National Clinical Prioritisation Programme (Including Evidence Based Interventions)

Frequently Asked Questions

Version 3 03/11/20

1. **What is the Clinical Prioritisation Programme?**

The clinical prioritisation programme is a technical and clinical review of patients waiting for elective care treatment. In the first instance, the review will focus on patients with a decision to treat. The review will:

- Categorise patients from P2-P6 by checking their condition and risk factors.
- Establish the patient's wishes regarding treatment
- Provide good communication with the GP and the patient
- Introduce categories P5 and P6 which allow patients to postpone treatment whilst remaining active (clock continues) on the waiting list.

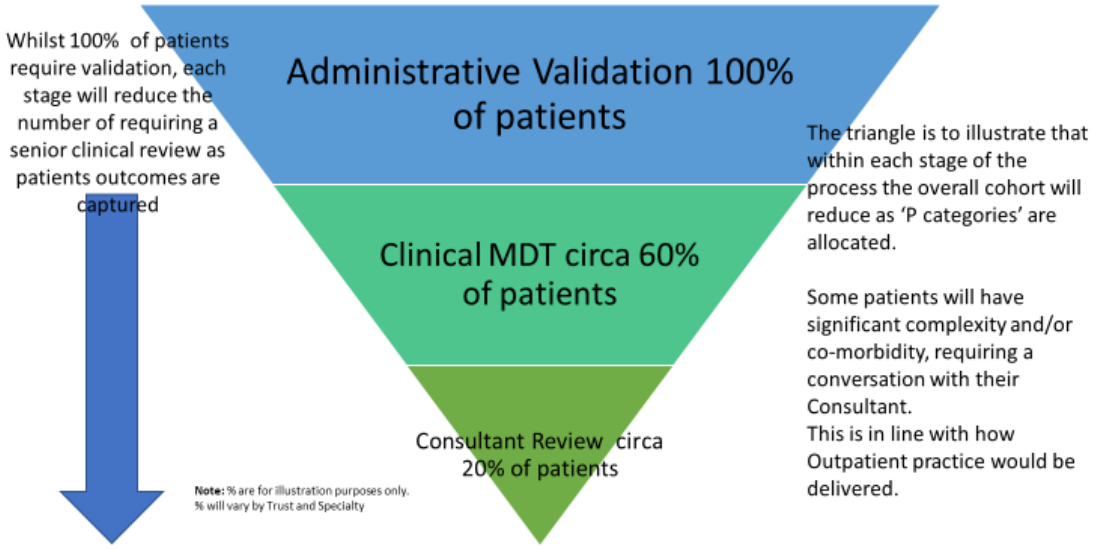
2. Why is there a requirement to undertake clinical prioritisation?

Clinical prioritisation is required due to patients waiting significantly longer for treatment, following the loss of elective care activity and reduced productivity as a result of Covid 19. Since capacity is restricted it is necessary to ensure that treatments are prioritised for the most urgent patients to effectively manage clinical risk on the waiting list. In addition, it is important to update patients on their treatment options, ascertain their current status, and agree next steps. More broadly, the clinical prioritisation programme will enable providers and the wider NHS to understand the level of risk on the waiting list and the volume of patients delaying treatment both locally and nationally. In addition, the review will ensure that patients are not included on the waiting list where they do not meet the criteria in the EBI guidance and are provided an alternative for their clinical condition.

3. What is the benefit of undertaking clinical review?

The clinical prioritisation programme will enable providers to understand the level of clinical risk on their waiting lists, prioritise treatments for the most clinically urgent, remove interventions that should not be offered from their WL and inform discussions with patients over their next steps. Discussions with patients can support ongoing management and help inform decisions regarding treatment and non-treatment options depending on the patient's clinical needs and best interests.

The diagram below is to illustrate the potential impact of each of the stages in the process, it is widely acknowledged that the challenge to undertake the process is considerable. However, the benefits the clinical prioritisation programme could deliver, will enable providers and the wider NHS to understand the level of risk on the waiting list and the volume of patients delaying treatment both locally and nationally.



4. What approach should we take to clinical prioritisation?

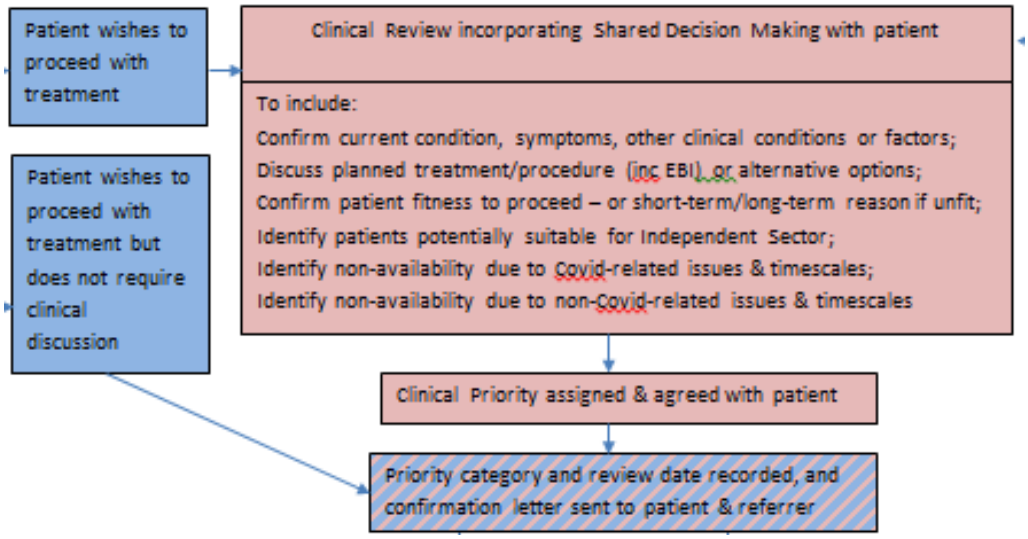
Waiting lists should be validated and prioritised in two or three stages:

Stage 1: **Administrative Validation:** ensure the waiting list is accurate and up to date. All patients on an admitted pathway should receive either a telephone call or letter to identify their preferred next step to establish the following outcomes:

a. Remain on the waiting list and proceed to treatment planning.
b. Remain on the waiting list and postpone treatment.
c. Remove from the admitted waiting list.

Stage 2: If the patient requires treatment and does not need a clinical review: If there is sufficient information that the treatment required is clear, as well as feedback from the patient following the administrative review, the clinician may decide to prioritise the patient without further discussion. This includes an assessment whether the patient meets the criteria of the EBI guidance where they are waiting for one of the 17 EBI interventions.

Stage 3: Where it is determined that a full clinical review is required with the patient: Where a clinician and/or patient determines a full shared decision-making conversation is required to determine the next steps with the patient this must occur. This includes an assessment whether the patient meets the criteria of the EBI guidance where they are waiting for one of the 17 EBI interventions. **Process flow below highlighting stages 2 and 3**



5. **What information do we need to record from the admin review?**

   Please refer to the national data set requirements for this programme .This can either be captured on a local system or on e-Review which is designed to capture the correct information.

6. **What information do we need to record from the clinical review?**

   Please refer to the national data set requirements for this programme. This can either be captured on a local system or on e-Review which is designed to capture the correct information. To support ongoing waiting list management, it will be important for providers to be able to see the patient's clinical priority alongside other waiting list information including wait time.

7. **We validated earlier in the year and have already written to patients and GPs -do we have to repeat the communication?**

   If the validation was completed prior to 1st June 2020 then we would ask that this is repeated as the clinical condition of the patient and their wishes may have changed. If you have communicated with patients on their prioritisation category since 1st June 2020 then we would ask that you undertake the administrative part of the validation process only.

8. **When do we need to have completed the clinical prioritisation programme by?**

   The **Administration Validation Stage** should be commenced by the **23rd October 2020**. However, we would ask that this process is commenced as soon as possible.

Full prioritisation (including stages 2 and 3 above) should be completed by the **31st December 2020**. However, we would ask that providers commence this programme of work as soon as possible, undertaking the process for patients at the greatest clinical risk, followed by the longest waiters. It is at the provider's discretion how these cohorts are identified and prioritised.

9. What is shared decision making (SDM)?

SDM is the process whereby patients and clinicians work together to make evidence-based decisions centred on patient values and preferences – The example provided has been adapted for the clinical prioritisation of waiting lists. Within the context of waiting list support for patients, the SDM tool may be used by clinicians for planning for patient care and delivery. Please refer to the national framework.

10. Is there a requirement to review all patients on a waiting list?

In phase 1 providers are asked to validate and prioritise all active patients on an elective admitted pathway waiting list. There will be some circumstances where patients that are not on an RTT pathway are clinically appropriate to include within the prioritisation programme and this is to be determined locally.

It is recognised that the total size of the admitted waiting list may be different to the total incomplete RTT pathway dataset.

11. How many priority categories are there?

There are six categories, of which five relate to the clinical prioritisation of elective care patients (P1 relates to emergency patients). Categories P2-P4 relate to the period of time in which it would be clinically appropriate for a patient to wait for their procedure. Categories P5 and P6 should be used for patients who wish to delay their procedure. The descriptions of the categories are shown below:

<1 month	P2
<3 months	P3
>3 months Delay 3 months possible	P4
Patient wishes to postpone surgery because of COVID-19 concerns**	P5
Patient wishes to postpone surgery due to non-COVID-19 concerns**	P6

12. Is there guidance on the recording and reporting of the P5 and P6?

Yes, guidance is available on the definition of P5 and P6. Please refer to the national data set requirements for further information. This can either be captured on a local system or on e-Review which is designed to capture the correct information.

13. **Do we need to identify which patients fall into Category P5 and P6 retrospectively or can we prospectively capture this information?**

    It is important that patients who wish to delay treatment are captured retrospectively. We recognise that it will be challenging to capture the breakdown retrospectively. We would therefore ask that all patients who have previously been reviewed since 1 June and wish to delay treatment are captured as P5 and for those patients for which a review needs to be undertaken the separation between P5 and P6 is implemented.

14. **What are the RTT implications for a patient that chooses to delay treatment (P5 and P6 categories)**

    The RTT clock will remain active and continue for both P5 and P6 patient cohorts. Recording this information will enable the provider and the wider NHS to understand the impact of these patient cohorts on the waiting list and RTT performance.

15. **Should we update our clinic outcome form to include P2-P6?**
    Yes – it would be helpful to ensure that you are recording the data required at the time of the appointment and avoid the need for a retrospective process.

16. **Do all patients need to be reviewed by a clinician in a consultation?**

    No – there will be a significant number of patients for which you are able to identify their preferred next steps via the administrative process. Clinicians will be able to prioritise based on the information available.

17. **Does a consultant have to be the clinician who undertakes the review?**

    No – We anticipate that the majority of clinical reviews will be undertaken by clinical staff at the direction of the consultant. This could include registrars, specialist nurses, extended scope practitioners, etc. There will be a cohort of patients who the consultant will wish to personally review, and this should be determined locally.

18. **Is there a requirement to include the patient in the prioritisation programme?**

    Yes, patient involvement/shared decision making is at the heart of this programme. The involvement of the patient is good practice throughout the NHS. However, this could be a decision based on the administration validation that includes the patient confirming wishes regarding their treatment.

19. **Is there a digital solution to support the programme?**

Yes, e-Review has been developed specifically to facilitate the clinical review programme where appropriate. The EBI checker is also available for use when reviewing patients on the waiting list for EBI interventions.

20. Do we have to use e-Review?

No, e-Review is available to providers if there is no alternative solution that can capture and report on the level of data required.

21. What will we need to provide to the national programme if we do not use e-Review?

For those providers that are using e-Review, we will extract the data directly out of the system to inform local and national reporting. Those providers that use a local system will be required to submit a standard weekly data set to the national programme.

22. What will we need to provide to the national programme if we do not use EBI checker?

For those providers that are using EBI checker, we will extract the data directly out of the system to inform local and national reporting. Those providers that use a local system will be required to submit the national data set at procedure level.

23. Is there a priority order to review waiting lists?

It is at the provider's discretion to prioritise cohorts of patients; however, we would suggest that cohorts are organised into the most clinically urgent and then chronological order from the longest waiting patient.

24. Do we need to review patients with TCI dates?

Patients with a TCI date prior to the 23rd October 2020, who have previously been reviewed, do not need to be included in the programme. It is at the providers local discretion to determine if this cohort requires a re-review.

25. Do we need to review patients who have just had a decision to admit?

If patients with a decision to admit have already been prioritised since the 1st June, it is only necessary to complete an administrative review. If patients with a decision to admit have not been prioritised since the 1st June 2020, they will need to be re-reviewed and prioritised. It is important for providers to record whether any of the patients in this cohort are P5 or P6 if they have or wish to delay their treatment since these categories were only established from October 2020.

26. How long do we give a patient to respond to the initial validation letter? Can we discharge after a period?

If a patient does not respond to the validation letter it does not warrant removing them from the waiting list. The provider should seek alternative avenues e.g. contacting the GP or calling the patient to ascertain their status.

27. What process and outcome do we follow if a patient is currently unwell or is managing another condition?

There is no change to the way that patient fitness to proceed should be managed. Providers should refer to their access policy and national rules regarding the management of these patients.

28. What should we do if a patient does not want their procedure, but their condition is not resolved?

Patients in this cohort should be clinically reviewed and options for ongoing care discussed and agreed with the patient using the principles of shared decision making. The outcome of this decision will inform the clock status in line with the provider's local access policy and national rules.

29. A patient has been categorised as a P2 however wishes to delay treatment how should this be recorded and clinically managed?

If a patient wishes to delay their treatment it is critical that they are informed of the risks and impact of the delay on their health and wellbeing. If the patient insists on delaying treatment despite the risks associated with the delay, a suitable follow-up appointment should be agreed with the patient to review their care. The patient's record should be updated to either P5 (Covid 19 related) or P6 (non-Covid 19 related) depending on the reasons behind the delay. Providers may wish to isolate high risk P5 or P6 patients that were previously P2 or P3 to ensure clinical review dates have been organised to avoid lengthy delays without a clinical review. Each patient must be given a date by which they will be re-reviewed in the future. For high risk patients this will be a shorter time frame.

30. The guidance issued says a patient can change their mind within 28 days. How do we manage this under access rules?

It is recognised this is not currently part of policy, however given the current circumstances it is acknowledged that patient circumstances may change. In line with local access policies, patients should be re-instated on the waiting list with the correct RTT clock where appropriate.

31. How should we involve referrers in this process?

The programme guidance asks that the referring GP receives communication on the clinical condition and confirmed next steps following review.

32. Does this include tertiary referrals?

Yes – all referrals for an admitted pathway.

33. How often should we carry out the clinical review?

It will be standard operational process for providers to regularly undertake a review of the patients on the waiting list. As a basic principle, providers should aim to review patients once their time category has expired i.e. a category 2 patient should be reviewed if they have not been treated after a month has expired.

34. Are we expected to continue prioritising the waiting list post December 31st 2020 and using the same categories?

Yes, due to the initial and ongoing impact of Covid 19 on elective care it will be necessary to continue prioritising the waiting list to understand the composition and prioritise patients based on clinical urgency.

35. Will we be required to validate other parts of the pathway in future?

Given the impact of the pandemic on all activity we are planning to expand the programme to other parts of the pathway to ensure clinical risk is reduced and to enable effective prioritisation. Phase 2 is expected to include diagnostics; however, we are unable to confirm the timescales at this time.

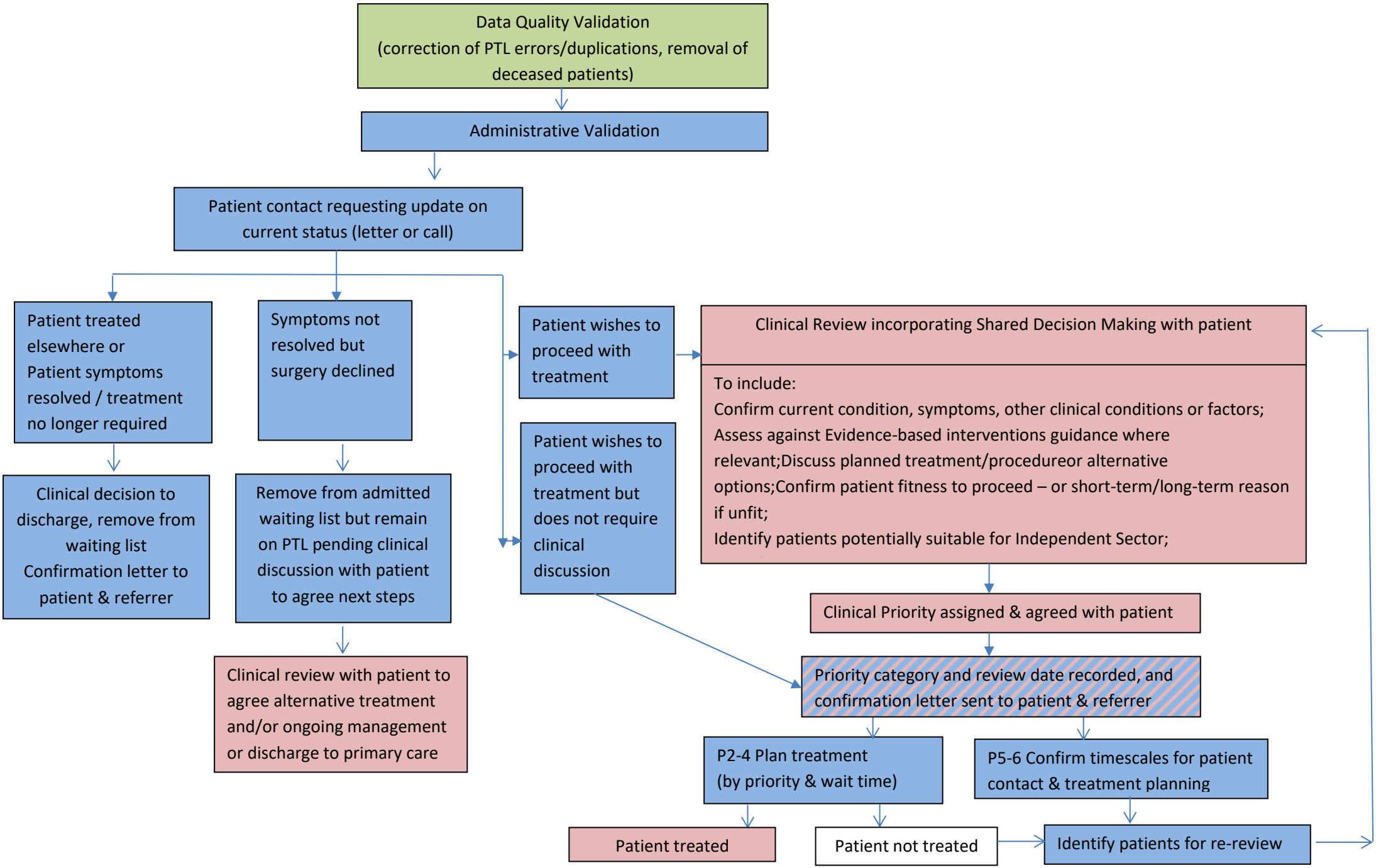
36. There are some specialties which their Royal College has a different approach to prioritisation eg Ophthalmology – how should we report this?

Reporting should be in line with the National Clinical Prioritisation Programme. We would ask that the priority categories are mapped across for reporting purposes.

37. Are patients already transferred to be treated in the Independent Sector included in this process?

Patients should have been validated and prioritised by the NHS Provider as part of the decision to transfer treatment to the independent sector. There is no requirement for the ISP to re-review this cohort of patients. Where the patient has been directly referred to the ISP, the patients will still require validation and prioritisation in line with national access reporting requirements.

National Clinical Prioritisation Programme – Admitted Waiting List



Evidence Based Interventions Requirements within the Clinical Validation Programme

Frequently Asked Questions

1. **As part of the clinical review you refer to using the EBI guidance, what is this guidance?**

   This is national guidance that was developed in partnership with NICE and the AoMRC which reflects NICE, NICE accredited guidance and the latest guidance from the relevant specialist societies. The aim of the guidance is to reduce harm and unnecessary interventions, by ensuring that interventions routinely available on the NHS are evidence-based and appropriate. The national EBI guidance can be found here: https://www.england.nhs.uk/publication/evidence-based-interventions-guidance-for-clinical-commissioning-groups-ccgs/

2. **What information do we need to record on EBI and when do we need to have completed this by?**

   Please refer to the national data set requirements for this programme. For providers who are using a local system to review patients against EBI guidance, you will be required to capture whether the patient meets the criteria of the EBI guidance or not at procedure level and record this on the MDS. Check against EBI guidance forms part of your clinical prioritisation so should be completed as part of your full clinical prioritisation for patients on an admitted pathway by the **31st December 2020** and embedded in standard practice moving forward.

3. **Is there a digital solution to support the programme?**

   Yes, e-Review has been developed specifically to facilitate the clinical review programme where appropriate. The EBI checker is also available for use when reviewing patients on the waiting list for EBI interventions.

4. **Is the EBI checker part of e-Review?**

   No, they are separate systems. Providers can use both systems together, separately with a local system or not at all.

5. **Do we have to use EBI checker?**

   No, it is not mandatory. The EBI checker is available to support providers, where an alternative local technical solution is not in use. This assists in applying the Evidence-based interventions guidance identifying where a treatment may not be appropriate for a patient and a mechanism for capturing and reporting the data required.

6. **What if our local policies go further than the national EBI policy?**

   The application of the national EBI policy is a minimum requirement. Providers should follow local commissioning arrangements alongside national EBI policy**.**

7. **We have reviewed a patient's clinical condition against the EBI guidance and they do not meet the criteria. How should we manage this patient?**

   Shared decision making is at the heart of the clinical prioritisation programme. The clinician should have a conversation with the patient and outline the relevant EBI guidance and the alternative treatments available to them. They can use the patient information leaflets and direct them to the patient videos for more information.

8. **What if the clinician believes there is clinical exceptionality and should be offered the intervention?**

   If clinical exceptionality can be demonstrated then the provider should apply for an Individual Funding Request, during which time the RTT clock will continue to run. If clinical exceptionality cannot be demonstrated, then the clinician should agree with the patient that they will be removed from the waiting list for the procedure but remain on the waiting list for any alternative treatment and the RTT clock continues to run. Where an IFR is agreed the patient remains on the waiting list and again the RTT clock continues to run.

9. **Do we know which patients are impacted by the EBI guidance?**
   Across the country we have assessed the approximate number of patients on a waiting list for one of the 17 evidence-based interventions by provider. At this time this is approximately 100,000 patients which is 10% of the admitted national waiting list. We will share this data with all providers so you understand the volume of patients we anticipate will need reviewing against the evidence-based interventions guidance.

10. **We have clinically reviewed a cohort of patients since 1 June, 2020 but this did not include a review against EBI guidance, do we have to repeat the review process specifically to determine EBI compliance?**

    No. Where reviews have already been carried out we do not require the process to be repeated. For all reviews carried out with immediate effect an assessment should now be completed against the EBI guidance during clinical prioritisation for any interventions listed in the EBI guidance.

11. **We do not currently use a technical system for assessing against EBI guidance. What system should we use?**

    EBIchecker is a technical solution which is available to all providers to determine whether a patient meets the criteria for an intervention in the EBI guidance. The National Delivery Team will support providers in training and user set-up to use this system. Data will be

extracted directly from EBIchecker where it is used by a provider. Only where EBIchecker is not used will a provider need to submit this information via the national dataset.

12. **EBI Phase 2 has recently been out to consultation. Will the phase 2 EBI procedures and diagnostics be included in the scope of the clinical prioritisation programme?**

    Yes over time. We will communicate with all providers when the requirement will be included in the programme.

National EBI Implementation (part of clinical prioritisation programme)