Centre for Sustainable Delivery

NHS SCOTLAND

Self Assessment Tool

A Framework for Perioperative Services in Scotland

Introduction

This self-assessment tool is designed to support Health Boards in implementing the “Framework for Perioperative Services in Scotland”, which can be accessed **here**. It is recommended that healthcare teams familiarise themselves with this Framework.

The self-assessment tool has been divided into sections mirroring the structure of the Framework. Each of the key actions from each section of the Framework is reproduced in this document.

Further information providing greater detail on each section can be found within the Framework:

- Section 1 – **Scheduling**
- Section 2 – **Pre-operative Assessment**
- Section 3 – **Protecting Planned Care**
- Section 4 – **Wider Perioperative Team Development**
- Section 5 – High-Volume High-Flow
- Section 6 – Data for Improvement

This self-assessment tool is intended to drive improvement in perioperative throughput, productivity, quality and safety. It is not a checklist or performance management tool, but a tool to benchmark each Health Board’s current position to facilitate measurement of improvement and change over time.

Using the self-assessment tool

- **Responsible owners and senior sponsorship:**
  Each section includes a space to record the Responsible Owner and Senior Sponsor for that step in the perioperative pathway (e.g. an Executive Lead tasked with supporting improvement in that area). Ideally the score would be agreed between these individuals providing an opportunity for both coaching and removing of any perceived barriers and challenges. Depending on local arrangements, Responsible Owners and Senior Sponsors may be different for each section.

- **A realistic assessment:**
  Each action should be given a score from 1 (Just starting) to 4 (Closing the loop). Although there are descriptors for each section, these will be subjective. This is not a checklist. For each score, Health Boards should consider whether they have fully realised the benefit from that action. For scores of less than a 4, a 'next step' should be identified.

- **Action focused:**
  The self-assessment should identify appropriate 'next steps' for improvement – make sure key information on the 'next step' i.e. the action to be taken is captured (e.g. who will do it? by when? how will you know the next step has had the intended impact?)".

- **Specialty specific**: sections of the self-assessment may be considered on a specialty basis, for example, High-Volume High Flow.

- **Triangulate with utilisation data (e.g. from discovery and local data):**
  The self-assessment should drive improvement and not be seen as a goal in itself. If Health Boards are scoring lots of level 4s, but not seeing improvement, then those actions should be revisited to consider whether there are further steps to fully realise the benefit.

- **Coaching and going to see**:
  The self-assessment tool is not a performance management tool. Agreeing the scores provides an excellent opportunity for coaching from the Senior Sponsor. Where possible coaching should take place as close to where the action is as possible (e.g. in theatres, in the pre-operative assessment area or in the scheduling office).

- **Engage the team and revisit as regularly as possible:**
  The self-assessment should be transparent. The whole team should be aware of the actions and engaged in the steps being taken to move to the next level. The improvement effort should not be seen as something additional, but part of daily clinical and operational work.

Self-assessment and review dates

Section	Self-assessment date	Review date	Review date
Scheduling			
Pre-operative Assessment			
Protecting Planned Care			
Wider Perioperative Team Development			
High-Volume High-Flow			
Data for Improvement			

1. Scheduling

Framework and **Scheduling Principles**

Level descriptors	
Level	**Typical features**
Level 1: Just starting	• Standard Operating Procedures (SOPs) do not exist, or have not been reviewed recently. • Scheduling done by instinct and experience of individual staff. • Person-dependent system.
Level 2: Work underway	• Work in progress. • Principles established, but not adhered to. • Isolated examples of best practice (e.g. particular lists or specialties).
Level 3: Significant progress	• Data reviewed on regular basis and showing evidence of improvement. • Best practice spread across multiple specialties.
Level 4: Closing the loop	• Business as usual – changes embedded. • Culture of continuous improvement to ensure improvements are sustained.

Completing this assessment: **Responsible owner:** _____ **Coach/senior sponsor:** _____

	Key actions	Level 1-4	Next steps	Evidence
1.1	Develop local Standard Operating Procedures (SOPs) to support theatre scheduling processes with clearly defined expectations, roles and responsibilities.			
1.2	Implement digital scheduling solutions to maximise booking capacity, improve theatre efficiency and enhance data quality.			
1.3	Undertake regular Waiting List Validation to ensure on-going management of inpatient and daycase lists.			
1.4	Adopt 6-4-2-1-0 principles to avoid cancellations, empty theatre sessions and ensure all available slots are booked.			
1.5	Hold regular scheduling and speciality planning meetings to review bookable theatre capacity, maximise productivity, minimise delays and prevent cancellations.			
1.6	Review and update Pooled Patient Lists and Standby Lists on a regular basis.			

Completing this assessment: **Responsible owner:** _____ **Coach/senior sponsor:** _____

	Key actions	Level 1-4	Next steps	Evidence
1.7	Identify a senior responsible person with the authority to do so to reallocate resources as needed to reduce unnecessary waste.			
1.8	Strengthen multi-disciplinary collaboration across scheduling, clinical, and operational teams to improve allocation of theatre capacity and resources, and monitor list utilisation.			
1.9	Ensure clear communication frameworks are in place for sharing information and supporting decision-making between all key stakeholders involved in scheduling.			
1.10	Agree local considerations for listing patients to take account of operational factors, clinical factors and list position, including criteria for identifying the first patient on the list ("Golden Patient") to make sure theatre lists start on time.			
1.11	Agree clear communication processes to ensure patients receive all of the necessary information for their surgical procedure, inclusive of the To Come In (TCI), which should not be allocated until pre-assessment is complete.			
1.12	Use data to monitor performance against key utilisation metrics, provide feedback, and identify areas for learning and improvement.			

2. Pre-operative Assessment

Framework and Pre-operative Assessment Principles

Level descriptors	
Level	**Typical features**
Level 1: Just starting	• Limited use of national guidelines, SOPS etc. • Pre-operative assessment as pathway bottleneck. • Rework (e.g. repeat assessments due to hold-ups elsewhere).
Level 2: Work underway	• Work in progress. • Principles established, but not adhered to. • Isolated examples of best practice (e.g. particular lists or specialties).
Level 3: Significant progress	• Data reviewed on regular basis and showing evidence of improvement. • Best practice spread across multiple specialties.
Level 4: Closing the loop	• Business as usual – changes embedded. • Culture of continuous improvement to ensure improvements sustained.

Completing this assessment: **Responsible owner:** _____ **Coach/senior sponsor:** _____

	Key actions	Level 1-4	Next steps	Evidence
2.1	Follow the NICE guidelines for Routine Pre-operative Tests for Elective Surgery (NG 45) 2016.			
2.2	Plan services so as patients can be confident their surgery will go ahead on the To Come In (TCI) date offered in nearly all cases.			
2.3	Minimise the number of hospital visits for patients pre-operatively to reduce unnecessary travel.			
2.4	Screen patients at the point of surgical decision to treat to enable early optimisation of chronic conditions.			
2.5	Record patient preferences and availability for surgery, including at other local hospitals and health board locations, so as to facilitate early transfer to available resources and support efficient use of capacity.			
2.6	Signpost patients to Waiting Well advice and resources that will help them to begin preparing for surgery. Promote the concept of moving from a passive 'waiting list' to a proactive 'preparation list'.			

Completing this assessment: **Responsible owner:** _____ **Coach/senior sponsor:** _____

	Key actions	Level 1-4	Next steps	Evidence
2.7	Undertake regular Waiting List Validation to ensure patients still require and wish to proceed with their procedure prior to referral for pre-assessment.			
2.8	Triage patients to the appropriate level of pre-operative assessment, for example, virtually, by telephone or face to face.			
2.9	Ensure pre-operative assessment occurs prior to the To Come In (TCI) date provided to allow as much time as possible for timely pre-operative management of any health conditions, reduce surgical risk and improve recovery outcomes.			
2.10	Develop local Standard Operating Procedures (SOPs) to support the move towards a service in which no patient receives a To Come In (TCI) date prior to pre-operative assessment being completed.			
2.11	Extend the validity period of pre-operative assessment to 6 months from the date pre-assessment is completed. Recent trials have demonstrated no impact on late cancellations or loss of perioperative capacity by extending this to 6 months.			
2.12	Use data to monitor performance against key metrics to improve access to surgery and reduce delays for patients waiting for surgery e.g. by identifying causes of late cancellations.			

3. Protecting Planned Care

Framework and **Protecting Planned Care Principles**

Level descriptors	
Level	**Typical features**
Level 1: Just starting	• No protected planned care beds. • Surgery regularly cancelled due to operational pressures.
Level 2: Work underway	• Work in progress. • Principles established, but not consistently adhered to. • Escalation process recognises protected beds. • Isolated examples of best practice (e.g. particular lists or specialties).
Level 3: Significant progress	• Data reviewed on regular basis and showing evidence of improvement. • Best practice spread across multiple specialties. • Cancellation due to operational pressure only in most extreme cases or not at all.
Level 4: Closing the loop	• Business as usual – changes embedded. • Culture of continuous improvement to ensure improvements sustained.

Completing this assessment: **Responsible owner:** _____ **Coach/senior sponsor:** _____

	Key actions	Level 1-4	Next steps	Evidence
3.1	Encourage the use of data to understand local demand and capacity, monitor performance against key metrics, provide feedback, and identify areas for learning and improvement.			
3.2	Agree the number of beds to protect (3-5% of overall acute, adult bed capacity) to allow planned surgery to continue. Establish senior sign-off so the protected footprint is reflected in escalation procedures.			
3.3	Follow scheduling processes and procedures that will optimise perioperative capacity, including adopting technology-enabled scheduling solutions to provide intel on theatre session availability.			
3.4	Undertake a review of procedures currently delivered within each individual specialty, particularly those with a growing evidence base which questions clinical effectiveness.			
3.5	Promote day surgery as the norm for all procedures identified as appropriate to be undertaken as day cases, to help reduce the demand for in-patient beds.			
3.6	Be innovative about space and consider converting the use of areas to increase or create elective bed and trolley footprint. Start small and scale up.			

Completing this assessment: **Responsible owner:** _____ **Coach/senior sponsor:** _____

	Key actions	Level 1-4	Next steps	Evidence
3.7	Gain consensus on which procedures can be moved outwith of a traditional operating theatre into an alternative environment, for example, treatment room, out-patient setting in accordance with GIRFT's Right Procedure, Right Place (RPRP) principles.			
3.8	Decide on which procedures can be converted from General Anaesthetic (GA) to Local Anaesthetic (LA) for undertaking outwith a traditional operating theatre environment. This also reduces reliance on the need for anaesthetic cover.			
3.9	Manage patient expectations for surgery through early discussion and shared-decision making by using and adopting a shared language that promotes surgery being undertaken outwith of the traditional theatre environments.			
3.10	Create a culture of "proceeding without delay" for the first patients of the day in each operating theatre. It should be expected that the list will start at the allocated time, without waiting to be informed that a list can start.			
3.11	Establish a formal local process for escalation prior to cancellation of any planned care activity, which is supported by senior leadership teams, and is inclusive of a review process to return to normal planned care delivery as soon as possible.			
3.12	Encourage the development of a wide range of skills across the multi-disciplinary team to allow staff to be more flexible and adaptable across services, whilst supporting staff to practice at a level appropriate to their knowledge, skills and experience.			

4. Wider Perioperative Team Development

Framework and Wider Perioperative Team Development Principles

Level descriptors	
Level	**Typical features**
Level 1: Just starting	• Little evidence of team development. • Gaps in team structure. • Challenges with recruitment and retention. • Statutory training only. • No team engagement in improvement.
Level 2: Work underway	• Work in progress. • Principles established, but not consistently adhered to. • Isolated examples of best practice (e.g. particular teams or specialties).
Level 3: Significant progress	• Best practice spread across multiple specialties. • All staff engaged – i.e. multi-professional, all grades etc
Level 4: Closing the loop	• Business as usual – changes embedded. • Culture of continuous improvement to ensure improvements sustained.

Completing this assessment: **Responsible owner:** _____ **Coach/senior sponsor:** _____

	Key actions	Level 1-4	Next steps	Evidence
4.1	Foster a culture of shared leadership where all team members are involved in decision-making and contribute to decision-making processes.			
4.2	Ensure all perioperative team members understand their own role and responsibilities, as well as that of other team members.			
4.3	Uphold a team culture based on mutual respect, trust, and inclusivity.			
4.4	Create an environment based on psychological safety where team members are empowered to ask questions, raise concerns and report incidents.			
4.5	Ensure clear and consistent communication frameworks are in place for information sharing, especially during critical transitions, and resource planning.			
4.6	Conduct daily pre- and post-operative briefings and debriefings, which include an improvement element as well as clinical reflection.			

Completing this assessment: **Responsible owner:** _____ **Coach/senior sponsor:** _____

	Key actions	Level 1-4	Next steps	Evidence
4.7	Establish a system for continuous education, professional and skills development, including training in emerging technologies and scenario-based training.			
4.8	Provide opportunities for multi-professional team building, collaboration and education, with the whole team engaged and having a role in choosing potential topics.			
4.9	Take account of the optimum skill mix required as part of workforce planning to enhance workflow.			
4.10	Incorporate programmes to support the physical and emotional well-being of team members. Wellness initiatives can help maintain high performance and reduce staff turnover.			
4.11	Apply Human Factors Ergonomics (HFE) to enhance communication, decision-making, team working, situational awareness and patient safety.			
4.12	Encourage the use of data and analytics to monitor team performance, track patient outcomes, provide feedback, and identify areas for learning and improvement.			

5. High-Volume High-Flow

[Framework]

Level descriptors	
Level	**Typical features**
Level 1: Just starting	• Little/no High-Volume High-Flow surgery.
Level 2: Work underway	• Work in progress. • Principles established, but not consistently adhered to. • Isolated examples of best practice (e.g. particular consultants or specialties).
Level 3: Significant progress	• Best practice spread across multiple specialties, teams and surgeons. • Data reviewed regularly and showing evidence of improvement.
Level 4: Closing the loop	• Business as usual – changes embedded. • Culture of continuous improvement to ensure improvements sustained.

Completing this assessment: **Responsible owner:** _____ **Specialty:** _____ **Coach/senior sponsor:** _____

	Key actions	Level 1-4	Next steps	Evidence
5.1	Identify a senior executive sponsor with time and authority to lead service redesign, influence decisions, monitor progress and resolve issues.			
5.2	Standardise pathways to facilitate High-Volume High-Flow activity. Day surgery should be the default.			
5.3	Optimise opportunities to undertake procedures under Local Anaesthetic (LA) that can safely and effectively be delivered outwith of a traditional theatre environment, in accordance with GIRFT Right Procedure Right Place (RPRP) principles.			
5.4	Review how the environment is being used and where space could potentially be freed up and re-purposed. Aim to create a smoother flow for the patient throughout their journey.			
5.5	Form partnerships with peripheral teams that support and supply theatres such as estates, facilities, infection control and pharmacy. These teams will also need to adapt to meet any new demand. Ensure everyone understands the whole of the pathway.			
5.6	Adopt 6-4-2-1-0 principles to maximise effectiveness. Plan for full day theatre lists as the norm, with enough resource to continue without breaks. Monitor theatre utilisation.			

Completing this assessment: **Responsible owner:** _____ **Coach/senior sponsor:** _____

	Key actions	Level 1-4	Next steps	Evidence
5.7	Consider patient suitability when listing for High-Volume High-Flow lists, and remain mindful of safeguarding patients who may be unintentionally disadvantaged.			
5.8	Reduce unwarranted variation by identifying processses, procedures and protocols that can be standardised for maximum efficiency, e.g. session times and start times.			
5.9	Standardise equipment, supplementaries and consumables.			
5.10	Reduce the turnaround time (positive gap time) between procedures. The next patient should be ready to enter the operating room as the previous patient is exiting.			
5.11	Ensure there are sufficient and standardised instrument sets, supplementaries and consumables so that lists are not delayed for sterilisation. Consider rationalising tray sets.			
5.12	Map out how many staff are needed to deliver a high-volume list, and what role they will need to fulfil, based on the correct level of skills and competencies.			

Completing this assessment: **Responsible owner:** _____ **Coach/senior sponsor:** _____

	Key actions	Level 1-4	Next steps	Evidence
5.13	Promote a positive working environment that enhances team performance. Specialised, well-coordinated and motivated teams with clear roles, responsibilities and goals are essential for fast-paced, high-volume lists.			
5.14	Develop career pathways for the whole perioperative team. Invest in training and education, and identify opportunities to upskill staff to maximise productivity. Seek new ways to deliver surgical training for surgical trainees if considered a barrier to high-flow.			
5.15	Manage patient expectations for surgery through clear communications, shared decision-making and involving the patient in their perioperative journey. Embed the principles of Realistic Medicine.			
5.16	Apply the principles from high impact programmes such as ARISE and ERAS.			
5.17	Agree and embed criteria-led discharge. Discharge planning should begin early in the pathway. Provide clear discharge arrangements and post-operative information, including information regarding potential post-operative complications.			
5.18	Use data to embed a culture of continuous learning, share best practice, provide feedback and improve performance and drive efficiency.			

6. Data for Improvement

Framework

Level descriptors	
Level	**Typical features**
Level 1: Just starting	• Little use of data. • Clinical and operational team not engaged in data.
Level 2: Work underway	• Data is reviewed in key meetings. • Some clinical teams using the data for improvement.
Level 3: Significant progress	• Data is regularly used for improvement. • National data is used alongside local data to understand variation. • All operational teams (i.e. including clinical and non-clinical staff) are engaged with data. • Data is visible.
Level 4: Closing the loop	• Business as usual – changes embedded. • Culture of continuous improvement to ensure improvements sustained.

Completing this assessment: **Responsible owner:** _____ **Coach/senior sponsor:** _____

	Key actions	Level 1-4	Next steps	Evidence
6.1	Analyse and interpret local demand and capacity.			
6.2	Understand local utilisation – in terms of total hours, or as a proportion of total time. Reflect on where time is lost (e.g. by theatre, specialty, start and finish times, turnaround times, over-runs and under-runs, cancellations and fallow theatres).			
6.3	Seek to identify, challenge and eliminate unwarranted variation. While some variation is warranted, in other cases it can highlight opportunities for improvement.			
6.4	Interrogate the data (e.g. is a reduction in the number of patients due to increased clinical complexity or a higher number of co-morbidities?).			
6.5	Ensure the whole perioperative team is engaged with, and familiar with, the data. Consider sharing local utilisation data through notice boards or information boards outside theatres.			
6.6	Agree time-stamps and metrics at the team debrief (e.g. reasons for late starts or early finishes).			

Completing this assessment: **Responsible owner:** _____ **Coach/senior sponsor:** _____

	Key actions	Level 1-4	Next steps	Evidence
6.7	Guarantee operations are coded correctly using OPCS4 codes.			
6.8	Enter data accurately into local theatre management systems to safeguard data quality.			
6.9	Implement processes to review local and national performance data e.g. via PHS Discovery.			
6.10	Establish balancing measures to reduce incidence of risk. Any changes made should not negatively impact on other parts of the system.			
6.11	Participate in local audit and peer review processes.			
6.12	Undertake patient experience and feedback surveys. Consider including patient feedback into test of change cycles – an important opportunity to capture input from both patients and staff.			

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