

Operational Implementation and Support Guide for Early Screening, Risk Assessment and Optimisation for Adult Patients

November 2023



Introduction

There are significant challenges in scheduling and providing a timely 'to come in date' (TCI) for patients on elective surgical lists. These operational challenges are not unique to any provider and impact on the providers recovery of elective care. Feedback from clinical teams indicate that improving the following areas will improve patient flow to surgery:

- Early Screening and Optimisation
- Pre-operative Assessment (POA) Demand and Capacity
- Theatre Scheduling and Booking/Waiting List (WL) Management

To improve recovery of elective care, providers are advised to implement a system for early screening, risk assessment and health optimisation for all adult service users patients waiting for inpatient surgery early on their pathway by no later than 31 March 2024 as set out in section 3.20 of the [2023/24 NHS Standard Contract](#).

Providers are to determine which surgical pathways are their highest priority for implementing early screening and optimisation but as a minimum implement the [five core requirements](#) for all inpatient pathways by April 2024.

This delivery guide provides some principles to support with developing comprehensive processes and standard operating procedures at trust level including how to:

- Ensure effective theatre utilisation
- Ensure that all pathways (existing and new) to pre-operative assessment are considered in terms of capacity and demand planning
- Meet the new requirements in relation to early screening, risk assessment and health optimisation.

Who should read this guide?

This guide is intended to be of interest to operational managers, clinical leads for surgery and peri-operative care, pre-operative assessment teams, waiting list co-ordinators, scheduling, and booking teams aiming to enhance early screening, risk assessment and optimisation for existing and new adult patients awaiting surgery.

Purpose of this guide

This guide presents guidance of how providers and systems can enhance their services to provide early screening, risk assessment and optimisation of adult patients awaiting surgery in line with requirements within the standard contract. It also includes case studies aimed to support the implementation of this delivery guide.

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Opportunities to Improve the Patient Pathway

1. Early screening should be implemented across all inpatient pathways by 31 March 2024 but is likely to also be of benefit in some day case pathways. At the time a patient is added to an elective waiting list (at the latest) a screening assessment should be undertaken. **This is not the same as a full pre-operative assessment (POA).**
2. **Patients should not have a full POA at the time of listing** if the waiting time for that patients procedure is longer than the locally agreed duration of validity for POA. Sending patients who are likely to have a longer waiting time to POA at the time of listing carries the risk of creating duplicate appointments where a validity time is set. This can create excess demand and runs the risk of the patients appointment being postponed and cancelled at short notice or the patient deconditioning while waiting.
3. Providers should implement **digital screening** tools alongside existing non-digital alternatives and support patients in completing the screening tools provided by peri-operative co-ordinators or digital support workers.
4. **Registered healthcare professionals** working in POA clinics should be supported with dedicated time to focus on reviewing the results of digital screening and onward triaging, as well as continuing to undertake **full pre-operative assessments**, where appropriate and locally determined. This allows more time to facilitate and manage optimisation pathways for patients who need greater support to prepare for surgery.
5. **Screening should:**
 - Identify patients who require no optimisation (“green”). These patients would be suitable to be added to a waiting list ‘pool’ so they can come for full POA (where necessary), swabs and blood tests within 6 weeks prior to surgery:
 - these patients should be offered universal optimisation advice. This would include referral to smoking cessation or alcohol management services (where required) and signposting to the “My health and wellbeing” pages on Myplannedcare.nhs.uk and any similar trust resource.
 - Identify patients who have a long-term condition and/or other health challenges which requires pathway-guided optimisation (“amber”)
 - all trusts should have pathways for key long-term conditions which can be implemented unsupervised by peri-operative care co-ordinators with support from registered healthcare professionals
 - these pathways should specify the timing of POA prior to a date for surgery
 - these patients should also be offered universal optimisation advice in addition to long-term condition pathway specific support.

- Identify patients who have a significant long-term condition or multiple long-term conditions which require review by a senior decision-maker (“red”)
 - all trusts to have these decision points in a standardised pathway and ensure regular audit of resource allocation.

Figure 1 below indicates options for which early screening, optimisation and full POA may take place. Where and how these are done will be provider and system specific.

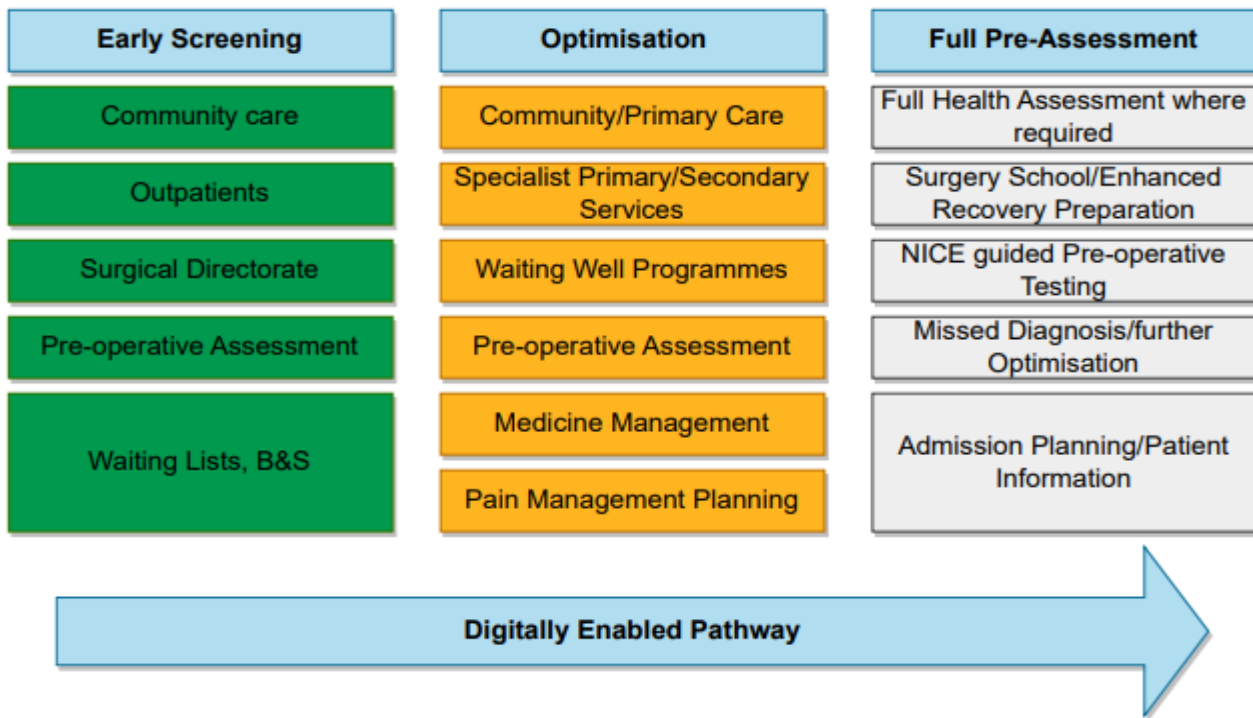


Figure 1: Early Screening, Optimisation and Pre-assessment Options

6. **Pathways should be locally developed** for the following conditions/risk factors:

- Diabetes
- Anaemia
- Frailty/specialist geriatrician review
- Exercise/activity if Duke Activity Status Index indicates low cardiorespiratory fitness
- Nutritional support for BMI<18 or >40
- Smoking cessation
- Alcohol management
- Pain management planning
- Medicines management
- Hypertension/dysrhythmias

Recommended intervention pathways for optimising patients with the conditions and risk factors listed above are shown in Figure 2 below, alongside the recommended pathway for optimisation in Figure 3.

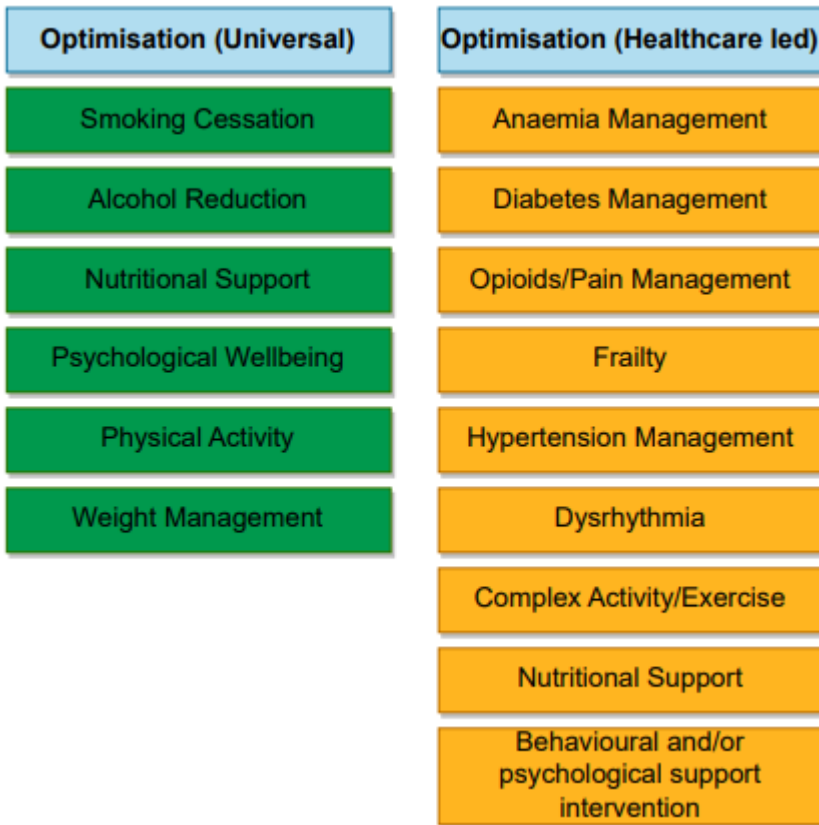
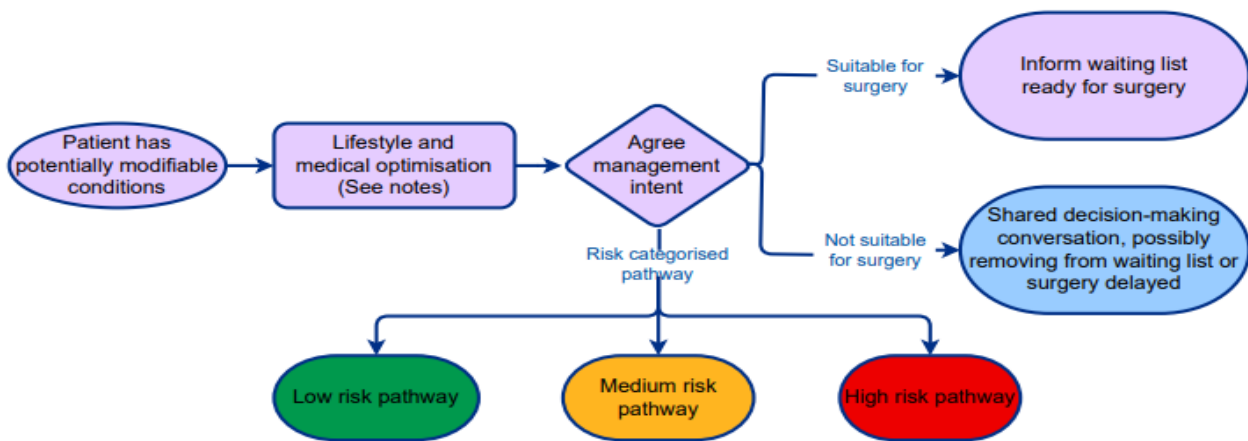


Figure 2: Recommended Intervention Pathways

All timescales (e.g. from a patient being added to the WL, through pre-screening , POA and decision for surgery) will vary by provider, but understanding the waiting times and reducing duplication for both pre-operative testing and appointments are key to pathway management.



<u>Lifestyle optimisation</u>	<u>Medical optimisation</u>	<u>Interventions</u>
Obesity	Opioids	Waiting well programme
Alcohol	Diabetes	Social prescribing
Smoking	COPD/OSA	Smoking cessation
Exercise	Frailty	Weight management
	Anaemia	Digital apps support
	Hypertension	Virtual wards
	Atrial fibrillation	Medical optimisation
		Referral to primary or secondary care

Figure 3: Recommended pathway for optimisation

7. **Patients already on waiting lists should be prioritised for screening** according to specified criteria including time on the waiting list (long-waiters first), clinical urgency and intended management (day-case or inpatient). POA resources may be limited so considering this is vital (see Table 1 below).

Table 1: Prioritising patients on waiting lists for screening

Priority Code	WL	POA (digital/telephone/F2F)
P2 – DC/IP	Urgent POA/TCI	Walk in/urgent protected slots within existing capacity Define approximate numbers
P3 – DC/IP	Early screen and risk assessment in line with RTT	POA (risk dependant) in line with estimated TCI to allow an appropriate time for review
P4 – DC/IP	Early screen and risk assessment in line with RTT	POA (risk dependant) in line with estimated TCI to allow appropriate time for review

8. Pathways should be co-designed with relevant stakeholders as illustrated in Figure 4 with appropriate governance structures and communication at every stage.

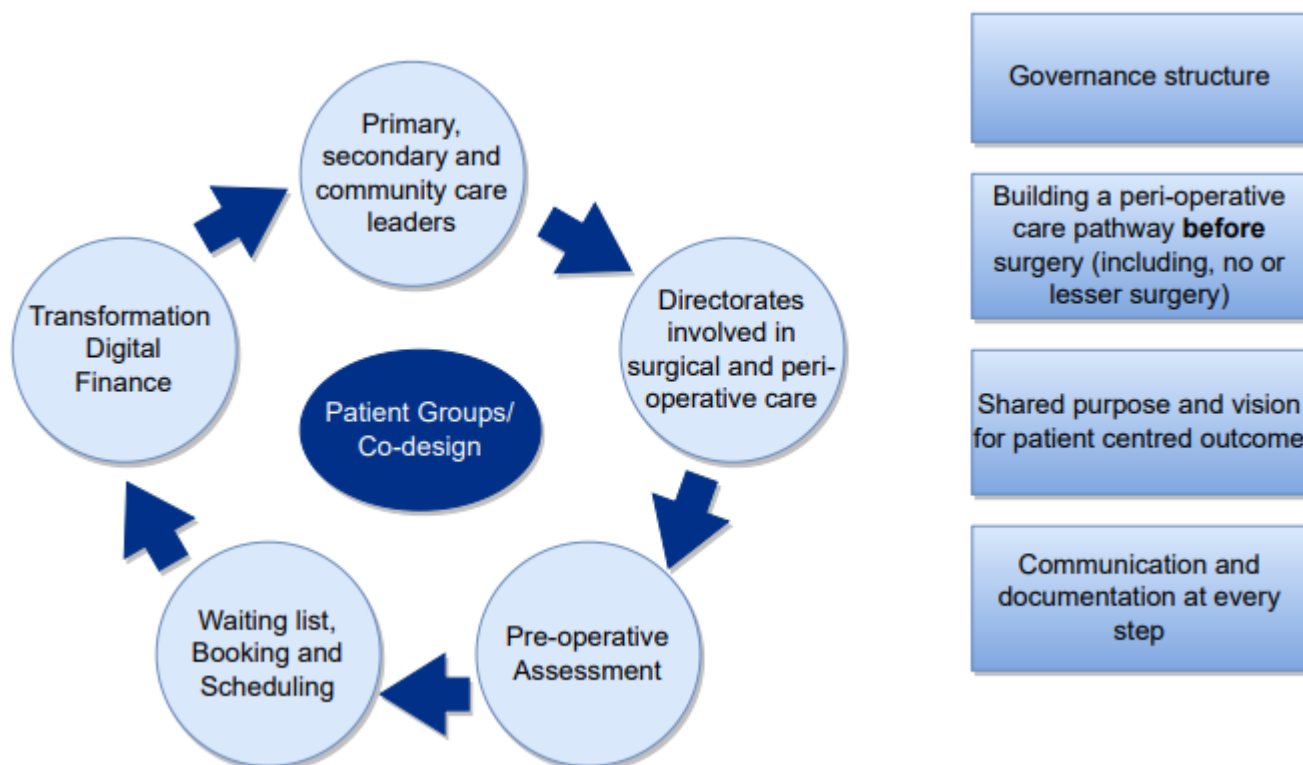


Figure 4: Key communications and stakeholders

The Existing Waiting List

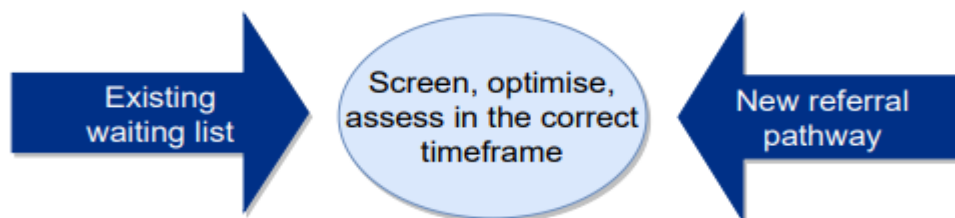
Each surgical directorate in collaboration with the booking, scheduling, and waiting list (WL) teams should identify the number of allocated POA appointments required to manage their patient caseload.

Ensuring there is adequate time for assessment and pre-operative planning is vital considering issues identified at POA are some of the main reasons for postponements and cancellation on the day, leading to patient disappointment and operational challenges to fill theatre lists.

1. A validation exercise should be undertaken for those patients already on the WL to assess if patients still require or want their surgical procedure.
2. Patients due to have their procedure under local anaesthetic will not always need to have a full POA and should be streamlined via a lighter touch pathway where possible. Local pathways should be developed to ensure that patients do not attend POA unnecessarily.
3. P2 patients are an urgent priority and surgical directorates should use a monthly average of patients listed (per month) to set the number of POA appointments required ensuring there is as much time as possible before TCI (at least 7 days but as much time as possible for 31/62 day waits).
4. Where there is opportunity for peri-operative workup for patients on cancer or other P2 pathways, this should be initiated (i.e., pre-operative testing and screening when initial investigations, tumour staging and/or treatment planning is undertaken).
5. P3/P4 patients POA capacity predictions should be calculated based on those existing on WL and those added to the WL (by week). This should allow for **at least** a six -week window from POA to TCI to allow for 6/4/2 theatre planning, while also maintaining the principle that there should be ***no TCI date offered until POA outcome is known.***
6. Each directorate should have a patient treatment list (PTL) report stating the waiting time for each elective surgical patient and then grouped by general anaesthetic and local anaesthetic (GA/LA) for those needing POA (if applicable) in addition to intended management of inpatient and day case (IP/DC) at the time of listing in line with [British Association Day Surgery \(BADs\)](#) recommendations. The longest referral to treatment (RTT) patients should be screened first to limit short notice cancellations and postponements at POA.
7. Day case pathways may be quicker where specific day care lists/sites exist. A mapping exercise of the waiting times for each speciality should be undertaken where possible. These patients may need a POA appointment in a timelier fashion to create a short notice 'patient pool' of patients willing to accept a date for their surgery at short notice following a cancellation.

Early Screening and Optimisation – New and Existing Pathways

Early screening and optimisation are mandated within the 23/24 NHS Standard Contract for ‘new’ patient IP pathways. Nonetheless, there is opportunity for patients already on an existing WL who are intended for DC/IP procedures to be screened earlier in the pathway.



Key principles

1. A **minimum dataset** of information should be made available from primary care to support the early screening process.
2. **Digital screening** tools can be used by patients to complete the early screening process. Non-digital alternatives should be available so some patients are not disadvantaged, and support provided for patients to complete the screening tools; this may be facilitated by peri-operative co-ordinators or digital support workers. See Table 2 for examples if there is no means of digital risk screening and slide 28 of the case study from [Buckinghamshire Healthcare NHS Trust: Primary to secondary care interface: identification of high/low risk patients](#)

Table 2 – Screening Priority

RTT/Intended Management	DC	IP
New Referrals	Screen for risk – lower priority	Screen for risk – high priority in line with NHSE 23/24 contract
0-32	Screen for risk – lower priority	Screen for risk – lower priority
33-44	Screen for risk – medium priority	Screen for risk – medium priority
45-52	Screen for risk – high priority (may be on a faster pathway to treatment, pooled lists/short notice)	Screen for risk – medium priority
53-65	Screen for Risk – urgent priority	Screen for Risk – urgent priority
>65	Screen for Risk – urgent priority, book POA where possible	Screen for Risk – urgent priority, book POA where possible

3. **Registered healthcare professionals** working in POA clinics should be allowed dedicated time to focus on reviewing the results of digital screening and onward triaging, as well as continuing to undertake **full preoperative assessments**, where appropriate and locally determined. This allows more time to facilitate and manage optimisation pathways for patients who need greater support to prepare for surgery. See a case study from [University Hospital Southampton NHS Foundation Trust: Preoperative Digital Patient Screening to Support Early Triage & Optimisation](#) for an example of how this is done.

4. **Patients already on waiting lists should be prioritised for screening** according to specified criteria including time on the waiting list (long-waiters first), clinical urgency and intended management (day case or inpatient). POA resources may be limited, so considering this is vital (see Table 1 above).

Following initial Screening (digital or questionnaire) to inform POA where needed.

Note: The opportunity for optimisation should be considered in every pathway in addition to universal health advice.

Intended Management RTT	DC – Low risk Digital /remote light touch/POA if required	DC – intermediate risk Digital/remote/ F2F where needed	DC – high risk F2F early POA advice and regular review/SDM	IP – Low risk Digital/remote/ F2F where needed	IP – Medium Risk – F2F	IP – high risk – F2F early POA advice and regular review/SDM
New referrals	POA 6-12 weeks before	POA 3 months before	Optimisation where possible/SDM	POA 3 months before	POA 3 months before	Optimisation where possible/SDM
0-32	POA 6-12 weeks before	POA 3 months before	Optimisation where possible	POA 3 months before	POA 3 months before	Optimisation where possible
33-44	POA 6-12 weeks before	POA 3 months before	Optimisation where possible	POA 3 months before	POA 3 months before	Optimisation where possible
45-52	POA 6-12 weeks before	POA 3 months before	Optimisation where possible	POA 3 months before	POA 3 months before	Optimisation where possible
53-65	POA 6-12 weeks before	POA 3 months before	Optimisation where possible	POA 3 months before	POA 3 months before	Optimisation where possible
>65	Book POA 4 weeks	Book POA 8 weeks	Optimisation where possible	Book POA 8 weeks	Book POA 8 weeks	Optimisation where possible

Risk Stratification Chart to Inform Patient Pathway

Green	Patients with no co-morbidities or behavioural risk factors or with stable co - morbidities not requiring optimisation
	Patients that would not always require a clinic appointment to see a healthcare professional after screening
	Low-risk patients that may not require a later pre-operative assessment according to local guidance
	Patients that can be added to pool of patients that can be listed for surgery with 6 weeks' notice, at which point they can attend pre-operative assessment if required, and have last-minute tests (e.g., MRSA screening (if indicated), blood tests and ECGs as recommended in NICE guidance)
Amber	Patients with co-morbidities or behavioural risk factors which can be optimised using a standardised locally developed pathway
	Patients that usually may not require a clinic appointment with a healthcare professional unless more targeted support is required
	Pathway should indicate the minimum time before surgery that the patient should be reviewed in pre-operative assessment in line with localised pre-operative testing
Red	Peri-operative risk factors which require senior clinical input and a shared decision-making conversation with the patient to explore the benefits, risks, and alternatives to surgery
	Patients that would usually require an early face-to-face appointment with a senior decision-maker. In most trusts, this will need to be preceded by a Registered Health Care Professional (RHCP) pre-operative assessment review

Booking, Scheduling and Waiting List

Booking and scheduling staff supported by their operational managers/clinical staff should identify patient risk and categorise them accordingly.

Low Risk	Low Risk	Intermediate Risk	Intermediate Risk	High Risk	High Risk
DC	IP	DC	IP	DC	IP
These patients may be categorised as 'green' for light touch/remote pathways		These patients may be categorised as 'amber' and require the telephone or face-to-face (F2F) pathway		These patients may be categorised as 'red' and need F2F or senior medical support	

Referral to Pre-operative Assessment

Referral to POA should be timely using the methods above to create advanced booking where required. For P3/P4 patients, a TCI should not be given until POA is complete.

1. Once initial risk is assigned (patient/surgery dependent), patients should be grouped into Referral to Treatment (RTT) weeks starting with the longest RTT down to the shortest.
2. POA referrals/bookings should commence and after early screening for all patients who have been waiting for longer than 52 weeks.
3. If POA capacity is full, alternative forms/pathways in POA should be considered, especially for low-risk patients. Examples of these are:
 - telephone updates for expired POA
 - low risk/remote pathways
 - digital enabled support for patient self-assessment
 - increasing time of validity of POA where it is safe to do so (reviewing local policies to support change i.e., pre-operative MRSA testing) ensuring that there is a way for patients to keep in touch to flag any changes in their health and for patients to be contacted to advise or remind them about preparations they may need to make before their TCI date (e.g., stopping certain medications).
4. Patients found to be unsuitable to proceed for surgery on their agreed TCI date after POA should have their pathway paused. Decision-making regarding whether or not to 'stop the clock' should be clinically led by a senior decision-maker in accordance with local guidance, with a comprehensive SOP in place for regular review. A dedicated point of contact is recommended, and local policies should be followed.
5. Where the POA has identified an opportunity for (further) optimisation to reduce peri-operative risks and to improve post-operative outcomes, a senior clinical decision-maker should review the patient, taking into account the urgency of the surgery, the risks of progressing to surgery versus the risks of delaying surgery, and the likelihood that, given greater time, further optimisation is achievable. The shared decision-making conversation with the patient should explore their ideas, concerns, and expectations.
6. POA alongside theatre, booking and scheduling teams should be working in a partnership to review capacity and engage in regular team updates with surgical directorates including operational leaders.

Workforce

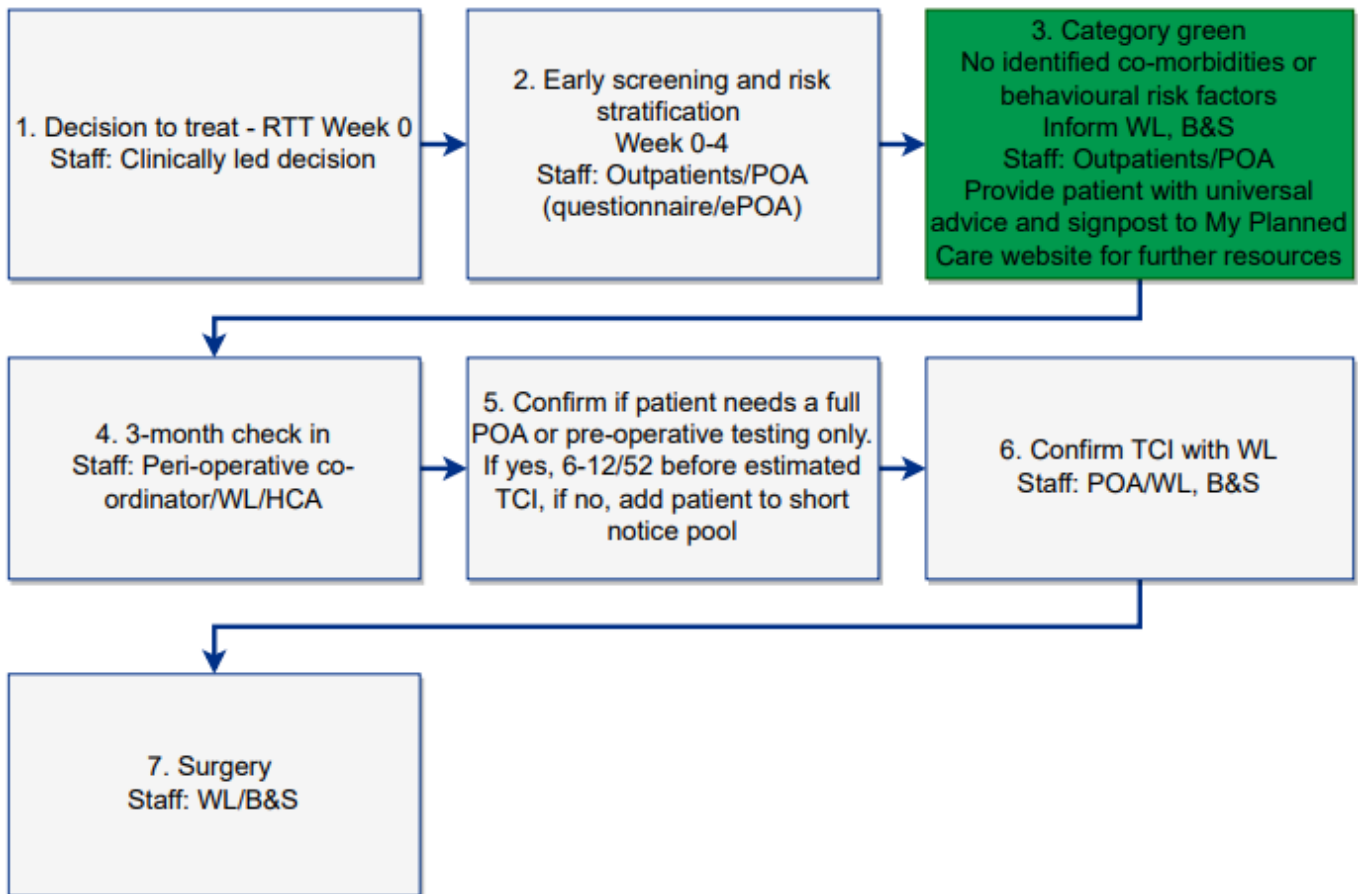
Additional resource may be required to manage both existing and new additions to inpatient PTLs because of implementing the early screening pathway. However, this may also present an opportunity to re-purpose existing resource dependent on POA capacity by following the above recommendations.

Opportunities to consider:

- Refer to [POA guidance](#) on appointment times/staffing and patient risk assessment.
- Ensure that low-risk patients having lower risk procedures can benefit from a lighter touch pathway, potentially with a reduction in appointment time, or telephone appointments instead of F2F. This will free up resource for higher risk patients and support early screening and risk assessment triage.
- Early screening and optimisation may not need a POA assessment nurse to support questions or stratify answers; however, risk stratification of patients into green/amber/red categories and decision-making about further intervention should be clinically led. Some digital screening tools may support a triaging recommendation and will require clinical validation. See guidance on the [peri-operative care co-ordinator role](#) and review resource available across the peri-operative pathway including all key stakeholders.

Patient Examples and Staff Support Roles

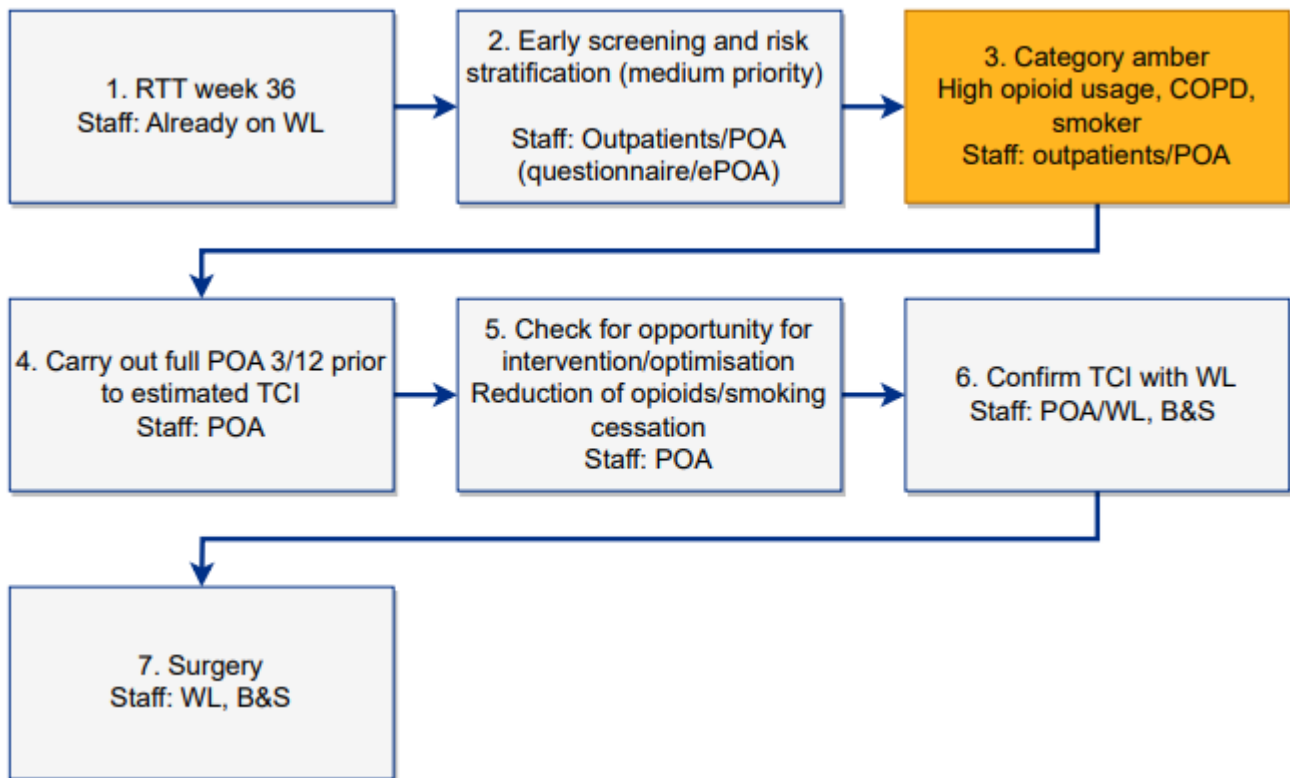
Below is an example of a new patients pathway undergoing a hernia repair. This has been categorised as Low Risk DC.



Learning Points:

- This patient potentially would be suitable for a low-risk pathway, with a telephone pre-operative assessment. Protocols should be developed locally to identify such patients.
- This patient may be suitable for a short notice pool.

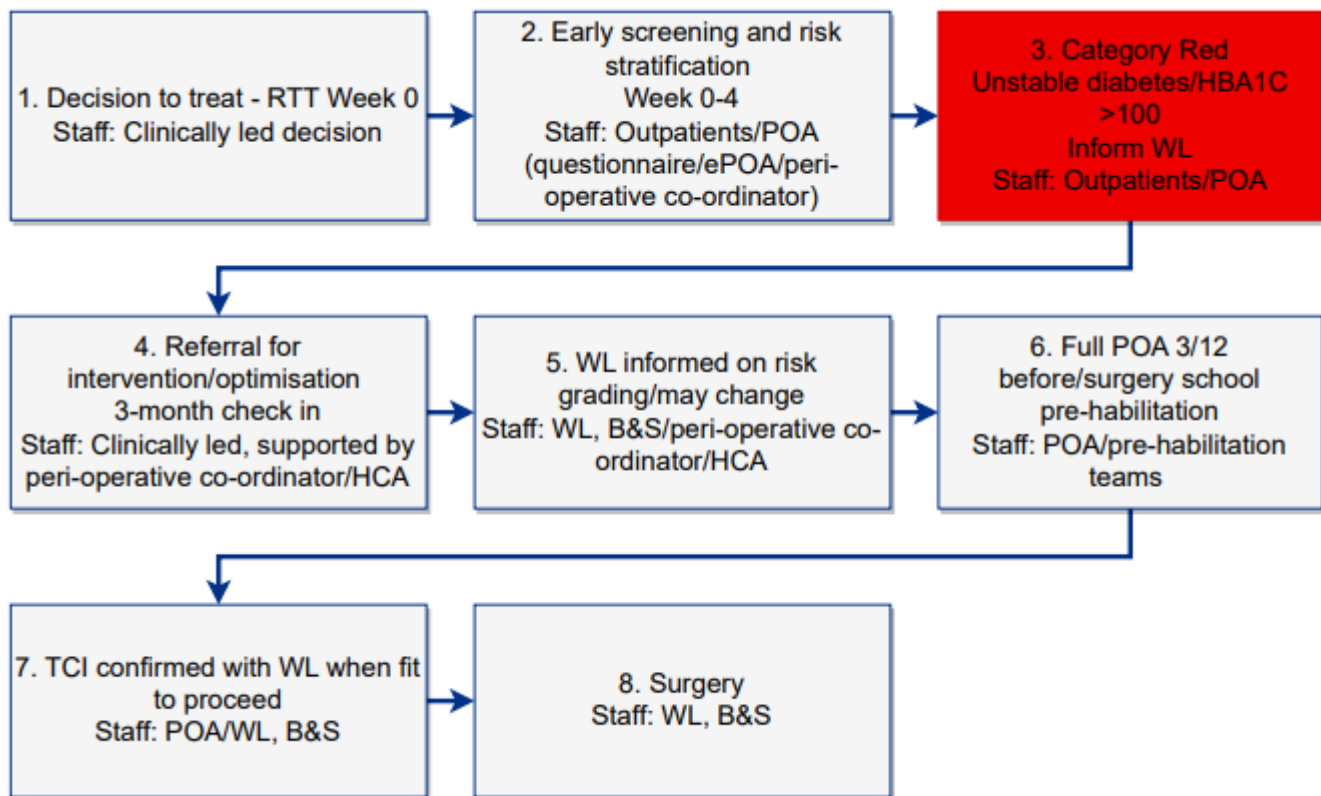
Below is an example of an existing patients pathway undergoing a spinal fusion. This has been categorised as Medium Risk IP.



Learning Points:

- Medium risk patients approaching their estimated TCI need up to 3 months for opportunity for intervention.
- POA needs a timely referral to reduce cancellations/postponement close to TCI.
- Considerations/opportunities around optimisation and intervention should be explored and support guidance/information on behavioural changes available for patients.

Below is an example of a new patients pathway undergoing a hip replacement. This has been categorised as High Risk IP.



Learning points

- A pathway should be in place to ensure that the risk stratification based on early screening is clinically validated, and that a member of the clinical POA team can implement local protocols for optimisation.
- Three months may be too long for a 'check-in' on optimisation. The decision regarding frequency of keeping in touch should be clinically led and based on locally developed protocols.
- A full POA should only be undertaken **once**, with the timing based on estimated TCI and POA validity

Factors for Success

Most Trusts should be able to implement early screening, risk and optimisation with adjustments to their operational procedures and infrastructure. Key learning from trusts that have provided supporting case studies for this guide are described below:

1. Engagement and communication of stakeholders in the co-design of pathways.
2. Developing standard operating procedures, pathways, and documentation requirements is essential.
3. Ensure risk stratification based on early screening is clinically validated.
4. Establish pathways within the trust to ensure timely investigations pre-operatively as required.
5. Audits should be carried out to evaluate, monitor and maintain efficiency. This will help to highlight areas for improvement.

Supporting Documents

Recommended document	Author	Overview
Preoperative Assessment Services Guidance	Getting It Right First Time	Guidance for non-medical pre-assessment lead, clinicians, and managers, who want to embed best practice in their pre-operative assessment processes.
Earlier Screening, Risk Assessment and Health Optimisation in Perioperative Pathways	NHS England in partnership with the Centre for Perioperative Care and the Royal College of Anaesthetists	Guide to support providers and integrated care boards to implement early screening, risk assessment and health optimisation for patients waiting for surgery.
2023/24 NHS Standard Contract	NHS England	A standard contract mandated by NHS England for use by commissioners for all contracts for healthcare services other than primary care.

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Non-medical National Network Group for Pre-operative Assessment	

GIRFT High Volume Low Complexity Programme and elective recovery

With demand for hospital treatment outstripping capacity prior to COVID-19, the demands of delivering care during a pandemic led to significant backlogs and longer waits for patients.

There is a significant need to improve the productivity and resilience of services, many of which are still disrupted by the consequences of the pandemic and impacted by ongoing operational pressures. Waiting times vary considerably across different parts of the country, but also between individual hospital trusts in the same system. In 2020, GIRFT established the High Volume Low Complexity ('**HVLC**') programme with the NHS London Region to address these challenges.

The HVLC programme promotes productivity through optimised delivery of services.

About GIRFT and the GIRFT Academy

Getting It Right First Time ('**GIRFT**') is an NHS programme designed to improve the quality of care within the NHS by reducing unwarranted variation. By tackling variation in the way services are delivered across the NHS, and by sharing best practice between trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings.

The GIRFT Academy has been established to provide easily accessible materials to support best practice delivery across specialties and adoption of innovations in care.

Importantly, GIRFT Academy is led by frontline clinicians who are expert in the areas they are working on. This means advice is developed by teams with a deep understanding of their discipline.

GIRFT has also published other resources which are available via FutureNHS. These are available at: [Theatre Productivity Programme - Getting It Right First Time - FutureNHS Collaboration Platform](#)

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