## Evidence Search Service Results of your search request

**Wait list stratification and risk assessment**

Thank you for requesting this evidence search. We hope you find the results useful. If you would like to discuss the findings or require an additional search, please contact: Alison McLaren[alisonmclaren1@nhs.net](mailto:alisonmclaren1@nhs.net)

Please acknowledge this work in any resulting paper or presentation as: *Evidence search: Wait list stratification and risk assessment* Alison McLaren. (25 March 2021). East Surrey Hospital, UK: Surrey and Sussex Library and Knowledge Services.

## Search notes

There does not appear to be specific information on waiting list stratification at individual Trust level, however, there is guidance from NHS England, European authorities and specific organisations, often with the caveat of using local knowledge and experience to inform the risk assessment.

A limited number of innovations are listed, one of which emphasises the importance of data quality tools to enable clean-up of waiting lists.

This scope of this search was not limited to post pandemic and therefore search terms for SARS-CoV-2 were not included in the strategy, however recent resources related to reset and recovery are incorporated.

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**UCL Partners**: Search and risk stratification tools register for access <https://uclpartners.com/proactive-care/search-and-risk-stratification-tools>

Technologies: **MyPathway**: <https://mypathway.healthcare/clinicalvalidation> Clinical Validation of Surgical Waiting Lists - MyPathway Waiting List Management provides revalidation and reprioritisation of waiting lists, including discharge where appropriate, in a patient-centric way. By using the app, patients can advise their clinician if their symptoms are getting worse, if they no longer have symptoms, they are able to self-discharge with clinician support, or if they still require an appointment, but it is not urgent, they can be reprioritised. MyPathway enables patients to feel more informed and in control of their care requirements

**Acumentice**: <https://acumentice.com/system-wide-management-of-elective-waiting-lists> System-wide management of elective waiting lists - implementation of a digital patient management system (Qubit Health) at Imperial Healthcare NHS Trust which offers a PAS agnostic aggregation of PTLs - services <https://acumentice.com/services>

**Qubit Health** smart software <http://qubit.health>

**Open Access Government** (2021) How technology can transform the elctive care challenge: <https://www.openaccessgovernment.org/how-technology-can-transform-the-elective-care-challenge/104699> - one area that remains ripe for disruption isn't the waiting list process itself, but the quality of data on it. These lists contain thousands of records and if some of those are inaccurate or no longer awaiting treatment, it places much greater significance on the coveted appointment slots for the patients that genuinely need them.

**Patient Safety Learning Hub**: (2020) An AI backed, risk-adjusted approach for prioritising the elective backlog and reducing avoidable harm <https://www.pslhub.org/learn/commissioning-service-provision-and-innovation-in-health-and-care/digital-health-and-care-service-provision/an-ai-backed-risk-adjusted-approach-for-prioritising-the-elective-backlog-and-reducing-avoidable-harm-r3169> - There is evidence that some trusts are attempting to build their own systems for prioritisation. This may be possible around matching operative type and resource availability but the efficiency of these systems overall should be a concern. Best intentions are fine but, when reviewed later, the ability to correctly prioritise patients to minimise harm and mortality is likely to be limited if not flawed. [C2-Ai's COMPASS Surgical List Triage system](https://c2-ai.net/compass-surgical-list-triage/) is an example of a system that can support evidence-based triage and individualised risk assessment of patients, while supporting the objectives of the CDC. It supports clinical decision making across all phases from crisis back to steady state. It has been developed by the creator of the [POSSUM system](https://jamanetwork.com/journals/jamasurgery/fullarticle/212013) and is built around the world's largest patient data set (140 million records from 46 countries) through the support of NHS Digital. The underlying algorithms are constantly refined against new and existing data sets to ensure relevance and accuracy. The Surgical List Triage tool combines the mortality and complication risks from the different patients to derive the prioritisation.

C2-Ai: <https://c2-ai.net/compass-surgical-list-triage> evidence-based triage of surgical lists

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National Institute for Health and Care Excellence (NICE)

[LiMAx system for assessing the functional capacity of the liver. Medtech innovation briefing [MIB168]](#Research883619)

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## A. National and International Guidance

#### British Geriatrics Society (BGS)

**Silver Book II: Holistic assessment of older people** (2021)

[Available online at this link](https://www.knowledgeshare.nhs.uk/index.php?PageID=link_resolver&link=d0b000693e16c5fe07df97e997657b81)

Silver Book II was written to address the care needs of older people, specifically older people living with frailty, during the first 72 hours of an urgent care episode. This chapter, edited by Finbarr Martin, Simon Conroy and Bianca Buurman, covers the assessment of older people in an urgent care situation.

#### Colorectal Disease

**The Association of Coloproctology of Great Britain and Ireland consensus guidelines in surgery for inflammatory bowel disease** (2018)

[Available online at this link](https://www.knowledgeshare.nhs.uk/index.php?PageID=link_resolver&link=62194f6130a9f56be0cf0fd83e889a39)

Aim There is a requirement of an expansive and up todate review of surgical management of inflammatory bowel disease (IBD) that can dovetail with the medical guidelines produced by the British Society of Gastroenterology. Methods Surgeons who are members of the ACPGBI with a recognised interest in IBD were invited to contribute various sections of the guidelines. They were directed to produce a procedure based document using literature searches that were systematic, comprehensible, transparent and reproducible. Levelsof evidence were graded. An editorial board was convened to ensure consistency of style, presentation andquality. Each author was asked to provide a set of recommendations which were evidence based and unambiguous. These recommendations were submitted to the whole guideline group and scored. They were then refined and submitted to a second vote. Only those that achieved >80% consensus at level 5 (strongly agree) or level 4 (agree) after 2 votes were included in the guidelines. Results All aspects of surgical care for IBD have been included along with 157 recommendations for management. Conclusion These guidelines provide an up to date andevidence based summary of the current surgical knowledge in the management of IBD and will serve as a useful practical text for clinicians performing this type of surgery.

#### EAU Guidelines Office Rapid Reaction Group

**An organisation-wide collaborative effort to adapt the EAU guidelines recommendations to the COVID-19 era** (2020)

[Available online at this link](https://www.knowledgeshare.nhs.uk/index.php?PageID=link_resolver&link=3de03bdc75d45ac1b30dc22d571f4bc0)

All recommendations in the Guidelines have been reviewed in light of the COVID-19 pandemic and have been adapted where appropriate. Panels also had access to and reviewed a range of national and local COVID-19 guidelines to ensure complementarity wherever possible. New evidence has been searched for by targeted (non-systematic) screening of the available published literature as well as including those recently accepted and in press with access provided by the publisher in strict confidence. The findings (mostly level 3/4 evidence) were discussed and approved by panel members across 21 EAU Guideline Panels using electronic communication. Regarding surgical approach that applies across several guidelines, it was decided that the GORRG will provide general recommendations instead of guideline-specific surgical approach recommendations in each disease area... Levels of priority: ...The GORRG produced a color-coded risk stratification tool (Figure 1) for completion by guideline panels to aid them with adaption of their recommendations:- LOW PRIORITY: Clinical harm (progression, metastasis, loss of function) very unlikely if postponed for 6 months (GREEN COLOUR) - INTERMEDIATE PRIORITY: cancel but reconsider in case of increase in capacity (not recommended to postpone more than 3 moths: Clinical harm (progression, metastasis, loss of organ function) possible if postponed 3 months but unlikely) (YELLOW COLOUR) - HIGH PRIORITY: the last to cancel, prevent delay of > 6 weeks. Clinical harm (progression, metastasis, loss of organ function and deaths very likely if postponed > 6 weeks (RED COLOUR) - EMERGENCY: cannot be postponed more 24 hours. Life threatening–organ function threatening condition (BLACK COLOUR)

#### NHS England

**Risk stratification: Learning and Impact Study Clinical validation of surgical waiting lists: framework and support tools** (2020)

[Available online at this link](https://www.knowledgeshare.nhs.uk/index.php?PageID=link_resolver&link=7a7b94965135b35b7e2c49567def9926)

Most long-waiting patients on the surgical waiting list will have agreed to undergo operative treatment before the coronavirus pandemic started. Many people’s circumstances may have changed as a result of the pandemic or other factors since then, and some patients may now have changed their minds about having surgery or wish to defer this until the pandemic is over. Similarly, some people’s condition may have changed, which they may not have wanted to inform their GP or specialist about. The clinical validation of surgical waiting lists project will produce a clinically validated waiting list that allows operating lists to run effectively, by: • checking on a patient’s condition and establishing any additional risk factors • establishing the patient’s wishes regarding treatment • providing good communication with patient and carer and GP • introducing the P5 and P6 categories that allows patients to postpone surgery but remain on the waiting lists

#### NHS England & NHS Improvement

**Urgent cancer diagnostic services during COVID-19 V2.0** (2021)

[Available online at this link](https://www.knowledgeshare.nhs.uk/index.php?PageID=link_resolver&link=21faecccaaa93c8dd217e4adeec95601)

p15: Local prioritisation arrangements should ensure that there is a single, clinician-managed route to urgent care for patients on both screening and symptomatic lists requiring this. Please refer to the 'clinicalguide for risk stratifying participants on the bowel cancer screening pathway'...p20: Existing risk stratification tools should be used to determine patients most at risk. This should consider factors including but not limited to: age, gender, smoking and alcohol histories,voice changes, difficult swallowing and presence of neck lumps

#### National Institute for Health and Care Excellence (NICE)

**LiMAx system for assessing the functional capacity of the liver. Medtech innovation briefing [MIB168]** (2019)

[Available online at this link](https://www.knowledgeshare.nhs.uk/index.php?PageID=link_resolver&link=9aaa30e2f7a4be538d6e0e9a60ceebdb)

The technology described in this briefing is the LiMAx liver function capacity test. It is intended to predict post-operative outcomes in people who are being considered for liver surgery or liver transplant, to allow individualised management mainly by informing the surgeon on the extent of resectability. The innovative aspects are that it offers point-of-care measurement of a novel marker of liver function. The intended place in therapy would be as well as standard tests and investigations in people being considered for liver surgery or transplant. The main points from the evidence summarised in this briefing are from 6 studies (1 randomised control trial and 5 observational studies) including over 1,700 adults with primary or secondary liver tumours having liver surgery and 266 liver transplant candidates. They show that LiMAx is useful for preoperative risk stratification and can help predict the likelihood of post-operative liver failure and mortality risk before surgery. Key uncertainties around the evidence or technology are how generalisable the results are to NHS practice because all available evidence is from the German healthcare system, and most are from 1 centre. There is less evidence on its use in liver transplants. The cost of each LiMAx test is £341 (excluding VAT) assuming a minimum annual usage of 50 tests. The resource impact would be an additional cost to current practice. If the test were to accurately predict post-operative outcomes, there could be savings from reductions in post-operative complications and reduced length of stay.

#### Royal College of Ophthalmologists (RCOphth)

**Ophthalmic Services Guidance: Restarting and Redesigning of Cataract Pathways in response to the COVID 19 pandemic** (2020)

[Available online at this link](https://www.knowledgeshare.nhs.uk/index.php?PageID=link_resolver&link=12ba2073738a64d5e17fd8ddb5790ad6)

Cataract surgery is probably the most cost-effective, quality of life improving procedure performed by the National Health Service. Prior to the COVID 19pandemic, it was the mos tcommon operation in the NHS. Approximately 440,000 NHS cataract procedures were performed in the 12 months up to April 2019 in England. At the start of the pandemic, routine cataract surgery was suspended to protect patients. It is likely that COVID 19 will continue to affect NHS activity for at least another 18 months. High flow cataract surgery needs to resume now to address the backlog and provide patients with a timely service. Failure to do so will compromise the quality of life of many elderly people for a significant proportion of their remaining lifespan. Restoration of cataract services will require a detailed review/redesign of the whole cataract pathway to ensure a safe environment for patients and staff. This also gives the opportunityto make changes that will have long-term benefits. This document provides generic guidance on the restarting of cataract services. Individual eye departments should tailor this guidance, taking into account their staffing, infrastructure, the needs of their local population as well as the expectations of local commissioners and regional NHS organisations... 4 Prioritisation of surgery: During times when capacity is significantly limited, prioritisation should be based on clinical and quality of life criteria, surgical risks, and the risk to the patient of COVID 19, rather than operational targets, to direct care to those most in need. Examples of criteria which make it desirable to prioritise operating sooner include severely limited binocular vision, inability to work or drive, high risk of falls due to vision, or surgery required to manage other sight threatening disease e.g. diabetic retinopathy...

#### Scottish Intercollegiate Guidelines Network (SIGN)

**SIGN 151 • Management of stable angina** (2018)

[Available online at this link](https://www.knowledgeshare.nhs.uk/index.php?PageID=link_resolver&link=00bd6e25dbe31209318037d831449da5)

Despite a steep decline in mortality from coronary artery disease (CAD) in Scotland over the last 20 years, CAD remains one of the leading causes of death in Scotland, responsible for 7,154 deaths in 2015. It is estimated that 18% of men aged 65–74 and 32% of men aged 75 and over are living with ischaemic heart disease ((IHD) heart attack or angina); the prevalence in women in these age groups is substantially lower at 9% and 20% respectively. Accurately distinguishing patients with stable angina from patients with unstable angina is problematic due to limitations in the way angina is coded in national data. In Scotland, data from 2012/13, submitted by Scottish general practices to Information Services Division Scotland through the Practice Team Information system recorded a rate of angina for men aged 65–74 and 75 years and over of 34.3 and 59.7 per 1,000 population, respectively. The comparable figures for women in the same age groups were 23.3 and 38.5 per 1,000 of the population. It is likely that the majority of people consulting their General Practitioner (GP) with angina will have stable angina. The Scottish Health Survey Topic Report on Older People’s Health reported the prevalence of angina, based on combined data from 2008–2010, as 18% in men and 15% in women aged 65 and over. The presence of stable angina signifies underlying CAD with an associated increased risk of subsequent cardiac events that can be reduced by appropriate medical treatment or surgical intervention.

## B. Synopses or Summaries

#### Health Information and Quality Authority, Ireland

**Evidence summary for care pathways support for the resumption of scheduled hospital care in the context of COVID-19** (2020)

[Available online at this link](https://www.knowledgeshare.nhs.uk/index.php?PageID=link_resolver&link=de7df59cea6dc93e9aa19aad9452506e)

Resumption of scheduled care within the hospital setting must occur in a manner which optimises patient care while minimising risks to the public, to healthcare staff, and to the wider health service. A key challenge will be in maintaining adequate capacity to deal with a potential resurgence of COVID-19 cases. ♣ The systematic search identified 45 relevant documents for review. These documents were mostly based on expert opinion and, other than one document, did not report a systematic approach to identifying and producing guidance. ♣ Despite coming from a broad range of medical disciplines, some consistencies were found across the included documents. These were categorised into three measure themes; organisational management, physical space, and patient flow. ♣ Guidance documents issued by Ministries for Health were mainly high level in nature and consistently referred to a gradual increase in activities with a requirement for adequate capacity, infection control and personal protective equipment (PPE) supplies. Detail was provided on patient prioritisation, suggested approaches to elective surgery, minimum requirements to restore scheduled treatment and the use of pathways to separate planned versus emergency care ♣ Guidance documents from professional societies covered a number of specialties including surgery, endoscopy, reproductive medicine, urology, cardiology, ophthalmology, gastroenterology, and radiology. The level of detail and breadth of the guidance varied considerably although most referred to prioritisation of care and a gradual resumption of service. Several documents described considerations for various stages of surgery and endoscopy, i.e., patient pathways. ♣ As more regions continue to ease restrictions related to COVID-19, it is anticipated that further guidance will be published, although, given the scope of guidance identified to date, additional novel recommendations are less likely. ♣ As the pandemic progresses, national organisations are likely to increasingly consider a broader population perspective, including issues such as cost-effectiveness, resource considerations and budget impact. ♣ Guidance documents emphasise the requirement for local data collection to assess the effectiveness of any measures introduced and to inform decisions around their escalation or de-escalation. There is likely to be a time lag before evidence on the effectiveness of measures specific to COVID-19 are available. Furthermore the transferability of such data is uncertain. Measures are typically multi-component, with effectiveness impacted by the scale of community transmission, local infrastructure, and staffing levels, among other factors.

#### NHS Halton CCG

**Operational plan 2019-20** (2019)

[Available online at this link](https://www.knowledgeshare.nhs.uk/index.php?PageID=link_resolver&link=36504243af9588f5dc79f4d0ed75b5b7)

Elective activity has been seasonally profiled with elective activity expected to be lower over the winter period but increasing again in March. CCG commissioned Aristotle risk stratification system... The CCG will continue to actively encourage the use of a risk stratification tool ensuring that it is aligned to the new PCN DES Anticipatory Care service specification as well as local service specifications and programmes of work... Cancer Alliances to have in place clinically-agreed protocols for stratifying breast, prostate and colorectal cancer patients & systems for remote monitoring...

#### Reform

**Making the right choices: Using data-driven technology to transform mental healthcare** (2019)

[Available online at this link](https://www.knowledgeshare.nhs.uk/index.php?PageID=link_resolver&link=0d77f1f00df10710712fbff77180230a)

... 3.1.3 Helping practitioners make better decisions: Operational pressures are an ongoing challenge for mental health services in the current context of staffing challenges and growing demand for services. This is particularly a concern for mental health acute wards which, given the high threshold for admission, are high-risk environments. As it stands, however, the Carter Review of efficiency in hospitals found half of trusts routinely go beyond planned staffing levels in order to meet the needs of patients. Data-driven technologies can be used in inpatient care to help providers better manage staffing levels in the context of these limited resources. For example, one NHS Trust is developing a tool to identify which inpatient wards are deemed high or low risk according to several factors to enable staff to be better allocated across the hospital and avert likely incidents. Further, as part of a wider initiative to improve collaboration across four mental health trusts in the West Midlands, the Mental Health Alliance for Excellence, Resilience Innovation and Training (MERIT) is working to formalise data sharing agreements between different trusts. This will allow bed managers to see more information about the availability of beds across the region, to tackle the current problem where “other hospitals may have available beds, but there is no visibility of this.”

## C. Systematic Reviews

#### Cochrane Database of Systematic Reviews

**Interventions to reduce waiting times for elective procedures** (2015)

Ballini L., Negro A., Maltoni S., Vignatelli L., Flodgren G., Simera I., Holmes J., Grilli R.

[Available online at this link](https://www.knowledgeshare.nhs.uk/index.php?PageID=link_resolver&link=81ed3e60ba622a6e2b426f900efc1d95)

Abstract - Background Long waiting times for elective healthcare procedures may cause distress among patients, may have adverse health consequences and may be perceived as inappropriate delivery and planning of health care. Objectives To assess the effectiveness of interventions aimed at reducing waiting times for elective care, both diagnostic and therapeutic. Search methods We searched the following electronic databases: Cochrane Effective Practice and Organisation of Care (EPOC) Group Specialised Register, the Cochrane Central Register of Controlled Trials (CENTRAL), MEDLINE (1946‐), EMBASE (1947‐), the Cumulative Index to Nursing and Allied Health Literature (CINAHL), ABI Inform, the Canadian Research Index, the Science, Social Sciences and Humanities Citation Indexes, a series of databases via Proquest: Dissertations & Theses (including UK & Ireland), EconLit, PAIS (Public Affairs International), Political Science Collection, Nursing Collection, Sociological Abstracts, Social Services Abstracts and Worldwide Political Science Abstracts. We sought related reviews by searching the Cochrane Database of Systematic Reviews and the Database of Abstracts of Reviews of Effectiveness (DARE). We searched trial registries, as well as grey literature sites and reference lists of relevant articles. Selection criteria We considered randomised controlled trials (RCTs), controlled before‐after studies (CBAs) and interrupted time series (ITS) designs that met EPOC minimum criteria and evaluated the effectiveness of any intervention aimed at reducing waiting times for any type of elective procedure. We considered studies reporting one or more of the following outcomes: number or proportion of participants whose waiting times were above or below a specific time threshold, or participants' mean or median waiting times. Comparators could include any type of active intervention or standard practice. Data collection and analysis Two review authors independently extracted data from, and assessed risk of bias of, each included study, using a standardised form and the EPOC 'Risk of bias' tool. They classified interventions as follows: interventions aimed at (1) rationing and/or prioritising demand, (2) expanding capacity, or (3) restructuring the intake assessment/referral process. For RCTs when available, we reported preintervention and postintervention values of outcome for intervention and control groups, and we calculated the absolute change from baseline or the effect size with 95% confidence interval (CI). We reanalysed ITS studies that had been inappropriately analysed using segmented time‐series regression, and obtained estimates for regression coefficients corresponding to two standardised effect sizes: change in level and change in slope. Main results Eight studies met our inclusion criteria: three RCTs and five ITS studies involving a total of 135 general practices/primary care clinics, seven hospitals and one outpatient clinic. The studies were heterogeneous in terms of types of interventions, elective procedures and clinical conditions; this made meta‐analysis unfeasible. One ITS study evaluating prioritisation of demand through a system for streamlining elective surgery services reduced the number of semi‐urgent participants waiting longer than the recommended time (< 90 days) by 28 participants/mo, while no effects were found for urgent (< 30 days) versus non‐urgent participants (< 365 days). Interventions aimed at restructuring the intake assessment/referral process were evaluated in seven studies. Four studies (two RCTs and two ITSs) evaluated open access, or direct booking/referral: One RCT, which showed that open access to laparoscopic sterilisation reduced waiting times, had very high attrition (87%); the other RCT showed that open access to investigative services reduced waiting times (30%) for participants with lower urinary tract syndrome (LUTS) but had no effect on waiting times for participants with microscopic haematuria. In one ITS study, same‐day scheduling for paediatric health clinic appointments reduced waiting times (direct reduction of 25.2 days, and thereafter a decrease of 3.03 days per month), while another ITS study showed no effect of a direct booking system on proportions of participants receiving a colposcopy appointment within the recommended time. One RCT and one ITS showed no effect of distant consultancy (instant photography for dermatological conditions and telemedicine for ear nose throat (ENT) conditions) on waiting times; another ITS study showed no effect of a pooled waiting list on the number of participants waiting for uncomplicated spinal surgery. Overall quality of the evidence for all outcomes, assessed using the GRADE (Grades of Recommendation, Assessment, Development and Evaluation) tool, ranged from low to very low. We found no studies evaluating interventions to increase capacity or to ration demand. Authors' conclusions As only a handful of low‐quality studies are presently available, we cannot draw any firm conclusions about the effectiveness of the evaluated interventions in reducing waiting times. However, interventions involving the provision of more accessible services (open access or direct booking/referral) show some promise. Plain language summary Effects of interventions to reduce waiting times for non‐urgent health procedures Long waiting times for non‐urgent procedures are common in public healthcare systems, where care is provided free of charge and supply is limited by budget constraints. This may cause distress among patients as well as adverse health consequences. We reviewed the evidence on the effects of interventions in reducing waiting times. We found eight eligible studies (three randomised controlled trials and five interrupted time series studies) involving 135 primary care clinics, seven hospitals and one outpatient clinic. Different interventions, elective procedures and clinical conditions across included studies made pooling of data unfeasible. The quality of the included evidence (to November 2013) ranged from low to very low, as data were obtained from randomised controlled trials that for the most part suffered from serious bias, and from non‐randomised studies without a control group. The single study that evaluated an intervention aimed at prioritising demand showed that introducing a system for streamlining elective surgery reduced the number of semi‐urgent patients waiting longer than recommended, but did not affect urgent or non‐urgent groups. Seven studies evaluated interventions aimed at restructuring the intake assessment/referral process. Three of four studies evaluating effects of open access or direct booking/referral showed beneficial effects: One study showed reduced waiting times for open access to sterilisation through keyhole surgery; another showed that open access to investigative services may lead to reduced waiting times for patients with urinary symptoms (but not for patients with microscopic blood in urine); and one study reported that same‐day scheduling reduced waiting times for those seeking child health outpatient services. One study showed no effect of a direct booking system on the proportion of patients reported to have moderate or severe cell changes on the neck of the womb who received an appointment for further investigation within four weeks. Two studies of distant consultancy (instant photography for skin conditions and telemedicine for ear, nose and throat conditions) showed no effect on waiting times to see a specialist. One study reported that using a pooled waiting list did not change the number of patients waiting for routine back surgery within the recommended time. We found no studies evaluating interventions aimed at increasing capacity or rationing demand. As only a handful of low‐quality studies are presently available, we cannot draw any firm conclusions about the effectiveness of the evaluated interventions in reducing waiting times. However, interventions involving the provision of more accessible services (open access or direct booking/referral) show some promise.

#### Physiotherapy

**Intermediate care pathways for musculoskeletal conditions--are they working? A systematic review.** (2015)

Hussenbux A., Morrissey D., Joseph C., McClellan CM

[Available online at this link](https://www.knowledgeshare.nhs.uk/index.php?PageID=link_resolver&link=2261fb6971e195927f25024a4821f99d)

BACKGROUND: Musculoskeletal condition assessment and management is increasingly delivered at the primary to secondary care interface, by inter-disciplinary triage and treat services. OBJECTIVES: This review aimed to describe Intermediate Care pathways, evaluate effectiveness, describe outcomes and identify gaps in the evidence. DATA SOURCES: PubMed, ISI Web of Science, EMBASE, Ovid Medline, PEDro, Google Scholar to October 2013. STUDY SELECTION/ELIGIBILITY CRITERIA: Studies in English that evaluated relevant services were considered for inclusion. Studies evaluating paediatric or emergency medicine and self-referral were excluded. RESULTS: Twenty-three studies were identified. Between 72% and 97% of patients could be managed entirely within Intermediate Care with a 20% to 60% resultant reduction in orthopaedic referral rate. Patient reported outcome measures typically showed significant symptom improvements. Knee conditions were most commonly referred on to secondary care (35% to 56%), with plain films (5% to 23%) and MRI (10% to 18%) the commonest investigations. Physiotherapists' clinical decision making and referral accuracy were comparable to medical doctors in 68% to 96% of cases. Intermediate Care consistently leads to significantly reduced orthopaedic waiting times and high patient satisfaction. LIMITATIONS: These findings are not based on strong evidence and there is an urgent need for high-quality, prospective, comprehensive evaluation of Intermediate Care provision, including cost-effectiveness and impact on other services. FUNDING: Part funded by EPSRC and AXA-PPP. CONCLUSION: Intermediate Care consistently improves patient outcome, typically results in appropriate referral and management, reduces waiting times and increases patient satisfaction. There is a case for wider provision of Intermediate Care services to effectively manage non-surgical musculoskeletal patients.

## D. Original Research

1. **A pragmatic proposal for triaging DXA testing during the COVID-19 global pandemic.**  
   Sapkota HR Osteoporosis International 2021;32(1):1-6.

The COVID-19 pandemic has resulted in huge disruption to healthcare provision, including to dual-energy X-ray absorptiometry (DXA) imaging. Increased waiting lists for DXA from the pandemic mean potential long and uncertain delays in treatment for osteoporosis. To address these increased waiting lists, we propose a rapid, simple, one-stop algorithm incorporating medication use (aromatase inhibitor, corticosteroid) and clinical risk stratification supplementing a standard FRAX assessment. Our pragmatic algorithm produces a recommendation to treat empirically, image with DXA, or observe. If applied, we model a significant reduction in DXA scan requirements with a corresponding reduction in treatment delays for those awaiting DXA. We estimate this will reduce DXA scan numbers by about 50%, whilst pragmatically ensuring those with the highest clinical need correctly receive treatment without delay. This algorithm will help many clinicians including general practitioners/family physicians prioritise DXA when they may not always have the expertise to make this judgement based on clinical information alone. Although we have used UK guidelines as an example, this approach is flexible enough for adaptation by other countries based on their local guidelines, licensing, prescribing requirements, and DXA waiting list times. There are some limitations to our proposal. However, it represents one way of managing the uncertainty of the current COVID-19 pandemic.

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1. **Cataract risk stratification and prioritisation protocol in the COVID-19 era.**  
   Cheng KK BMC health services research 2021;21(1):153.

BACKGROUND: The COVID-19 pandemic halted non-emergency surgery across Scotland. Measures to mitigate the risks of transmitting COVID-19 are creating significant challenges to restarting all surgical services safely. We describe the development of a risk stratification tool to prioritise patients for cataract surgery taking account both specific risk factors for poor outcome from COVID-19 infection as well as surgical 'need'. In addition we report the demographics and comorbidities of patients on our waiting list. METHODS: A prospective case review of electronic records was performed. A risk stratification tool was developed based on review of available literature on systemic risk factors for poor outcome from COVID-19 infection as well as a surgical 'need' score. Scores derived from the tool were used to generate 6 risk profile groups to allow prioritised allocation of surgery. RESULTS: There were 744 patients awaiting cataract surgery of which 66 (8.9 %) patients were 'shielding'. One hundred and thirty-two (19.5 %) patients had no systemic comorbidities, 218 (32.1 %) patients had 1 relevant systemic comorbidity and 316 (46.5 %) patients had 2 or more comorbidities. Five hundred and ninety patients (88.7 %) did not have significant ocular comorbidities. Using the risk stratification tool, 171 (23 %) patients were allocated in the highest 3 priority stages. Given an aging cohort with associated increase in number of systemic comorbidities, the majority of patients were in the lower priority stages 4 to 6. CONCLUSIONS: COVID-19 has created an urgent challenge to deal safely with cataract surgery waiting lists. This has driven the need for a prompt and pragmatic change to the way we assess risks and benefits of a previously regarded as low-risk intervention. This is further complicated by the majority of patients awaiting cataract surgery being elderly with comorbidities and at higher risk of mortality related to COVID-19. We present a pragmatic method of risk stratifying patients on waiting lists, blending an evidence-based objective assessment of risk and patient need combined with an element of shared decision-making. This has facilitated safe and successful restarting of our cataract service.

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1. **Developing a prioritization model for endoscopy and colorectal cancer 2-week wait referrals during the COVID-19 pandemic-is faecal immunochemical testing the answer?**  
   Habib Bedwani N. The British journal of surgery 2021;108(1):e18-e19.

The COVID-19 pandemic has significantly delayed 2-week wait (2WW) bowel cancer endoscopy. We propose a FIT (Faecal Immunochemical Test) based model to risk-stratify patients for 2WW endoscopy.

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1. **Elective orthopaedic cancellations due to the COVID-19 pandemic: where are we now, and where are we heading?**  
   Oussedik S. Bone & joint open 2021;2(2):103-110.

AIMS: The primary aim is to estimate the current and potential number of patients on NHS England orthopaedic elective waiting lists by November 2020. The secondary aims are to model recovery strategies; review the deficit of hip and knee arthroplasty from National Joint Registry (NJR) data; and assess the cost of returning to pre-COVID-19 waiting list numbers. METHODS: A model of referral, waiting list, and eventual surgery was created and calibrated using historical data from NHS England (April 2017 to March 2020) and was used to investigate the possible consequences of unmet demand resulting from fewer patients entering the treatment pathway and recovery strategies. NJR data were used to estimate the deficit of hip and knee arthroplasty by August 2020 and NHS tariff costs were used to calculate the financial burden. RESULTS: By November 2020, the elective waiting list in England is predicted to be between 885,286 and 1,028,733. If reduced hospital capacity is factored into the model, returning to full capacity by November, the waiting list could be as large as 1.4 million. With a 30% increase in productivity, it would take 20 months if there was no hidden burden of unreferred patients, and 48 months if there was a hidden burden, to return to pre-COVID-19 waiting list numbers. By August 2020, the estimated deficits of hip and knee arthroplasties from NJR data were 18,298 (44.8%) and 16,567 (38.6%), respectively, compared to the same time period in 2019. The cost to clear this black log would be £198,811,335. CONCLUSION: There will be up to 1.4 million patients on elective orthopaedic waiting lists in England by November 2020, approximate three-times the pre-COVID-19 average. There are various strategies for recovery to return to pre-COVID-19 waiting list numbers reliant on increasing capacity, but these have substantial cost implications. Cite this article: Bone Jt Open 2021;2(2):103-110.

[Available online at this link](https://www.knowledgeshare.nhs.uk/index.php?PageID=link_resolver&link=b1fd550a846211bac569da963127b884)

1. **How to prioritize patients and redesign care to safely resume planned surgery during the COVID-19 pandemic.**  
   Logishetty K. Bone & joint open 2021;2(2):134-140.

AIMS: Restarting planned surgery during the COVID-19 pandemic is a clinical and societal priority, but it is unknown whether it can be done safely and include high-risk or complex cases. We developed a Surgical Prioritization and Allocation Guide (SPAG). Here, we validate its effectiveness and safety in COVID-free sites. METHODS: A multidisciplinary surgical prioritization committee developed the SPAG, incorporating procedural urgency, shared decision-making, patient safety, and biopsychosocial factors; and applied it to 1,142 adult patients awaiting orthopaedic surgery. Patients were stratified into four priority groups and underwent surgery at three COVID-free sites, including one with access to a high dependency unit (HDU) or intensive care unit (ICU) and specialist resources. Safety was assessed by the number of patients requiring inpatient postoperative HDU/ICU admission, contracting COVID-19 within 14 days postoperatively, and mortality within 30 days postoperatively. RESULTS: A total of 1,142 patients were included, 47 declined surgery, and 110 were deemed high-risk or requiring specialist resources. In the ten-week study period, 28 high-risk patients underwent surgery, during which 68% (13/19) of Priority 2 (P(2), surgery within one month) patients underwent surgery, and 15% (3/20) of P(3) (< three months) and 16% (11/71) of P(4) (> three months) groups. Of the 1,032 low-risk patients, 322 patients underwent surgery. Overall, 21 P(3) and P(4) patients were expedited to 'Urgent' based on biopsychosocial factors identified by the SPAG. During the study period, 91% (19/21) of the Urgent group, 52% (49/95) of P(2), 36% (70/196) of P(3), and 26% (184/720) of P(4) underwent surgery. No patients died or were admitted to HDU/ICU, or contracted COVID-19. CONCLUSION: Our widely generalizable model enabled the restart of planned surgery during the COVID-19 pandemic, without compromising patient safety or excluding high-risk or complex cases. Patients classified as Urgent or P(2) were most likely to undergo surgery, including those deemed high-risk. This model, which includes assessment of biopsychosocial factors alongside disease severity, can assist in equitably prioritizing the substantial list of patients now awaiting planned orthopaedic surgery worldwide. Cite this article: Bone Jt Open 2021;2(2):134-140.

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1. **A system for risk stratification and prioritization of breast cancer surgeries delayed by the COVID-19 pandemic: preparing for re-entry.**  
   Smith BL Breast cancer research and treatment 2020;183(3):515-524.

PURPOSE: During the COVID-19 pandemic, most breast surgery for benign and malignant conditions has been postponed, creating a backlog of patients who will need surgery. A fair and transparent system for assessing the risk of further delaying surgery for individual patients to prioritize surgical scheduling is needed. METHODS: Factors related to risk of delaying surgery for breast patients were identified. Scores were assigned to each factor, with higher scores indicating a greater risk from delaying surgery. REDCap and Microsoft Excel tools were designed to track and score delayed patients. RESULTS: Published data and multidisciplinary clinical judgement were used to assign risk scores based on patient and tumor factors, length of delay, and tumor response to preoperative therapy. Patients completing neoadjuvant chemotherapy were assigned the highest scores as their options for delaying surgery are most limited. Among patients receiving neoadjuvant endocrine therapy or no medical therapy, higher scores were assigned for low-estrogen receptor or high-genomic risk scores, higher grade, larger tumors, younger age and longer delay. High priority scores were assigned for progression during preoperative therapy. Low scores were assigned for re-excisions, atypical lesions and other benign indications. There was good agreement of the tool's ranking of sample patients with rankings by experienced clinicians. The tool generates risk-stratified patient lists by surgeon or institution to facilitate assignment of surgery dates. CONCLUSIONS: This tool generates a clinically consistent, risk-stratified priority list of breast surgical procedures delayed by the COVID-19 pandemic. This systematic approach may facilitate surgical scheduling as conditions normalize.

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1. **Comparison of different algorithms for the assessment of cardiovascular risk after kidney transplantation by the time of entering waiting list.**  
   Herzog Anna Laura Clinical kidney journal 2020;13(2):150-158.

Background: The prevalence of cardiovascular disease is high among patients with chronic kidney disease and cardiovascular events (CVE) remain the leading cause of death after kidney transplantation (KT). We performed a retrospective analysis of 389 KT recipients to assess if the European Society of Cardiology Score (ESC-Score), Framingham Heart Study Score (FRAMINGHAM), Prospective Cardiovascular Munster Study Score (PROCAM-Score) or Assessing cardiovascular risk using Scottish Intercollegiate Guidelines Network Score (ASSIGN-Score) algorithms can predict cardiovascular risk after KT at the time of entering the waiting list., Methods: 389 KT candidates were scored by the time of entering the waiting list. Pearsons chi-square test, cox regression analysis and survival estimates were performed to evaluate the reliability of the cardiovascular scoring models after successful KT., Results: During a follow-up of 8 +/- 5.8 years, 96 patients (30%) died due to cardiovascular problems, whereas 13.9% suffered non-fatal CVE. Graft loss occurred in 84 patients (21.6%). Predictors of CVE, survival and graft loss were age and the length of end-stage kidney disease. All scores performed well in assessing the risk for CVE (P < 0.01). Receiver-operating characteristic analysis using the ESC-SCORE, as an example, suggested a cut-off for risk stratification and clinical decisions., Conclusions: We found all tested scores were reliable for cardiovascular assessment. We suggest using cardiac scores for risk assessment before KT and then taking further steps according to current guidelines. Copyright © The Author(s) 2019. Published by Oxford University Press on behalf of ERA-EDTA.

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1. **Development and validation of a Surgical Prioritization and Ranking Tool and Navigation Aid for Head and Neck Cancer (SPARTAN-HN) in a scarce resource setting: Response to the COVID-19 pandemic**  
   John R. de Almeida Cancer 2020;126(22):4895-4904 .

Background: In the wake of the coronavirus disease 2019 (COVID-19) pandemic, access to surgical care for patients with head and neck cancer (HNC) is limited and unpredictable. Determining which patients should be prioritized is inherently subjective and difficult to assess. The authors have proposed an algorithm to fairly and consistently triage patients and mitigate the risk of adverse outcomes. Methods: Two separate expert panels, a consensus panel (11 participants) and a validation panel (15 participants), were constructed among international HNC surgeons. Using a modified Delphi process and RAND Corporation/University of California at Los Angeles methodology with 4 consensus rounds and 2 meetings, groupings of high-priority, intermediate-priority, and low-priority indications for surgery were established and subdivided. A point-based scoring algorithm was developed, the Surgical Prioritization and Ranking Tool and Navigation Aid for Head and Neck Cancer (SPARTAN-HN). Agreement was measured during consensus and for algorithm scoring using the Krippendorff alpha. Rankings from the algorithm were compared with expert rankings of 12 case vignettes using the Spearman rank correlation coefficient. Results: A total of 62 indications for surgical priority were rated. Weights for each indication ranged from -4 to +4 (scale range; -17 to 20). The response rate for the validation exercise was 100%. The SPARTAN-HN demonstrated excellent agreement and correlation with expert rankings (Krippendorff alpha, .91 [95% CI, 0.88-0.93]; and rho, 0.81 [95% CI, 0.45-0.95]). Conclusions: The SPARTAN-HN surgical prioritization algorithm consistently stratifies patients requiring HNC surgical care in the COVID-19 era. Formal evaluation and implementation are required.

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1. **Effect of delays in the 2-week-wait cancer referral pathway during the COVID-19 pandemic on cancer survival in the UK: a modelling study.**  
   Sud A. The Lancet. Oncology 2020;21(8):1035-1044.

BACKGROUND: During the COVID-19 lockdown, referrals via the 2-week-wait urgent pathway for suspected cancer in England, UK, are reported to have decreased by up to 84%. We aimed to examine the impact of different scenarios of lockdown-accumulated backlog in cancer referrals on cancer survival, and the impact on survival per referred patient due to delayed referral versus risk of death from nosocomial infection with severe acute respiratory syndrome coronavirus 2. METHODS: In this modelling study, we used age-stratified and stage-stratified 10-year cancer survival estimates for patients in England, UK, for 20 common tumour types diagnosed in 2008-17 at age 30 years and older from Public Health England. We also used data for cancer diagnoses made via the 2-week-wait referral pathway in 2013-16 from the Cancer Waiting Times system from NHS Digital. We applied per-day hazard ratios (HRs) for cancer progression that we generated from observational studies of delay to treatment. We quantified the annual numbers of cancers at stage I-III diagnosed via the 2-week-wait pathway using 2-week-wait age-specific and stage-specific breakdowns. From these numbers, we estimated the aggregate number of lives and life-years lost in England for per-patient delays of 1-6 months in presentation, diagnosis, or cancer treatment, or a combination of these. We assessed three scenarios of a 3-month period of lockdown during which 25%, 50%, and 75% of the normal monthly volumes of symptomatic patients delayed their presentation until after lockdown. Using referral-to-diagnosis conversion rates and COVID-19 case-fatality rates, we also estimated the survival increment per patient referred. FINDINGS: Across England in 2013-16, an average of 6281 patients with stage I-III cancer were diagnosed via the 2-week-wait pathway per month, of whom 1691 (27%) would be predicted to die within 10 years from their disease. Delays in presentation via the 2-week-wait pathway over a 3-month lockdown period (with an average presentational delay of 2 months per patient) would result in 181 additional lives and 3316 life-years lost as a result of a backlog of referrals of 25%, 361 additional lives and 6632 life-years lost for a 50% backlog of referrals, and 542 additional lives and 9948 life-years lost for a 75% backlog in referrals. Compared with all diagnostics for the backlog being done in month 1 after lockdown, additional capacity across months 1-3 would result in 90 additional lives and 1662 live-years lost due to diagnostic delays for the 25% backlog scenario, 183 additional lives and 3362 life-years lost under the 50% backlog scenario, and 276 additional lives and 5075 life-years lost under the 75% backlog scenario. However, a delay in additional diagnostic capacity with provision spread across months 3-8 after lockdown would result in 401 additional lives and 7332 life-years lost due to diagnostic delays under the 25% backlog scenario, 811 additional lives and 14 873 life-years lost under the 50% backlog scenario, and 1231 additional lives and 22 635 life-years lost under the 75% backlog scenario. A 2-month delay in 2-week-wait investigatory referrals results in an estimated loss of between 0·0 and 0·7 life-years per referred patient, depending on age and tumour type. INTERPRETATION: Prompt provision of additional capacity to address the backlog of diagnostics will minimise deaths as a result of diagnostic delays that could add to those predicted due to expected presentational delays. Prioritisation of patient groups for whom delay would result in most life-years lost warrants consideration as an option for mitigating the aggregate burden of mortality in patients with cancer. FUNDING: None.

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1. **Emergency admission risk stratification tools in UK primary care: a cross-sectional survey of availability and use**  
   Kingston M. et al British Journal of General Practice 2020;70(699):e740-e748.

Background Stratifying patient populations by risk of adverse events was believed to support preventive care for those identified, but recent evidence does not support this. Emergency admission risk stratification (EARS) tools have been widely promoted in UK policy and GP contracts. Aim To describe availability and use of EARS tools across the UK, and identify factors perceived to influence implementation. Design and setting Cross-sectional survey in UK. Method Online survey of 235 organisations responsible for UK primary care: 209 clinical commissioning groups (CCGs) in England; 14 health boards in Scotland; seven health boards in Wales; and five local commissioning groups (LCGs) in Northern Ireland. Analysis results are presented using descriptive statistics for closed questions and by theme for open questions. Results Responses were analysed from 171 (72.8%) organisations, of which 148 (86.5%) reported that risk tools were available in their areas. Organisations identified 39 different EARS tools in use. Promotion by NHS commissioners, involvement of clinical leaders, and engagement of practice managers were identified as the most important factors in encouraging use of tools by general practices. High staff workloads and information governance were identified as important barriers. Tools were most frequently used to identify individual patients, but also for service planning. Nearly 40% of areas using EARS tools reported introducing or realigning services as a result, but relatively few reported use for service evaluation. Conclusion EARS tools are widely available across the UK, although there is variation by region. There remains a need to align policy and practice with research evidence.

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1. **Long Waiting Times for Elective Hospital Care - Breaking the Vicious Circle by Abandoning Prioritisation.**  
   Sæther SMM International journal of health policy and management 2020;9(3):96-107.

BACKGROUND: Policies assigning low-priority patients treatment delays for care, in order to make room for patients of higher priority arriving later, are common in secondary healthcare services today. Alternatively, each new patient could be granted the first available appointment. We aimed to investigate whether prioritisation can be part of the reason why waiting times for care are often long, and to describe how departments can improve their waiting situation by changing away from prioritisation. METHODS: We used patient flow data from 2015 at the Department of Otorhinolaryngology, Haukeland University Hospital, Norway. In Dynaplan Smia, Dynaplan AS, dynamic simulations were used to compare how waiting time, size and shape of the waiting list, and capacity utilisation developed with and without prioritisation. Simulations were started from the actual waiting list at the beginning of 2015, and from an empty waiting list (simulating a new department with no initial patient backlog). RESULTS: From an empty waiting list and with capacity equal to demand, waiting times were built 7 times longer when prioritising than when not. Prioritisation also led to poor resource utilisation and short-lived effects of extra capacity. Departments where prioritisation is causing long waits can improve their situation by temporarily bringing capacity above demand and introducing "first come, first served" instead of prioritisation. CONCLUSION: A poor appointment allocation policy can build long waiting times, even when capacity is sufficient to meet demand. By bringing waiting times down and going away from prioritisation, the waiting list size and average waiting times at the studied department could be maintained almost 90% below the current level - without requiring permanent change in the capacity/demand ratio.

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1. **Outpatient management of heart valve disease following the COVID-19 pandemic: implications for present and future care.**  
   Shah BN Heart (British Cardiac Society) 2020;106(20):1549-1554.

The established processes for ensuring safe outpatient surveillance of patients with known heart valve disease (HVD), echocardiography for patients referred with new murmurs and timely delivery of surgical or transcatheter treatment for patients with severe disease have all been significantly impacted by the novel coronavirus pandemic. This has created a large backlog of work and upstaging of disease with consequent increases in risk and cost of treatment and potential for worse long-term outcomes. As countries emerge from lockdown but with COVID-19 endemic in society, precautions remain that restrict 'normal' practice. In this article, we propose a methodology for restructuring services for patients with HVD and provide recommendations pertaining to frequency of follow-up and use of echocardiography at present. It will be almost impossible to practice exactly as we did prior to the pandemic; thus, it is essential to prioritise patients with the greatest clinical need, such as those with symptomatic severe HVD. Local procedural waiting times will need to be considered, in addition to usual clinical characteristics in determining whether patients requiring intervention would be better suited having surgical or transcatheter treatment. We present guidance on the identification of stable patients with HVD that could have follow-up deferred safely and suggest certain patients that could be discharged from follow-up if waiting lists are triaged with appropriate clinical input. Finally, we propose that novel models of working enforced by the pandemic-such as increased use of virtual clinics-should be further developed and evaluated.

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1. **Prioritisation by FIT to mitigate the impact of delays in the 2-week wait colorectal cancer referral pathway during the COVID-19 pandemic: a UK modelling study.**  
   Loveday C. Gut 2020;:No page numbers.

OBJECTIVE: To evaluate the impact of faecal immunochemical testing (FIT) prioritisation to mitigate the impact of delays in the colorectal cancer (CRC) urgent diagnostic (2-week-wait (2WW)) pathway consequent from the COVID-19 pandemic. DESIGN: We modelled the reduction in CRC survival and life years lost resultant from per-patient delays of 2-6 months in the 2WW pathway. We stratified by age group, individual-level benefit in CRC survival versus age-specific nosocomial COVID-19-related fatality per referred patient undergoing colonoscopy. We modelled mitigation strategies using thresholds of FIT triage of 2, 10 and 150 µg Hb/g to prioritise 2WW referrals for colonoscopy. To construct the underlying models, we employed 10-year net CRC survival for England 2008-2017, 2WW pathway CRC case and referral volumes and per-day-delay HRs generated from observational studies of diagnosis-to-treatment interval. RESULTS: Delay of 2/4/6 months across all 11 266 patients with CRC diagnosed per typical year via the 2WW pathway were estimated to result in 653/1419/2250 attributable deaths and loss of 9214/20 315/32 799 life years. Risk-benefit from urgent investigatory referral is particularly sensitive to nosocomial COVID-19 rates for patients aged >60. Prioritisation out of delay for the 18% of symptomatic referrals with FIT >10 µg Hb/g would avoid 89% of these deaths attributable to presentational/diagnostic delay while reducing immediate requirement for colonoscopy by >80%. CONCLUSIONS: Delays in the pathway to CRC diagnosis and treatment have potential to cause significant mortality and loss of life years. FIT triage of symptomatic patients in primary care could streamline access to colonoscopy, reduce delays for true-positive CRC cases and reduce nosocomial COVID-19 mortality in older true-negative 2WW referrals. However, this strategy offers benefit only in short-term rationalisation of limited endoscopy services: the appreciable false-negative rate of FIT in symptomatic patients means most colonoscopies will still be required.

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1. **Restarting elective orthopaedic services during the COVID-19 pandemic: Do patients want to have surgery?**  
   Chang J. Bone & joint open 2020;1(6):267-271.

AIMS: As the peak of the COVID-19 pandemic passes, the challenge shifts to safe resumption of routine medical services, including elective orthopaedic surgery. Protocols including pre-operative self-isolation, COVID-19 testing, and surgery at a non-COVID-19 site have been developed to minimize risk of transmission. Despite this, it is likely that many patients will want to delay surgery for fear of contracting COVID-19. The aim of this study is to identify the number of patients who still want to proceed with planned elective orthopaedic surgery in this current environment. METHODS: This is a prospective, single surgeon study of 102 patients who were on the waiting list for an elective hip or knee procedure during the COVID-19 pandemic. Baseline characteristics including age, ASA grade, COVID-19 risk, procedure type, surgical priority, and admission type were recorded. The primary outcome was patient consent to continue with planned surgical care after resumption of elective orthopaedic services. Subgroup analysis was also performed to determine if any specific patient factors influenced the decision to proceed with surgery. RESULTS: Overall, 58 patients (56.8%) wanted to continue with planned surgical care at the earliest possibility. Patients classified as ASA I and ASA II were more likely to agree to surgery (60.5% and 60.0%, respectively) compared to ASA III and ASA IV patients (44.4% and 0.0%, respectively) (p = 0.01). In addition, patients undergoing soft tissue knee surgery were more likely to consent to surgery (90.0%) compared to patients undergoing primary hip arthroplasty (68.6%), primary knee arthroplasty (48.7%), revision hip or knee arthroplasty (0.0%), or hip and knee injections (43.8%) (p = 0.03). CONCLUSION: Restarting elective orthopaedic services during the COVID-19 pandemic remains a significant challenge. Given the uncertain environment, it is unsurprising that only 56% of patients were prepared to continue with their planned surgical care upon resumption of elective services.Cite this article: Bone Joint Open 2020;1-6:267-271.

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1. **Waiting lists for symptomatic joint arthritis are not benign: prioritizing patients for surgery in the setting of COVID-19.**  
   Morris JA Bone & joint open 2020;1(8):508-511.

AIM: Restarting elective services presents a challenge to restore and improve many of the planned patient care pathways which have been suspended during the response to the COVID-19 pandemic. A significant backlog of planned elective work has built up representing a considerable volume of patient need. We aimed to investigate the health status, quality of life, and the impact of delay for patients whose referrals and treatment for symptomatic joint arthritis had been delayed as a result of the response to COVID-19. METHODS: We interviewed 111 patients referred to our elective outpatient service and whose first appointments had been cancelled as a result of the response to the COVID-19 pandemic. RESULTS: Patients reported significant impacts on their health status and quality of life. Overall, 79 (71.2%) patients reported a further deterioration in their condition while waiting, with seven (6.3%) evaluating their health status as 'worse than death'. CONCLUSIONS: Waiting lists are clearly not benign and how to prioritize patients, their level of need, and access to assessment and treatment must be more sophisticated than simply relying on the length of time a patient has been waiting. This paper supports the contention that patients awaiting elective joint arthroplasty report significant impacts on their quality of life and health status. This should be given appropriate weight when patients are prioritized for surgery as part of the recovery of services following the COVID-19 pandemic. Elective surgery should not be seen as optional surgery-patients do not see it in this way.

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1. **Should All Status 1A Patients Be Prioritized Over High MELD Patients? Concept of Risk Stratification in Extremely Ill Liver Transplant Recipients.**  
   Safwan Mohamed Transplantation 2019;103(10):2121-2129.

BACKGROUND: Status 1A patients are prioritized over liver disease patients regardless of Model for End-stage Liver Disease (MELD) score. We aimed to identify groups with high waitlist mortality in Status 1A and MELD >=40 patients to determine who would most benefit from transplantation., METHODS: Data on patients listed as Status 1A (n = 4447) and MELD >=40 (n = 3663) over 15 years (2002-2017) was obtained from United Network for Organ Sharing/Organ Procurement and Transplant Network registry. They were divided into 2-derivation and validation groups. Risk factors associated with 28-day waitlist mortality were identified in derivation group and provided risk scores to divide patients into risk groups. Score system was applied to validation group to check its applicability., RESULTS: Risk factors for waitlist mortality in Status 1A included life support, performance status, severe coagulopathy, severe hypo or hypernatremia, and grade 3-4 encephalopathy. Risk factors in MELD >=40 included higher MELD scores (>=45), age, sex, race, life support, and encephalopathy. On comparing 7- and 28-day mortality, both were higher in Status 1A and MELD >=40 high-risk groups compared with low-risk groups in the derivation group (P < 0.001). Probability of transplantation was lowest for high-risk MELD >=40 patients compared with all other groups (P < 0.001). These findings were reproduced in the validation set. Our proposed risk stratification system also showed acceptable 1-year graft and patient survival in high-risk groups., CONCLUSIONS: Our risk scoring system for extremely ill liver transplant candidates successfully stratified risk of waitlist mortality. Waitlist outcomes might be improved by modifications involving categorization of patients based on the presence/absence of risk factors.

1. **Anaemia as a risk stratification tool for symptomatic patients referred via the two-week wait pathway for colorectal cancer.**  
   Mashlab S. Annals of the Royal College of Surgeons of England 2018;100(5):350-356.

Introduction Anaemia is associated with cancer. In 2014 a new form was introduced in our department requesting a haemoglobin (Hb) result on every two-week wait referral for suspected colorectal cancer (CRC). The aim of this study was to review the impact of this intervention. In particular, the significance of any evidence of anaemia (without additional indices) was investigated. Methods A review was conducted of 1,500 consecutive suspected CRC referrals recorded prospectively over a 10-month period. Data on demographics, referral Hb, referral criteria and outcomes were analysed. Anaemia was defined according to World Health Organization criteria (Hb <120g/l for women, Hb <130g/l for men). Results Overall, 1,015 patients were eligible for inclusion in the study. Over a third (38.2%) were documented as anaemic on referral. These patients were three times more likely to be diagnosed with CRC than non-anaemic patients (odds ratio [OR]: 3.22, 95% confidence interval [CI]: 1.87-5.57). Using a more stringent threshold (Hb <100g/l for women and <110g/l for men), they were four times more likely to have CRC (OR: 4.27, 95% CI: 2.35-7.75). Almost a quarter (23.7%) were actually anaemic at the time of referral but not referred with anaemia. In this subgroup, there was a 2.8-fold increase in risk of CRC diagnosis compared with non-anaemic patients (adjusted OR: 2.77, 95% CI: 1.55-4.95). Conclusions Nearly a quarter of patients not referred with iron deficiency anaemia had evidence of anaemia and this was still associated with a higher rate of CRC detection. A full blood count alone might help to risk stratify symptoms such as change in bowel habit in patients on urgent pathways and identify those cases most likely to benefit from invasive investigation.

[Available online at this link](https://www.knowledgeshare.nhs.uk/index.php?PageID=link_resolver&link=df9cd53268c9cea15182b545eba0e170)

1. **Serum hypoalbuminemia predicts late mortality on the liver transplant waiting list.**  
   Porrett Paige M. Transplantation 2015;99(1):158-63.

BACKGROUND: The reduction of liver transplant wait list mortality remains a priority for transplant programs and depends on the accurate stratification of patients by mortality risk. Although estimation of 90-day mortality by Model for End-Stage Liver Disease (MELD) score has improved wait list survival, it is unclear how contemporary wait list mortality can best be diminished given the preponderance of listed patients with low MELD scores and long wait times., METHODS: In this intention-to-treat analysis of 289 consecutively listed patients with over 5 years of follow-up, we aimed to determine the contribution of late mortality to overall wait list outcome and identify clinical predictors that would help discriminate long-term survivors from fatalities., RESULTS: Seventy percent of wait list deaths occurred in patients listed with MELD scores less than 20, and 40% of deaths occurred in patients waiting longer than 1 year. Hypoalbuminemia at listing was a significant predictor of late mortality in all patients in both univariate and multivariate analyses, and it was most discriminatory among patients with MELD scores of 20 or less., CONCLUSION: Our data suggest that hypoalbuminemia at listing reveals a vulnerable population of low MELD patients who are underserved by their MELD score over time. Such patients comprise almost 40% of the contemporary wait list and contribute substantially to list mortality given their poor access to transplantation. Targeting these at-risk patients with grafts from living or extended criteria donors may thus significantly diminish overall list mortality, and future initiatives to decrease overall wait list mortality must focus on improved risk stratification for low MELD patients.

1. **The "two-week wait" referral pathway allows prompt treatment but does not improve outcome for patients with oesophago-gastric cancer**   
   Sharpe D. European journal of surgical oncology 2010;36(10):977-81.

INTRODUCTION: The Two Week Wait Referral Service (2WW) has been implemented as a means of fast-tracking patients with suspected upper gastrointestinal cancers for endoscopy. Whether or not it impacts on the outcome of these patients is unclear. The aim of this study was to compare the outcome of patients referred through 2WW with that of patients with oesophago-gastric cancer identified through alternate referral pathways (routine, emergency). METHODS: The study population was 340 patients with oesophago-gastric carcinoma (gastric 154) diagnosed during the time period 01/2006-12/2007 at University Hospitals of Leicester NHS Trust. Data were collected prospectively by the MDT co-ordinator and analysed retrospectively. RESULTS: 135 of the 340 patients with oesophago-gastric cancer were diagnosed through the 2WW, 115 patients through routine referral pathways, and 90 patients were admitted on an emergency basis. Patients referred through 2WW had a median referral to 1st treatment time of 47 days (routine 79, emergency 28, p < 0.001 all group comparisons). The number of patients treated with potentially curative intent was 37 of 135 for the 2WW, 42 of 115 for the routine referrals and 10 of 90 for patients admitted as emergencies. The corresponding median survivals for the groups were 239 days (2WW), 405 days (routine) and 121 days (emergency), p < 0.001 (log rank). CONCLUSIONS: Referral by 2WW resulted in more rapid treatment than routine referral but this did not translate into an improvement in survival. This suggests that the targeting of endoscopy to patients with alarm symptoms is flawed and a less selective approach should be promoted if curable cancers are to be detected.

[Available online at this link](https://www.knowledgeshare.nhs.uk/index.php?PageID=link_resolver&link=cbe8f8ebaf681ff377e800aa667faee1)

1. **Waiting-list prioritization in the National Health Service.**  
   Prasad S. The Journal of laryngology and otology 2004;118(1):39-45.

The aim of this study was to find out whether there is a consensus of opinion among healthcare providers and different sections of the public on the relative prioritization of common otolaryngological conditions for outpatient consultations and inpatient treatment. ENT consultants, general practitioners, administrators, NHS employees, non-ENT patients and members of the general public were given common scenarios of otolaryngological conditions and asked to prioritize them in order of importance. All the groups gave top priority for patients with suspected cancer of the larynx (outpatients) and for surgical treatment of cancer. Children with hearing problems were more commonly ranked in the top three categories than children requiring treatment for sore throats. All groups assigned those requiring rhinoplasty, treatment for snoring or hearing aids to the last three ranks. This study shows that there is a remarkable uniformity of opinion in determining clinical priorities which is similar to the traditional policies practised by UK ENT consultants.

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Select Edit from the menu, the Find and type in your term in the search box which is presented. The search function will locate the first use of the term in the document. By pressing 'next' you will jump to further references.

## Search History

Sources searched include: Cochrane Library; Google (Advanced); Medline; NHS England; NICE; Nuffield Trust; PubMed; TRIP PRO

**Date range used** (5 years, 10 years):   
**Limits used** (gender, article/study type, etc.):   
**Search terms and notes** (full search strategy for database searches below): wait\* list\* stratification assessment risk prioriti?e

This scope of this search was not limited to post pandemic and therefore search terms for SARS-CoV-2 were not included in the strategy, however recent resources related to reset and recovery are incorporated.

**TRIP PRO**: (stratification high risk assessment) ("wait list")

**NICE**: waiting list stratification risk assessment

**Database(s): Ovid MEDLINE(R) ALL 1946 to March 23, 2021   
Search Strategy**:

|  |  |  |
| --- | --- | --- |
| **#** | **Searches** | **Results** |
| 1 | Waiting Lists/ or (list, waiting or lists, waiting or waiting list or waiting lists).mp. | 19577 |
| 2 | stratification.mp. | 70708 |
| 3 | Risk Assessment/ or (assessment, health risk or assessment, risk or risk assessment or risk assessment, health or risk assessments).mp. | 320781 |
| 4 | 1 and 2 and 3 | 44 |
| 5 | from 4 keep 1-2, 9, 15, 29 | 5 |
| 6 | from 5 keep 1-3, 5 | 4 |

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| --- | --- | --- | --- |
| Search number | Query | Search Details | Results |
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**ID of request:** 28170  
**Date of request:** 10th March, 2021  
**Date of completion:** 25th March, 2021

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