DH Department of Health

Choice of Scan

Guidance

September 2005

DH INFORMATION READER BOX

Policy	Estates
HR / Workforce	Performance
Management	IM & T
Planning	Finance
Clinical	Partnership Working

Document Purpose	Best Practice Guidance
ROCR Ref:	**Gateway Ref:**
Title	Choice of Scan Guidance
Author	DH/Access/Diagnostic Services/Choice of Scan Team
Publication Date	30 Sep 2005
Target Audience	PCT CEs, NHS Trust CEs, SHA CEs, Foundation Trust CEs , Medical Directors, Directors of Finance, GPs, Communications Leads
Circulation List	
Description	This Guidance outlines how Choice of Scan is designed to work from November 2005 when patients facing long waits for scans in their local hospital will be offered the choice of another provider to have their scans within a maximum of 26 weeks. This will reduce to 20 weeks from April 2006.
Cross Ref	N/A
Superseded Docs	
Action Required	Phase 1 - Choice of Scan starts for any patients waiting longer than 20 weeks- maximum wait will be 26 weeks
Timing	**By 30 Nov 2005**
Contact Details	Chioce of Scan Team Diagnostics Services 4N34 Quarry House Leeds LS2 7UE www.dh.gov.u/policyandguidance/organisationpolicy/secondarycare #REF!
For Recipient's Use	

1. Introduction

From the 30th November 2005, patients facing long waits for scans in their local hospital will be offered the choice of going to another provider and having their scan within a maximum of 26 weeks. This will reduce to 20 weeks from the 1st April 2006.

Choice of Scan has two phases:

- November 2005 – Phase 1 – Choice of Scan commences for CT/MRI for any patients waiting longer than 20 weeks, who do not already have a date within 26 weeks scheduled – the maximum wait will be 26 weeks.
- April 2006 – Phase 2 – Choice of Scan extended to cover other imaging scans including ultrasound and DEXA and for patients waiting longer than 16 weeks who do not already have date within 20 weeks scheduled – the maximum wait will be 20 weeks.

The reduction of waiting times for diagnostics is a key element in the drive to reduce overall access times for the benefit of patients. Choice of Scan will also contribute to delivering the 2008 18-week GP referral to treatment target.

Delivery of Choice of Scan is an important objective but must not impact on achievement of the seven national priorities for the NHS confirmed at the Top Team in July, which are currently:

- Delivery of 13 week out-patient and 6 month in-patient maximum waiting times;
- Choice and Choose and Book;
- Cancer 31-day and 62-day maximum waiting times;
- Reduction in MRSA;
- Financial balance;
- Implementation of Agenda for Change;
- A and E waiting times.

Choice of scan aims to ensure that patients waiting for **routine** scans are offered choice in order to reduce potential long waits. It is critical that patients waiting for **urgent** scans, such as cancer and other urgent patients continue to be treated as a priority. It is intended that Choice of Scan will help to reduce waiting times for both urgent and routine scans.

Discussions are taking place between Monitor and the DH about how Choice of Scan relates to NHS Foundations Trusts. There is no reason, however, that NHS

Foundation Trusts should not accept MRI/CT patients from other providers where they wish to do so and have the available capacity.

In this guidance the term *Originating Trust* refers to those providers needing to offer choice to their patients. The term *Alternative Provider* refers to providers who can provide capacity to facilitate choice.

This guidance outlines how Choice of Scan is designed to work from November 2005. Further guidance on Choice of Scan from April 2006 will be provided in early 2006.

This guidance covers:

- Patient identification and waiting list management;
- Best practice;
- Identification of Alternative Providers;
- Role of Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs);
- Exceptions outside Choice of Scan;
- Patient empowerment;
- Contacting patients;
- Maintaining patient scanning waiting list record;
- Patients choosing not to accept an alternative provider offer;
- Transfer of scans and reports;
- Financial flows and price;
- DH contact details.

This guidance has been developed with stakeholders from the NHS at Trust, PCT and SHA levels. The aim has been to adopt similar principles to those followed for Choice at 6 months, although there are some specific variations to reflect the unique differences in diagnostics. This guidance will be reviewed between Phase 1 and Phase 2 in discussion with the NHS to ensure any useful lessons and amendments can be incorporated.

2. Patient Identification and Waiting List management

2.1 Trusts will identify patients from their scanning waiting lists who would otherwise wait more than a maximum wait for each phase, initially 26 wks for MRI or CT.

2.2 A patient's waiting time for a scan will commence from the date of receipt of the request for external referrals (e.g. GPs) and the date the decision to request was made for internal requests (e.g. internal consultant requests). This reflects the same approach as that for outpatient and elective waiting lists.

2.3 A patient's waiting time will end when the scan is completed. However, Trusts will need to avoid further delays in completing reports. This is clinical governance and a waiting time issue. It also has financial implications Trusts will want to consider. (see 12.8 & 12.9)

2.4 To ensure patients are treated before 26 weeks, Trusts need to identify patients who have waited 18 weeks and do not have a scheduled date within the maximum of 26 weeks, so that these patients can be offered choice no later than 20 weeks. This will allow Alternative Providers sufficient time to make appointments and complete scans/reports.

2.5 To identify the patients, Trusts will, in due course, be able to use the new Diagnostics Data Collection being introduced later in 2005-06. For further information contact Rachel McDonald at rachel.mcdonald@dh.gsi.gov.uk. During the intervening period, Trusts will need to ensure that local systems are in place to identify qualifying patients.

2.6 The waiting list rules should reflect those already in existence for electives and outpatients in determining the following:

- suspensions;
- deferrals;
- elective vs. planned cases.

2.7 Trusts must ensure details of a patient's scanning waiting list record, especially where it relates to suspensions or deferral, are recorded and auditable.

2.8 The DH will not require any new data or information on Choice of scan. However Trusts and PCTs may choose locally to collect data on the numbers eligible for choice, the numbers offered choice and the numbers accepting choice. This will not be mandatory and can be decided locally.

2.9 The Department of Health will take the following steps as part of its Choice of Scan assurance plan.

2.9.1 Use the new Diagnostic Data collection to collect information on activity and waiting times for CT and MRI.

2.9.2 Use the 18 week pilot sites CT and MRI data as a sample to assess the impact of Choice of Scan.

2.9.3 Use the existing DH/SHA Choice Forum to explore progress, particularly in December 2005 and January 2006.

2.9.4 Identify with agreement a number of 'test bed' sites where a more detailed quantitative analysis on the uptake of choice will be undertaken.

3. Best Practice

3.1 It is appreciated that the discipline of waiting list management is less advanced in Diagnostics than in waits for elective and outpatient activity. Trusts need to be able to apply such disciplines to diagnostics and this will complement the introduction of the 18-week target in December 2008 where the entire patient journey between referral and treatment will need to be recorded.

3.2 Trusts should clinically and clerically validate their imaging waiting lists, as is common practice for elective lists.

3.3 Partial booking should be introduced where appropriate.

3.4 Trusts should have maximised the benefit from previous guidance, which is available via http://www.wise.nhs.uk or http://www.improvement.nhs.uk

3.5 The number of separate queues should be minimised with the ideal being no more than two queues for electives i.e. urgent and non-urgent. Choice of scan aims to ensure that patients waiting for routine scans are offered choice in order to reduce potential long waits. It is critical that patients waiting for urgent scans, such as cancer and other urgent patients continue to be treated as a priority. It is intended that choice of scan will reduce waiting times for both urgent and routine scans.

3.6 Trusts should seek to minimise 'carve out' (i.e. protected slots for different queues) which has been demonstrated to extend total waiting times.

3.7 Trusts should seek wherever possible to empower radiology staff to book and manage lists with protocols so that capacity can be maximised.

3.8 Where appropriate, lists of similar sub-specialty work should be grouped together to help reporting workflow.

3.9 Trusts may wish to use scanner throughput and/or diagnostic targeted list tools piloted in some SHAs such as Cumbria and Lancashire (http://nww.clha.nhs.uk/dfhome.php).

4. Identification of Alternative Providers

4.1 Trusts and PCTs will be responsible for working together to identify Alternative Providers.

4.2 In preparation for this, Originating Trusts (i.e. those Trusts needing to arrange Choice) who may have difficulty meeting the waiting time threshold will need to compile a list of the type of scans/procedures (e.g. body part, complexity) likely to be required, and together with their local PCT, identify Alternative Providers.

4.3 PCTs will be responsible for ensuring an Originating Trust with patients potentially waiting longer than the threshold has compiled such a list and in doing so should be proactive and share information across the local health economy on possible Alternative Providers.

4.4 As part of this compilation Originating Trusts and PCTs will wish to clarify the availability of the Alliance Medical Mobile MRI initiative in their locality working with and through the SHA lead.

4.5 Originating Trusts and PCTs will be aware that the Alliance Medical Mobile MRI initiative costs are covered centrally and there is an expectation that the purchased capacity will be used to reduce waiting times and offer choice where required.

4.6 Originating Trusts should be aware that the Alliance Medical MRI mobile contract capacity is finite and that indicative activity for each SHA has been distributed amongst SHAs on a 'fair shares' basis. There are brokerage arrangements in place to move unutilised capacity to where it is needed and this would need to be agreed with SHA leads.

4.7 If required SHAs will coordinate any discussion on how the Alliance Medical Mobile MRI capacity is best used locally to ensure this target is met.

4.8 New Alternative Providers can subsequently apply to be added to the list by contacting Originating Trusts.

4.9 Alternative Providers can be either NHS Foundation Trusts, NHS Trusts or independent sector organisations who have the capacity at the necessary quality to scan additional patients, within the timescale required, and can ensure the scan and report can be transmitted effectively back to the Originating Trust.

4.10 Originating Trusts will liaise with Alternative Providers and agree any specific operational details and requirements (e.g. format for transmission of scan/result, turnaround time etc).

4.11 Alternative Providers may request some minimum guarantee on numbers in order to provide additional capacity. Originating Trusts unable to resolve waiting times alone will need to take account of this in their negotiations with Alternative Providers.

5. Role of Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs)

5.1 The role of the PCT will be to help generate and share lists of Alternative Providers with Originating Trusts so that at least one Alternative Provider can be offered to a patient waiting over 20 weeks without a date already scheduled.

5.2 The role of the PCT will also be to audit the provision of Choice of Scan at each Trust.

5.3 PCTs will need to ensure real, reasonable offers of at least one alternative provider are being provided and will contact some patients to audit this.

5.4 PCT audit should also be designed to check if patients were fully informed of how long a wait could be if they opt not to go to an Alternative Provider.

5.5 SHAs will ensure that PCTs undertake these responsibilities.

6. Exceptions outside Choice of Scan

6.1 If patients cannot be offered an Alternative Provider 'locally' the Originating Trusts should still seek to make an offer from a wider network of Alternative Providers within a reasonable distance. PCTs should audit that a reasonable offer from a wider network has been made if required.

6.2 There are no exceptions on account of geography, although patients may decline an offer (Note: for what happens if a patient declines an offer see 10.2 and 10.3).

6.3 There are no clinical exceptions where Choice of MRI or CT scan does not need to be offered.

7. Patient empowerment

7.1 Trusts will need to ensure that patients added to an MRI or CT waiting list are informed that they are entitled to the offer of at least one Alternative Diagnostic Provider if they have to wait in excess of 26 weeks from November 2005.

7.2 Trusts can determine the point at which this is conveyed to patients and should include information on the process that will be followed. It should also include that the patients will be advised how long they will have to wait if they choose not to accept the offer, and that the Originating Trust will remain responsible for all aspects

of the quality of scan and report ensuring these get back to the patients consultant so their care is not delayed.

7.3 Therefore patients for whom Choice of Scan may apply will be better able to respond if the Alternative Provider offer stage is reached.

8. Contacting Patients

8.1 Patients will be contacted and offered Choice of Scan no later than at 20 weeks unless they already have a date agreed which ensures they do not breach 26 weeks.

8.2 Originating Trusts will be responsible for contacting patients.

8.3 This may be based on the Patient Care Advisor (PCA) model used for Choice at 6 months or a similar equivalent. The approach is for the Originating Trusts to determine.

8.4 Trusts must clearly explain to patients contacted how long the wait could be if they opt not to go to an Alternative Provider.

8.5 Trusts will offer at least one Alternative Provider date convenient for the patient.

8.6 Alternative Providers may require some basic questions be answered by the patient (e.g. does the patient have a pacemaker or other clinically relevant details). Originating Trusts should resolve as many of these in advance as possible so the patient's scan is not delayed.

9. Maintaining Patient Scanning Waiting List record

9.1 A patient's waiting list record will always be the responsibility of the Originating Trust.

9.2 If a patient accepts an Alternative Provider the waiting list record at the Originating Trust should remain active i.e the patient cannot be removed or suspended.

9.3 This is different from Choice at 6 months because the patients care remains the responsibility of the Originating Trust. The scan is just one part. This will avoid patients getting lost in the system.

9.4 The Alternative Provider will need to notify Originating Trusts of the date a scan is booked, subsequently confirm completion, and report availability so the patient's waiting list record can be accurately maintained.

9.5 The Alternative Provider will be responsible for ensuring the scan and report are completed within the timescale agreed with the Originating Trust.

10. Patient choosing not to accept an Alternative Provider offer

10.1 Patients can choose not to accept an offer of Choice of Scan at an Alternative Provider.

10.2 If a patient chooses not to accept an Alternative Provider offer the waiting list record at an Originating Trust will still remain active (i.e. a period of suspension cannot be applied). This corresponds with the approach to Choice at 6 months.

10.3 Therefore the Originating Trust must either scan the patient within the waiting time target or make the patient an Alternative Provider offer the patient is happy to accept which is within the time frame required.

10.4 Originating Trusts can opt to offer choice before the 20-week period if they believe this will help them avoid breaches of the target.

11. Transfer of scans and reports

11.1 The Alternative Provider may require a copy of the original scan request form from the Originating Trust. Originating Trusts and Alternative Providers will need to agree this process.

11.2 Originating Trusts will need to ensure arrangements they make with Alternative Providers specify how, in what form and in what timescale they wish to receive copies of the scan and report, and the financial arrangements if the specification is not met.

11.3 Originating Trusts remain responsible for ensuring patients do not fall into any gaps in the process of offering choice. However if an Originating Trust finds that an Alternative Provider has failed in its duties it should notify the PCTs and their SHA so that this information can be shared.

11.4 If the performance issue relates to the Alliance Medical Mobile MRI initiative Originating Trusts can report this to their SHA Mobile MRI leads.

12. Financial Flows and Price

12.1 There is no additional funding available to support Choice of Scan.

12.2 Funding will follow patients as part of the outpatient/in-patient HRGs. Originating Trusts will be responsible for payments to Alternative Providers, excluding the Alliance Medical Mobile MRI initiative that is funded centrally. Prices must be negotiated locally for patients transferred under Choice of Scan and should cover the marginal cost of each additional scan and associated administration.

12.3 Trusts recoup costs for diagnostics through tariff income for outpatient attendances and elective admissions. The cost of diagnostics is assumed within outpatient and elective spell tariffs as these have been calculated using average NHS Reference Costs, which include diagnostic costs.

12.4 The Alliance Medical Mobile MRI initiative is funded centrally and will not be chargeable to Originating Trusts. Trusts may want to maximise their use of this service.

12.5 Enhancements in efficiency, service redesign, improvements in waiting list management may all be considered by Trusts to reduce any financial risk.

12.6 As Originating Trusts are accountable for ensuring choice is offered and meeting waiting list targets it is for them to determine whom they contract with and at what price, excluding the Alliance Medical Mobile MRI initiative, which is funded centrally.

12.7 Originating Trusts will be responsible for any costs associated with patient transport. Trusts can determine policy they follow on paying for patient transport, but if a patient rejects an offer because of additional transport costs, their waiting list record should remain active at the Originating Trust.

12.8 Expenditure incurred on scans is recouped via tariff payments under Payment By Results (PBR), once patients are either seen in outpatients or treated. Delays in reporting are therefore likely to also delay Trusts recouping such expenditure.

12.9 The exception to 12.8 is where Trusts have direct access contracts with GPs or with other referrers just for scans. The assumption is that for these the contract assumes minimal delays in reporting and commissioners will reflect this in their commissioning decisions if the service is sub-standard.

13. Contact details at Department of Health

Enquiries to Matthew Kershaw, National Implementation Director for 18 weeks via the Choice of Scan mailbox at choiceofscan@dh.gsi.gov.uk

Department of Health
September 2005