British Orthopaedic Association

BRITISH HIP SOCIETY

BODS (British Orthopaedic Directors Society)

BSSH
The British Society for Surgery of the Hand

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Dear Member

Caring for patients awaiting surgery

We are writing to all members of the BOA and the specialist societies listed above regarding the current challenges of restarting elective care and handling the unprecedented waiting lists after the COVID-19 surge at the start of the year.

The waiting list raises a number of important issues regarding caring for those patients awaiting surgery. A paper, prepared by the BOA and supported by the specialist societies listed above, covering the following themes is attached with this letter (p2 onwards):

- When and how often should our patients be reviewed?
- How should any review happen and how can potential harm be identified?
- How should patients be prioritised for surgery?
- What should happen to P5 patients? (P5 = Those on waiting list who chose to delay surgery due to Covid.)

We hope the information is useful, and we will keep in touch as we all work to tackle the current challenges. If there are particular issues you would like to bring to our attention, please contact the BOA policy team at policy@boa.ac.uk.

Kind regards,

Bob Handley

BOA President

BOA and Specialist Society Position paper on caring for patients awaiting surgery

Context

In June 2020, in the early stages of the Covid-19 pandemic, a prioritisation system for surgery was put in place to categorise surgical interventions in ‘P’ categories based on their urgency:

Category	Urgency	Timescale
P1a	Urgent	<24 hours
P1b	Urgent	<72 hours
P2	Soon	<1 month
P3	Routine	<3months
P4		>3 months

Since this system was introduced, priority has been given to P1 and P2 patients, with only limited operating on P3 and P4 patients at times when there has been greater NHS capacity available. The waiting lists now contain many thousands of patients awaiting priority 3 and 4 procedures.

Orthopaedics has been disproportionately affected by this situation because a large number of the orthopaedic procedures are in the lowest P4 category; this includes most of those awaiting life-changing hip and knee replacement, which are two of the largest volume procedures in orthopaedics (over 200,000 procedures per year in total). Very many patients have now been waiting considerable periods far in excess of the P3 cut off. This document outlines our guidance for managing patients experiencing an extended wait and reducing avoidable harms.

When and how often should P3 and P4 patients be reviewed?

- This document assumes that P1 and P2 patients receive their operation within the appropriate timescale, whereas P3 and P4 patients are likely to encounter an extended wait: they are the focus of this advice.

- Both NHS England and NHS Scotland have guidance relating to the review of waiting lists and those patients experiencing a long wait.[1] Neither guidance defines specific time intervals or processes for ongoing reviews, but both indicate support for this concept.

- We consider that the NHS has a duty of care for those on the waiting list and a principle of active waiting list management has been referred to in NHS England and NHS Scotland. In

[1] In NHS England ‘Clinical validation of surgical waiting lists: framework and support tools’,[1] the process of validation of waiting lists, included (among other things) “checking on a patient’s condition and establishing any additional risk factors.” https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/10/C0760-Clinical-validation-of-surgical-waiting-lists-1-2.pdf. For P5s (who have deferred treatment due to Covid), the maximum time interval before a review is 6 months). In Scotland in November 2020, guidance gave a requirements that: “long waits are actively reviewed (particularly priority level four patients)”[1]; “waiting lists should continue to be reviewed regularly to ensure up-to-date clinical categorisation of patients” and “patients within specialities such as Orthopaedics and Ophthalmology should be reviewed and communicated with frequently”. https://www.gov.scot/publications/supporting-elective-care-clinical-prioritisation-framework/pages/principles/

order to ensure active care and support, **P3 and P4 patients should be reviewed at intervals to check: their condition, symptoms and co-morbidities, to identify any deterioration and any reasons for expediting the surgery to avoid harm to the patient.**

- The BOA and specialist societies are aware that reviewing patients on the waiting list may be a very significant task due to numbers involved. Each review requires health professional time to hold the review and document it, and for any follow-up needed. **Resources need to be allocated to this process and the time required to review the list and the patients must be job planned for the relevant staff.**

- We have discussed whether a fixed time interval should be set for reviewing patients; however, on balance we concluded that **the time interval for reviews should be taken on a case-by-case basis for each patient, but as a guide:**

    - **For P3 patients (who should have received their operation within 12 weeks), the review should usually occur at 10-12 weeks if the surgery has not been scheduled within that time period.**
    - **For P4 patients, a review should occur every 6 months but the clinician should consider whether an earlier review is required, for example if there is a risk of deterioration or changes to the patient's condition.**
- **The time interval until the next review should be explained to the patient at the end of the consultation and internal processes should be in place to ensure that this can be followed up appropriately.**

- **A process for patient-initiated review should be in place, ensuring that patients awaiting surgery who are concerned about their symptoms or condition have a point of contact and relevant information about changes that should trigger an earlier or urgent review.**

How should any review happen and what about patients I am concerned about?

- **These reviews will be expected to take place as a virtual consultation, but in some cases additional imaging or a face-to-face assessment and examination of the patient may be needed (and conducted in a Covid-secure manner). Local arrangements should allow for both.** Remote consultations are most efficient if they are organised as a clinic and performed in a designated session. 'Cold calling' patients is not considered good practice.

- **The review should cover some key points:**

    (1) Assess current state, change in condition and any changes to their overall health. It should be used as an opportunity to assess whether a change to the operation or its complexity is likely.

    (2) Where patients have been shielding or have reduced their activities, they may have deconditioned. Discussion about diabetes control,[2] weight, blood pressure, anaemia and

[2] Newly published guidance on diabetes may be relevant: Guideline for Perioperative Care for People with Diabetes Mellitus Undergoing Elective and Emergency Surgery (March 2021), available at: https://www.cpoc.org.uk/guidelines-resources-guidelines-resources/guideline-diabetes

smoking/drinking could all be relevant. They could be directed to the 'Fitter, better, sooner'[3] (or similar) website or given advice on any self-directed 'prehab' that would be beneficial relevant to their surgery. For example, Versus Arthritis have a 'Let's Move' programme for people with arthritis.[4]

(3) The assessment should answer the question: does the priority level need to be changed. There is a national framework for assessing patients on the waiting list called the 'Recovery Prioritisation Matrix' available from the Federation of Surgical Specialty Associations, which we support.[5] It highlights seven clinical and personal issues where it can be appropriate to move the patient to a higher priority level. These are[6]:

- Risk to life
- Risk to function
- Worsening disability
- Worsening pain/physical symptoms
- Existing pain/physical symptoms
- Existing disability
- Psychological distress

For each issue, the patient can be assessed as at 'low', 'intermediate' or 'significant' risk.

For children, an alternative, validated and more focussed assessment tool is the HAPPS (holistic assessment paediatric patient score) which has 3 domains:

- Current life affected
- Future life affected
- Failure of current treatment

Each of these domains carries a score 0-2. Where the total is 0, the RCS grade is unchanged. A score of <=3 indicates an upgrade of 1 level (eg P4 to P3) and where the score is >=4, 2 levels.

- **For any patient judged as needing to be moved up a priority band, the clinician responsible should consult another member of the department to validate that decision.** This helps ensure accountability and fair decision making across the department.

- It may also be helpful to refer to the NHSI June 2020 "'How to' Guide: Clinical Harm Review Process"[7] document. This defines a Red, Amber, Green prioritisation based on the level of harm caused by delay to surgery using variables including symptoms, change in treatment

[3] Produced RCoA, and supported by RCSEngland and RCGP: https://cpoc.org.uk/patients/fitter-better-sooner-toolkit. Short overview video available at: https://youtu.be/0NMHMX-nFgY
[4] https://action.versusarthritis.org/page/64082/-/1
[5] Available from: https://fssa.org.uk/covid-19_documents.aspx. NB This is also explicitly supported by NHS Scotland - It appears at their site here: https://www.gov.scot/publications/supporting-elective-care-clinical-prioritisation-framework/pages/active-waiting-list-management/
[6] Additional factors that could be considered are 'worsening deformity' and 'age-dependent surgery', relevant to paediatric surgery, which we would support although they are not part of the FSSA Matrix.
[7] https://future.nhs.uk/ElecCareIST/view?objectId=77066405 (NHS Futures account needed)

options and poorer expected outcomes. This traffic light system allows the clinical urgency to override the waiting time as the defining factor.

- The outcome of any review consultation should be confirmed in writing to the patient (and their GP). They should also be offered any support available, either through the hospital, community care or relevant charities, to help them prepare for their surgery.

How should patients be prioritised for surgery?

- We are aware that at present, many hospitals are continuing to prioritise P1-P2 patients because of the continuing effects of the Covid surge; however, we expect this to broaden out soon and we urge all members to contribute to planning and decision making about restoring services wherever they are asked to do so. The prioritisation system so far has been generally effective in ensuring rapid surgery for those in P1 and P2, but at the expense of P3 and P4 patients who will be increasingly affected by delays to their surgery.

- We urge all trusts and health boards to ensure that T&O receives an equivalent proportion of the theatre lists to that seen pre-pandemic. Without significant action to restore substantial volumes of T&O operating the waiting list situation will only deteriorate further.

- As operating resumes important decisions will need to be made about the order in which to operate on the waiting list patients. We feel there are two main factors that should determine the relative priority of P3 and P4 patients.

    - **First is clinical need** which should be paramount in ensuring that those patients who are likely to come to serious harm from further delay should be prioritised (as per the FSSA Matrix or HAPPS above).
    - **Second is the length of time spent waiting for surgery.** There are concerns regarding unconscious bias occurring with patient selection, meaning that those patients from more disadvantaged backgrounds tend to wait longer, and this effect can be reduced if they are taken in waiting list order. We believe that it is important to be fair and transparent in decision making and that this process is documented.

What should happen in the case of P5 patients?

- When the category P5 was introduced (in October 2020) the expectation was that they should be reviewed within 6 months. These patients should be included within the review protocol as for P3/P4 patients. The P5 patients were those who wanted to stay on the waiting list but defer treatment because of concerns about their risks from COVID-19. NHS England guidance was that these patients 'remain on the appropriate active waiting list(s) and therefore remain visible'.[8] As the COVID-19 situation has improved, these patients may no longer feel that treatment should be deferred. If so, they should change category and continue on the waiting list in the same way as others who hadn't opted for P5 would have done.

[8] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/10/C0760-Clinical-validation-of-surgical-waiting-lists-1-2.pdf

Other resources

Members may find it useful to review the NHS England tools and resources that were made available as part of the 'Clinical validation' programme,[9] which include:

- a shared decision-making tool for use when a patient requests a clinical review (Appendix A)
- frequently asked questions, both for trusts and patients (Appendix B)
- supporting distressed patients (Appendix C)
- clinical prioritisation (Appendix D)
- pre-habilitation options (weight loss, activity, mental health, diabetes, smoking). These provide generic national resources but local options should be substituted when available
- template pre-habilitation advice sheet and list of national resources
- template letters to patients published in word to allow easy local adaptation

Version notes:

Version 1.1 published 6/5/21 with correct link inserted for footnote 7.

[9] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/10/C0760-Clinical-validation-of-surgical-waiting-lists-1-2.pdf