National Good Practice Guidance on Pre-operative Assessment for Inpatient Surgery
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Electronic copies of this guidance and examples of good practice documents are available from
www.modern.nhs.uk/theatreprogramme/preop
1. Introduction

**Definition of pre-operative assessment**
Pre-operative assessment establishes that the patient is fully informed and wishes to undergo the procedure. It ensures that the patient is as fit as possible for the surgery and anaesthetic. It minimises the risk of late cancellations by ensuring that all essential resources and discharge requirements are identified and co-ordinated.

The NHS Modernisation Agency’s Operating Theatre & Pre-operative Assessment Programme (the Theatre Programme) has developed this guidance for pre-operative assessment before admission for inpatient surgery. It builds on the previous work of the pilot sites that were involved in developing and testing ways to implement pre-operative assessment.

Patients want to be fully informed about their operation and fit for surgery on the agreed date. Implementing pre-operative planning and assessment before admission should improve the patient’s experience of surgery, by providing information about the operation and giving patients the opportunity to ask questions.

By ensuring patients are as fit as possible and identifying any resource requirements for the operation, peri-operative stay and subsequent discharge, pre-operative planning and assessment could improve hospital efficiency by reducing length of stay and minimising the risk of last minute cancellations.

The Theatre Programme’s work in nine NHS Trust pilot sites has shown that patient cancellations account for around half of all cancelled operations for inpatient surgery. All cancellations involve the hospital in a significant amount of further work, as dates for surgery have to be re-arranged.

**Source of all inpatient cancellations Aug 01 - Nov 02**

![Pie chart showing the source of inpatient cancellations]

The nearer these cancellations are to the time of surgery, the greater the impact on scheduling of theatre lists and theatre utilisation. Where operations are cancelled on the
day or the day before surgery, it is less likely that these vacant theatre slots can be utilised by another patient.

For example, in the Theatre Programme’s pilot sites, between August 2001 and November 2002, 21% of all inpatient operations cancelled on the day, or the day before surgery, were potentially avoidable (see red bars in the table below). Many of these cancellations could have been prevented by expanding pre-operative assessment to include more time for detailed discussion with patients about their surgery, noting requirements for admission, surgery and discharge, and facilitating patient choice in the date of their surgery.

The Association of Anaesthetists (2001) suggests that pre-operative assessment could improve ‘did not attend’ (DNA) rates for surgery. The Theatre Programme’s pilot sites are currently collecting key performance indicators (KPI) to demonstrate additional benefits that could be achieved by improving the pre-operative assessment process. Examples of the key performance indicators can be found on: www.modern.nhs.uk/theatreprogramme/preop

If pre-operative assessment includes discussion about risks and benefits, this may decrease the numbers of patients listed for surgery, who would have subsequently decided not to have the surgery.

To achieve these benefits and provide a co-ordinated patient focused service, pre-operative assessment must be properly planned to engage all necessary healthcare professionals.
Pre-operative assessment is an important part of the surgical patient’s pathway. It must be integrated within the wider system, including waiting list management, elective and emergency admissions, booking of dates, operating theatre list compilation, bed management and discharge planning. A single central contact point within secondary care, with links to primary care and social services, should enable planning and optimisation of care to occur across the whole health community. This central co-ordination should benefit both staff and patients by reducing confusion and duplication. Improvement programmes should be linked at NHS Trust, Strategic Health Authority and national levels to ensure a whole systems approach.

This guidance concentrates primarily on the processes required for efficient pre-operative assessment. This document does not address clinical issues such as:

- Detailed guidelines for referral from a pre-operative service.
- Guidelines for pre-operative investigations (to be published by NICE).
- Whether traditional medical clerking is necessary for all surgical patients.
- Appropriate degree of clinical examination necessary for each patient.
- The competent health professional who should perform this examination.
2. Objectives of pre-operative assessment

Pre-operative assessment is usually seen as a process to ensure that the patient is as fit as possible for surgery and anaesthetic. It should also ensure that the patient fully understands the proposed operation and is ready to proceed. By noting special requirements for surgery and peri-operative stay, scheduling of theatre lists could be improved. Identification and co-ordination of all essential resources and discharge requirements should minimise the risk of late cancellations and may reduce length of stay.

Pre-operative assessment should:

- Provide the opportunity for further explanation and discussion of the information given by the surgeon. This should minimise any fears or anxieties by ensuring the patient fully understands the proposed procedure.

- Assess the patient's fitness for surgery and anaesthesia and provide an assessment of the risks and benefits of the proposed surgery and anaesthesia, and confirm the patient wishes to have the operation in the light of these risks and benefits.

- Identify any condition that may require intervention prior to admission and surgery and take appropriate action, eg patients taking warfarin, oral contraception, etc.

- Refer the patient, if necessary, for optimisation of their health before surgery, eg to a primary care and/or a secondary care specialist.

- Ensure any necessary investigations are performed, results are available and any necessary action taken (NICE guidelines due to be published). This should reduce any unnecessary duplication of investigations.

- Assess the patient's suitability for day surgery, if the operation could be performed as a day surgery procedure (See National Good Practice Guidance on Pre-operative Assessment for Day Surgery (2002) and Day Surgery: Operational Guide (2002)).

- Identify requirements to aid scheduling of the surgical procedure, including specialist equipment, approximate length of surgery and any special requirements for the post-operative stay, eg critical care beds.

- Provide information about any specific pre-operative instructions, eg any fasting instructions.

- Provide a contact point for any further queries, or if they want to cancel the operation.

- Provide information about the anticipated post-operative recovery, eg rate of mobilisation, measures to relieve pain, etc. Videos, information leaflets and picture diaries are effective methods of providing information.

- Provide an opportunity to discuss with patients any self-help matters to improve the outcome of their surgery, eg stopping smoking, losing weight, etc.

- Identify any cultural requirements and any communication or other special needs.

- Assess the home support available to the patient post-discharge, and identify any special requirements to facilitate prompt discharge, eg co-ordinating with social services, where appropriate.

- Prepare the multi-disciplinary pre-operative documentation.
3. The pre-operative assessment process for inpatient surgery.

3.1 Who should undergo pre-operative assessment?

All patients should undergo pre-operative assessment. Using the categories as defined by the National Confidential Enquiry for Peri-operative Deaths (2002) (NCEPOD), this includes elective, scheduled, urgent and emergency patients.

The NCEPOD categories are as follows:

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCEPOD 1</td>
<td>Immediate life saving operation, resuscitation simultaneous with surgical treatment (eg trauma, ruptured aortic aneurysm).</td>
<td>Within one hour.</td>
</tr>
<tr>
<td>NCEPOD 2</td>
<td>Operation as soon as possible after resuscitation (eg irreducible hernia, intussusception, oesophageal atresia, intestinal obstruction, major fractures).</td>
<td>Within 24 hours.</td>
</tr>
<tr>
<td>NCEPOD 3</td>
<td>An early operation, but not immediately life-saving (eg malignancy).</td>
<td>Within 3 weeks.</td>
</tr>
<tr>
<td>NCEPOD 4</td>
<td>Operation at a time to suit both patient and surgeon (eg cholecystectomy, joint replacement).</td>
<td>At time to suit patient &amp; surgeon.</td>
</tr>
</tbody>
</table>

Pre-operative assessment for patients requiring emergency, urgent, scheduled surgery (NCEPOD 1,2 and 3)

The degree of pre-operative assessment, investigation and optimisation differs for patients who require emergency, urgent or scheduled surgery.

Patients requiring emergency surgery (NCEPOD 1)

The anaesthetist will assess patients in this category, and organise relevant examinations, investigations and optimisation. Further information on improvements in emergency care can be found on www.modern.nhs.uk/emergency

Patients requiring urgent surgery (NCEPOD 2)

The anaesthetist responsible for urgent surgery will supervise the relevant investigations and optimisation. Some NHS Trusts use clinical nurse specialists working collaboratively with anaesthetists, to co-ordinate the preparation of these patients for surgery and schedule the operation. (See effective practice examples, page 21)
Patients requiring scheduled surgery (NCEPOD 3)

These patients may be seen in out-patients or may present as emergencies. They should be seen by the pre-operative assessment service as soon as possible so that their condition can be optimised within the short time available. Investigations should be fast tracked and the results acted on promptly. Treatment of chronic medical conditions should be managed within the secondary care service, as there is usually little time for referral to primary care for management. Prompt referral to the anaesthetic department will enable provision of a suitable anaesthetist.

Pre-operative assessment for patients who require elective surgery (NCEPOD 4)

All elective patients should undergo pre-operative assessment. For some patients this will be a swift process, as they may not require a full medical assessment, eg patients having a local anaesthetic infiltration. For others, more detailed discussion, investigations and visits to their general practitioner or other consultants may be necessary. Ideally there should be standard processes across each health community, agreed by all relevant healthcare professionals.
Pre-operative process for scheduled (NCEPOD 3) inpatient surgery

Patient requires an operation

Patient attends pre-operative assessment and has any necessary tests

Does patient meet locally agreed criteria? Yes

Is there an explicit protocol for referral? Yes

Urgent referral within secondary care

Does patient need tests or treatment? No

Yes

Patient has tests or treatment

Does patient meet locally agreed criteria? Yes

No

Perform any tests required near time of surgery

Are test results satisfactory? No

Yes

Treat patient to correct abnormalities

Consider other forms of treatment

Surgeon, anaesthetist + critical care consultant (if appropriate) to reconsider risks and benefits with patient

Do benefits of surgery outweigh risks? Yes

No

Agree* date for surgery within 3 weeks. Give pre-operative information and instructions. Agree date for tests needed near to time of surgery.

Agree* date for surgery within 3 weeks. Give pre-operative information and instructions. Agree date for tests needed near to time of surgery.

*Agree is defined as 'the patient is able to choose from a reasonable range of available dates'. This should take into account the availability of resources.
Pre-operative process for elective (CEPOD 4) booked inpatients

1. Patient requires an operation
   - Patient attends pre-operative assessment and has any necessary tests
     - Does patient meet locally agreed criteria?
       - Yes
         - Patient referred to primary or secondary care specialist
           - Does patient need referral?
             - Yes
               - Patient has tests or treatment
                 - Can a date for surgery be booked?
                   - Yes
                     - Surgeon, anaesthetist + critical care consultant (if appropriate) to reconsider risks and benefits with patient
                       - Do benefits of surgery outweigh risks?
                         - No
                           - Consider other forms of treatment
                         - Yes
                           - Agree* date for surgery and any tests required near to time of surgery. Give pre-operative instructions and information
                             - Patient contacted 2 weeks before operation to confirm attendance, ensure no changes have occurred and repeat instructions
                               - Perform any tests as required near time of surgery
                                 - Are test results satisfactory?
                                   - No
                                     - Treat patient to correct abnormalities
                                       - Patient has operation
                                     - Yes
                                       - Patient has operation
                                   - Yes
                                     - See NCEPOD 4 partially booked flow chart (page 10)
                               - No
                                 - See NCEPOD 4 partially booked flow chart (page 10)
                             - No
                               - See NCEPOD 4 partially booked flow chart (page 10)
                           - No
                             - See NCEPOD 4 partially booked flow chart (page 10)
                         - No
                           - See NCEPOD 4 partially booked flow chart (page 10)
                       - Yes
                         - darling
                           - See NCEPOD 4 partially booked flow chart (page 10)
                     - No
                       - See NCEPOD 4 partially booked flow chart (page 10)
                 - No
                   - See NCEPOD 4 partially booked flow chart (page 10)
           - No
             - See NCEPOD 4 partially booked flow chart (page 10)
       - No
         - Anaesthetic review
           - Does patient meet locally agreed criteria?
             - Yes
               - Surgeon, anaesthetist + critical care consultant (if appropriate) to reconsider risks and benefits with patient
                 - Do benefits of surgery outweigh risks?
                   - No
                     - Consider other forms of treatment
                   - Yes
                     - Agree* date for surgery and any tests required near to time of surgery. Give pre-operative instructions and information
                       - Patient contacted 2 weeks before operation to confirm attendance, ensure no changes have occurred and repeat instructions
                         - Perform any tests as required near time of surgery
                           - Are test results satisfactory?
                             - No
                               - Treat patient to correct abnormalities
                                 - Patient has operation
                             - Yes
                               - Patient has operation
                         - Yes
                           - See NCEPOD 4 partially booked flow chart (page 10)
                       - No
                         - See NCEPOD 4 partially booked flow chart (page 10)
                 - No
                   - See NCEPOD 4 partially booked flow chart (page 10)
           - No
             - See NCEPOD 4 partially booked flow chart (page 10)
       - No
         - See NCEPOD 4 partially booked flow chart (page 10)
     - No
       - See NCEPOD 4 partially booked flow chart (page 10)
   - No
     - See NCEPOD 4 partially booked flow chart (page 10)

*Agree is defined as 'the patient is able to choose from a reasonable range of available dates'. This should take into account the availability of resources.
Pre-operative process for elective (CEPOD 4), partially booked inpatients following pre-operative assessment

1. **Patient meets locally agreed criteria**
   - Note any tests or re-assessment requirement immediately pre-operatively
   - Add to waiting list
   - Contact patient 6-8 weeks before operation

2. **Does patient need tests or re-assessment?**
   - Yes: Agree date for re-assessment or tests in primary or secondary care
   - No: Ask questions to ensure no changes in condition have occurred

3. **Review by anaesthetist**
   - Surgeon, anaesthetist + critical care consultant (if appropriate) to reconsider risks and benefits with patient

4. **Does patient meet locally agreed criteria?**
   - Yes: Agree* date of operation and any necessary tests and give pre-operative information and instructions
   - No: Consider other forms of treatment

5. **Do benefits of surgery outweigh risks?**
   - Yes: Patient contacted 2 weeks before operation to confirm attendance, ensure no changes have occurred and repeat instructions
   - No: Consider other forms of treatment

6. **Are test results satisfactory?**
   - No: Treat patient to correct abnormalities
   - Yes: Patient has operation
3.2 When should pre-operative assessment take place?

Ideally an initial pre-operative assessment should be performed immediately following the decision to operate. If the patient is fit and undergoing simple surgery, this could be a one-stop service. If this is not possible, or is not desirable or convenient for the patient, a time should be agreed with the patient to return as soon as possible. The patient should be given a reasonable estimate of the time required for the pre-operative assessment.

Early pre-operative assessment ensures that patients with medical conditions requiring further investigation or treatment are identified early and appropriate action is taken. It reduces the peri-operative workload of the anaesthetist, as patients should arrive for surgery optimised and informed. The discussion on the day of surgery between the anaesthetist and patient can then be directed entirely at the proposed anaesthetic and post-operative course, rather than assessing fitness and searching for investigation results.

If GPs are booking directly onto operating lists, only those patients who fulfil the local standardised criteria should be booked on to the operating list. In these circumstances the pre-operative process should follow the same guidelines as in secondary care to ensure consistent approach and avoid last minute cancellations.

3.3 Where should pre-operative assessment take place?

Traditionally pre-operative assessment has occurred in secondary care. The value of including primary care in the development and running of the pre-operative assessment service should not be underestimated. Some of the medical conditions that lead to cancellations are usually managed in primary care, eg hypertension.

Pre-operative assessment can take place in a variety of ways, eg as a face-to-face consultation in primary or secondary care, by postal questionnaire, by telephone, by using NHS Direct or possibly by using a questionnaire on the Internet. The chosen method should be acceptable and convenient for the patient but must adhere to the standards and guidelines in use by the health community.

On the basis of information given during primary care assessment, postal, telephone or Internet assessment, a visit to the pre-operative assessment service may be required to explore issues in more detail. In the absence of a face to face assessment, other methods of obtaining factual data such as blood pressure, height and weight will be necessary.

Pre-operative assessment for patients undergoing major surgery should be conducted in secondary care, as patients will require input from specialist services, eg anaesthetists, pain control specialists, pharmacists, physiotherapists and nurse specialists.

Ideally, dedicated pre-operative assessment facilities should be provided, with near patient testing and/or IT access to laboratory results and administrative support.

Consulting and examination rooms, equipped with blood pressure monitors, equipment for simple respiratory function tests, electrocardiogram machine, phlebotomy services, etc, should be available to allow a full pre-operative assessment to be performed. The availability of this equipment should enable investigations to be performed within the pre-operative assessment area, so that the patient does not have to walk all over the hospital or queue outside a series of rooms.
Patients may wish to have time to consider the implications of surgery and return for an unhurried assessment and further discussion at a later date. Some patients may wish to return after the assessment to discuss aspects of the surgery in further detail, with the relevant healthcare professional.

3.4 Who should perform pre-operative assessment?

Increasing numbers of elderly patients with co-morbidity are presenting for surgery. A higher proportion of surgery now consists of long and complex operations. Both of these factors increase the need for an early, systematic pre-operative assessment and optimisation of patients for surgery.

Anaesthetists have traditionally been responsible for determining whether a patient is fit for surgery. The NCEPOD report (2002) *Functioning as a team?* suggests pre-operative assessment requires a team approach. The anaesthetic department, surgeons, pre-operative assessment service and primary care should develop guidelines collectively to ensure this team approach. These criteria should be developed, taking into account the type of surgery, patient’s general health, previous anaesthetic difficulties and the urgency of the surgery. Some patients will need co-ordinated input from surgeons, anaesthetists, pre-operative assessors, critical care consultants and other health professionals to ensure an optimum outcome. The pre-operative service is ideally suited to this function as it is essential all these interventions are co-ordinated throughout the patient’s journey. Other patients may only need a brief discussion to ensure they have understood the implications of their surgery and they are fit for the proposed operation.


A trained pre-operative assessor, whose competence in this task has been assessed, could perform the initial assessment. If specifically trained, they may perform any relevant physical examination, eg chest and heart sounds and airway assessment. This pre-operative assessor should be trained to recognise abnormal findings and refer to the appropriate professional for diagnosis.

NCEPOD (2002) recognises the need for an anaesthetist to be available to the pre-operative service to see patients referred by the pre-operative assessment staff. The presence of an anaesthetist in the pre-operative assessment clinic will ensure a full risk assessment is given to complex patients and prevent patients having to return for another appointment. NHS Trusts should assess the demand for anaesthetic consultation following pre-operative assessment to determine the optimum requirements.

The pre-operative assessor should be empowered to order and perform basic investigations as identified locally, and in line with the NICE guidelines (to be published). They should also be able to make referrals according to locally developed criteria to primary care, social services and to other specialist services, eg anticoagulant teams, diabetic teams.

Although many patients will need additional assessment by an anaesthetist, some will not need to see an anaesthetist until the day of operation. The anaesthetist giving the anaesthetic is ultimately responsible for the decision to proceed, but if all anaesthetists work within the agreed guidelines, the number of cancellations close to the time of surgery will be reduced. A European Working Time Directive pilot will be testing the role of the peri-operative specialist practitioner (PSP), who will be trained in pre- and post-operative management of elective and emergency surgical patients, including pre-operative assessment. For further information visit [www.doh.gov.uk/workingtime](http://www.doh.gov.uk/workingtime)
Role of the pre-operative assessor in pre-operative assessment

The role of the pre-operative assessor in pre-operative assessment is to:

- Work to guidelines and competencies agreed by the anaesthetists, surgeons and other allied health professionals to ensure a consistent approach.
- Take a targeted history and conduct a relevant physical examination of the patient, including airway assessment.
- Refer patients who fall outside the agreed criteria to an anaesthetist, who may then make further referrals.
- Arrange and perform investigations in accordance with NICE guidelines (to be published).
- Ensure that the results of tests are evaluated and refer abnormal investigation results to the available anaesthetist, surgeon and/or primary care, according to local guidelines.
- Refer a patient back to primary care or another healthcare professional to optimise the patient’s medical condition, according to local guidelines.
- Take responsibility for following up referrals to ensure the patient remains in the pre-operative system.
- Liaise actively with the anaesthetic department.
- Arrange and co-ordinate any assessment and/or investigations needed near time of surgery.
- Take responsibility for all communication with the patient throughout their pre-operative journey.
- Commence necessary planning for the peri-operative stay and to ensure a timely discharge.
- Identify factors that may influence the dates of surgery offered, eg school holidays.
- Collate all information prior to surgery and ensure that the multi-disciplinary documentation is available for anaesthetists to see at least 48 hours prior to admission.
- Communicate approximate length of operation, any special requirements and essential resources to the waiting list office, bed management, operating theatre department and/or theatre scheduler.
- Contact all patients failing to attend pre-operative assessment to identify the reason. Act on the reason, following local protocols for the management of DNAs in pre-operative assessment.
Role of the anaesthetist in pre-operative assessment

- Development, agreement and support of pre-operative processes and explicit protocols that enable the pre-operative assessors to assess and prepare patients for surgery.
- Development, agreement and support of explicit protocols for pre-operative assessors to refer patients not currently fit for surgery, to primary care or appropriate hospital services for investigation and/or optimisation of commonly occurring chronic conditions, e.g., hypertension, diabetes, etc.
- Access to consultant anaesthetist when pre-operative assessment clinics take place, to allow discussion of any patient with complex needs.
- Referral of any complex patients requiring investigations and treatment to the relevant consultant or department, if guidelines do not exist for this to be done by the pre-operative assessor.
- Co-ordination of the optimisation for surgery of the unfit patient, both before and after admission. This may require early discussion between anaesthetist, surgeon and critical care consultant of any patient at a substantially increased risk from surgery.
- Liaison with the anaesthetist who will anaesthetise the patient, if the patient poses considerable anaesthetic difficulties.
- Any essential anaesthetic requirements are noted in the multi-disciplinary pre-operative documentation.
- There is a training and accreditation programme for pre-operative assessment staff, which is acceptable to the department.
3.5 Risks, benefits and informed consent

All operations and anaesthetics carry a risk. The surgeon will have discussed the risks and benefits of surgery with the patient. At pre-operative assessment it may become evident that there is considerable additional risk due to co-morbidity. Co-morbidities may be previously known or newly diagnosed. They may be well controlled, poorly controlled or uncontrolled. Pre-operative investigation, referral and treatment may be necessary.

If the anaesthetist decides that there is a significant risk attached to surgery even when the patient’s condition is well controlled, the risks and benefits of alternative courses of action should be discussed with the surgeon, and if appropriate, the critical care consultant. When agreement on the options is reached, these should be fully discussed with the patient, including clear guidance on the risks and benefits of the operation and the anaesthetic. This will allow the patient to make an informed decision about the options available. These options may include:

- Proceeding with the operation, understanding the risk.
- Proceeding with modified surgery.
- Not proceeding with any surgery.

Discussions about risks, benefits, and decisions reached, should be documented in multi-disciplinary pre-operative documentation.

Patients should be fully informed about the planned procedure by implementing the Good Practice in Consent Implementation Guide: Consent to Examination or Treatment (2001). Appendix A provides 12 key points on consent taken from the Department of Health website on www.doh.gov.uk/consent

3.6 What should happen after pre-operative assessment?

Once the patient has decided to undergo the procedure and is as fit as possible for surgery and anaesthesia, they may agree a date for surgery at the time of pre-operative assessment, or be added to a waiting list.

Agreeing a date for surgery with the patient at the time of assessment

Essential resources to perform an operation include the bed, surgeon, anaesthetist, staffed operating theatre and any other special equipment. To ensure bed availability, an estimation of the beds available for elective surgery each week of the year is necessary. Co-ordination of these beds, possibly through central bed management, is required. In addition, policies for medical staff leave should be adhered to.

Following pre-operative assessment, if these essential resources will be available, it may be possible to agree a date for surgery with the patient. (Booked admission).
If the patient is added to the waiting list

If it is not possible to agree a date at the time of pre-operative assessment, patients will be added to a waiting list. These patients should be contacted 6-8 weeks prior to surgery (partial booking) to:

- Confirm they still wish to proceed.
- Confirm there has been no alteration in medical and social circumstances, eg
  - Any admission to hospital since the pre-operative assessment.
  - Any significant illness requiring hospital out-patient consultation or a new treatment since the pre-operative assessment.
  - Any change in medication.
  - Any relevant change in social circumstances.
- Agree a date to attend for investigations or re-assessment if required.
- Agree the final date for surgery from a reasonable range of available dates.
- Reinforce information about the proposed surgery and anaesthesia.
- Discuss pre-operative instructions and provide further opportunity for questions.

Any arrangements agreed by telephone should be confirmed in writing and any additional information sent with this letter.

If a patient suffers any ill health that will prevent or delay surgery, the primary or secondary care service managing that ill health, should inform the pre-operative service.

Further information about developing and operating booking systems may be found on www.modern.nhs.uk/booking

If re-assessment is required nearer the time of surgery

Most patients will not suffer any deterioration in their general health between assessment and the proposed surgery. Those with co-morbidity may require re-assessment of their health nearer the time of surgery. This may take place in primary or secondary care and can be targeted at specific previously identified conditions. These patients should be identified at the initial assessment and contacted approximately 6-8 weeks before the predicted date of surgery to arrange this re-assessment. When the patient has been confirmed fit for surgery, a date for the surgery should be agreed. Some patients will need blood tests, eg cross matching. A date for these tests can be agreed with the patient when confirming the operation date.
Patient responsibilities

Patients should be asked to inform the pre-operative assessment service immediately if they:

- Want to change the date of their operation (although subsequent date changes should be discouraged).
- If there is a significant change in their general health.
  - If they have a minor illness that will not resolve by the date of surgery.
  - Decide not to go ahead with the operation, or have the surgery elsewhere.

3.7 What information should be given to patients?

Before pre-operative assessment, patients should be given written information about the pre-operative assessment process.

The topics below should be discussed with the patient and full understanding ensured. This should be followed up with written information. Videos and picture diaries of recovery from surgery can be used. Some national initiatives to standardise patient information can be found on: www.youranaesthetic.info and www.doh.gov.uk/nhsidentity/toolkit-patientinfo.htm

<table>
<thead>
<tr>
<th>Information for patients should include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Details of the operation to be performed.</td>
</tr>
<tr>
<td>Expected benefits of the surgery and risks involved.</td>
</tr>
<tr>
<td>Approximate length of hospital stay.</td>
</tr>
<tr>
<td>Diary of usual recovery for that operation, including when patients usually eat, drink, mobilise and return home.</td>
</tr>
<tr>
<td>Degree of pain anticipated and how the pain will be relieved, eg details of techniques such as epidurals and patient controlled analgesia.</td>
</tr>
<tr>
<td>Approximate time needed off work.</td>
</tr>
<tr>
<td>When it will be safe to resume normal activities, eg driving, etc.</td>
</tr>
<tr>
<td>The pre-operative assessor’s contact details for the patient to ring if:</td>
</tr>
<tr>
<td>- They cannot attend.</td>
</tr>
<tr>
<td>- There has been a significant change to their medical condition.</td>
</tr>
<tr>
<td>- Their medication has changed.</td>
</tr>
<tr>
<td>- They need advice.</td>
</tr>
<tr>
<td>What to bring on the day of admission, eg medication.</td>
</tr>
<tr>
<td>Car parking/hospital map and/or other transport arrangements.</td>
</tr>
<tr>
<td>Whether or not relatives can accompany them and visiting arrangements.</td>
</tr>
<tr>
<td>Fasting times (see Appendix B) and other pre-operative preparation can be discussed but should be confirmed nearer the time of surgery.</td>
</tr>
</tbody>
</table>
3.8 How should records be kept?

The patient’s medical record must be available at pre-operative assessment to obtain the previous medical history. A standard document, preferably electronic, for recording information from the pre-operative assessment should be utilised, throughout the health community. This all inclusive, single multi-disciplinary document should be focused so that only relevant questions are asked. This would reduce duplication and could be designed to replace the traditional medical clerking and nursing assessment. Although each specialty may have their own additional “bolt-on” pre-operative documentation, core documentation should be identical for all specialties.

Core components of a multi-disciplinary document

Suggestions for core components of a multi-disciplinary document include:

- Demographics.
- Proposed surgery, length of stay and any special requirements.
- Baseline observations, height, weight, blood pressure, etc.
- Medical history, including clear documentation of drug history, allergies and relevant examination.
- Nursing assessment, including the need for an interpreter.
- Anaesthetic assessment and summary of special requirements.
- Life-style advice, eg smoking cessation, weight loss.
- Referrals made and outcomes.
- Investigation results.
- Summary of any discussions regarding risks of procedure.
- Special requirements for admission, eg critical care bed.
- Social requirements for admission, eg alternative arrangements for dependent relatives.
- Discharge planning.

Scheduling information, eg approximate length of procedure and any special requirements should be accessible to relevant personnel, to enable effective scheduling of operating lists.

Specialty or procedure specific information

Suggestions for specialty or procedure specific “bolt on” documentation might include:

- Specialist documentation, eg dietary advice, physiotherapy treatment record, specialist nursing notes, etc
- Counselling services information.

The multidisciplinary pre-operative documentation should be readily available to the anaesthetist and surgeon responsible for the patient’s care before surgery.
3.9 How should the pre-operative assessment service be audited?

The pre-operative assessment service should be continuously audited and the results sent to all professionals involved. The information highlighted in bold below, may show improvements due to the implementation of pre-operative assessment. These data items could be translated into useful indicators by analysing them as a percentage of scheduled (cancellations plus elective) activity, and displaying them as run charts. This information should be presented regularly at audit meetings and to the Theatre Management Group, to monitor compliance with established policy. Action should be taken to ensure services are continually developed and improved. An example of the key performance indicators and run charts can be found on: www.modern.nhs.uk/theatreprogramme/preop

Audit information should include:

- Number of patients who attended pre-operative assessment.
- Number of patients who did not attend pre-operative assessment.
- Number of patients selected for day surgery.
- Number of patients who did not have surgery following pre-operative assessment.
- Average time spent by patient in pre-operative assessment clinic.
- Number of referrals to primary care for optimising chronic ill health.
- Number of patients who ‘did not attend’ surgery (DNA).
- Number of operations cancelled on the day of surgery or the day before surgery because:
  - The patient said the appointment was inconvenient.
  - The patient no longer wanted the operation.
  - The consultant advised the patient that the operation was no longer necessary.
  - The patient had a pre-existing medical condition.
  - The patient did not follow pre-operative instructions.
- Number of operations cancelled by the hospital because essential resources were not available, eg beds, surgeons, anaesthetists, equipment.
- Staff and patient satisfaction.
- Any other locally agreed audit requirements

Information about cancelled operations can be obtained from the Cancelled Operations Diagnostic Tool available from www.modern.nhs.uk/theatreprogramme/tools

During the pre-operative process, specific clinical data could be collected and audited, eg lifestyle assessment, cognitive assessment, disease specific scores.
3.10 Is the pre-operative assessment service suitable for training?

The pre-operative assessment service should enable training for medical students, nurses, and specialist doctors in training and allied health professionals. A CD-ROM and training manual, commissioned from Southampton University by the Operating Theatre & Pre-operative Assessment Programme, was published in 2002. This will assist multidisciplinary training.

As patients spend less time in hospital prior to surgery, there is less time for training of medical students and pre-registration house officers. It is suggested that medical students, pre-registration house officers, nursing students and anaesthetic trainees should spend dedicated time in the pre-operative assessment service.
Examples of effective practice – pre-operative assessment

A specialist nursing team clinically examines and assesses all emergency patients prior to surgery to ensure patients are as fit as possible. Working with the anaesthetic and surgical teams, the nurse completes further investigations and initiates a treatment and optimisation plan. The patient’s care process is then co-ordinated by the team within existing hospital and theatre capacity. Strategies used include, redistributing cases from emergency to elective theatre schedules, day case emergency surgery, and ‘booking’ parts of the emergency care process. These strategies have resulted in significant operational and clinical improvements in the care delivery for emergency surgical patients, including;

- 50% reduction in cancellation of minor emergency surgery from emergency lists.
- Reduction by half of the admission to surgery time for minor emergency surgery.
- 97% of minor procedures have their emergency operation completed within 24 hours of admission with many not having to stay in as an inpatient.
- Fractured neck of femur, admission to theatre time has halved to 1.6 days, with a reduction in length of stay of 10 days.
- Theatre utilisation risen from 37% to 73%.
- 10% of emergency cases relocated to elective lists (during normal working hours).
- Reduction in ‘out of hours’ operating by 23% with only 12% emergency patients operated on during this time.

Good Hope Hospital NHS Trust, contact Mark Radford, Nurse Consultant in Peri-operative Emergency Care, on 0121 378 2211 ex 1121, email mark.radford@goodhope.nhs.uk

A retrospective audit showed that the waiting times for investigations in the nurse-led orthopaedic clinic were between 2-3 hours. Patients had to walk 820 steps uphill to access these investigations. Funding was arranged for an ECG machine and training granted for phlebotomy services. An agreement was made with our main x-ray department that our pre-assessment patients would access this department which is only 40 steps away from pre-assessment clinic.

North Middlesex University Hospital NHS Trust, contact Ann-Marie Garbutt, Project Nurse on 0208 887 4086, email Ann-Marie.Garbutt@nmh.nhs.uk

Following the introduction of pre-operative assessment for inpatient surgery:

- ‘On the day’ cancellations that could be prevented by pre-operative assessment have reduced from 5% to 2%
- Urology cancellations have fallen from 11% to 5.7%
- In gastro-intestinal/colorectal surgery a very low cancellation rate of 4.3% has been lowered to 1.1% and for several months has been 0%.
- ENT cancellations have fallen from 5.6% to 3.6%
- Gynaecology cancellations have been reduced from 6% to 4.2%
- 4% of all patients pre-operatively assessed have been removed from the waiting list as the procedure is no longer being required, or upon request of the patient.

Doncaster & Bassetlaw Hospitals NHS Trust, contact Ian Boldy Pre-operative Assessment Project Manager, on 01302 381394, email ian.boldy@dbh.nhs.uk
In General Surgery a trial of a one-stop clinic for inpatient pre-operative assessment, immediately after outpatient attendance, has shown:

- 100% attendance for operations.
- 100% patients reported a positive experience from the one-stop clinic.
- 80% patients reported they did not expect this level of input at their outpatient appointment. All said they were really pleased to receive it.
- 80% patients had further investigations completed (in accordance with their diagnosis and general health).
- 100% patients felt prepared for their operation.

Comments include:

“I had a full MOT in clinic, blood tests, heart trace. I thought it was marvellous. I am elderly and it meant I did not have to walk round the hospital to several departments”

“I have been through both systems, I prefer the one-stop system. It was much more efficient.”

“It was nice to see the consultant and then have the information explained again, it helped my understanding.”

“I felt I had enough time for the information to sink in”

“I felt involved in the arranging of my care.”

Southern Derbyshire Acute Hospitals NHS Trust, contact David Ainsworth, Project Manager, on 01332 347141 ext 4183, email david.ainsworth@sdah-tr.trent.nhs.uk

Southern Derbyshire Acute Hospitals NHS Trust, contact Helen Phillips, Clinical Lead in Pre-operative Assessment, on 01332 347141, email helen.phillips@sdah-tr.trent.nhs.uk

Nurse-led pre-operative assessment for trauma patients has reduced pre-operative delay and length of stay for some diagnostic groups. Pre-operative delays for trauma patients were reduced for 11 hours to 6 hours. Length of stay for patients having open reduction and internal fixation has been reduced from 8 days to less than 3 days.

Princess Alexandra Hospital NHS Trust, contact Pam Gurton, Project Manager, on 01279 927393, email pam.Gurton@pah.nhs.uk
Appendix A – 12 key points on consent: the law in England

This summary is taken from www.doh.gov.uk/consent. It cannot cover all situations. For more detail, consult the Reference guide to consent for examination or treatment, available from the NHS Response Line 08701 555 455 and at www.doh.gov.uk/consent

When do health professionals need consent from patients?

1. Before you examine, treat or care for competent adult patients you must obtain their consent.

2. Adults are always assumed to be competent unless demonstrated otherwise. If you have doubts about their competence, the question to ask is: “Can this patient understand and weigh up the information needed to make this decision?” Unexpected decisions do not prove the patient is incompetent, but may indicate a need for further information or explanation.

3. Patients may be competent to make some health care decisions, even if they are not competent to make others.

4. Giving and obtaining consent is usually a process, not a one-off event. Patients can change their minds and withdraw consent at any time. If there is any doubt, you should always check that the patient still consents to your caring for or treating them.

Can children consent for themselves?

5. Before examining, treating or caring for a child, you must also seek consent. Young people aged 16 and 17 are presumed to have the competence to give consent for themselves. Younger children who understand fully what is involved in the proposed procedure can also give consent (although their parents will ideally be involved). In other cases, someone with parental responsibility must give consent on the child’s behalf, unless they cannot be reached in an emergency. If a competent child consents to treatment, a parent cannot override that consent. Legally, a parent can consent if a competent child refuses, but it is likely that taking such a serious step will be rare.

Who is the right person to seek consent?

6. It is always best for the person actually treating the patient to seek the patient’s consent. However, you may seek consent on behalf of colleagues if you are capable of performing the procedure in question, or if you have been specially trained to seek consent for that procedure.

What information should be provided?

7. Patients need sufficient information before they can decide whether to give their consent: for example, information about the benefits and risks of the proposed treatment and alternative treatments. If the patient is not offered as much information as they reasonably need to make their decision, and in a form they can understand, their consent may not be valid.

Is the patient’s consent voluntary?

8. Consent must be given voluntarily: not under any form of duress or undue influence from health professionals, family or friends.
Does it matter how the patient gives consent?

9. No: consent can be written, oral or non-verbal. A signature on a consent form does not itself prove the consent is valid – the point of the form is to record the patient’s decision, and also increasingly the discussions that have taken place. Your Trust or organisation may have a policy setting out when you need to obtain written consent.

Refusals of treatment

10. Competent adult patients are entitled to refuse treatment, even where it would clearly benefit their health. The only exception to this rule is where the treatment is for a mental disorder and the patient is detained under the Mental Health Act 1983. A competent pregnant woman may refuse any treatment, even if this would be detrimental to the foetus.

Adults who are not competent to give consent

11. No-one can give consent on behalf of an incompetent adult. However, you may still treat such a patient if the treatment would be in their best interests. ‘Best interests’ go wider than best medical interests, to include factors such as the wishes and beliefs of the patient when competent, their current wishes, their general well-being and their spiritual and religious welfare. People close to the patient may be able to give you information on some of these factors. Where the patient has never been competent, relatives, carers and friends may be best placed to advise on the patient’s needs and preferences.

12. If an incompetent patient has clearly indicated in the past, while competent, that they would refuse treatment in certain circumstances (an ‘advance refusal’), and those circumstances arise, you must abide by that refusal.
Appendix B – Fasting guidelines

These guidelines are from *Pre-operative Assessment – The Role of the Anaesthetist*, Association of Anaesthetists of Great Britain and Ireland (AAGBI), 2001.

- For safety reasons, patients should not eat or drink prior to anaesthesia.
- The AAGBI recommends the minimum fasting periods based on the American Society of Anaesthesiologists (ASA) guidelines:
  - 6 hours for solid food, infant formula, or other milk.
  - 4 hours for breast milk.
  - 2 hours for clear non-particulate and non-carbonated fluids. (One cup of tea or coffee with small amounts of skimmed/semi skimmed milk is reasonable).
- Each NHS Trust should have agreed written policies.
- The following patients should not be left for long periods without hydration, and may require intravenous fluids prior to surgery:
  - Elderly patients.
  - Patients who have undergone bowel preparation.
  - Sick patients.
  - Children.
  - Breast-feeding mothers.
- The chewing of gum is controversial but the pragmatic approach is to treat it as if it were oral fluid and prohibit for 2 hours pre-operatively. The greatest danger is of a foreign body potentially blocking the airway.
Appendix C – References & links

Anaesthesia & anaesthetic services


Consent and patient information

- Good practice in consent implementation guide: consent to examination or treatment, Department of Health, November 2001, www.doh.gov.uk/consent
- Patient information web site supported by Association of Anaesthetists and Royal College of Anaesthetists www.youranaesthetic.info

Day surgery

- British Association of Day Surgery, www.bads.co.uk
- Day Surgery Follow-up – Progress against indicators from A Short Cut to Better Services, Audit Commission, 2001, www.audit-commission.gov.uk

Operating theatres

Pre-operative assessment

- Guidelines for Pre-operative Investigations. Due to be published by National Institute of Clinical Effectiveness (NICE)
- Handbook of Preoperative Assessment & Management, BJ Sweitzer (ed), 2000, Lippincott Williams & Wilkins, Philadelphia, PA, USA
- NHS Changing Workforce Programme. www.nhs.uk/modernnhs/cwp
- The Pre-registration House Surgeon, Improving Education and Training by Rationalisation of Pre-anaesthetic Assessment and Streamlining Elective Surgical Admissions, Dr J Bem, NHS Executive Northern & Yorkshire, University of Leeds and Department of Postgraduate Medical Education Yorkshire

Bed management

- Audit Commission due to publish a review on bed management in Spring/Summer 2003.
- Emergency Services Collaborative. Due to publish good practice guidance on bed management, in early summer 2003. www.modern.nhs.uk/emergency

Access, Booking and Choice

Appendix D – Acknowledgements

The Operating Theatre & Pre-operative Assessment Programme National Team would like to thank the following organisations and individuals for their contributions to the development of this guidance:

Amanda Bassett and Pam Parry, NHS University
Mr Charles Collins, Royal College of Surgeons
Dr Stephanie Greenwell, Association of Anaesthetists of Great Britain and Ireland
Christobel Hargraves, National Confidential Enquiry into Peri-operative Deaths (NCEPOD)
Mr Graham Layer, Honorary Secretary, Association of Surgeons of Great Britain and Ireland
Dr Gillian Leng, National Institute of Clinical Effectiveness
Julie Pearce, Department of Health
Dr Anna-Maria Rollin, Royal College of Anaesthetists

Members of the Pre-operative Assessment Steering Board for this guidance
Jenny Bramhall, Consultant Nurse, Birmingham Heartlands & Solihull NHS Trust
Mr Joseph Cahill, Consultant Surgeon, Kingston Hospital NHS Trust
Dr Chris Corrigan, GP, Brunswick House Medical Group, Carlisle
Dr Antony Fisher, Consultant Anaesthetist, Kings Healthcare NHS Trust
Mr Sunil Jain, Consultant Orthopaedic Surgeon, Medway NHS Trust
Dr Huw Jones, Consultant Anaesthetist, Birmingham Heartlands & Solihull NHS Trust
Mr Roddy Nash, Consultant Surgeon, Southern Derbyshire Acute Hospitals NHS Trust
Mr Andrew Northeast, Consultant Surgeon, South Buckinghamshire NHS Trust
Johanna Reilly, Project Manager for Pre-operative Assessment, NHS Modernisation Agency
Dr David Sanders, Consultant Anaesthetist, Royal Devon and Exeter NHS Trust
Dr Wendy Scott, Consultant Anaesthetist, Southern Derbyshire Acute Hospitals NHS Trust
Carole Speirs, Project Manager, Kettering General Hospital NHS Trust
Dr Mark Tidmarsh, Consultant Anaesthetist, North Cumbria Acute Hospitals NHS Trust
Dr Jenny Warner, Consultant Anaesthetist, Nottingham City Hospital NHS Trust
Dr Alistair Williamson, Consultant Anaesthetist, Good Hope Hospital NHS Trust

NHS Trust Pre-operative Assessment Services
Doncaster & Bassetlaw Hospitals NHS Trust
Good Hope Hospital NHS Trust
North Middlesex University Hospital NHS Trust
Princess Alexandra Hospital NHS Trust
Southern Derbyshire Acute Hospitals NHS Trust

Pre-operative assessment project pilot sites (see Appendix E)

NHS Modernisation Agency
Elizabeth Bradbury, Associate Director, Emergency Services Collaborative
Jill Copeland, Programme Director, Hospital Improvement Partnership
Dr Valerie Day, Director of External Corporate Affairs, Service Improvement Team
Mr Hugh Rogers, National Clinical Lead, Booking Programme, (Access, Booking & Choice)
Julie Smith, National Programme Manager, Day Surgery Programme
Jackie Younger, Workforce Designer, NHS Changing Workforce Programme
Appendix E – Pre-operative assessment pilot sites

Doncaster & Bassetlaw Hospitals NHS Trust

The current project is building on the considerable work already undertaken by the Trust, which resulted in the development of a standardised approach to pre-operative assessment. This includes generic and specialty-specific guidelines, and covers all surgical specialities, both inpatients and day cases. It will develop a Trust-wide Pre-operative Assessment Coordinator, who will facilitate the development of pre-operative assessment practitioners. This will be linked to the training CD-ROM being developed by Southampton University. The project will look at how the pre-operative service can be further developed, including the involvement of patients.

For further details contact: Ian Boldy, on 01302 381394, fax 01302 553266 or email ian.boldy@dbh.nhs.uk

Hillingdon Hospital NHS Trust

In order to decrease last minute cancellations, orthopaedic patients will be pre-operatively assessed following the decision to operate at the outpatient visit, before they are added to the waiting list. This will allow early identification of medical conditions that need referral to other specialities prior to surgery. It will enable early referral to occupational therapy and physiotherapy and should facilitate earlier discharge. The project aims to improve the patient journey through the development of a knowledge-based computer system to support nurses during pre-operative assessment. This will allow direct referral to a specialist and reduce the delay in achieving fitness for surgery. There will be specialist training for pre-operative assessment nurses in using the software, and patient examinations. This new system will facilitate immediate decision-making using clinical protocols.

For further details contact: Margaret McFarlane, on 01895 238282, ext. 3916 or email margaret.mcfarlane@thh.nhs.uk

Kettering General Hospital NHS Trust

As a pilot site, the Trust lead for pre-operative assessment successfully developed a one-stop nurse led pre-assessment for all day case patients. Since extending the pilot work in February 2002, the Trust has continued to roll out nurse-led pre-operative assessment in a standardised format across the Trust. Specialties covered include orthopaedics, general surgery, gynaecology and ENT – for both day cases and inpatients. Current developments include the design of a training programme for all pre-operative assessment nurses in the Trust, and extension of pre-operative assessment clinics from the Trust's main site to peripheral community clinics. The project is also looking at introducing anaesthetic-led clinics for the complex patient.

For further details contact: Carole Speirs, on 01536 493605, fax 01536 493357 or email carole.speirs@kgh.nhs.uk

County Durham & Darlington Acute NHS Trust

The project includes all new additions to the waiting list in plastic surgery and orthopaedics. It aims to redesign the clinical processes to include pre-operative screening following the decision to admit. A baseline measurement of Body Mass Index (BMI) and lifestyle assessment is undertaken. This pre-screening assessment alerts staff to those patients who may not be fit for surgery and may require a pre-operative treatment plan. It also identifies those patients who do not need to be brought back for a second full assessment, prior to admission. In this group, a telephone assessment is carried out approximately 2-4 weeks
before surgery, to confirm the health of the patient and also that the patient still wants the
surgery. Patients requiring a local anaesthetic also benefit from this process.

For further details contact: Val Elliott, on 0191 333 2122, or email
valerie.elliott@ndhcnt.northy.nhs.uk

North Cumbria Acute Hospitals NHS Trust

This is a collaborative project involving hospital, primary care, and social services. The
project has created a centralised nurse-led Pre-operative Assessment Unit that provides
standardised pre-operative assessment using a computerised assessment tool. Both day
case and inpatients are seen in the unit directly from the surgical clinic. The computerised
system automatically generates relevant paperwork such as correspondence, referrals and
clinical summaries. The unit has a resident social worker and is co-ordinated by an
anaesthetist who conducts clinics twice per week in the department. There is a named
community pre-operative assessment contact in each GP surgery, and information systems
are being developed to allow for efficient community follow-up, supporting the 'direct
assessment approach'.

For further details contact: Dr Mark Tidmarsh, on 01228 523444 ext 4312, or email
mark.tidmarsh@ncumbria-acute.nhs.uk

Salisbury Health Care NHS Trust

This project will explore methods of pre-operative assessment for patients accessing inpatient
regional services who would have to travel a long distance for assessment. It will look at ways
of improving current pre-operative assessment for inpatients by working with other
modernisation projects such as the Booking Programme, Orthopaedic Collaborative and the
Cancer Collaborative. Access to information, and the content of the information provided to
the patient will be improved. The project aims to link with an Integrated Clinical Information
Database (ICID) to provide electronic access for patients and health care professionals across
the entire health community. ICID is a collaborative multi-professional tool, which is
established, and being further developed to enable the patient or primary healthcare
professionals to access information about the Trust. Referral of patients for treatment or
assessment documentation to improve the patient’s preparation for surgery will be included.
The project will explore further the development of procedure specific integrated pathways and
generic pathways, reviewing the requirement for investigations and tests as part of this
process.

For further details contact: Mandy Cripps on 01722 336262 ext. 4265, or email
mandy.cripps@salisbury.nhs.uk

South Devon Healthcare NHS Trust

This project will focus on improving the prediction of risk of an operation for individual patients.
A more accurate assessment of risk will enable resources to be used effectively. It will also
evaluate whether the commonly used pre-operative clinical tests, eg bloods, ECG, urinalysis,
lead to measurable changes in patient outcome. A pre-operative assessment research nurse
has been appointed to audit the ongoing developments made within the service. The aim is to
determine the optimum time between pre-operative assessment and surgery, and for how long
the pre-operative assessment is valid.

For further details contact: Dr John Carlisle, email carlislejohn@hotmail.com
# Appendix F – National Team Contact List

**Operating Theatre & Pre-operative Assessment Programme National Team**

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