, partially or individually.

13.1. Block Transfer

This transfer will happen at day end. The entire patients from one waiting list will be transferred to another.

If the Waiting List you have transferred the patient from is now empty and will remain unused i.e. the Consultant has left, please contact the ICT Service Desk on 02392 682680 to have staff access withdrawn. This will reduce your workload when dealing with schedule reports.
13.2. Delete Block Transfer Request
Prior to day end, you may delete a transfer requested in error. A list of appropriate outstanding transfer requests will appear on the screen. Select the transfer to be deleted and enter Yes to confirm the deletion.

13.3. Individual Patient Transfers
1. Select <WTR>.
2. Select appropriate choice.
3. Search and select the patient.
4. Select the Waiting List episode to be transferred.
5. Complete the Perform Transfer screen with the appropriate information.

![Waiting List Transfer Screen]

13.4. Partial List Transfers
This transfer will take place at day end.
1. Select <WTR>.
2. Select the Partial option.
3. Complete the Waiting List Transfer screen using Superhelp. Use Help (F8) to see descriptive help at the ALL Patients field.
If Yes selected  The screen will require WL Code to be transferred to.

If No selected  A list of patients who meet the criteria will be displayed for individual selection. You may use F11 to multi select.

4. Complete the Perform Transfer screen with the appropriate information.

**NOTE:** Within the individual Waiting List Episodes, will be details of the Waiting List Transfer.
13.5. Delete Waiting List Transfers <DWT>

This function will allow you to correct Waiting List Transfers, errors on an individual patient basis.

Select <DWT>.

Search & select the patient.

Select the Waiting List episode that you want to correct the activity for.
Select the appropriate WL Transfer.

You will be asked if you are sure you want to delete. If you enter Yes, the patient will be returned to the original waiting list.
14. WAITING LIST REPORTS <WLR>

The Waiting List Reports Function <WLR> allows you to print reports containing information necessary to the successful management of any Waiting List.

This section will:
- describe the availability of the reports
- provide instructions on how to request the reports
- contains sample reports showing test data
- offer guidance as to the frequency reports should be requested

14.1. Report Availability

Reports are available in a variety of ways; they can be requested to answer a specific query or to provide set information at a regular frequency.

AD-HOC One off request to be run on a given day, after day end
ON DEMAND One of request to be run immediately
REPRINT Reprint of an existing report to be run immediately
SCHEDULED Request to be run, after day end, and repeated at a given interval

14.2. Command Prompt

When using the reporting facility there are occasions when you need to access and view, or change reports previously set up. At the "command" prompt the following options are available:

ADD Add a new report request
DELETE Delete existing report request
OVERRIDE Override exiting report request
LIST Look at existing report request
REVISE Revise existing report request
14.3. General Requesting Instructions

Not all of the following questions will be prompted for on each request. There is a full range of report dependant prompts that you may be prompted for depending on which report has been requested, see each report sample for further details.

**NOTE**: When requesting reports you are asked for a REQUEST DESCRIPTION. This should be filled in to help in the identification of reports when you need to access them to revise, delete or even just look. A list of all reports, from the whole hospital will be displayed and the only way to recognise the one you want is from the REQUEST DESCRIPTION.

Here is an example:

Orthopaedics at QAH has requested a Management report for the IAJHA list. The REQUEST DESCRIPTION could be Orthopaedic WHA

14.3.1. Ad-Hoc

<table>
<thead>
<tr>
<th>REQUEST TYPE</th>
<th>Select AD-HOC &lt;F9&gt; Superhelp for list</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMMAND</td>
<td>&lt;F9&gt; Superhelp (ADD / DELETE / LIST / REVISE)</td>
</tr>
<tr>
<td>REQUEST DESCRIPTION</td>
<td>Enter title for report <strong>see note above</strong></td>
</tr>
<tr>
<td>REQUEST FOR REPORT TO BE PRODUCED ON</td>
<td>Enter date required, remember the report will be produced at day end</td>
</tr>
<tr>
<td>START DATE</td>
<td>Enter the date the report is to start from</td>
</tr>
<tr>
<td>END DATE</td>
<td>Enter the date the report is to end on</td>
</tr>
<tr>
<td>DESTINATION</td>
<td>Enter the printer code of the printer that it is to be produced on</td>
</tr>
<tr>
<td>No. OF COPIES</td>
<td>Enter number of copies required, the default is one</td>
</tr>
<tr>
<td>ENTER</td>
<td>Enter Yes / NO</td>
</tr>
</tbody>
</table>

14.3.2. On Demand

<table>
<thead>
<tr>
<th>REQUEST TYPE</th>
<th>Select ON DEMAND, &lt;F9&gt; Superhelp for list</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMMAND</td>
<td>&lt;F9&gt; Superhelp (ADD/ LIST)</td>
</tr>
<tr>
<td>REQUEST DESCRIPTION</td>
<td>Enter title for report <strong>see note above</strong></td>
</tr>
<tr>
<td>START DATE</td>
<td>Enter the date the report is to start from</td>
</tr>
</tbody>
</table>
END DATE Enter the date the report is to end on

DESTINATION Enter the printer code of the printer that it is to be produced on

No. OF COPIES Enter number of copies required, the default is one

ENTER Enter Yes / NO

14.3.3. Reprint

REQUEST TYPE Select REPRINT <F9> Superhelp for list

SELECT / CONTINUE Select one of the reports from displayed list

DESTINATION Enter the printer code of the printer that it is to be produced on

No. OF COPIES Enter number of copies required, the default is one

ENTER Enter Yes / NO

14.3.4. Scheduled

REQUEST TYPE Select SCHEDULED, <F9> Superhelp for list

COMMAND <F9> Superhelp (ADD / DELETE / LIST / OVERRIDE / REVISE)

REQUEST DESCRIPTION Enter title for report **see note above **

REPORT FREQUENCY Enter the frequency of the report, i.e.

D Daily
7D Weekly
28D 4 Weekly
M Monthly
3M Quarterly
12M Yearly

REQUEST FOR REPORT TO BE PRODUCED ON Enter date required, remember the report will be produced at day end

START DATE Enter the date the report is to start from

END DATE Enter the date the report is to end on

NEXT REPORT WILL BE PRODUCED ON Date will default
<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>START DATE</td>
<td>Date will default</td>
</tr>
<tr>
<td>END DATE</td>
<td>Date will default</td>
</tr>
<tr>
<td>SCHEDULE ACTIVE</td>
<td>Yes / No &lt;F8&gt; help, (normally yes)</td>
</tr>
<tr>
<td>PRINT RETROSPECTIVE REPORTS</td>
<td>Yes / No &lt;F8&gt; help, (normally yes)</td>
</tr>
<tr>
<td>DESTINATION</td>
<td>Enter the printer code of the printer that it is to be produced on</td>
</tr>
<tr>
<td>No. OF COPIES</td>
<td>Enter number of copies required, the default is one</td>
</tr>
<tr>
<td>ENTER</td>
<td>Enter Yes / NO</td>
</tr>
</tbody>
</table>
14.4. Mandatory and Recommended Reports

14.4.1. MANDATORY MONTHLY REPORTS

The reports mentioned below can be pulled as frequently as necessary. However, it is recommended that they are pulled monthly as a minimum.

- **SUSPENSION REPORT** - on the last day of the calendar Month

  Shows all patients, for each Waiting List, who have a status of suspended. This report should be reviewed and any necessary action taken.

  It is possible to set up one schedule to provide you with all the necessary information. Select ALL at waiting list code and leave the other paramatised fields blank.

  This will produce a page, for each Waiting List that you have access to, that has suspended patients. This way the number of schedules is drastically reduced and you won't be producing reports for Waiting Lists that don't have any Suspended patients.

- **DEFERRAL REPORT** - on the last working day of the calendar month

  Shows all patients for each Waiting List, who have a status as deferred. This report should be used to identify patients who need further action i.e. reinstatement to the active list.

  It is possible to set up one schedule to provide you with all the necessary information. Select ALL at waiting list code and leave the other paramatised fields blank.

  This will produce a page, for each Waiting List that you have access to, that has deferred patients. This way the number of schedules is drastically reduced and you won't be producing reports for Waiting Lists that don't have any deferred patients.

14.4.2. RECOMMENDED MONTHLY REPORTS

**Cancellation Report**

This report shows patients who have been removed from the waiting list.

**Treatment Cancellation Report**

The treatment cancellation report can be used to monitor the rebooking of cancelled patients to ensure the Patients Charter is met. The report is produced on two pages, one showing patients who have had their treatment cancelled once and the second showing patients who have had their treatment cancelled at least twice. The report will indicate whether or not the cancellation was in the interest of the patient.
14.4.3. **MANDATORY WEEKLY REPORTS**

**Management Report & Management Summary Reports**

At least one of these reports should be produced once a week for Waiting List giving details of all patients on the active Lists. This should be used for reference in the selection of lists, in the management of long waiters and patients needing special notice.

The full Management Report can also be used to provide information to and about specific purchasers etc. This report can be scheduled for All Waiting Lists. However it is recommended that a report so large should be requested on an ad hoc basis and not at the end of month with all the other reports.

14.4.4. **RECOMMENDED WEEKLY REPORTS**

**Operation Report**

This report shows all the patients with a specified operation date for a particular Consultant or Ward and can be used in the production of theatre lists.

**Management Report**

There are lots of variations on how you can request this report to produce the information you require to operate your waiting lists and provide the necessary information to the purchasers.
14.5. Report Examples

14.5.1. Management Report
This report can be produce either Ad hoc, Scheduled or On Demand.

<table>
<thead>
<tr>
<th>Request Description</th>
<th>Date: 19/03/2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Request for report to be produced</td>
<td>Latest Adm Date:</td>
</tr>
<tr>
<td>Latest Dua Adm Date:</td>
<td>Waiting List Code:</td>
</tr>
<tr>
<td>Report Order:</td>
<td>No. of days until Recall:</td>
</tr>
<tr>
<td>High group(s):</td>
<td>Min Wait:</td>
</tr>
<tr>
<td>Up to Urgency:</td>
<td>Max Wait:</td>
</tr>
<tr>
<td>Intd Hgnt:</td>
<td>Min Days on List:</td>
</tr>
<tr>
<td>Inpatient Category:</td>
<td>Min Days on Orig List:</td>
</tr>
<tr>
<td>Age Group:</td>
<td>Short Notice:</td>
</tr>
<tr>
<td>Procedure:</td>
<td></td>
</tr>
<tr>
<td>Referral Code:</td>
<td></td>
</tr>
<tr>
<td>Practice Code:</td>
<td></td>
</tr>
<tr>
<td>Purchaser Code:</td>
<td></td>
</tr>
<tr>
<td>Destination:</td>
<td></td>
</tr>
<tr>
<td>No. of Copies:</td>
<td></td>
</tr>
<tr>
<td>Enter?:</td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:** If Waiting List Code is completed at all it is restricted to the user's access and is site specific. However a page will print for each waiting list (even if there are no patients on that list matching the criteria entered.

Examples:

- **Page 43**
  - WL Code = PMPMAJ
  - Purchaser = ALL

- **Page 44**
  - WL Code = All
  - Purchaser = QD200

- **Page 45**
  - WL Code = PMPMAJ
  - Purchaser = 9AC20
<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
<th>DOB</th>
<th>GP Code</th>
<th>Diagnosis</th>
<th>Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reader, Francis</td>
<td>02/11/1945</td>
<td>04/5250</td>
<td>SAC10</td>
<td>Malignant melanoma of thyroid gland</td>
<td>C71.7</td>
</tr>
<tr>
<td>Scherer, Martin</td>
<td>08/12/1945</td>
<td>08/5262</td>
<td>SAC10</td>
<td>Venous varices lower extremities</td>
<td>L40.1</td>
</tr>
<tr>
<td>Seaf, Tracey</td>
<td>23/09/1945</td>
<td>05/5262</td>
<td>SAC10</td>
<td>Venous varices lower extremities</td>
<td>L40.1</td>
</tr>
<tr>
<td>Richards, Gary</td>
<td>05/09/1945</td>
<td>05/5262</td>
<td>SAC10</td>
<td>Bilateral variced leg veins without ulcer or inflammation</td>
<td>L40.1</td>
</tr>
<tr>
<td>Anderson, John</td>
<td>03/11/1945</td>
<td>03/5262</td>
<td>SAC10</td>
<td>Venous varices lower extremities</td>
<td>L40.1</td>
</tr>
<tr>
<td>Smith, Alison</td>
<td>31/02/1973</td>
<td>02/5262</td>
<td>SAC10</td>
<td>Venous varices lower extremities</td>
<td>L40.1</td>
</tr>
<tr>
<td>Reddhill, Mary</td>
<td>27/03/1945</td>
<td>03/5262</td>
<td>SAC10</td>
<td>Venous varices lower extremities</td>
<td>L40.1</td>
</tr>
<tr>
<td>Name</td>
<td>Sex</td>
<td>DOB</td>
<td>Date on List</td>
<td>Urgency</td>
<td>Code</td>
</tr>
<tr>
<td>---------------</td>
<td>-----</td>
<td>-------</td>
<td>--------------</td>
<td>---------</td>
<td>-------</td>
</tr>
<tr>
<td>ROBERTS, Joan</td>
<td>F</td>
<td>17/12/86</td>
<td>12/06/1945</td>
<td>3</td>
<td>SURG</td>
</tr>
<tr>
<td>LETTLETTA, Flora</td>
<td>F</td>
<td>17/06/1945</td>
<td>17/12/96</td>
<td>3</td>
<td>SURG</td>
</tr>
<tr>
<td>REEF, Tracey</td>
<td>F</td>
<td>23/09/1976</td>
<td>18/12/96</td>
<td>3</td>
<td>SURG</td>
</tr>
<tr>
<td>ROBERTS, Judy</td>
<td>F</td>
<td>18/09/1976</td>
<td>18/12/96</td>
<td>3</td>
<td>SURG</td>
</tr>
<tr>
<td>LAURENCE, Dorothy</td>
<td>F</td>
<td>07/12/1938</td>
<td>07/12/97</td>
<td>3</td>
<td>SURG</td>
</tr>
</tbody>
</table>
## Waiting List Management Report

### Queen Alexandra Hospital

#### for List PMFMJ1 PERRY MAJOR SURGERY LIST

**Run Date:** 18/03/1997 13:03

### Selection:
- Days on list: 0
- Urgent Days: 0

### GFH Code:
- SAC20

### Sorted By:
- GROUP, URGENCY, DATE, MANAGEMENT

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Case Note No</th>
<th>Sex</th>
<th>DOB</th>
<th>Home Phone</th>
<th>Short Notice</th>
<th>Work Phone</th>
<th>Admission Reason</th>
<th>Operation</th>
<th>Expiry Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reader, Francis</td>
<td>3411109</td>
<td>F</td>
<td>12/11/1989</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Provisional Diagnosis
- C73.2: Malignant neoplasm of thyroid gland

### Secondary Intended Procedure
- 808.2: Subtotal Thyroidectomy

### Theatre

---

Number of Patients reported for waiting list = 1

---
14.5.2. Management Summary Report (MSD)
This report can be produce either Ad hoc or scheduled.
14.5.3. MANAGEMENT SUMMARY REPORT (MSO)

This report can only be produce On Demand.

The example on the following page is an MSO for WL Code PMPMAJ and all other requests criteria defaulting to all.
<table>
<thead>
<tr>
<th>Case Note No</th>
<th>Patient Surname</th>
<th>First Name</th>
<th>Admission Reason</th>
<th>Operation</th>
<th>Test Adm Reason</th>
<th>Test Operation</th>
<th>Diag Group</th>
<th>Dth</th>
</tr>
</thead>
<tbody>
<tr>
<td>S411100</td>
<td>READER</td>
<td>FRANCIS</td>
<td>TEST ADMISSION REASON</td>
<td>TEST OPER</td>
<td>TEST AD</td>
<td>TEST OF</td>
<td>SURG</td>
<td>0 0 0</td>
</tr>
<tr>
<td>Q720987</td>
<td>ROBES</td>
<td>JOAN</td>
<td>TEST AD</td>
<td>TEST OF</td>
<td>SURG</td>
<td>0 0 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q230986</td>
<td>REAF</td>
<td>TRACEY</td>
<td>TEST AD</td>
<td>TEST OF</td>
<td>SURG</td>
<td>0 0 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q986598</td>
<td>RICHARDS</td>
<td>GARY</td>
<td>TEST AD</td>
<td>TEST OF</td>
<td>SURG</td>
<td>0 0 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q845918</td>
<td>RICE</td>
<td>ALISON</td>
<td>TEST ADM REASON</td>
<td>TEST OF</td>
<td>SURG</td>
<td>0 0 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q859335</td>
<td>REDMILL</td>
<td>MARY</td>
<td>TEST ADM REASON</td>
<td>TEST OF</td>
<td>SURG</td>
<td>0 0 0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

***Number of Patients on report = 6***
14.5.4. Deferral Report

This report can be produced either Ad hoc, Scheduled or On Demand.

<table>
<thead>
<tr>
<th>Waiting List Deferred Patients Report</th>
<th>19/03/09 15:27 QM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Request Description :</td>
<td></td>
</tr>
<tr>
<td>Request for report to be</td>
<td></td>
</tr>
<tr>
<td>Produced on                          : 19/03/2009</td>
<td></td>
</tr>
<tr>
<td>Showing Data until                  :</td>
<td></td>
</tr>
<tr>
<td>Waiting List Code :                  :</td>
<td></td>
</tr>
<tr>
<td>Production Parameter :               :</td>
<td></td>
</tr>
<tr>
<td>GP Practice Code :                   :</td>
<td></td>
</tr>
<tr>
<td>GPFH Code :                          :</td>
<td></td>
</tr>
<tr>
<td>Purchaser Code :                     :</td>
<td></td>
</tr>
<tr>
<td>Sex Sort?                           :</td>
<td></td>
</tr>
<tr>
<td>Destination                         :</td>
<td></td>
</tr>
<tr>
<td>No.of Copies :                       :</td>
<td></td>
</tr>
<tr>
<td>Enter?                               :</td>
<td></td>
</tr>
</tbody>
</table>

This list can be pulled in many ways, the most common (as shown on the example on page 50) is by individual list. This could be broken down further to result in "by purchaser / GPFH, by list or could be pulled under the wider heading of "All lists by purchaser / GPFH".

It may be useful to consider having one scheduled for all lists and not broken down any further; this will produce a list of all patients that are deferred, restricted only by your access and the site you are logged in to. This could prevent the need to have so many scheduled at the end of the month.

**NOTE**: If a deferral is extended the extension details (i.e. new Until Date) will be shown in the line underneath the original details. However they are not displayed in the same order.
### Deferred Patients Report

**Run Date:** 10/03/1997 13:59  
**Latest Deferral End Date:**

<table>
<thead>
<tr>
<th>GP Practice Code</th>
<th>GPFS Code</th>
<th>Purchaser Code</th>
<th>Cat Date on List</th>
<th>Contract ID</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Case Note No</th>
<th>Patient Name</th>
<th>Sex</th>
<th>Hosp Constraints</th>
<th>Spec Case</th>
<th>Approx DGA</th>
<th>ELS</th>
<th>Adn Reason</th>
<th>Operation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Patient Deferred on 18/03/1997

- **Reason:** PT HBP
- **Until:** 01/04/1997

#### Patient Deferred on 18/03/1997

- **Reason:** PT UNWELL
- **Until:** 08/04/1997

---

**End of Report**
14.5.5. Suspension Report (SUSP RPT)

This report can be produce either Ad hoc, Scheduled or On Demand.

<table>
<thead>
<tr>
<th>Waiting List Suspension Report</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>On Demand Report Request [OBD]</td>
<td>19/03/09 15:20 QAA</td>
</tr>
</tbody>
</table>

Request Description : [Redacted]
Request for report to be Produced on : 19/03/2009
Showing Data until : [Redacted]

Waiting List Code : [Redacted]
Production Parameter : [Redacted]
GP Practice Code : [Redacted]
Purchaser Code : [Redacted]
Sex Sort? : [Redacted]
Destination : [Redacted]
No.of Copies : [Redacted]
Enter? : [Redacted]

This list can be pulled in many ways; the most common is by individual list. This could be broken down further to result in "by purchaser / GPFH, by list or could be pulled under the wider heading of "All lists by purchaser / GPFH".

It may be useful to consider having one scheduled for all lists and not broken down any further; this will produce a list of all patients that are suspended, restricted only by your access and the site you are logged in to. This could prevent the need to have so many scheduled at the end of the month. If this is requested it will print a separate page for each WL Code that has any suspended patients.

**NOTE**: If a suspension is extended the extension details (i.e. new Until Date) will be shown in the line underneath the original details, however they are not displayed in the same order. For an example see page.

The examples are

- **Page 52**
  - WL Code = IAJHA
  - Production Parameters = ALL

- **Page 55**
  - WL Code = PMPMAJ
  - Production Parameters = GPFH - 9AE2I
<table>
<thead>
<tr>
<th>Waiting List</th>
<th>Sex</th>
<th>GP Practice Code</th>
<th>GPPH Code</th>
<th>Purchaser Code</th>
<th>Contract ID</th>
<th>Cat Date on List</th>
</tr>
</thead>
<tbody>
<tr>
<td>IAJHA</td>
<td>NO</td>
<td></td>
<td></td>
<td>Q200</td>
<td>NRS</td>
<td>20/01/1997</td>
</tr>
</tbody>
</table>

**Suspension Report Example 1**

Patient Suspended on 06/03/1997

**Reason:** TEST SECOND SUSPENSION

**By:** PAT

Until: 21/03/1997

**Extended Until:** 10/04/1997

**Reason:** TEST EXTEND SECOND SUSPENSION

**By:** CON

***End of Report***
Suspension Report Example 2
14.5.6. Treatment Cancellation Report

This report can be produce either Ad hoc, Scheduled or On Demand.

The report has two pages:

1. The first shows those patients who have been cancelled at least twice.
2. The second shows patients who have only been cancelled once.

**NOTE:** You will notice on the left hand side of the report is a field called Canc/ Defer Ind, this will contain a Yes or No to indicate if the cancellation was in the interest of the patient or not.
### Treatment Cancellation Report Example 1

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Case Note No</th>
<th>Secondary Intended Procedure</th>
<th>Primary Intended Procedure</th>
<th>Primary Reason</th>
<th>Secondary Reason</th>
<th>Test AD Date</th>
<th>Test AD Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peters</td>
<td>0473659</td>
<td>Bladder-neck obstruction</td>
<td>Bladder-neck obstruction</td>
<td>10/02/97</td>
<td>10/02/97</td>
<td>10/02/97</td>
<td>10/02/97</td>
</tr>
<tr>
<td>Creasey</td>
<td>0473659</td>
<td>Bladder-neck obstruction</td>
<td>Bladder-neck obstruction</td>
<td>10/02/97</td>
<td>10/02/97</td>
<td>10/02/97</td>
<td>10/02/97</td>
</tr>
<tr>
<td>Smith</td>
<td>0473659</td>
<td>Bladder-neck obstruction</td>
<td>Bladder-neck obstruction</td>
<td>10/02/97</td>
<td>10/02/97</td>
<td>10/02/97</td>
<td>10/02/97</td>
</tr>
<tr>
<td>Brown</td>
<td>0473659</td>
<td>Bladder-neck obstruction</td>
<td>Bladder-neck obstruction</td>
<td>10/02/97</td>
<td>10/02/97</td>
<td>10/02/97</td>
<td>10/02/97</td>
</tr>
<tr>
<td>Green</td>
<td>0473659</td>
<td>Bladder-neck obstruction</td>
<td>Bladder-neck obstruction</td>
<td>10/02/97</td>
<td>10/02/97</td>
<td>10/02/97</td>
<td>10/02/97</td>
</tr>
<tr>
<td>Black</td>
<td>0473659</td>
<td>Bladder-neck obstruction</td>
<td>Bladder-neck obstruction</td>
<td>10/02/97</td>
<td>10/02/97</td>
<td>10/02/97</td>
<td>10/02/97</td>
</tr>
<tr>
<td>White</td>
<td>0473659</td>
<td>Bladder-neck obstruction</td>
<td>Bladder-neck obstruction</td>
<td>10/02/97</td>
<td>10/02/97</td>
<td>10/02/97</td>
<td>10/02/97</td>
</tr>
<tr>
<td>Red</td>
<td>0473659</td>
<td>Bladder-neck obstruction</td>
<td>Bladder-neck obstruction</td>
<td>10/02/97</td>
<td>10/02/97</td>
<td>10/02/97</td>
<td>10/02/97</td>
</tr>
</tbody>
</table>

*Note: The table above is an example of a Treatment Cancellation Report. It includes patient information, case note numbers, and reasons for cancellation.*
<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Canc/Defer Ind</th>
<th>Date</th>
<th>Reason</th>
<th>Case Note No</th>
<th>Urg</th>
<th>Orig Date</th>
<th>Date on List</th>
<th>Guaranteed Date</th>
<th>Latest Date</th>
<th>Exp Adm</th>
<th>Dt</th>
<th>Ward</th>
<th>Category</th>
<th>Intd Mt</th>
<th>Sex</th>
<th>Age</th>
<th>Contr Id</th>
<th>GPRN</th>
</tr>
</thead>
</table>

No Patients Potted
14.5.7. Operation Report
This report can be produce either Ad hoc, Scheduled or On Demand.

The report can be request by Ward, Consultant or by ALL. If ALL is selected a sort order will need to be defined. Regardless of the above a page will be printed for each date within the specified timescale, these pages will be subdivided according to the request criteria. This may be useful in the production of theatre lists.

The example on page 6058 shows PMP for all wards on 20/03/97.
The example on page 61 shows all patients for E2 on 18/03/97
<table>
<thead>
<tr>
<th>Patient Surname, Initials</th>
<th>DOB</th>
<th>Spec</th>
<th>Adm Area</th>
<th>Casenote No</th>
<th>I/Mgt Operation</th>
<th>Admission Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>LEGGETT, L</td>
<td>20/02/51</td>
<td>F</td>
<td>GENERAL</td>
<td>Q650011</td>
<td>1</td>
<td>OPERATION</td>
</tr>
<tr>
<td>LAWRENCE, A</td>
<td>11/07/72</td>
<td>F</td>
<td>GENERAL</td>
<td>Q000023</td>
<td>1</td>
<td>ADM REASON</td>
</tr>
<tr>
<td>LETTIA, F</td>
<td>17/06/71</td>
<td>F</td>
<td>GENERAL</td>
<td>Q125894</td>
<td>1</td>
<td>OPERATION</td>
</tr>
<tr>
<td>ROBERTS, J</td>
<td>18/09/64</td>
<td>F</td>
<td>GENERAL</td>
<td>Q628192</td>
<td>1</td>
<td>ADM REASON</td>
</tr>
</tbody>
</table>
Operation Report Example 2
14.5.8. Cancellation Report

This report can be produce either Ad hoc or scheduled.
<table>
<thead>
<tr>
<th>Casenote</th>
<th>Patient Name</th>
<th>Sex</th>
<th>DOB</th>
<th>Adm Reason</th>
<th>WL Canc Date</th>
<th>Canc By Reason</th>
<th>Last Pre Canc Date</th>
<th>Last Pre Canc By Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q647386</td>
<td>PICKLES, KAREN</td>
<td>F</td>
<td>08/06/1961</td>
<td>TEST AD REASON</td>
<td>13/03/97</td>
<td>2</td>
<td>DONE AS AN EMERGENCY</td>
<td></td>
</tr>
<tr>
<td>S2723600</td>
<td>PATEL, ABDUL</td>
<td>M</td>
<td>02/04/1986</td>
<td>TEST AD REASON</td>
<td>16/03/97</td>
<td>4</td>
<td>GONE PRIVATE</td>
<td></td>
</tr>
</tbody>
</table>

*** Number of Patients on Report = 2 ***
Maximum Target Admission Times Report

This report can be produced either Ad hoc, Scheduled or On Demand.

The report will list the WL Maximum Admission Times for the WL either in order of Consultant or Speciality and is restricted by the user’s access.
<table>
<thead>
<tr>
<th>Specialist Code/Description</th>
<th>WL Max Adm Time O</th>
<th>WL Max Adm Time D</th>
</tr>
</thead>
<tbody>
<tr>
<td>100 GENERAL SURGERY</td>
<td>52W</td>
<td>52W</td>
</tr>
<tr>
<td>52W</td>
<td>52W</td>
<td>52W</td>
</tr>
</tbody>
</table>

**Waiting List Procedures – v2.12**

**Maximum Target Admission Times Report**

Run Date: 10/03/1997 09:06

Consultant: PHF MR FM PERRY

**Maximum Target Admission Times by Consultant**

Max Adm Time for Ordinary Pts = 52W
Max Adm Time for Day Cases = 52W

**WL Code/Description**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Max Adm Time O</th>
<th>Max Adm Time D</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>GENERAL SURGERY</td>
<td>52W</td>
<td>52W</td>
</tr>
<tr>
<td>52W</td>
<td>52W</td>
<td>52W</td>
<td>52W</td>
</tr>
</tbody>
</table>

**Diagnostic Group**

<table>
<thead>
<tr>
<th>PHFMAJ</th>
<th>PERRY MAJOR SURGERY LIST</th>
</tr>
</thead>
<tbody>
<tr>
<td>SURG</td>
<td>GENERAL SURGERY</td>
</tr>
</tbody>
</table>
15. FAULT REPORTING

From time to time you may experience problems with faulty equipment, software problems or access to the Patient Administration System (PAS) ie password non acceptance problems. To resolve your problem a call with need to be logged with the ICT Service Desk.

15.1. ICT Service Desk

<table>
<thead>
<tr>
<th>Email</th>
<th><a href="mailto:ict.servicedesk@porthosp.nhs.uk">ict.servicedesk@porthosp.nhs.uk</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone</td>
<td>023 9268 2680 or SJH (7703) 2680.</td>
</tr>
</tbody>
</table>

You will need to give the Service Desk certain information, so always ensure you have the following information available. They may need to know:

- Your Username.
- The KB Number of the equipment. This is found on a small label (usually red or blue) stuck to the equipment.
- The clinical system you were working on.
- The patient’s details e.g. case note no.
- Exactly what you were attempting to do, e.g. log on, view a patient’s results.

15.2. Out of office hours

Contact the ICT Service Desk and leave a message on the answer machine. They will deal with the problem as soon as they can. Alternatively email them.

If you feel there is a major system problem contact the switchboard for them to contact the engineer on call.
15.3. ICT Training
If you identify an error in this manual or think that it would be useful to include something that has not been covered, please contact ICT Training.

<table>
<thead>
<tr>
<th>Email</th>
<th><a href="mailto:ict.training@porthosp.nhs.uk">ict.training@porthosp.nhs.uk</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>External Phone</td>
<td>023 9228 6000</td>
</tr>
<tr>
<td>Internal Phone</td>
<td>QAH (7700) 5867</td>
</tr>
</tbody>
</table>

16. HELP WITH USING PAS
If you have only just attended the course and feel you may need additional support, help or advice, you can contact the ICT Training Office.

* If you have not used PAS for more than 12 months you will be required to re-attend your training.

<table>
<thead>
<tr>
<th>Email</th>
<th><a href="mailto:ict.training@porthosp.nhs.uk">ict.training@porthosp.nhs.uk</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>External Phone</td>
<td>023 9228 6000</td>
</tr>
<tr>
<td>Internal Phone</td>
<td>QAH (7700) 5867</td>
</tr>
</tbody>
</table>
17. ICT TRAINING CANDIDATE APPEALS PROCEDURE..

- Candidates who are unhappy with any aspect of the end of course/test assessment decision should first discuss the problem with the ICT Trainer at the time of receiving the result.
- The reasons must be made clear by the candidate at this time.
- If the candidate is still unhappy with the result further discussion should take place involving the ICT Training Team Leader within 3 days of the course/test date.
- The ICT Training Department will keep a record of such discussion together with date and outcome.
- Where necessary the 1st marker will be asked to re-mark and the marking checked by the ICT Training Team Leader.
- It should be noted that if the candidate was borderline double marking should already have been undertaken.
- If this does not provide satisfaction the candidate may raise a formal appeal.
- Appeals will only be accepted if made in writing (not e-mail) to the ICT Training Manager within 10 days of the candidate receiving their result, outlining clearly the circumstance of the appeal.
- The 1st & 2nd markers will meet with the Training Manager to consider if there are any aspects that should be taken into account in the candidate’s performance.
- In some circumstances the candidate may be offered a re-test (e.g. hardware or software problems).

If this is not the case and the result remains unchanged then the candidate may write to the ICT Training Manager (within 5 days of receiving the 3rd result) who will consider all evidence and circumstances of the appeal also taking into consideration responsibilities to the Trust and Data Protection Act to make a final decision.

ICT Training, QAH, July 2011
## VERSION CONTROL/LOG

<table>
<thead>
<tr>
<th>Manual</th>
<th>Waiting List Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Version</strong></td>
<td>2.12</td>
</tr>
<tr>
<td><strong>Date</strong></td>
<td>July 2011</td>
</tr>
</tbody>
</table>

### Revisions

<table>
<thead>
<tr>
<th>Updated</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Added New header and footer to document. Repaginated</td>
<td>All</td>
</tr>
<tr>
<td>Updated Information Governance information &amp; Confirmation of Details</td>
<td>5 - 7</td>
</tr>
<tr>
<td>Updated candidate appeals procedure</td>
<td>68</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Manual</th>
<th>Waiting List Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Version</strong></td>
<td>2.11</td>
</tr>
<tr>
<td><strong>Date</strong></td>
<td>April 2010</td>
</tr>
</tbody>
</table>

### Revisions

<table>
<thead>
<tr>
<th>Updated</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 7 – Patient Pathways – to include new function PPA.</td>
<td>15</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Manual</th>
<th>Waiting List Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Version</strong></td>
<td>VN2.1</td>
</tr>
<tr>
<td><strong>Date</strong></td>
<td>March 2009</td>
</tr>
</tbody>
</table>

### Revisions

<table>
<thead>
<tr>
<th>Reordered</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sections reordered to reflect lesson structure</td>
<td>All</td>
</tr>
<tr>
<td>Updated</td>
<td>Various</td>
</tr>
<tr>
<td>Formatting and text refinements (unlisted as content and meaning unchanged)</td>
<td></td>
</tr>
<tr>
<td>New</td>
<td>5-4</td>
</tr>
<tr>
<td>Extra field for Expected Anaesthetic on Waiting List Details screen 2.</td>
<td></td>
</tr>
<tr>
<td>New</td>
<td>5-5</td>
</tr>
<tr>
<td>18 Week Pathway instructions for – WLA</td>
<td></td>
</tr>
<tr>
<td>New</td>
<td>7-1</td>
</tr>
<tr>
<td>Patient Pathway Maintenance – PPM</td>
<td></td>
</tr>
<tr>
<td>New</td>
<td>8-1</td>
</tr>
<tr>
<td>18 Week Pathway instructions for – WLC</td>
<td></td>
</tr>
<tr>
<td>New</td>
<td>9-1</td>
</tr>
<tr>
<td>Note added with instructions regarding Patient Pathway management and WLS</td>
<td></td>
</tr>
<tr>
<td>Updated</td>
<td>11-1</td>
</tr>
<tr>
<td>CEA – more detail written into Cancel/Defer section</td>
<td></td>
</tr>
<tr>
<td>New</td>
<td>11-2</td>
</tr>
<tr>
<td>Note added with instructions regarding Patient Pathway management and CEA.</td>
<td></td>
</tr>
<tr>
<td>New</td>
<td>14-1+</td>
</tr>
<tr>
<td>Inclusion of Waiting List Reports – WLR, merged from separate manual</td>
<td></td>
</tr>
</tbody>
</table>