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Clinical prioritisation of waiting lists for endoscopy and diagnostic procedures

Framework and operational guidance

Version 2, June 2021 [Changes from previous version have been highlighted in yellow]

Contents

Section 1: Framework and support tools 2

1.1 Principles 2
1.2 Validation stages 3
1.3 Clinical review of referral +/- medical records 4
1.4 Remote clinical consultation 5

Section 2: Operational guidance 7

2.1 Data quality validation 7
2.2 Administrative validation 8
2.3 Clinical validation 12

Appendices 16

Appendix A: Waiting list prioritisation codes 16
Appendix B: Diagnostics prioritisation timeline 17
Appendix C: Links to further information 18
Appendix D: Diagnostic waiting list review process flow (i) – DM01 diagnostic waiting list 19
Appendix E: Diagnostic waiting list review process flow (ii) – Planned waiting list 20

Section 1: Framework and support tools

Following the prioritisation of surgical waiting lists, the next step is to extend the programme to include patients who are waiting for a diagnostic procedure.

The clinical validation of diagnostic waiting lists project will produce a clinically validated waiting list that allows diagnostic lists to run effectively, by:

- Prioritising access to procedures based on individual patient needs, while considering the need of the population.
- Facilitating good communication between the patient, GP and secondary care provider.
- Producing a validating waiting list that is up to date and that allows procedures to run effectively.
- Minimising waits where possible, but particularly for those with immediate need.
- Recognising that for less urgent or routine diagnostics, some patients may experience a delay.

This framework is designed to support local systems and clinical teams to validate their diagnostic waiting list as part of the recovery of elective care. This project is supported by the royal colleges and specialist societies.

1.1 Principles

The principles are:

- Diagnostic **procedures need to be prioritised according to clinical need** rather than waiting time.

- **Patients should receive personalised communications that provide clarity on likely timescales**. This should be supported with interim information and advice on managing their condition, and a specific contact point should they have questions about their upcoming care.

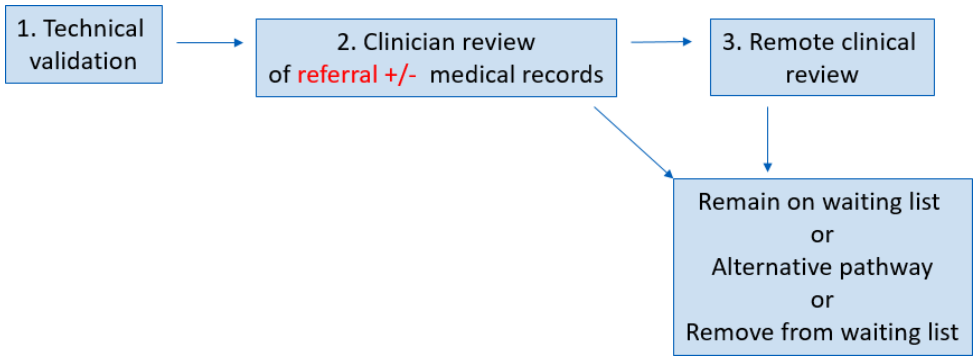
- **Take a holistic approach to patient care** and consider if there are alternative pathways that are appropriate, available and with capacity
- **Local design and delivery of the validation process**: core standards but local design and application with specialist advice
- Clinicians and organisations that have already started validating their waiting lists **should NOT stop**
- **We must narrow rather than widen health inequalities**: eg pro-active support for people whose first language is not English; appropriate arrangements for those with learning and behavioural difficulties; avoiding digital inequalities
- In summary: the project is about and **making the best recommendations for diagnostic pathways** and reviewing the current indications for investigation

1.2 Validation stages

Waiting lists should be validated in two or three stages:

1. Technical validation: ensure the waiting list is accurate and up to date.
2. Clinical team review the referral +/- medical records to establish if the referral is still appropriate and if so to determine clinical urgency.
3. Remote clinical consultation or discussion with referring clinician and provider. This step is for patients where it is not possible to make a recommendation based upon referral details, the available records and investigations.

Figure 1: Validation stages



Please note:

- The clinician and provider retain responsibility for any changes to the patient's pathway and it is essential that the patient's GP is notified of the outcome.
- Local organisations or systems should design their own processes for validation based upon the principles in this framework. In some areas, a multidisciplinary approach may be needed.
- Many specialties will require imaging tests as part of their high priority pathways. It is essential that all specialties recognise the cross-specialty nature of imaging and the capacity issues faced by imaging departments

1.3 Clinical review of referral +/- medical records

- Delivered by local organisations and systems.
- Referral letter/medical records/investigations of all patients on endoscopy/diagnostic procedures waiting list to be reviewed by a clinician with appropriate experience for this work.
- Discussion with a local radiologist may be of value.

Clinician to establish which of the following applies:

- Remain on waiting list and establish priority
- Remain on waiting list at present but remote consultation with patient or discussion with GP required
- Arrange for alternative pathway recognizing the importance of a multi-disciplinary approach where pathways do not function in isolation
- Procedure not required. Return care to GP or arrange appropriate follow up

Clinician to establish priority for diagnostics based upon clinical need and impact on quality of life:

- **D1**: Potentially life-threatening or time-critical conditions eg, cancer (i.e. spinal cord compression), acute heart failure with no recent imaging, significant bleeding, chest pain with murmur or heart failure and no recent imaging, renal failure, vision loss. Patients who are an emergency would fit into this category.
- **D2**: Potential to cause severe disability or severe reduction to of quality of

life eg, intractable pain. Urgent patients, including 2ww for investigation of suspected cancer, would fit within this category.

- **D3**: Chronic complaints that impact on quality of life and may result in mild or moderate disability. Routine patients who would normally be seen within the next 4-6 weeks.

- **D4**: Chronic complaints that impact on quality of life and may result in mild or moderate disability. Routine patients that would normally be seen within the next 6-12 weeks.

As soon as possible after review, a letter should be sent to the patient (copied to GP) summarising the recommendation:

- An honest approach with patients to explain that for some there may be further delays following re-prioritisation. If a patient's care is subject to delay, interim information and services should be discussed.

- Appropriate safety netting to ensure that patients are aware of, and can present to or contact a healthcare professional. It must be easy for patients to get information about their care via a specific contact point.

Please note:

- This work is likely to be time-consuming and involves direct clinical care. Clinicians will need appropriate IT support and time to do this work.

- A list of patients who require a remote consultation with a clinician should be generated.

- Trusts should monitor the process of prioritisation of waiting lists to check they are not disadvantaging particular groups.

1.4 Remote clinical consultation

- The clinical review of the medical records will generate a list of patients who require a remote consultation before a recommendation on next steps can be made. In some cases, this may require a discussion with the patient's GP or the referee from secondary care rather than the patient themselves.

- The local team should establish who is the appropriate clinician to have this discussion. It may be the consultant, associate specialist, an experienced junior doctor or a nurse/allied health professional (AHP) specialist.

- Patients need to be prepared for this call – experience has shown that ‘cold calls’ do not work. An initial letter inviting them for the clinical consultation should be sent, followed up by further contact (eg SMS text) to remind patients.

- These calls are probably best arranged as part of a formal remote clinic and as part of a direct clinical care session.

- Trusts might consider developing local teams with either a specialist nurse or a non-medical information giver who could provide supporting information.

- The call should be followed up with a letter to the patient and their GP.

- Trusts should monitor the process of clinical validation of waiting lists to check they are not disadvantaging particular groups.

Section 2: Operational guidance

The information in this section has been compiled to support a national framework for consistency across systems and providers. This operational guidance is based on the work completed to date as part of this programme.

The clinical prioritisation programme is part of the third phase of the NHS response to COVID-19 and is designed to support the prioritisation of waiting lists as part of the recovery of elective activity. Following the clinical prioritisation of all patients on an admitted patient care pathway, the next step is to extend the programme to include patients awaiting a diagnostic procedure.

The purpose of clinical prioritisation is to support discussions with patients about their planned care, to give greater clarity of the number of patients awaiting procedures at each priority level, to inform service capacity planning, and support the booking of patients.

The process is aimed at reviewing and identifying the clinical priority of routine patients that have had an extended wait. Urgently referred patients, including those referred on two-week pathways, should continue to be prioritised in line with current guidelines.

The diagnostic prioritisation categories can be viewed in appendix A.

2.1 Data quality validation

Data quality issues and potential errors should be reviewed and corrected as far as possible prior to clinical validation, to provide as accurate and up-to-date a list as is possible for clinical review.

For patients awaiting a diagnostic procedure, potential issues are likely to include:

- Missing or incomplete procedure details.
- Missing due dates for patients on a planned or surveillance waiting list.

- Duplicate waiting list entries, or out of date waiting list information for patients who have undergone the diagnostic procedure on another pathway or separate to the waiting list entry (which may be checked through cross-referencing admissions for diagnostic procedures).

Data quality validation should not delay the clinical prioritisation process, but checks should be completed to an adequate level to support the generation of a list of patients awaiting diagnostic procedures to be contacted by the trust.

It is important to note that all patients on the planned waiting list should have a clinically agreed due date recorded. When patients on planned lists are clinically ready for their care to commence and reach the date of their planned appointment, they should either receive that appointment, or be transferred to an active waiting list and a waiting time clock should start.[1]

Where clinical guidelines may allow for safe tolerance levels or periods beyond agreed dates, referral to treatment (RTT) reporting rules require that an RTT pathway is activated on the due date if patients are not seen by that date.

2.2 Administrative validation

An administrative process should be undertaken to identify those patients requiring review, across the DM01 waiting list and planned (or surveillance) waiting list.

The categories to be reviewed are:

- Where more than 50% of patients within a modality reported on the DM01 return have been waiting for more than six weeks, administrative validation and clinical prioritisation should be undertaken for any patient who has waited more than six weeks since the request for a diagnostic procedure.

  (NB – this may include patients whose DM01 is less than six weeks if their diagnostic clock has been reset; period since request should be used rather than period since clock start.)

- Where patients on the planned or surveillance waiting list do not have a recorded due date, the clinical due date should be recorded. This may be identifiable from information already recorded on trust systems or through

[1] Recording and reporting RTT waiting times for consultant-led elective care, October 2015 section 5

review of the patient record or clinical letters, or may require a clinical discussion to agree the patient's due date. This date should reflect the clinically appropriate date and should not be influenced by availability of capacity or likely booking timeframe.

- Patients on the planned waiting list who have not had their procedure in line with their clinically agreed due date, or do not have a recorded due date.

- Patients on the active diagnostic waiting list (DM01) or planned waiting list for procedures included in the current guidance on evidence-based interventions (EBIs) should be reviewed to identify those patients whose condition meets the criteria set out within the policy, and those patients for whom the procedure may no longer be considered appropriate.

Please note: a patient may be included in more than one of these categories.

Contacting patients

Patients identified as overdue for their planned procedure, or who have waited more than six weeks since their diagnostic procedure was requested for those DM01 modalities categorised as above, should be contacted. This is to confirm their current circumstances, needs and preferences relating to their diagnostic procedure, so that up-to-date information is available to support the clinical prioritisation process.

Patients (or for paediatric patients, a parent or appropriate guardian) should be contacted by letter, telephone, or email. The means of contact is likely to depend on the volume of patients, urgency of booking, patient demographics, and staff availability.

The trust should take into account those patients who may already have agreed appointment or admission dates in the near future. Patients who have an agreed date booked for their procedure within the next six weeks should not be contacted, unless that date is cancelled or delayed.

Patients contacted as part of validation and prioritisation of the admitted waiting list, who require a diagnostic procedure or repeat test as part of that pathway, will not usually need to be contacted again. However, if there has been a significant delay since their last contact, an update on the patient's condition or circumstances may be required.

- Patients should be asked to indicate whether they still require the diagnostic procedure, or whether the procedure has been undertaken elsewhere (eg in the private sector); or if their condition (or other need for the diagnostic procedure) has resolved.

- Patients should be reassured about the trust's approach to managing their care during the COVID-19 pandemic, and given the opportunity to indicate if they are willing to proceed. Patients who are not currently willing to proceed due to COVID-19 should remain on the waiting list and be categorised D5.

  A clinical review and shared decision-making discussion may still be appropriate, particularly where alternative options or attending at an alternative site may be suitable and may influence the patient's decision. Patients who are not willing to proceed should be provided with clear information and advice about managing their care in the interim.

- Patients should also be asked to provide details of any periods of unavailability, and the general reason for this. It may be appropriate for the patient to have a clinical review with their referring clinician. Where patients are offered reasonable dates for diagnostic tests or procedures which are declined for non-COVID reasons, these patients will be categorised D6.

- Patients who may experience a delay to their care should receive personalised, honest communications. They should understand likely timescales on when they can expect to receive further information regarding their appointment. Patients should also be provided with interim information and advice on managing their care, and a specific contact point should they wish to raise any concerns or questions.

Diagnostic clock changes

In line with DM01 rules, the diagnostic clock can be stopped and reset for those patients who decline reasonably offered dates, or who request deferral of diagnostic tests or procedures while remaining on the diagnostic waiting list. Depending on the information provided by the patient and any discussion with them about their condition and preferences, patients may remain on the diagnostic waiting list, or may be referred back to their referring clinician to discuss their condition as appropriate.

Patients who are also on an active RTT pathway will continue with their RTT clock unaffected, unless there is a clinical decision to discharge the patient from their RTT pathway.

Providing information on next steps

Clear information should be provided to the patient about next steps. Some patients will proceed to a shared decision-making discussion with a clinician, and information should be provided about this to enable patients to participate fully in that discussion with an appropriate clinician.

This will include where further information is needed to enable the clinical team to assign or update a prioritisation category; where patients are undecided about whether to proceed with treatment, or wish to discuss their condition and their treatment options; or where a patient is awaiting a procedure included in national guidance on EBIs.

If contacting by letter or email, patients should be given adequate time to respond (at least two weeks from receipt of letter), with clear information about the need to respond and next steps if they do not. Further attempts must be made to contact any patients who do not respond to the letter or who cannot be contacted by telephone. Some of these attempts should be made outside of normal working hours, as well as contacting the patient's GP or referrer.

Recording information

Different systems are commonly used for diagnostic procedure requests (or orders), booking, and management that may be separate to the trust patient administration system (PAS). Trusts should identify where information can be recorded consistently regarding the clinical prioritisation category and any additional information (eg patient availability, concerns, preferences).

This information should be easily accessible to support ongoing clinical review, prioritisation and booking processes. Where possible, this information should be recorded on the trust PAS to enable the information to be visible to all staff involved in the management of the patient's pathway.

Diagnostic waiting lists

Patients should not be removed from the diagnostic waiting list without a clinical decision involving communication and agreement with the patient. Likewise, any

decision to remove a patient from an active RTT pathway on the basis of a discussion about their diagnostic procedure must be a clinical decision, communicated and agreed with the patient. For any patient removed from an RTT or planned waiting list, a reason for removal should be recorded.

Administrative validation should be completed to an adequate level to enable identification of those patients awaiting a diagnostic procedure with a clear decision to proceed with their procedure, and those patients where further information, or a shared decision-making discussion is required. A list of those patients requiring further review should be generated to support the clinical validation process.

2.3 Clinical validation

An ongoing process should be established so that patients are identified for review to ensure priority category and waiting list information are kept up to date, to support risk assessment, capacity planning and booking processes:

1. Patients already overdue – ie patients on the DM01 waiting list who have waited more than six weeks since their procedure was requested, within those modalities where more than 50% of patients have been waiting more than six weeks, and patients on the planned waiting list who are overdue their agreed due date.

2. Patients previously reviewed who have been delayed further, and consequently have waited beyond the appropriate period indicated by their priority category.

3. Patients approaching their due date – to ensure patients are booked according to their clinical priority as they become due.

4. Patients being added to waiting lists – ie as patients are added to the planned waiting list or as new DM01 requests are received.

Information provided by the patient regarding their current condition, fitness and availability to proceed should be collated to enable a modality-level review of patients awaiting a diagnostic procedure.

Where a patient has indicated that they wish to proceed with the diagnostic test or procedure, and there are otherwise no indications requiring a shared decision-

making discussion between the patient and an appropriate clinician, a diagnostic priority category may be assigned and recorded – based on the locally agreed process appropriate for the patient's pathway/procedure. A separate clinical discussion with the patient will not usually be required.

The specialty team may also be able to identify those patients potentially suitable to be seen for their diagnostic procedure in the Independent Sector based on this information.

Clinical review

For patients where a shared decision-making discussion is appropriate (either required by the clinician or requested by the patient), a clinical review should be undertaken by an appropriate clinician. It may be appropriate for the patient to have this discussion with the clinician referring their diagnostic procedure, for example if the patient wishes to discuss alternative options or their condition.

The list of patients to be reviewed should be ordered to enable patients with the most urgent conditions to be reviewed first, based on the information available. This information could include urgency indicated at referral or decision to admit, procedure type, specialty, the length of time that the patient has been waiting for the diagnostic procedure – or is overdue their surveillance procedure – and the patient's overall waiting time.

Appropriate information should be available to support the process, including information provided by the patient during the administrative validation process on their current condition, fitness and availability to proceed.

Patient discussion

The discussion with the patient should include the following elements:

- The clinician's assessment of the patient's priority level.
- The patient's current condition and symptoms, and any other clinical conditions or factors that may affect their treatment.
- The patient's understanding and agreement to the diagnostic test or procedure, or whether there are more suitable alternative options.

- For patients listed for a procedure, whose condition or symptoms are within the criteria included in national guidance on evidence-based interventions,[2] or in local policy on procedures of low clinical value or limited clinical effectiveness, options for alternative condition management should be discussed, and next steps agreed with the patient. This may include ongoing review of symptoms, or discharge back to the patient's GP or referring clinician.

- The patient's fitness to proceed with the diagnostic procedure. If the patient is not currently fit to proceed, the reasons for this should be established, whether this is likely to be a short-term or long-term reason, and if any treatment or other steps are required to optimise the patient to enable the procedure to be carried out. The patient's pathway should be managed in accordance with RTT rules, so that patients are not removed from the waiting list due to a short-term condition.

- Whether the patient is potentially suitable to be seen in the independent sector (where the trust has access to independent sector capacity for diagnostic procedures).

- The patient's availability, whether this is due to COVID-related issues or non-COVID-related issues. COVID-related issues could include clinical risk factors, anxiety about COVID-19, or that the patient is currently self-isolating.
  - Where a patient is unavailable, timescales about their period of unavailability should be noted and an appropriate timescale for further contact and re-review should be agreed. The D5 or D6 category should be recorded and where appropriate the diagnostic clock may be reset in accordance with DM01 reporting guidance.

  - The patient should not be removed from the diagnostic waiting list, and their RTT pathway remains active with a continuing RTT clock. A new DM01 clock would start on the date a new appointment is agreed.

  - If a patient requests a significant delay that is likely to affect the ongoing management of their pathway, it may be appropriate to consider removing the patient from the diagnostic waiting list and considering

[2] https://www.aomrc.org.uk/wp-content/uploads/2020/12/EBI_list2_guidance_050121.pdf

options for ongoing management or monitoring of their condition. This should be done in line with RTT guidance on managing patient choice.

The outcome of the discussion, including the priority category and date that the review was undertaken, should be recorded on the trust PAS where possible so it is available as part of the patient pathway information. The outcome should also be confirmed in writing to the patient and their GP or referrer.

The completion of clinical validation should support a diagnostic waiting list view of patients to be booked by clinical priority and wait time, with appropriate supporting information to enable their procedure to be planned, including information about the patient's fitness to proceed and availability. This list should support capacity planning including the identification of patients clinically suitable for the independent sector.

Maintaining a clinically stratified waiting list

The review information, including the priority category and the clinical review date (ie the date that the priority level is assigned) should enable the trust to identify any patients requiring re-review if they are not seen within the indicated timescale, or for re-contact at an appropriate time for those patients in D5 or D6 categories. Patients remaining on the waiting list should be re-reviewed no later than six weeks after their previous review.

To support ongoing maintenance of the waiting list, and reduce the need for re-review, the above points to be discussed with the patient should be included when a new request for a diagnostic procedure is made, so that the prioritisation category and supporting information can be recorded as part of the diagnostic test request.

Clinicians should take into account the latest guidance on evidence-based interventions when adding patients to the planned waiting list for ongoing surveillance, and when either requesting or triaging new requests for diagnostic procedures.

Appendices

Appendix A: Waiting list prioritisation codes

Table 1: Clinical validation of diagnostics waiting lists prioritisation codes, including feedback from clinical engagement

Waiting list prioritisation	
D1	Potentially life threatening or time critical conditions eg cancer (i.e. spinal cord compression), acute heart failure with no recent imaging, significant bleeding, chest pain with murmur or heart failure and no recent imaging, renal failure, vision loss. **Patients who are an emergency would fit into this category**
D2	Potential to cause severe disability or severe reduction of quality of life eg, intractable pain. **Urgent patients, including 2ww for investigation of suspected cancer, would fit within this category**
D3	Chronic complaints that impact on quality of life and may result in mild or moderate disability **Routine patients who would normally be seen within the next 4-6 weeks**
D4	Chronic complaints that impact on quality of life and may result in mild or moderate disability **Routine patients who would normally be seen within the next 6-12 weeks**
D5	Patient wishes to postpone procedure because of COVID-19 concerns
D6	Patient wishes to postpone procedure due to non-COVID-19 concerns

Appendix B: Diagnostics prioritisation timeline

Table 2: Timeline for diagnostics prioritisation

Deliverable	Timescale
Agree which diagnostic modalities/waiting lists require review	Monday 7 June 2021
Commencement of delivery of validation programme	Monday 7 June 2021
Inclusion of D code in national waiting list data submission	Friday 30 July 2021
Completion of diagnostic validation programme for all patients on waiting list	Tuesday 31 August 2021
Proactive prioritisation of diagnostic referrals	Ongoing

Appendix C: Links to further information

RTT rules are unchanged and should be followed. RTT guidance, including rules relating to patients awaiting planned or surveillance procedures can be accessed here: https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-guidance/

Diagnostic waiting times recording, and reporting rules are unchanged, the latest guidance and FAQs can be accessed here: https://data.england.nhs.uk/dataset/monthly-diagnostic-waiting-times-and-activity-guidance-and-documentation

National guidance on clinical prioritisation of surgical waiting lists including support tools: https://www.england.nhs.uk/coronavirus/publication/validating-waiting-lists-framework/

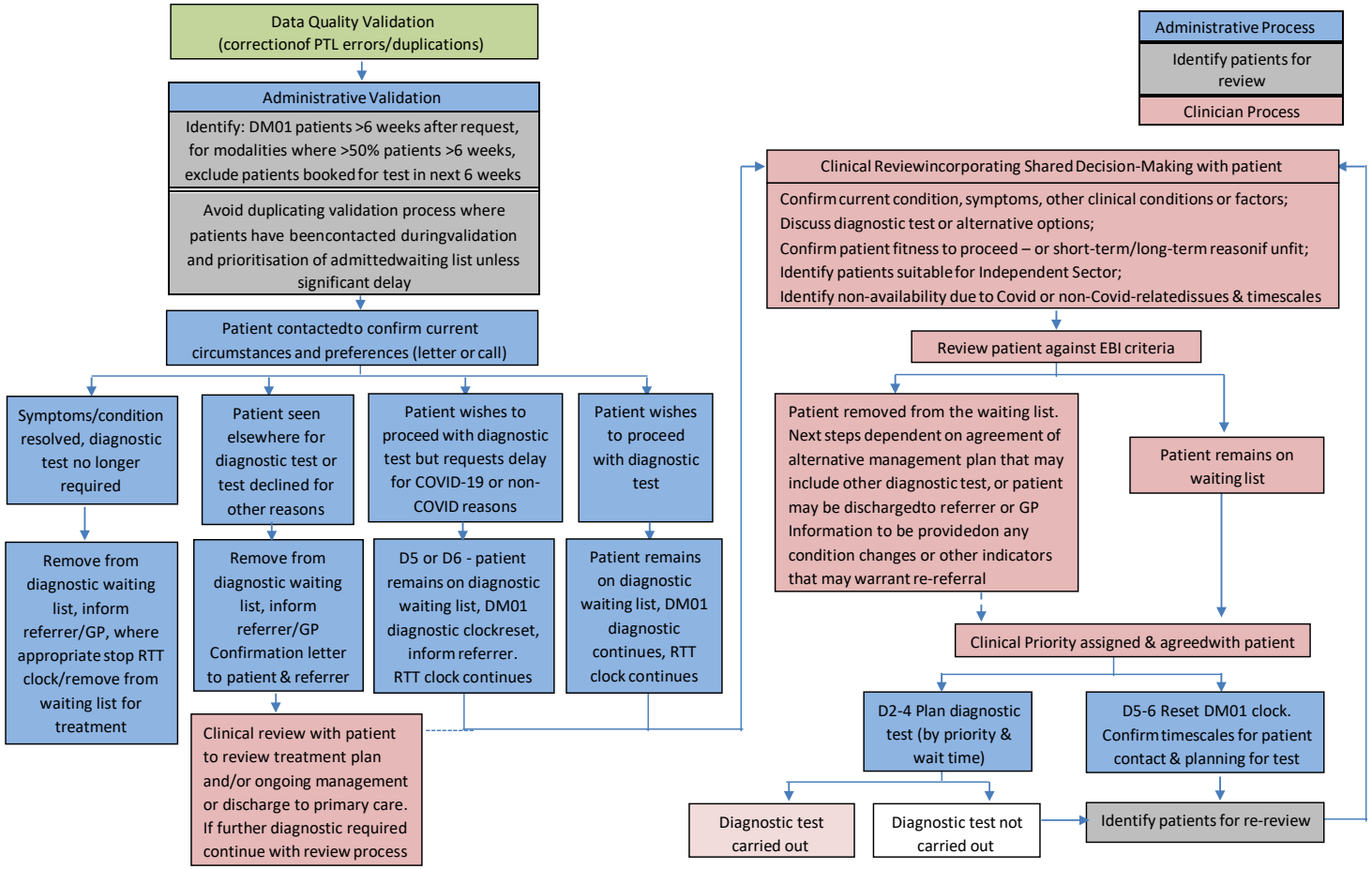
The Elective Care Improvement Support Team (IST) Waiting List Review guide provides general advice on waiting list validation: https://future.nhs.uk/ElecCareIST/view?objectId=80186501

Academy of Medical Royal Colleges EBI guidance and FAQs (phase 2 guidance December 2020): https://www.aomrc.org.uk/ebi/

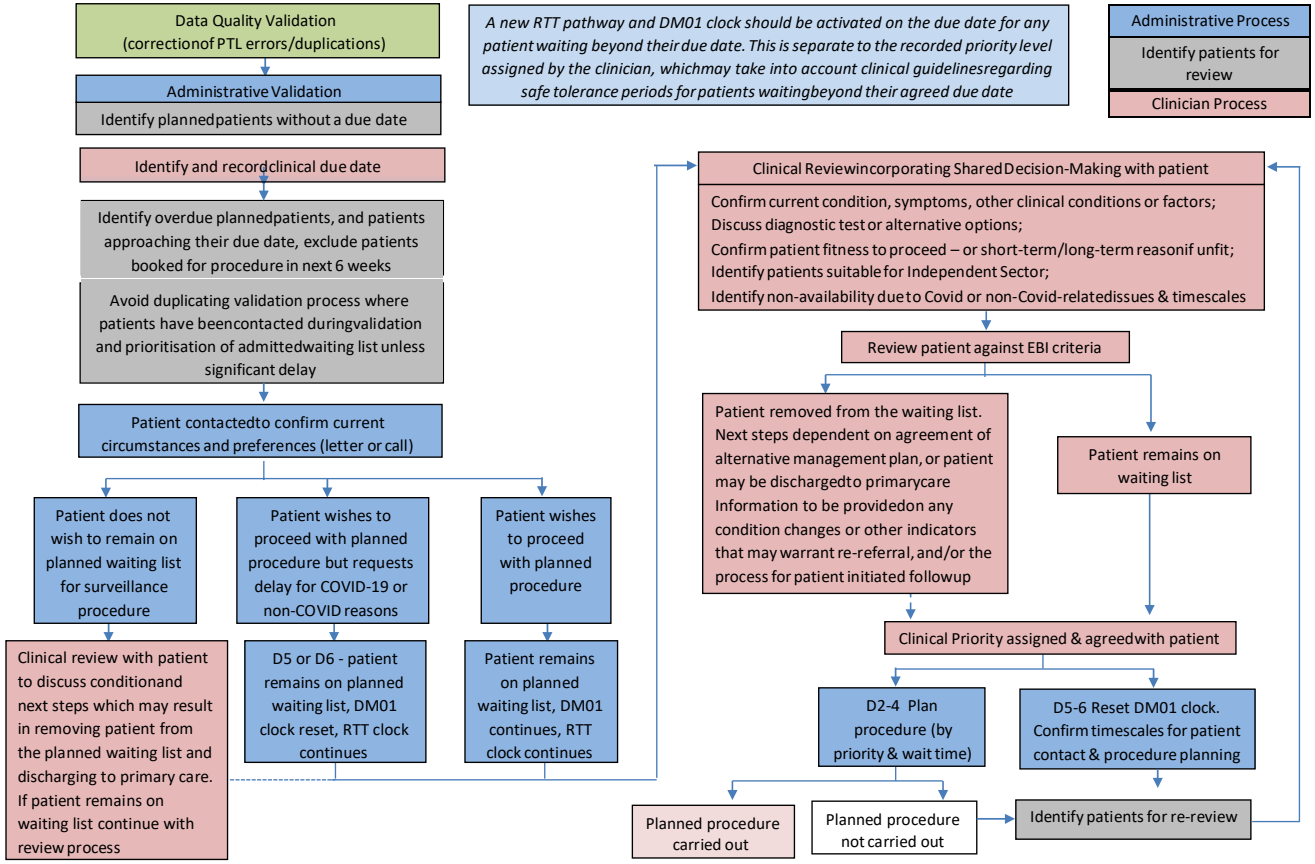
EBI programme: https://www.england.nhs.uk/evidence-based-interventions/

Good communication with patients guidance: https://www.england.nhs.uk/coronavirus/publication/good-communication-with-patients/

Appendix D: Diagnostic waiting list review process flow (i) – DM01 diagnostic waiting list



Appendix E: Diagnostic waiting list review process flow (ii) – Planned waiting list



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