Outline Process for Clinical Prioritisation – NHS Grampian

**1. CATEGORISATION OF IMAGING EXAMINATIONS**

• Radiology request received and vetted by Radiologist/Radiographer/Sonographer using agreed clinical prioritisation categories (as listed at bottom of this document - these categories are not exhaustive and a degree of clinical discretion will be required regarding interpretation and the assignment of a prioritisation category.

Priority level 1 — can wait up to 2 weeks (or as planned for cancer surveillance)

Priority level 2 — can wait up to 6 weeks

Priority level 3 — can wait more than six weeks

Patients in the Priority 3 category will receive a letter indicating that they are on a waiting list of longer than 6 weeks (this will kick in if waiting longer than 12 weeks) and will be updated on an interval basis.

**2. APPLICATION OF THE PRIORITISATION PROCESS**

The application of the clinical prioritisation process is outlined as follows:

• This process would be followed when the routine waiting time exceeds 12 weeks or if the NHS Board has decided to curtail some or all imaging services.

• The urgency categories allocated by the electronic ordering system should be matched to prioritisation categories during the vetting process. Urgent OP – Priority 1, Semi Urgent OP – Priority 2, Routine OP – Priority 3.

• Priority 1 and 2 scans will be booked as soon as possible within the noted timescales in order of priority, or according to the scheduled date in the case of planned treatment follow up.

• Priority level 3 patients will be booked next in date order but some may not be booked during the period of capacity curtailment and would be instead held on a waiting list.

• Patients would be informed that they were held on this list.

• This waiting list would be reviewed by Radiologist/Radiographer every 12 weeks followed by communication with the patient. Standard agreed reprioritisation processes as described below could be implemented by administrative staff.

• Some types of exam may automatically become priority 2 after a certain timeframe while others may become priority 2 purely based on duration of wait ie the longest waiters.

• Clinical prioritisation would continue until capacity issues have resolved and the waiting time has fallen below 12 weeks.

• Clinical priority can be upgraded on change in clinical picture generally communicated from the referrer to radiologist.

**TO DO**

· Once approval has been given the criteria tables will be circulates to all Medical staff and Superintendents in CT, MRI & US

· Inform all staff that Urgent OP – Priority 1, Semi Urgent OP – Priority 2, Routine OP – Priority 3. This needs to be shown on RIS to reflect the Priority at vetting.

· Reports can be produced to show patients in Priority 3, this will ensure letters are sent to correct patient group and follow ups will are carried out where needed.

· Wording of letter to be checked and approved. Bank Admin staff can be used if necessary to help with letters.

**Imaging Clinical Prioritisation – Clinical Categories**

The following tables outline suggestions regarding which examinations should be included within each Priority Level. These suggestions are split by modality and should form the basis of a Clinical Prioritisation framework for vetting Radiologists or Radiographers.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Priority 1** | | | **Priority 2** | | **Priority 3** |
| USOC | Cancer Pathway | Urgent | Routine | Cancer Surveillance | Non-Urgent Non-Cancer |
| Examinations for patients where there is significant concern of cancer. | Examinations for patients on an active cancer pathway, where imaging is high priorityincluding assessment of treatment response. | Examinations to diagnose and/or alter treatment for significant disease or injury where delay is likely to result in: risk to function; worsening disability; or worsening pain. | Examinations which do not fall into any of the other priority levels. | Examinations for patients undergoing surveillance after cancer treatment | Examinations to diagnose and/or alter treatment for disease or injury where delay is unlikely to result in: risk to function; worsening disability; or worsening pain. |

**Imaging Clinical Prioritisation – CT Categories**

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| --- | --- | --- | --- | --- | --- | --- |
|  | **Priority 1** | | | **Priority 2** | | **Priority 3** |
| **USOC** | **Cancer Pathway** | **Urgent** | **Routine Non-Cancer** | **Cancer Surveillance** | **Non-Urgent Non-Cancer** |
| **Neurology** | USOC  Primary staging | Tumour treatment assessment | First seizure  Infection FU | Recurrent seizures  Aneurysms and AVM FU  JC positive  Headache | Routine surveillance |  |
| **ENT** | USOC  Primary staging | Tumour treatment assessment | Suspected infection  Stridor  Assessment of epistaxis  Unilateral sinonasal lesions | Throat pain (no red flags)  Sinus infection/polyps  4D CT for parathyroid  Cholesteatoma | Routine surveillance | SCC dehiscence |
| **Respiratory** | USOC  Primary staging | Tumour treatment assessment |  | ILD to determine treatment | Routine surveillance  First nodule FU scan | 2nd or subsequent nodule FU scan  ILD FU |
| **GI/HPB** | USOC  Primary staging | Tumour treatment assessment | Symptomatic IBD | Non-severe weight loss, CIBH  Pancreatitis FU  Cirrhosis staging | Routine surveillance | New diagnosis of diabetes |
| **Urology** | USOC  Primary staging | Tumour treatment assessment | CT IVU for new haematuria or hydronephrosis  Initial assessment of complex renal cyst | Bosniak cyst surveillance  Adrenal characterisation | Routine surveillance | CT for stone burden  CT IVU for anatomy  Adrenal nodule FU |
| **Gynae** | USOC  Primary staging | Tumour treatment assessment |  |  | Routine surveillance |  |
| **MSK** | USOC  Primary staging | Tumour treatment assessment | Acute trauma where imaging alters management  Infection | Assess fracture healing | Routine surveillance | Leg length  Prosthesis position |
| **Vascular** |  |  | Critical or acute limb ischaemia  Carotid stenosis assessment for endarterectomy | EVAR or other graft follow up  Acute vasculitis |  | Thoracic outlet syndrome  Stable claudication  Low risk chest pain (CT coronary artery) |

**Imaging Clinical Prioritisation – MRI Categories**

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| --- | --- | --- | --- | --- | --- | --- |
|  | **Priority 1** | | | **Priority 2** | | **Priority 3** |
| **USOC** | **Cancer Pathway** | **Urgent** | **Routine Non-Cancer** | **Cancer Surveillance** | **Non-Urgent Non-Cancer** |
| **Neurology** | USOC  Primary staging | Tumour  treatment assessment | MS relapse requiring treatment  First seizure  Infection FU | MS monitoring on biological  Recurrent seizures  Aneurysms and AVM FU  JC positive  Cervical myelopathy  MND? | Routine surveillance | MS routine monitoring  Radiculopathy |
| **ENT** | USOC  Primary staging | Tumour  treatment assessment | Suspected infection  Unilateral sinonasal lesions | Throat pain (no red flags)  Cholesteatoma | Routine surveillance | Tinnitus  SDHB screening |
| **GI/HPB** | USOC  Primary staging | Tumour  treatment assessment | Liver lesion characterisation  MRCP with biliary ductal dilatation  Symptomatic SB Crohn’s  Fistula – unwell  Cirrhosis staging | MRCP without biliary dilatation  Initial pancreatic cyst assessment | Routine surveillance | Pancreatic cyst follow-up  Hernia  Fistula – not unwell  Hernia  Dynamic pelvis |
| **Urology** | USOC  Primary staging | Tumour  treatment assessment | Initial assessment of complex renal cyst | Bosniak cyst surveillance  Adrenal characterisation | Routine surveillance | Chronic pelvic/testicular pain  Urethral diverticulum |
| **Gynaecology** | USOC  Primary staging | Tumour  treatment assessment | Adnexal lesion characterisation  PMB (failed hysteroscopy) | Endometriosis or pelvic pain | Routine surveillance | Dysfunctional uterine bleeding (smear up to date)  Mullerian Duct Anomalies  Mesh assessment  Fibroid assessment  Urethral diverticulum |
| **MSK** | USOC  Primary staging | Tumour treatment assessment | Acute trauma where imaging alters management  Infection/acute joint  Cord compression/cauda equina  Locked knee | Chronic trauma/cuff tears in surgical candidates  Severe synovitis which will alter management | Routine surveillance | OA/degenerative disease  Non-surgical candidates for joint assessment  Tendinopathy  Screening for inflammatory spondyloarthritis |
| **Vascular** |  |  | Critical or acute limb ischaemia for surgery  Carotid stenosis assessment for endarterectomy | Acute vasculitis |  | Thoracic outlet syndrome  Stable claudication |

**Imaging Clinical Prioritisation –Ultrasound Categories**

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|  | **Priority 1** | | | | | **Priority 2** | | **Priority 3** |
| USOC | | Cancer Pathway | | Urgent | Routine | Surveillance | Non-Urgent Non-Cancer |
| **UROLOGY** | Testicular lump | |  | | Visible haematuria  Hydronephrosis | Renal stones  Non visible haematuria | RCC | Chronic pelvic/testicular pain |
| **ENT** | Neck lump with red flag suspicion of malignancy  Lesion biopsy | | Urgent neck lump | |  | New thyroid lumps (low index of suspicion)  Thyroid pathology follow up  parathyroid |  | Lipoma  Sebaceous cyst  Thyroglossal duct cyst |
| **MSK** | Assessment or biopsy of lump suspicious for malignancy |  | | Trauma requiring urgent surgery eg finger tendon,  Achilles  Aspiration for infection if not possible clinically | | Chronic trauma/cuff tears in surgical candidates  Severe synovitis which will alter management |  | Hernia  Bakers cyst  Lipoma  Non suspicious lumps  Nerve assessment  tendinopathy |
| **GI/GENERAL** | Targeted liver biopsy | | Targeted liver biopsy | | DVT | Non targeted liver biopsy  US abdo - ? gallstones  Deranged LFTs? cause  AAA | HCC  Liver US in melanoma | GB polyp surveillance |
| **GYNAE** | Ovarian/uterine mass | | Postmenopausal bleeding | |  | Bloating and normal Ca- 125  Ovarian cyst follow up |  | PCOS  Ovaries for infertility |
| **Vascular** |  | |  | | Carotid Doppler for stroke | Aneurysm follow up |  | Varicose vein assessment / vein aping for routine procedures. |