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Action on Smoking and Health	General	General	In general, quitting smoking improves the outcomes of surgical interventions. Not only is the effectiveness of the surgery improved, the costs of surgery are reduced as recovery time is faster and patients need less time in hospital after the surgery. Quitting isn't straightforward, and patients need access to evidence based smoking cessation programs. *1. Moore S, Mills BB, Moore RD, et al. Perisurgical smoking cessation and reduction of postoperative complications. American Journal of Obstetric Gynaecology 2005; 192: 1718-21.* *2. van Domburg RT, Meeter K, van Berkel DFM. et al. Smoking cessation reduces mortality after coronary artery bypass surgery: a 20 year follow-up study. Journal American College of Cardiology 2000; 36 (3): 878-883.* *3. Szatkowski L, Murray R, Hubbard R, et al. Prevalence of smoking among patients treated in NHS hospitals in England: a national audit. Thorax 2015; 70 (5): 498-500* *4. ASH. Ready Reckoner, 2016.* *London Health Observatory. Stop before the op. LHO and SmokeFree London. 2006* *5. A summary of the health impact of smoking and the short-term benefits of pre-operative smoking cessation in Wales. Welsh Government. Last updated Feb. 2009.*	Thank you for your comment. We agree that people should be in the best health possible before surgery to aim for the best surgical outcome and in the scope section outlining the key areas to be covered pre-operative optimisation is included. There are other NICE guidelines that address lifestyle modification interventions (for example Smoking: acute, maternity and mental health services (2013) NICE guidance PH48) and we will cross refer to the appropriate guidelines ensuring clinicians and patients using this guideline have access to this information.
Action on Smoking and Health	3	75-76	We recommend including information on the benefits of stopping smoking. Not only should patients be aware of the risk of smoking, but their families and carers should as well. *ASH, RCSEd, RCS, RCP, RCGP, RCoA, FPH. Joint briefing: Smoking and surgery. April 2016.*	Thank you for your comment. We agree that people should be in the best health possible before surgery to aim for the best surgical outcome. There are other NICE guidelines that address lifestyle modification interventions (for example Smoking: acute, maternity and mental health services (2013) NICE guidance PH48) and we will cross refer to the appropriate guidelines ensuring clinicians and patients using this guideline have access to this information.
Action on Smoking and Health	3	78-79	Smoking is a large risk factor for surgical complication and should be considered when measuring risk. *ASH, RCSEd, RCS, RCP, RCGP, RCoA, FPH. Joint briefing: Smoking and surgery. April 2016.*	Thank you for your comment. The identification and measurement of risk in adults undergoing surgery has been included in the scope. The draft review questions include a question on validated risk tools. We will bring the detail of your comment to the committee's attention. The information will be used to inform the committee's decision making as they develop the review protocols throughout the guideline to guide the searches for the review of the evidence. All evidence that meets the criteria set out by the committee in the protocol will be considered.
Action on Smoking and Health	4	86	Smokers are more likely to suffer a range of complications before, during, and after surgery, and so this must be taken into account when considering lifestyle optimisation. *Theadom A, Cropley M. Effects of preoperative smoking cessation on the incidence and risk of intraoperative and postoperative complications in adult smokers: a systematic review. Tobacco Control 2006; 15: 352–8*	Thank you for your comment. We agree that people should be in the best health possible before surgery to aim for the best surgical outcome. In the scope section outlining the key areas to be covered pre-operative optimisation is included. There are other NICE guidelines that address lifestyle modification interventions (for example Smoking: acute, maternity and mental health services (2013) NICE guidance PH48) and we will cross refer to the appropriate guidelines ensuring clinicians and patients using this guideline have access to this information.
Action on Smoking and Health	4	96	Smoking can hinder recovery from surgery. We recommend that smoking cessation programs be incorporated into this section on recovery.	Thank you for your comment. We agree that lifestyle modification is important to enable people to have the best health possible. There are other NICE guidelines that address lifestyle modification interventions (for example Smoking: acute,

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			Moore S, Mills BB, Moore RD, et al. Perisurgical smoking cessation and reduction of postoperative complications. American Journal of Obstetric Gynaecology 2005; 192: 1718-21.	maternity and mental health services (2013) NICE guidance PH48) and we will cross refer to appropriate guidelines ensuring clinicians and patients using this guideline have access to this information.
Action on Smoking and Health	7	174-175	Reword the question to: "Do pre-operative lifestyle interventions help improve surgical outcomes?"	Thank you for your comment. We have taken into account the discussion from the stakeholder meeting and the comments from this consultation and have discussed in detail the topics to be included in the scope. On reflection this draft question has been removed as there are other NICE guidelines that address lifestyle modification interventions (for example Smoking: acute, maternity and mental health services (2013) NICE guidance PH48) and we will cross refer to the appropriate guidelines ensuring clinicians and patients using this guideline have access to this information.
Action on Smoking and Health	7	200	Smokers are 38% more likely to die after surgery. We recommend the risk that smoking has on survival rates is discussed. *Turan A, Mascha EJ, Roberman D, et al. Smoking and perioperative outcomes Anaesthesiology 2011; 14*	Thank you for your comment. Smoking will be considered in the preoperative risk assessment section of the scope. If the evidence fits the agreed protocol developed by the committee it will be included.
Action on Smoking and Health	7	201	Smoking contributes to complications during and after surgery. We recommend making such risk of complications prominent. *ASH, RCSEd, RCS, RCP, RCGP, RCoA, FPH. Joint briefing: Smoking and surgery. April 2016.*	Thank you for your comment. Smoking will be considered in the preoperative risk assessment section of the scope.
Action on Smoking and Health	8	202	Following surgery, smokers have higher risks of post-operative infection, and smoking impairs wound healing. We recommend making such risks prominent. 1. Jorgensen LN, Kallchave F, Christensen E, et al. Less collagen production in smokers. Surgery 1998; 123:450–5. 2. Jones RM. Smoking before surgery: the case for stopping. BMJ 1985; 290: 1763-1764. 10. 3. Sørensen LT, Horby J, Friis E. et al Smoking as a risk factor for wound healing and infection in breast cancer surgery. European Journal of Surgical Oncology 2002; 28 (8): 815-820. DOI: 10.1053/ejso.2002.1308 4. Jones JK, Triplett RG. The relationship of cigarette smoking to impaired intraoral wound healing: a review of evidence and implications for patient care. J Oral Maxillofac Surg 1992; 50: 237-9. 5. Sørensen LT. Wound healing and infection in surgery: the clinical impact of smoking and smoking cessation: a systematic review and met-analysis. Arch Surg. 2012; 147 (4): 373-383	Thank you for your comment. Smoking will be considered in the preoperative risk assessment section of the scope. If the evidence fits the agreed protocol it will be included.
Action on Smoking and Health	8	205 -206	Following surgery, smokers are more likely to be admitted to an intensive care unit and require longer hospital stays. We recommend making such risks prominent.	Thank you for your comment. Smoking will be considered in the preoperative risk assessment section of the scope. If the evidence fits the agreed protocol developed by the committee it will be included.

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			1. NICE Guidelines (PH48) Smoking: acute, maternity and mental health services. 2013. *2. Møller AM, Maaloe R, Pedersen T. Post-operative intensive care admittance: the role of tobacco smoking. Acta Anaesthesiol Scand 2001; 45: 345-8.*	
Association of Paediatric Anaesthetists of Great Britain and Ireland	General	General	We are disappointed that this guideline is restricted to adults, though appreciate that the driving forces for pre-assessment and peri-operative care in the adult population are very different to children. Children's surgery can, for the large part, take place as a day case or as a day of surgery admission for inpatient work provided that appropriate pre-assessment has taken place. In addition there are huge advantages in keeping children and parents out of hospital for a long as possible perioperatively just for psychological and social reasons. Pre-assessment allows clinical assessment, familiarisation with the environment for both parents and children and peri-operative preparation for surgery and anaesthesia in advance of admission and is paramount for the delivery of a safe, high quality service. It is a shame that this is only provided in an ad-hoc fashion around the UK. National guidance from a body such as NICE would be ideally placed to drive this agenda forwards. We hope that NICE reconsiders and at some stage in the not too distant future a dedicated guideline for children's pre-assessment is considered.	Thank you for your comment. We have discussed in detail whether the perioperative care of children should be included in the scope. The perioperative care of children is significantly different to that of adults and to extend the scope to include children would require additional evidence reviews and expertise. It is important the final scope is a size that is practical to produce and the final guideline is timely. Most stakeholders did not identify this as a priority for this guidance. Taking these issues into consideration we will not address the specific management of children and as such have made no change to the scope.
British Acupuncture Council	7	188-189	The only question declared in the scope in respect of postoperative management is whether or not to use a dedicated pain management service. I'm sure that this is an important question but please explain why there is no consideration of what tools should be available to such a service (or equally to a non-dedicated service). For example, in the current 'opioid crisis' climate how much emphasis will be placed on non-pharmacological approaches? Acupuncture appears to be as good as anything in this respect, and may deliver some measure of pain control while also reducing opioid use (e.g. Tedesco et al, 2017), so will it be an available option?	Thank you for your comment. We agree that pain management is a major topic. We have taken into account the discussions on pain in the stakeholder meeting and the comments from this consultation and discussed in detail the areas of pain management to be included in the scope. It is important that the clinical management of pain is clearly set out before the service delivery needs can be evaluated. As a result the management of acute post-operative pain has been identified as an important area to focus on. This will support clinicians to identify the best pain management strategies. We will bring the detail of your comment to the committee's attention. The information will be used to inform the committee's decision making as they develop the review protocols that guide the searches for the review of the evidence.
British Pain Society	General	General	A consultation within the BPS by the Acute Pain Special Interest Group was undertaken. Respondents were concerned to ensure that pain management, which is a major topic on its own, receives enough consideration within this guideline. There was a strong view that pain management should be seen as a perioperative rather than postoperative service. Acute pain services currently undertake assessment of complex pain patients preoperatively, plan and execute individualised intra-operative analgesia, implement opioid-sparing procedure specific multimodal analgesic approaches postoperatively and give	Thank you for your comment. We agree that pain management is a major topic. We have taken into account the discussions on pain in the stakeholder meeting and the comments from this consultation and discussed in detail the areas of pain management to be included in the scope. It is important that the clinical management of pain is clearly set out before the service delivery needs can be evaluated. As a result the management of acute post-operative pain has been identified as an important area to focus on. We agree that pain management is important throughout the patient's journey and we will bring the detail of your comment to the committee's attention. The information will be used to inform the

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			instructions in relation to opioid and analgesic reduction post discharge with follow-up, particularly for those patients felt to be at risk of persistent postoperative pain An overarching question might be: What is the clinical effectiveness of a dedicated acute pain service involved throughout the patient's journey? Work such as that from the Toronto transitional pain service (Katz et al 2015) and from the US veteran's pain task force would offer some insight.	committee's decision making as they develop the review protocols that guide the searches for the review of the evidence.
British Pain Society	General	General	If consideration is given to the areas identified by NICE the following might be helpful: **Information and support** – Good practice evident in some enhanced recovery after surgery (ERAS) areas – involvement of acute pain services in joint schools/rapid recovery preop information days. **Preoperative assessment** – Include use of risk tools for identifying patients at risk of persistent postoperative pain e.g. those who are taking high dose opioid analgesics preoperatively; those with psychological distress and pain issues. Does preop psychological distress impact on postop pain? **Preoperative optimisation** – In patients taking high-dose opioids does reducing this preoperatively improve postop pain outcomes? Does treating preoperative psychological distress improve postop pain outcomes? **Intraoperative management** – ensuring the use of individualised multi-modal analgesia; use of atypical agents (eg IV lidocaine for analgesia and reduced ileus); reducing peripheral and central sensitisation linked to persistent postop pain (eg ketamine). **Postoperative management** – What is the make up of an effective postoperative acute pain service? What are the outcome measures – will pain scores be included, will there be a functional measure around mobility? What about the management of pain in complex trauma / major specialist surgery / day surgery? Should psychological services be available for complex patients or those with preexisting psychological distress? **Recovery** – pain management is central to ERAS achieving its aims. Also the involvement of acute pain services in the follow up of complex pain patients and working with primary care to advise regarding appropriate use of opioids.	Thank you for your comment. We have taken into account the discussions on pain in the stakeholder meeting and the comments from this consultation and discussed in detail the areas of pain management to be included in the scope. It is important that the clinical management of pain is clearly set out before the service delivery needs can be evaluated. As a result the management of acute post-operative pain has been identified as an important area to focus on. We agree that pain management is important throughout the patient's journey and we will bring the detail of your comment to the committee's attention. The information will be used to inform the committee's decision making as they develop the review protocols throughout the guideline to guide the searches for the review of the evidence.
Deltex Medical	2	36	Deltex Medical believes it is important that the guideline defines adverse postoperative outcomes, identifies their frequency, their causes and their consequences. Consequences should separate short and long term harm to patients, immediate costs to the NHS of treating complications and the QALY impact of reduced post-operative survival.	Thank you for your comment. Outcomes specific to each review protocol are discussed with the committee, and we agree it is important to understand their frequency, severity, and long term impact to allow appropriate economic considerations on costs and quality of life.

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			Evidence suggests that around one in four patients undergoing major surgery suffers a post-operative complication and that over half of these are avoidable through evidence based intra-operative haemodynamic monitoring and management. The purpose of advanced haemodynamic monitoring is both to identify patients undergoing periods of haemodynamic harm and to guide interventions to bring them back into safer states. The immediate additional cost to the NHS of treating such avoidable haemodynamic harm associated complications averages around £8,000 for each patient, meaning the NHS is spending about £1,000 on average per patient undergoing major surgery. The post-operative survival of patients suffering complications is reduced by an average of seven or more years, suggesting an opportunity QALY cost of c£175,000 for each patient suffering post-operative complications.	
Deltex Medical	4	89	Deltex Medical believes the scope should be extended to include haemodynamic interventions other than intravenous fluid during surgery: use of inotropes, vaso-dilators and vaso-pressors. Used appropriately these interventions can protect patients from adverse post-operative events, but, equally, inappropriate use can cause avoidable harm.	Thank you for your comment. We have taken into account the discussion from the stakeholder meeting and the comments from this consultation and have discussed in detail the topics to be included in the scope. It is not possible to include all topics that stakeholders request in the scope. It is important that we have a scope that provides the outline for a guideline that will be timely and useful for clinicians and patients. Reflecting on the number of comments and the strength of the discussion from stakeholders and experts we have decided that haemodynamic monitoring will not be added to the key areas to be considered.
Deltex Medical	4	90	The term "cardiac monitoring" should be defined. Does is mean "cardiac output monitoring?". If it does include cardiac output monitoring then the guideline should evaluate the variation in outcomes associated both with different haemodynamic management strategies and different haemodynamic monitoring technologies. Deltex Medical believes it would be clearer to use a term such as "advanced haemodynamic monitoring" in preference to "cardiac output monitors": cardiac output monitors are focused conceptually on blood flow, whereas haemodynamics covers each of blood flow, pressure and resistance. Deltex Medical notes that harm caused by periods of hypo-tension under anaesthesia is, similar to hypo- and hyper-volaemia, becoming a 'hot' topic in anaesthesia as 'Big Data' studies that highlight the prevalence of related adverse post-operative events.	Thank you for your comment. This has now been amended to 'non-invasive cardiac output monitoring' for clarity.
Deltex Medical	4	93	Deltex Medical believes the scope should specifically address post-operative haemodynamic management as a distinct subject to intra-operative haemodynamic management. What, if anything, should be done in the various levels of post operative care from intensive care to general ward?	Thank you for your comment. We have taken into account the discussion from the stakeholder meeting and the comments from this consultation and have discussed in detail the topics to be included in the scope. It is not possible to include all topics that stakeholders request in the scope. It is important that we have a scope that provides the outline for a guideline that will be timely and useful for clinicians and patients. Reflecting on the number of comments and the

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				strength of the discussion from stakeholders and experts we have decided that haemodynamic monitoring will not be added to the key areas to be considered.
Deltex Medical	5	123	Deltex Medical notes that the scope identifies MTG3 as NICE guidance to be "partially" updated in this guideline whereas the recent potential review of MTG3 led to the statement "NICE has reviewed this guidance and will update MTG3 within the perioperative care guideline. Once this guideline has published, MTG3 will be withdrawn." These two positions are inconsistent and should be clarified. Deltex Medical believes that the clinical and economic evidence supporting oesophageal Doppler monitoring ('ODM') use to guide protective intravenous fluid management strategies during surgery is sufficiently strong to merit stand-alone guidance as well as incorporation within this broader clinical guideline and that MTG3 should be updated in its own right.	Thank you for your comment. MTG3 Cardiac monitoring devices will be withdrawn once this new guideline has published. This has been clarified in the scope. Following a review of MTG3 the decision was made to update MTG3 as a part of this guideline, in line with an analysis of all of the comments submitted during the review process.
Deltex Medical	7	182	Deltex Medical believes the question as drafted is too broad and may lead to avoidable confusion and controversy. Deltex Medical recommends re-phrasing the question to be consistent with that re fluids (p 7, line 178) and to address a number of related but separate key questions: 1."What is the most clinically and cost effective advanced haemodynamic monitoring technology to guide protective intravenous fluid management strategies during surgery in adults?" 2."What is the most clinically and cost effective protective intravenous fluid management strategy during surgery in adults? Which patients are at sufficiently high risk of postoperative harm associated with periods of intra-operative haemodynamic compromise for such a protective strategy to be initiated from the start of surgery?" 3."What factors should determine appropriate levels of advanced haemodynamic monitoring in those patients assessed at moderate risk of postoperative harm associated with periods of intra-operative haemodynamic compromise to enable appropriate interventions in response to markers of haemodynamic compromise?" 4."What is the most clinically and cost effective advanced haemodynamic monitoring technology to identify the impact of interventions during surgery with inotropes and vaso-active drugs?" Deltex Medical also believes that that scope should specifically address the challenges of haemodynamic management in laparoscopic as opposed to or bundled with open surgery cases: this is an area where there is wide variation in clinical practice.	Thank you for your comment. The question had been rephrased to, 'What is the clinical and cost effectiveness of non-invasive cardiac output monitoring during surgery in adults?'.This clarifies the question in line with the scope area and the update of MTG3. We have taken into account the discussion from the stakeholder meeting and the comments from this consultation and have discussed in detail the topics to be included in the scope. It is not possible to include all topics that stakeholders request in the scope. It is important that we have a scope that will provide the outline for a guideline that will be timely and useful for clinicians and patients. Reflecting on the number of comments and the strength of the discussion from stakeholders and experts we have decided that haemodynamic monitoring will not be added to the key areas to be considered.
Deltex Medical	7	199, 205	It is unclear the extent to which MTG3 on CardioQ-ODM is to be updated based on a QALY economic evaluation or a cost consequence evaluation, or both.	Thank you for your comment. As with all NICE clinical guidelines economic evaluation will be carried out on a QALY basis. However, economic priorities are discussed with the committee for

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				the guideline as a whole and areas prioritised for modelling are based on factors like availability of existing economic evidence, cost impact, and ability to reduce uncertainty via modelling,
Deltex Medical	8	202, 203	In addition to surgical site infection and respiratory complications, Deltex Medical believes the scope should also specifically address acute kidney injury and postoperative myocardial injury which are frequent, dangerous and expensive adverse postoperative events.	Thank you for your comment. Acute kidney injury and postoperative myocardial injury have now been added to the list of adverse events and complications in the main outcomes.
Department of Health	General	General	I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.	Thank you for your comment.
Edwards Lifesciences Ltd	Consultation question 1	General	Q1 – No Comment	Thank you for your comment.
Edwards Lifesciences Ltd	Consultation Question 2	General	Q2 - No we think the scope for this guideline should only consider adults	Thank you for your comment.
Edwards Lifesciences Ltd	4	87-91	Intraoperative Management: Please add: Haemodynamic Monitoring	Thank you for your comment. We have taken into account the discussion from the stakeholder meeting and the comments from this consultation and have discussed in detail the topics to be included in the scope. It is not possible to include all topics that stakeholders request in the scope. It is important that we have a scope that provides the outline for a guideline that will be timely and useful for clinicians and patients. Reflecting on the number of comments and the strength of the discussion from stakeholders and experts, we have decided that haemodynamic monitoring will not be added to the key areas to be considered.
Edwards Lifesciences Ltd	4	87	The scope should include Intensive Care Unit Management as a main area amongst the three areas as it is as important as the others in the sequence of perioperative care	Thank you for your comment. Intensive care will be considered in the context of post-operative recovery but it is acknowledged that the management of the post-operative recovery starts at the beginning of the patient's journey and this will be taken into account when the committee considers this area.
Edwards Lifesciences Ltd	4	103	Please clarify: "other specific types of surgery"	Thank you for your comment. Other specific types of surgery refer to specific procedures, for example, caesarean section. The guideline is unable to include all types of surgery and to provide this level of detail about different conditions and procedures in the recommendations.
Edwards Lifesciences Ltd	5	122	Please ensure all monitor types currently used in the NHS are included	Thank you for your comment. This is related NICE guidance. Evidence for any non-invasive cardiac output monitor will be considered in this guideline if they are evaluated in studies that meet the inclusion criteria in the review protocols.
Edwards Lifesciences Ltd	7	187-189	Postoperative Management: Certain types of monitoring may continue into this area	Thank you for your comment. We agree that certain types of non-invasive cardiac monitoring may continue postoperatively, however after taking into account the discussion from the stakeholder meeting and the comments from this consultation we have decided that this is not an area of high priority for review and will not be included in the scope. It is not possible to include all topics that stakeholders request in the scope. It is important that we have a scope that provides the outline for a guideline that will be timely and useful for clinicians and patients.
Edwards Lifesciences Ltd	7	182-183	Include Clinical & Cost Effectiveness of Haemodynamic Monitoring	Thank you for your comment. We have taken into account the discussion from the stakeholder meeting and the comments from this consultation and have discussed in detail the topics to be included in the scope. It is not possible to include all topics that stakeholders request in the scope. It is important that we

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				have a scope that provides the outline for a guideline that will be timely and useful for clinicians and patients. Reflecting on the number of comments and the strength of the discussion from stakeholders and experts we have decided that haemodynamic monitoring will not be added to the key areas to be considered.
Edwards Lifesciences Ltd	7	186	Include ICU Management section	Thank you for your comment. Evidence for the clinical and cost effectiveness of postoperative recovery in specialist areas, including intensive care will be reviewed. This question is in the 'recovery' section of the scope.
Faculty of Pain Medicine of the Royal College of Anaesthetists	General	General	'The Transitional Pain service' Katz et al 2015 Journal of Pain Research and Clinical Journal of Pain needs to be considered. Although not yet employed in the UK, it will be in the future.	Thank you for your comment. We have taken into account the discussions on pain in the stakeholder meeting and the comments from this consultation and discussed in detail the areas of pain management to be included in the scope. It is important that the clinical management of pain is clearly set out before the service delivery needs can be evaluated. As a result the management of acute post-operative pain has been identified as an important area to focus on. We agree that pain management is important throughout the patient's journey and we will bring the detail of your comment to the committee's attention. The information will be used to inform the committee's decision making as they develop the review protocols throughout the guideline to guide the searches for the review of the evidence.
Faculty of Pain Medicine of the Royal College of Anaesthetists	General	General	Pain medicine supports perioperative medicine and will allow enhanced recovery after surgery (ERAS) programmes to achieve their goals in a higher proportion of patients. This involvement begins with discussions around the decision to operate and ends with full functional recovery (or not) in post discharge period.	Thank you for your comment. We have taken into account the discussions on pain in the stakeholder meeting and the comments from this consultation and discussed in detail the areas of pain management to be included in the scope. It is important that the clinical management of pain is clearly set out before the service delivery needs can be evaluated. As a result the management of acute post-operative pain has been identified as an important area to focus on. We agree that pain management is important throughout the patient's journey and we will bring the detail of your comment to the committee's attention. The information will be used to inform the committee's decision making as they develop the review protocols throughout the guideline to guide the searches for the review of the evidence.
Faculty of Pain Medicine of the Royal College of Anaesthetists	General	General	Procedures and risks should be fully explained to the patient. They should be informed of how they may feel after the treatment and about recovery.	Thank you for your comment. In the key areas that will be covered and in the associated draft question the information and support needs of adults undergoing surgery and their families and carers will be considered before, during and after surgery.
Faculty of Pain Medicine of the Royal College of Anaesthetists	General	General	Concerned if there is not a pain specialist in the committee to work on issues such as the clinical and cost effectiveness of acute pain services.	Thank you for your comment. We have advertised for this role and will be interviewing the applicants for membership on the committee.
Faculty of Pain Medicine of the Royal College of Anaesthetists	General	General	Neither acute nor chronic pain after surgery is an outcome measure of interest	Thank you for your comment. Pain has now been added to the list of main outcomes.

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Faculty of Pain Medicine of the Royal College of Anaesthetists	General	General	Pain affecting other outcomes such as mobility, discharge, chest function etc have not been eluded to in the document	Thank you for your comment. The importance of pain management has been acknowledged in the scope. The information in the scope is limited to an overview of the area and does not aim to include all clinical scenarios.
Faculty of Pain Medicine of the Royal College of Anaesthetists	General	General	Pain and potential risk of long term pain should be factored in.	Thank you for your comment. Pain has been added to the list of main outcomes and will be evaluated in the identified evidence if it meets the review protocol criteria set out by the committee.
Faculty of Pain Medicine of the Royal College of Anaesthetists	General	General	Early mobilisation and diet are key to enhanced recovery and reduced length of stay. Effective (facilitating mobilisation/reducing stress response) and low impact (motor block/nausea and vomiting) pain management are fundamental, working alongside physical and occupational therapy. For example, effective pain management post oesophagectomy can have a significant impact on morbidity and mortality.	Thank you for your comment. We will bring your comments on pain management and enhanced recovery to the attention of the committee. The committee will develop the review questions and the protocols that guide the searches for the review of the evidence. All evidence that meets the criteria set out by the committee in the protocol will be considered.
Faculty of Pain Medicine of the Royal College of Anaesthetists	General	General	The Acute Pain Group for Guidelines for the Provision of Anaesthetic Services (GPAS) is carrying out the same NICE accredited data trawl to come up with the same recommendations resulting in a duplication of work.	Thank you for your comment.
Faculty of Pain Medicine of the Royal College of Anaesthetists	3	80	There should be consideration for preoperative pain management as a separate heading.	Thank you for your comment. We have taken into account the discussions on pain in the stakeholder meeting and the comments from this consultation and discussed in detail the areas of pain management to be included in the scope. As a result the management of acute post-operative pain has been identified as an important area to focus on and most appropriately placed in the post-operative section of the guideline. However we agree that pain management is not easily categorised in this way and is important throughout the patient's journey. We will bring the detail of your comment to the committee's attention. The information will be used to inform the committee's decision making as they develop the review protocols throughout the guideline to guide the searches for the review of the evidence.
Faculty of Pain Medicine of the Royal College of Anaesthetists	4	93	Post-operative pain management is one of 6 key areas to be addressed. We are unsure if a pain management expert with experience in both acute and chronic pain forms part of the committee or advised on the draft document and we feel that it is important that they are.	Thank you for your comment. We have advertised for this role and will be interviewing the applicants for membership on the committee.
Faculty of Pain Medicine of the Royal College of Anaesthetists	6	159	Areas that should be covered: -Education regarding expected acute and chronic pain outcome -Assessment of risks including risks of severe acute or persistent pain-pharmacological and psychological -Pharmacological management including reducing opioid intake -Psychological management	Thank you for your comment. Evidence for education regarding expected pain outcome will be included in the review of information and support needs before during and after surgery if it fits the review protocol developed by the committee. The identification and measurement of risk in adults who will be undergoing surgery is included in the key areas to be covered. We will make the committee aware of your comment when they are considering the protocol for this question. Reflecting on the number of comments and the strength of the discussion from stakeholders and experts we have decided that specific topics of

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				pharmacological management will be included in the key areas to be considered. Anaemia management and the management of anti-coagulation medication were considered important topics to address and have been added to the scope as a key area for review. The management of acute post-operative pain is included in the scope and we will bring your comment about opioids to the committee's attention. The information will be used to inform the committee's decision making as they develop the review protocols that guide the searches for the review of the evidence. We have taken into account the discussion from the stakeholder meeting and the comments from this consultation and have discussed in detail the topics to be included in the scope. It is not possible to include all topics that stakeholders request in the scope. It is important that we have a scope that provides the outline for a guideline that will be timely and useful for clinicians and patients. Reflecting on the number of comments and the strength of the discussion from stakeholders and experts we have decided that psychological management will not be added to the key areas to be considered.
Faculty of Pain Medicine of the Royal College of Anaesthetists	7	177	Areas that should be covered: -Using opioid sparing multimodal analgesia, optimised as above for individual patients -Attention to atypical agents which may improve recovery in a variety of ways e.g. IV lidocaine for analgesia and ileus. -Attention to reducing peripheral and Central sensitisation (NSAIDs and ketamine etc)	Thank you for your comment. We agree that pain management is a major topic. We have taken into account the discussions on pain in the stakeholder meeting and the comments from this consultation and discussed in detail the areas of pain management to be included in the scope. It is important that the clinical management of pain is clearly set out before the service delivery needs can be evaluated. As a result the management of acute post-operative pain has been identified as an important area to focus on. This will support clinicians to identify the best pain management strategies. We will bring the detail of your comment to the committee's attention. The information will be used to inform the committee's decision making as they develop the review protocols that guide the searches for the review of the evidence.
Faculty of Pain Medicine of the Royal College of Anaesthetists	7	187	Areas that should be covered: -Opioid tapering instructions -Telephone follow up on high risk patients	Thank you for your comment. We have taken into account the discussion from the stakeholder meeting and the comments from this consultation and have discussed in detail the topics to be included in the scope. It is not possible to include all topics that stakeholders request in the scope. It is important that we have a scope that provides the outline for a guideline that will be timely and useful for clinicians and patients. We have taken into account the discussions on pain in the stakeholder meeting and the comments from this consultation and discussed in detail the areas of

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				pain management to be included in the scope. It is important that the clinical management of pain is clearly set out before the service delivery needs can be evaluated. As a result the management of acute post-operative pain has been identified as an important area to focus on. This will support clinicians to identify the best pain management strategies. We will bring the detail of your comment to the committee's attention. The information will be used to inform the committee's decision making as they develop the review protocols that guide the searches for the review of the evidence.
Royal College of Anaesthetists and Association of Anaesthetists of Great Britain and Ireland	General	General	While supportive of the Department of Health and NICE's ambition to develop guidance in perioperative care, we are concerned that the guideline document as currently proposed is too large in scope for it to be useful and meaningful for healthcare professionals working in this emerging discipline.	Thank you for your comment. We have taken into account discussion from the stakeholder meeting and the comments from this consultation and discussed in detail the topics to be included in the scope. Taking this and expert advice into account we believe the scope will provide a guideline that will be timely and of value for clinicians and patients.
Royal College of Anaesthetists and Association of Anaesthetists of Great Britain and Ireland	General	General	Perioperative medicine covers patient care from the moment of contemplation of surgery to full functional recovery and encompasses predominantly medical care of all surgical patients, elective and emergency.	Thank you for your comment. For the purpose of this guideline, the perioperative period is defined as the time of booking for surgery to the time of discharge from care following surgery. These time points were chosen to ensure that the guideline is sufficiently focused and the final scope is a size that is practical to produce and of value for clinicians and patients.
Royal College of Anaesthetists and Association of Anaesthetists of Great Britain and Ireland	General	General	The perioperative care of surgical patients is a previously under-investigated topic of NICE Guidelines. Guidelines already exist for preoperative investigations. However, the list of perioperative care guidelines that would need to be produced to cover the discipline adequately would run into numerous separate areas, evidence for which can be derived from anaesthesia and all other medical specialties. Example areas include: • Diagnostic use of cardiopulmonary exercise testing and biomarkers before surgery • The use of risk stratification calculators and other methodology to determine perioperative risk. • The use of decision aids and shared decision-making discussions to make informed patient choice decisions. • Optimisation of medical comorbidities: Preoperative management of diabetes, atrial fibrillation, hypertension, heart failure etc. These could prove extensive in their own right e.g. the American guidelines for investigation of cardiac disease before non-cardiac surgery runs to 117 pages and has 490 references. • There are enhanced recovery guidelines for all the surgical specialties that encompass perioperative care on the Enhanced Recovery After Surgery Society UK (ERASUK) website. • Lifestyle factors including cessation of smoking and reduction in alcohol before surgery.	Thank you for your comment. We have taken into account discussion from the stakeholder meeting and the comments from this consultation and discussed in detail the topics to be included in the scope. Taking this and expert advice into account we believe the scope provides the outline for a guideline that will be timely and useful for clinicians and patients. The following examples from your list; risk assessment prior to surgery, patient information and support, enhanced recovery, anaemia, frailty and the perioperative optimisation of older people, have been included in the scope. There are other NICE guidelines that address lifestyle modification interventions (for example Smoking: acute, maternity and mental health services (2013) NICE guidance PH48) and we will cross refer here to appropriate guidelines ensuring clinicians and patients using this guideline have access to this information. The management of specific types of surgery (for example, caesarean section) has been excluded from the scope.

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			• The prehabilitative use of exercise and activity training before surgery. • Reversible components of illness before surgery: Anaemia, Shared Decision Making, Surgical Consent. • Optimisation of process and patient related to surgical type: Management of patients undergoing cesarean section; analgesic management of patients undergoing colorectal surgery with enhanced recovery. Perioperative management of the emergency laparotomy. Frailty and the role of geriatricians	
Royal College of Anaesthetists and Association of Anaesthetists of Great Britain and Ireland	General	General	As a guideline for patients, we are very supportive of an overarching review of the remit of perioperative medicine, which will enable a greater understanding of the scope of perioperative care and the impact it has on the clinical pathway. However, we believe that more thought needs to be given to how an overarching guideline for perioperative care will work in practice for healthcare professionals.	Thank you for your comment. We have taken into account discussion from the stakeholder meeting and the comments from this consultation and discussed in detail the topics to be included in the scope. Taking this into account and the expert advice we have had, we believe the scope provides the outline for a guideline that will be timely and useful for clinicians and patients.
Royal College of General Practitioners	3	62	Consider preoperative assessments for elderly patients that focus on physiologic characteristics specific to elderly patients. At present the pre operative outcomes of interest tend to focus on are primarily based on single-organ systems (eg, cardiac, pulmonary). Furthermore, most of the tools currently available are unable to accurately predict outcomes such as length of stay, functional recovery, or need for institutionalisation. Consider albumin and prealbumin levels This paper high https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4279607/	Thank you for your comment. Elderly patients will be included in the question on preoperative risk assessment. The guideline committee will have the opportunity to specify population strata, which will enable us to review evidence for these groups separately. Alternatively, the committee can identify population subgroups, which we will investigate separately if there is heterogeneity in the evidence.
Royal College of General Practitioners	3	64	Consider potential risk factors for people with intellectual disability A study from Taiwan (Lin 2011) http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0026977 reported controls were compared with 3983 surgical patients with intellectual disability for inpatient major surgery in Taiwan between 2004 and 2007 . Risks for postoperative major complications were increased in patients with intellectual disability, including acute renal failure (odds ratio 3.81, 95% confidence interval 2.28 to 6.37), pneumonia (odds ratio 2.01, 1.61 to 2.49), postoperative bleeding (odds ratio 1.35, 1.09 to 1.68) and septicemia (odds ratio 2.43, 1.85 to 3.21) without significant differences in overall mortality. Disability severity was positively correlated with postoperative septicemia risk. Medical service use was also significantly higher in surgical patients with intellectual disability..	Thank you for your comment. We will bring your comment about considering risk factors for people with intellectual disability to the committee's attention when they are considering the preoperative assessment question. The information will be used to inform the committee's decision making as they develop the review protocols in the key scope areas. The committee will have the opportunity to specify population strata, which will enable us to review evidence for these groups separately. Alternatively, the committee can identify population subgroups, which we will investigate separately if there is heterogeneity in the evidence.
Royal College of General Practitioners	4	94	Consider physiotherapy requirements postopearively particularly mobilisation after hip and knee operations. Private hospitals appear to be able mobilise and discharge most patients within 2 days whilst many NHS hospitals appear to take 4-5 days to mobilise and discharge patients	Thank you for your comment. The focus of the draft question on enhanced recovery programmes is on the access to most appropriate enhanced postoperative recovery programmes not specific clinical areas. The management of specific types of surgery is excluded from the scope. We will bring the detail of your comment to the committee's attention. The information will be used to inform the committee's decision making as they develop the review protocols that guide the searches for the review of the evidence for the key areas in the guideline scope.

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Royal College of Nursing	General	General	The Royal College of Nursing (RCN) welcomes proposals to develop guidelines for the perioperative care in adults. The RCN invited comments from professionals who care for and have knowledge of perioperative care in adults.	Thank you for your comment.
Royal College of Nursing	4	98	Should we also be considering the minor procedures undertaken in cosmetic private clinics as minor surgery or is this under the guise of 'other'?	Thank you for your comment. In the section 'who the guideline is for' we have listed non-NHS organisations commissioned to provide services for the NHS or local authorities. If cosmetic private clinics are commissioned to provide a service for the NHS, the recommendations are relevant to them. If the surgery is a minor procedure that is equivalent to minor surgery in out-patient clinics, then this surgery is not included in the scope rather than the setting it is taking place in.
Royal College of Nursing	4	105	Should we also link to the deteriorating adult – NICE Acutely ill adults in hospital: recognising and responding to deterioration Clinical guideline [CG50] Published date: July 2007?	Thank you for your comment. This has been added.
Thrombosis UK	General	General	Thrombosis UK would like to thank NICE for preparing a scope on this important area of care and patient safety	Thank you for your comment.
Thrombosis UK	4 General	85	**Perioperative medicine management:** Mainly for elective surgery and non-urgent surgery, and to secure full and accurate communications and so safe-guard each individual in perioperative care, we believe a patient's management of their own medication preoperatively should be well documented and communicated to the patient. Ideally this needs to be done by an Anaesthetist or by a specialised Pharmacist. Some medication if taken prior to surgery can have a negative influence on the outcome of the procedure and some medication must not be interrupted. The only resource in the UK that I know of is the "Handbook of perioperative medicine" by UKCPA.	Thank you for your comment. We have taken into account the discussion from the stakeholder meeting and the comments from this consultation and have discussed in detail the topics to be included in the scope. It is not possible to include all topics that stakeholders request in the scope. It is important that we have a scope that provides the outline for a guideline that will be timely and useful for clinicians and patients. Reflecting on the number of comments and the strength of the discussion from stakeholders and experts we have decided that specific topics of pharmacological management will be included in the key areas to be considered. Anaemia management and the management of anti-coagulation medication were considered important topics to address and have been added to the scope as a key area for review.
Thrombosis UK	4 General	Point 6, Line 94	**Postoperative Nausea & Vomiting (PONV):** Postoperative nausea and vomiting is described by patient as the most worrying factor prior to surgery (more than pain). Also, it is well published that if well managed, a PONV prevention service is financially beneficial to organisations. Thrombosis UK would suggest consideration that the "APFEL" score should be used in order to pre-determine the patients susceptible of developing PONV/PDNV (PDNV -> Post Discharge... for day surgery patients, an increasing issue).	Thank you for your comment. The focus of the draft question on preoperative risk assessment will be on which risk tools best identify increased risk of adverse events. We will bring the detail of your comment to the committee's attention. The information will be used to inform the committee's decision making as they develop the review protocols that guide the searches for the review of the evidence for the key areas in the guideline scope. Nausea and vomiting have been added to the list of adverse events and complications in the main outcomes.
Thrombosis UK	4 General	105 – Related NICE Guidance	**"Think kidney"** We are aware that surgery is always a strain on the kidneys and so suggest consideration that the guidance should be linked to NICE QS76 and to NICE AKI QS Standards page 'Using Think Kidney's Resources': https://www.nice.org.uk/sharedlearning/linking-nice-aki-quality-standards-with-think-kidneys-resources	Thank you for your comment. Quality standards are not linked to in the scope.

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Thrombosis UK	5	119 & 120	**Venous Thromboembolism (VTE) / Hospital Acquired Thrombosis (HAT):** We would respectfully suggest that it would be very valuable to link guidance on this topic to NICE documents: CG92, QS3 and QS29 to ensure full awareness, promote valuable communication and so protect patients from risk, harm and avoidable events.	Thank you for your comment. NICE guideline CG92 Venous thromboembolism in adults: reducing the risk in hospital (2010) is listed under related NICE guidance.
Vifor Pharma UK Limited	1	1	Vifor Pharma UK welcomes the development of new guidelines on perioperative care. We believe that this offers an excellent opportunity to embed international best practice of Patient Blood Management (PBM) into routine practice in England, particularly in the preoperative assessments.	Thank you for your comment. Blood products and blood transfusion have been excluded from the scope. There are other NICE guidelines that address blood management, for example, Blood transfusion NG24.
Vifor Pharma UK Limited	2	44	This guideline should also be for 'commissioners', who are responsible for ensuring appropriate services are commissioned that allow for optimal perioperative care.	Thank you for your comment. This has been added.
Vifor Pharma UK Limited	3	78	Perioperative assessment is a significant area that can impact on the quality of care for patients undergoing elective surgery. One area of risk which should be considered in preoperative assessment is iron deficiency anaemia (IDA). Preoperative anaemia is detected in up to 40% of patients, with varying prevalence depending on the type of surgery (Fowler AJ et al. Br J Surg. 2015;102(11):1314–24; Muñoz M et al. Anaesthesia. 2017;72(2):233–47; Dunkelgrun M et al. Am J Cardiol. 2008;101:1196–20; Karkouti K et al. Circulation. 2008, 117:478–84; Richards T et al. PLoS One. 2015;10(7):e0130861) and associated risks include higher probability of infection, kidney injury and mortality (Fowler AJ et al. Br J Surg. 2015;102(11):1314–24).	Thank you for your comment. The clinical and cost effectiveness of strategies for the preoperative management of anaemia has now been added to the scope as a key area for review.
Vifor Pharma UK Limited	4	81	Rates of iron deficiency anaemia are particularly high amongst older people, therefore pro-active pre-operative care for this patient group is particularly beneficial (Patel, Semin Hematol. 2008 Oct; 45(4): 210–217).	Thank you for your comment. The clinical and cost effectiveness of strategies for the preoperative management of anaemia has now been added to the scope as a key area for review. The guideline committee will have the opportunity to specify population strata, which will enable us to review evidence for these groups separately. Alternatively, the committee can identify population subgroups, which we will investigate separately if there is heterogeneity in the evidence.
Vifor Pharma UK Limited	4	85	Pre-optimisation pharmacological management should be part of a planned perioperative package and any pre-optimisation pharmacological management should be allowed an appropriate time to take effect. Iron deficiency anaemia is an easily modifiable risk factor for patients undergoing elective surgery.	Thank you for your comment. We have taken into account the discussion from the stakeholder meeting and the comments from this consultation and have discussed in detail the topics to be included in the scope. It is not possible to include all topics that stakeholders request in the scope. It is important that we have a scope that provides the outline for a guideline that will be timely and useful for clinicians and patients. Reflecting on the number of comments and the strength of the discussion from stakeholders and experts we have decided that specific topics of pharmacological management will be included in the key areas to be considered. Anaemia management and the management of anti-coagulation medication were considered important topics to address and have been added to the scope as a key area for review.

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Vifor Pharma UK Limited	4	92	Post-operative management should also include management of post-operative iron deficiency anaemia, which may be the result of poor pre-operative optimisation and/or blood loss during surgery. Many patients will become anaemic post-operation irrespective of their IDA status pre-operatively (Lasocki et al, PREPARE, Eur J Anaesthesiol. 2015 Mar;32(3):160-7), especially in specific groups such as women with post-partum anaemia who require rapid restoration of haemoglobin and iron stores (Van Wyck, Obstet Gynecol., Aug2007;110(2 Pt 1):267-78.; Breymannn, Int J Gynaecol Obstet. Apr 2008;101(1):67-73). Therefore, post-operative management guidelines should include management of iron levels.	Thank you for your comment. Strategies for the preoperative management of anaemia was considered an important topic to address as part of perioperative medicines management and has now been added to the scope as a key area for review in the preoperative optimisation section. The focus of anaemia management will be on the effectiveness of a service across the patient journey. This is reflected in the draft question in section 3.5 of the scope.
Vifor Pharma UK Limited	4	99	Routine preoperative testing for elective surgery is covered by existing NICE guidance and we agree that this does not need to be covered (Routine preoperative tests for elective surgery: Major or complex surgery, NICE guideline [NG45], published April 2016).	Thank you for your comment.
Vifor Pharma UK Limited	4	100	Blood products and blood transfusion is covered by existing NICE guidance and we agree that this does not need to be covered (Blood transfusion: 1.1 Alternatives to blood transfusion for patients having surgery, NICE guideline [NG24], published November 2015).	Thank you for your comment.
Vifor Pharma UK Limited	6	163-164	Preoperative anaemia has a negative impact on quality and safety performance indicators for surgeries. Preoperative anaemia is associated with higher probability of infection, kidney injury and mortality (Fowler AJ et al. Br J Surg. 2015;102(11):1314–24). Even mild preoperative iron deficiency anaemia is associated with an increased risk of 30 day morbidity and mortality (Mussallam, Lancet, Oct 2011, 378(9800):1396–1407). Preoperative optimisation of iron levels can improve clinical and cost effectiveness. Preoperative iron optimisation is associated with shortening length of hospital stay and reducing need for blood transfusions (Froessler B. et al. Annals of Surgery 2016, 264:41–46; Khalafallah AA et al. Lancet Haematol. 2016 Sep;3(9):e415-25). Such outcomes can reduce cost to the NHS: an estimate of the budget impact of introducing PBM, including preoperative anaemia management, in patients undergoing primary hip and knee arthroplasties in a UK hospital showed a net saving of £569 per patient (Spahn DR et al. British Journal of Anaesthesia 2012; 108 (6): 889–92; Kotzé A et al. Br J Anaesth. 2012, Jun;108(6):943-5). Preoperative optimisation guidance should include examples of best practice in clinical effectiveness, including the Royal Cornwall Hospitals NHS Trust's Patient Blood Management service. International best practice guidelines should be taken into account, including in Australia (National Blood Authority, 'Patient Blood Management Guidelines: Module 2: Perioperative', 2012).	Thank you for your comment. The clinical and cost effectiveness of strategies for the preoperative management of anaemia has now been added to the scope as a key area for review.

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Vifor Pharma UK Limited	6	159	Improving perioperative care requires a culture change, particularly in preoperative assessment, to adopt the practice of Patient Blood Management (PBM). PBM is a multidisciplinary, evidence-based approach to optimising the care of patients who might need a blood transfusion, which represents an international initiative in best practice for transfusion medicine (Joint UK Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee). Patient Blood Management guidelines have 3 pillars of care covering perioperative care and these all rely on good pre-operative tests to identify IDA – these are: optimising red blood cell mass, minimising loss and bleeding, and optimising physiological reserve Good practice in PBM includes the management of pre- and post-operative iron deficiency anaemia, which has shown both in clinical studies and clinical practice to improve quality of pre-operative care. A culture change to adopt PBM best practice could help to deliver greater long-term benefits to health outcomes. Many national and international guidelines and recommendations state that elective surgery should be postponed until IDA is corrected (Munoz et al., Anaesthesia, Feb 2017, 72(2): 233-247; WHO, Global forum for blood safety: patient blood management. Priorities for action. 14–15 March 2011). Indeed, the EU recommends that national authorities actively pursue the dissemination and implementation of PBM. The most recent NHS Blood & Transplant comparative audit of Patient Blood Management in adults undergoing elective, scheduled surgery highlights that further work is required to improve pre-operative anaemia management (NHSBT, 'Audit of Patient Blood Management in adults undergoing elective, scheduled surgery', 2016). Perioperative care guidelines offer an opportunity to address this. Guidelines should advice testing for iron deficiency anaemia pre-operatively to reduce risk of adverse events in adults undergoing surgery. There are numerous risk stratification tools to assess fitness for surgery, including haemoglobin level, such as CR-POSSUM, P-POSSUM – such tools which assess haemoglobin level should be used to assess pre-operative anaemia.	Thank you for your comment. Blood products and blood transfusion have been excluded from the scope. There are NICE guidelines that address blood management, for example, Blood transfusion NG24. The clinical and cost effectiveness of strategies for the preoperative management of anaemia has now been added to the scope as a key area for review.