Centre for Sustainable Delivery

NHS SCOTLAND

Pre-operative Assessment Principles

A Framework for Perioperative Services in Scotland

Background

The Perioperative Delivery Group (PDG) was established in November 2023 to ensure a national approach to:

- Maximising flow through perioperative services.
- Maximising productive time in theatres.
- Reducing the time patients wait for perioperative services.

To help realise these aims, several Task and Finish Groups were set up to focus on key actions to realise the overall ambitions of the PDG. The Pre-operative Assessment Task and Finish Group was established to standardise the pathway for patients in Scotland from the point of surgical decision to treat through to completion of the pre-assessment process.

Remit

Through stakeholder engagement and drawing on the expertise of its members, the group was tasked with identifying current pre-operative assessment processes and cultures within health boards, and make recommendations for a standardised approach to **planned surgical** pre-operative assessment across NHS Scotland for **adults' aged 16 years and over, excluding maternity and paediatric services**.

Key areas of focus included:

- Reviewing of the current pre-operative pathway.
- Screening at decision to treat including screening for pre-operative comorbidities.
- Embedding Waiting Well resources into the pathway.
- Waiting List Validation.
- Optimising the referral timeline to pre-operative assessment services.
- Triaging appropriate patients to the right services.
- Standardising pre-operative testing and clinical guidelines.
- Standardising the validation period following completion of pre-operative assessment.

Core principles

Patient experience

- Patients should be confident that when offered a To Come In (TCI) date it will take place.
- Hospital visits should be minimised pre-operatively to reduce travel.
- Information about patient availability should be communicated to all relevant team members.
- Patients should be given sufficient time to optimise their health prior to surgery to support the best possible recovery and minimise perioperative risk.

Pre-operative assessment service

- Patients are screened at the point of surgical decision to treat to enable early optimisation of chronic conditions.
- Patients are given, as a minimum, Waiting Well advice and resources to begin preparing for surgery at point of surgical decision to treat.
- Waiting List validation should be carried out routinely to confirm whether the patient still requires and wishes to proceed with the procedure prior to referral for pre-assessment, and to update any periods of unavailability. Preferences and availability to travel to a different location should be noted, (e.g. a National Treatment Centre.)
- Patients should be triaged to the most appropriate level of assessment (virtual, telephone or face-to-face) to improve access and use of resources.
- Pre-operative assessment should take place at least 12 weeks prior to the TCI date.
- Pre-operative assessment should be valid for 6 months after completion.

Principle 1 – Decision To Treat and Early Screening

Early screening at surgical decision to treat is a key recommendation to support identification of comorbidities and to inform service planning for pre-operative assessment. It provides an opportunity to begin optimisation of patients with modifiable health conditions, it allows for early discussions and it enables patients to be prioritised for face to face and senior clinical review.

Early screening at the point of entry onto the surgical waiting list, Decision To Treat (DTT) should include the following:

- Screening for comorbid disease to enable early optimisation (e.g. diabetes, hypertension, anaemia, sleep apnoea)
- Frailty
- Body Mass Index (BMI)
- Poor functional capacity due to reduced cardiorespiratory reserve
- Severity of planned surgical procedure
- Consideration of risk scoring to identify high-risk candidates early
- Polypharmacy

A standardised screening tool will be developed and tested across NHS Scotland. Engaging both primary and secondary care teams at this early stage will support comorbid disease optimisation.

It is also recommended that patients' preferences and availability for surgery at alternative NHS Scotland sites are recorded during early screening. This will help enable early transfer of patients to available resources where appropriate.

Principle 2 – Embed 'Waiting Well' Principles into the Pathway

This principle aims to shift the focus from a passive 'waiting list' to a 'preparation list', where patients are actively encouraged to begin preparing for their surgery. Modifiable risk factors such as general fitness, diet, smoking cessation, alcohol intake and improving psychological well-being have all be proven to improve recovery after surgery.

To support this, the Scottish Government, in partnership with NHS Inform has developed a national resource designed to support patients during the waiting period: (**Waiting well | NHS inform)**

At the point of DTT all patients should:

- Have a proactive conversation with the clinical team about how to begin preparing for surgery.
- Be signposted to Waiting Well and other relevant local resources.

- Be referred to additional support services if required.
- Be provided with accessible resources on the surgical procedure, including prehabilitation and self-directed rehabilitation as required.

In addition, developing an asynchronous clinician helpline to respond to questions would enhance support for patients throughout the pathway.

Principle 3 – Waiting List Validation

Waiting list validation is essential to ensure the effective management of Inpatient (IP) and Day Case (DC) lists.

Evidence from the National Elective Coordination Unit (NECU) demonstrates that an average 9% of patients are removed from waiting lists through on-going validation.

Validation should occur before referral to pre-operative assessment to avoid unnecessary use of resources.

Common reasons for removal include:

- No longer requiring treatment.
- Treatment completed privately.
- Change of mind.

Principle 4 – Referral to Pre-operative Assessment Before Surgery Date is Arranged

Key to ensuring timely access to and active management of patients waiting for surgery is ensuring, wherever possible, that pre-operative assessment is started before a TCI date is confirmed.

A move to this model for planned surgery will require a significant shift in operational and clinical processes, and should be implemented using a staged approach:

- **Stage 1:** Ensure a minimum of 8 weeks between the pre-operative assessment date and the TCI date.
- **Stage 2:** Move towards a 12-week minimum between the pre-operative assessment date and the TCI date (recommended minimum standard).
- **Stage 3:** Establish a model where no patient receives a TCI date until the pre-operative assessment is complete.

Local teams should develop Standard Operating Procedures (SOPs) to support this approach. Implementation should be supported through a process of continuous audit and ongoing monitoring of outcome measures to evidence improvement in key metrics such as a reduction in late cancellations.

Principle 5 – Triaging of Patients to the Right Level of Pre-operative Assessment

Currently, most units across NHS Scotland provide a face-to-face nursing appointment for pre-operative assessment, regardless of the patient's medical history or the complexity of the planned surgical procedure. This approach places significant demand on resources.

By implementing Principle 1 (early screening at the point of DTT), patients can be proactively triaged to the most appropriate level of service. This ensures patients are seen by the right professional at the right time, embeds shared-decision making conversations, and allows access to detailed assessment for more complex cases.

Suggested triage approach:

- Patients with no co-morbidities and who are comfortable with digital access: offer an online or virtual consultation and arrange any necessary pre-operative tests.
- Patients with minimal and stable comorbidities: offer online, virtual or nurse-led pre-assessment as appropriate.
- Patients with moderate to significant comorbidities: offer nurse-led pre-assessment, supported by digital pre-assessment where appropriate, anaesthetic notes review, and as needed, face to face anaesthetic review.

All units should provide anaesthetic cover to enable anaesthetic review of more complex cases with appropriate time recognised within job plans including necessary administrative time.

The development of a national screening tool for NHS Scotland will help services implement a consistent triage process tailored to local service needs. While it is not yet possible to stipulate the levels of triage to specific levels of care, this work helps shape a more consistent approach moving forward.

The use of asynchronous digital pre-operative assessments will also help services work more efficiently. Several NHS Boards in Scotland have already adopted digital systems, and shared learning from these sites will be key to supporting a 'digital first' strategy going forward.

Principle 6 – Standardising and Implementing Clinical Guidelines for Pre-operative Assessment

A core recommendation from colleagues across NHS Scotland is the need to develop a standardised approach to pre-operative assessment.

The following standard nationally recognised clinical guidelines have been agreed by peers from across NHS Scotland for implementation into all pre-operative assessment services. The summaries and links to these guidelines are included in the appendices:

- **Routine pre-operative testing** - NICE guidelines for Routine Pre-operative Tests for Elective Surgery (2016).
- **Diabetes** – Centre for Perioperative Care (CPOC) Guideline for Perioperative Care of People with Diabetes Mellitus Undergoing Elective and Emergency Surgery (2023).

- **Echocardiography** – European Society Cardiology Guidelines on cardiovascular assessment and management of patients undergoing non cardiac surgery (2022).
- **Anaemia** – CPOC. Guideline for the Management of Anaemia in the Perioperative Pathway. May 2025.
- **Hypertension** –The measurement of adult blood pressure and management of hypertension before elective surgery – AAGBI/BHS (2016).
- **Sleep Apnoea** – CPOC Perioperative Management of OSA in Adults (2025).

Future work should look to re-evaluate previous work undertaken on development of the core pre-operative assessment questionnaire.

Principle 7 – Extending the Validity Period of Pre-operative Assessment to 6 Months

Current practice across NHS Scotland varies considerably regarding the validity period of a pre-operative assessment. Some units apply a 3-month validity period, whilst others use 6 months. Recent trials extending the validity period to 6 months in additional boards has been undertaken with no impact on late cancellations or loss of perioperative capacity.

It has therefore been agreed that, where clinically safe:

- The validity of pre-operative assessment should be routinely extended to 6 months from the date of pre-assessment completion.
- Where blood or other specific tests require repeating - these should be performed by a Healthcare Support Worker (HCSW) with appropriate training.
- If there are concerns that a patient may significantly deteriorate during the waiting period, a shorter validity period may be set. Clear written explanations for this should be documented, along with a plan to review if the TCI date has not passed.
- If a patient's clinical condition changes significantly after pre-assessment, there should be a clear process for alerting the pre-assessment team so pre-assessment can be repeated.
- Ongoing audit of late cancellations and reasons for cancellation should be monitored to assess the impact of the planned change.

Appendix 1

Pre-operative anaemia

Sonya McKinlay, Consultant Anaesthetist, NHS Greater Glasgow and Clyde

1. Identify anaemia early in the pathway

Any patient undergoing surgery with an expected blood loss greater than 500 ml (or 10% of blood volume) should have a Full Blood Count (FBC) taken as early as possible. This could occur in primary care (pre-referral), surgical outpatients, pre-assessment and other referral areas e.g. endoscopy, colonoscopy.

The diagnosis of anaemia should be made using locally agreed values for haemoglobin (Hb): <130g/L in males and Hb <130g/L in females (International Consensus Definition) or Hb < 130g/l in males and Hb < 120g/L in females (World Health Organisation (WHO) definition).
Onward referral for investigation of anaemia should be agreed locally between surgical teams, pre-assessment clinics and where appropriate primary care*.

*The use of trigger testing of haematinics and C-reactive protein (CRP) should be considered as part of perioperative pathways.

2. Find the cause for anaemia

Pre-operative assessment units should develop pathways for investigating and treating anaemia in patients requiring surgery, based on the Centre for Perioperative Care's (CPOC) Guideline for the Management of Anaemia in the Perioperative Pathway or the Royal College of Anaesthetist's (RCoA) Scottish Standard for the Optimisation of Preoperative Anaemia.

a) If anaemia is diagnosed, non-urgent surgical pathways should allow time for appropriate investigation and correction of the anaemia.

b) During investigation, the possibility of a malignancy must be considered. Pathways for the investigation of a possible malignancy are to be agreed at local level and should include access to QFit testing and upper and lower gastrointestinal (GI) endoscopy.

c) Treatment protocols for iron deficiency, Vitamin B12 and folate deficiency should be agreed locally. First line treatment for Iron-deficiency Anaemia (IDA) should be with oral iron. (Oral iron, B12 and folate may be prescribed by the Pre-Assessment clinic, GP or other member of the multi-disciplinary team (MDT) or dispensed using Patient Group Direction, PGD)

d) Patients with anaemia of inflammation with iron deficiency (a functional iron deficiency) should be treated as iron deficient. However, the first line treatment should be with intravenous (IV) iron.

e) Patients with anaemia of inflammation without iron deficiency are a challenging group who may have a lower target haemoglobin. Expert advice should be sought in the management of this group.

3. Provision of IV iron

Pre-operative assessment units must ensure access to IV iron for:

- Patients intolerant of oral iron
- Patients with anaemia of inflammation
- Patients with functional iron deficiency
- Patient requiring urgent surgery which cannot be delayed, even if there is a higher risk of perioperative blood transfusion

4. Person-centred care

Management of pre-operative anaemia should be individualised. Patients must be fully informed of the benefits and risks of investigations and treatments, with clear communication between all members of the multidisciplinary team (MDT) to avoid delays and cancellations.

References:

1. CPOC. Guideline for the Management of Anaemia in the Perioperative Pathway. May 2025. **https://cpoc.org.uk/sites/cpoc/files/documents/2025-05/CPOC-AnaemiaGuideline2025.pdf**
2. Royal College of Anaesthetists. Scottish Standard Guideline for the Optimisation of Preoperative Anaemia Pathway. January 2018. **https://www.cpoc.org.uk/sites/cpoc/files/documents/2021-07/CSQ-Optimisation-Preop-Anaemia.pdf**

Appendix 2

National consensus statement: Perioperative management of Diabetes

Elizabeth Neale, Consultant Anaesthetist, NHS Ayrshire and Arran

Patients with diabetes continue to experience longer hospital stays and higher rates of perioperative morbidity compared to patients without diabetes.

Each Health Board should develop local pathways based on the Centre of Perioperative Care's (CPOC) Guideline for Perioperative Care for People with Diabetes Mellitus Undergoing Elective and Emergency Surgery, October 2023, with input from local Diabetes specialist teams.

The following principles should apply:

1. Early assessment of glycaemic control within the perioperative pathway:

- Assessment of glycaemic control should be done in primary care (pre-referral) or in surgical outpatients.

2. Early referral for diabetes optimisation, according to agreed local pathways:

- Patients listed for planned surgery with an HbA1c >69mmol/mol should be considered for referral for optimisation, following locally agreed pathways.

3. Early identification and optimisation of co-morbidities:

- Patients should be referred for pre-operative assessment as early as possible in the pathway.

4. Individualised and person-centred care and shared decision making:

- A personalised perioperative diabetes management plan should be documented for each patient. This plan should be individualised and take into account patient preferences after a Benefits, Risks, Alternatives, do Nothing (BRAN) discussion.
- The UK Clinical Pharmacy Association (UKCPA) provides comprehensive and up-to-date advice regarding the perioperative management of medications used to manage diabetes. This guidance should be consulted when considering changes to patients' usual diabetes medications pre-operatively.

5. Utilise opportunities for lifestyle modification and behaviour change.

References

1. CPOC. Guideline for Perioperative Care for People with Diabetes Mellitus Undergoing Elective and Emergency Surgery. October 2023. https://www.cpoc.org.uk/sites/cpoc/files/documents/2024-05/CPOC-DiabetesGuideline2023.pdf
2. UK Clinical Pharmacy Association. Handbook of Perioperative Medicines; Expert Medicines Advice. https://periop-handbook.ukclinicalpharmacy.org/

Appendix 3

Perioperative management of Obstructive Sleep Apnoea (OSA)

Miriam Stephens, Consultant Anaesthetist, NHS Lanarkshire

Obstructive Sleep Apnoea (OSA) is a risk factor for increased cardiovascular and pulmonary morbidity and is often undiagnosed. It is important that Pre-Assessment services have a screening pathway in place and a suitable referral pathway for sleep studies.

A comprehensive guideline on the Perioperative Management of OSA in Adults has been published by the Centre of Perioperative Care (CPOC). Key points are as follows:

1. **Do not delay urgent surgery to obtain a diagnosis of OSA.**
2. **Priority factors for rapid assessment include:**
   - Vocational driving or vigilance-critical job
   - Unstable cardiovascular disease
   - Pregnancy
   - Preoperative assessment for major surgery
3. **In those patients who get CPAP pre-operatively, aim for 4-6 weeks therapy prior to surgery.**
4. **OSA does not preclude day surgery:**
   - If co-morbidities are controlled, with opioid-sparing or regional anaesthesia many procedures can safely be performed as day cases, however, High Dependency Unit (HDU) and Inpatient (IP) beds should still be provisionally booked and utilised at list anaesthetist's discretion.
5. **In line with the British Thoracic Society Position Statement pre-assessment teams should not offer any advice on driving:**
   - Driving advice should be provided only by specialist teams.
   - Pre-assessment teams should ensure referrals include pertinent information on priority cases, such as those involving vocational drivers or vigilance critical roles (e.g. operating heavy machinery).
   - General advice not to drive while sleepy applies to all drivers.

References

1. British Thoracic Society. Position Statement Driving and Obstructive Sleep Apnoea (OSA). 2018 https://www.brit-thoracic.org.uk/document-library/governance-and-policy-documents/position-statements/position-statement-on-driving-and-obstructive-sleep-apnoea/
2. Centre for Perioperative Care (CPOC). Perioperative Management of Obstructive Sleep Apnoea in Adults. March 2025 https://cpoc.org.uk/guidelines-and-resources/guidelines/perioperative-management-osa-adults

Appendix 4

Guidelines for Transthoracic Echocardiography (TTE) in patients undergoing non-cardiac surgery

Karen Stevenson, Consultant Anaesthetist, NHS Lothian

It is expected that these recommendations will be modified for local use within each health board or hospital, however, they should continue to be based on the 2022 European Society of Cardiology recommendations.

It is important that local guidelines are multi-disciplinary and are formed in collaboration with the relevant Cardiology teams.

Recommendations
1. Transthoracic echocardiography is recommended in patients with poor functional capacity and/or high Natriuretic Peptide Tests (NT-proBNP/BNP), and/or if murmurs are detected before high-risk non-cardiac surgery in order to undertake risk reduction strategies (Class I, Level B).
2. TTE should be considered in patients with suspected new cardiovascular disease (CVD) or unexplained signs or symptoms before high-risk non-cardiac surgery (NCS) (Class IIa, Level B).
3. TTE may be considered in patients with poor functional capacity, abnormal electrocardiogram (ECG) (pathological Q wave, ST-T wave changes, non-sinus rhythm, left bundle branch block), high NT-proBNP/BNP,d or ≥1 clinical risk factor (including age 65 or more) before intermediate-risk NCS (Class IIb, Level B).
4. Routine pre-operative evaluation of Left Ventricular (LV) function is not recommended (Class III, Level C).

Pre-operative Focused Cardiac Ultrasound (FoCUS) examination with a hand-held ultrasound device for the assessment of murmurs, haemodynamic instability, ventricular function, and dyspnoea may impact patient management by improving the diagnostic accuracy of clinical assessment, and help to triage candidates for standard TTE, plan surgery and anaesthesia technique, and post-operative monitoring.

However, current evidence remains mostly confined to uncontrolled or retrospective observational studies with no clear benefits on the outcome, despite a favourable impact on perioperative management. If an abnormality is detected via preoperative TTE, it is essential that the patient is appropriately referred to and followed up by local Cardiology teams, and that surveillance is carried out if necessary.

References
1. European Society of Cardiology (ESC). ESC Guidelines on cardiovascular assessment and management of patients undergoing non cardiac surgery. August 2022. https://www.escardio.org/Guidelines/Clinical-Practice-Guidelines/ESC-Guidelines-on-non-cardiac-surgery-cardiovascular-assessment-and-managem

Resources

- British Hypertension Society (BHS), March 2016, The measurement of adult blood pressure and management of hypertension before elective surgery 2016, The Association of Anaesthetists of Great Britain & Ireland (AAGBI), https://anaesthetists.org/Home/Resources-publications/Guidelines/Measurement-of-adult-blood-pressure-and-management-of-hypertension-before-elective-surgery, Accessed 30 May 2025

- British Thoracic Society, (BTS), 2018, Position Statement Driving and Obstructive Sleep Apnoea (OSA), British Thoracic Society, https://www.brit-thoracic.org.uk/document-library/governance-and-policy-documents/position-statements/position-statement-on-driving-and-obstructive-sleep-apnoea/, Accessed 30 May 2025

- Centre for Perioperative Care, (CPOC), March 2025, Perioperative Management of Obstructive Sleep Apnoea in Adults, CPOC, https://www.cpoc.org.uk/guidelines-and-resources/guidelines/perioperative-management-osa-adults, Accessed 30 May 2025

- Centre for Perioperative Care, (CPOC), May 2025, Guideline for the Management of Anaemia in the Perioperative Pathway, CPOC, https://cpoc.org.uk/sites/cpoc/files/documents/2025-05/CPOC-AnaemiaGuideline2025.pdf, Accessed 30 May 2025

- Centre for Perioperative Care, (CPOC), October 2023, Perioperative Care of People with Diabetes Undergoing Surgery, CPOC, https://www.cpoc.org.uk/guidelines-and-resources/guidelines/guideline-diabetes, Accessed 30 May 2025

- European Society of Cardiology (ESC), 26 August 2022, ESC Guidelines on cardiovascular assessment and management of patients undergoing non cardiac surgery, ESC, https://www.escardio.org/Guidelines/Clinical-Practice-Guidelines/ESC-Guidelines-on-non-cardiac-surgery-cardiovascular-assessment-and-managem, Accessed 30 May 2025

- National Elective Coordination Unit (NECU), Waiting List Validation, Centre for Sustainability (CfSD), NHS Golden Jubilee, https://nhscfsd.co.uk/our-work/national-elective-coordination-unit/waiting-list-validation, Accessed 30 May 2025

- NICE, 5 April 2016, Routine preoperative tests for elective surgery, NICE Guideline (NG 45), https://www.nice.org.uk/guidance/ng45/resources/routine-preoperative-tests-for-elective-surgery-pdf-1837454508997, Accessed 30 May 2025

- Royal College of Anaesthetists, (RCoA), January 2018, Scottish Standard Guideline for the Optimisation of Preoperative Anaemia Pathway, RCoA, https://www.cpoc.org.uk/sites/cpoc/files/documents/2021-07/CSQ-Optimisation-Preop-Anaemia.pdf, Accessed 30 May 2025

- UCLA Health, Anesthesiology Risk Stratification, UCLA Health, https://www.uclahealth.org/departments/anes/referring-providers/risk-stratification, Accessed 30 May 2025

Useful websites

- Association of Anaesthetists - https://anaesthetists.org/
- British and Irish Hypertension Society (BIHS) - https://bihs.org.uk/
- British Thoracic Society - https://www.brit-thoracic.org.uk/
- Centre for Perioperative Care (CPOC) - https://www.cpoc.org.uk/
- European Society of Cardiology (ESC) - https://www.escardio.org/
- Getting It Right First Time (GIRFT) - https://gettingitrightfirsttime.co.uk/
- Royal College of Anaesthetists (RCoA) - https://www.rcoa.ac.uk/
- National Institute for Health and Care Excellence (NICE) - https://www.nice.org.uk/
- NHS Inform/Waiting Well - https://www.nhsinform.scot/waiting-well/
- Scottish Society of Anaesthetists - https://www.ssa.scot/
- The Preoperative Association - https://www.pre-op.org/
- UK Clinical Pharmacy Association (UKCPA) - https://ukclinicalpharmacy.org/

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