Perioperative Care for Older People undergoing Surgery
The POPS Network

Cohort Two

February 2022

Launch Event
Part One

Agenda

09:00 START	
	Welcome and introduction **Dr Jugdeep Dhesi** Consultant GSTT and POPS Network Clinical Lead
	The POPS Model explained **Dr Jugdeep Dhesi** Consultant GSTT and POPS Network Clinical Lead
	Case Study - Liverpool POPS **Dr Mark Johnston** Consultant, Liverpool University Hospitals NHS FT
	Case Study Two - Salford POPS **Angeline Price** Advanced Nurse Practitioner, Salford Royal NHS FT
	Case Study Three - Cardiff POPS **Dr Nia Humphry** Consultant, Cardiff & Vale University Health Board
	An introduction to Measurement for Improvement **Matt Tite** Director and Measurement Lead, NHS Elect
	Wants and Offers **Lisa Godfrey** Director and QI Associate, NHS Elect
	Summary and Close **Dr Jugdeep Dhesi** Consultant GSTT and POPS Network Clinical Lead
11:00 CLOSE	

Housekeeping

Silence is golden, unless you want us to hear you

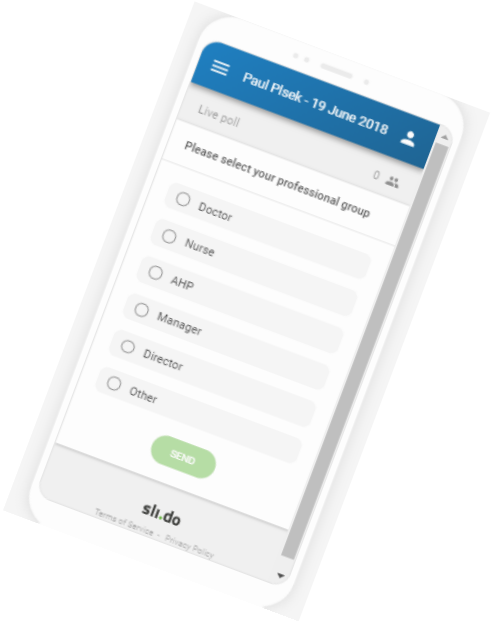
Please turn off your camera during presentations

We love to talk, we also love to be on time.

No mic, feeling shy? Send us some chat

Give us a wave if you need to get our attention

sli.do



Open a browser on any laptop, tablet or smartphone

- Go to **www.sli.do** or scan the QR code
- Enter the event code **#POPS2Launch1**
- Use the polls to give us feedback about the day

"Supporting teams to improve the peri-operative management of older people undergoing surgery"

Model for Improvement

What will we accomplish?
Establishing your AIM

How do we know a change is an improvement?
Identifying your **MEASURES**

What changes can we make?
Working with the **RECOMMENDATIONS**

FIRST PHASE - introducing teams to the POPS Network approach and the Model for Improvement

MID POINT - checking in with Network teams on where you are, what data you're collecting and next steps.

FINAL PHASE - achievements over the last six months of the programme, and looking to the future.

Introduction to concepts of **Experience Based Design** and signpost to EBD Moodle to be completed by core members of project team.

Application of EBD for patients and staff; using app and planning a study

Gathering experience data from patients and staff. Submission of data for thematic analysis by the POPS team

Reviewing results and sharing with POPS, agreeing plans for improvement

Undertake improvements

Follow up study to check how improvements have made a difference

Setting up your project::
- initial 'site visit'
- Quality Improvement expertise
- support to undertake Sustainability assessment
-developing plans to implement small cycles of change aligned to the recommendations
- online learning sessions

Implementing changes: :
- implementing small cycles of change aligned to recommendations
- undertaking EBD with staff and patients
- collecting and interpreting data
- regular team calls
- clinical input and support
- spread education and training

Time for reflection:
- what changes have you made?
- what improvements are you seeing?
- what is the data telling you?
- what is working well and not so well?
- continuing PDSA change cycles

Planning next steps:
- what improvements are you seeing?
- what is the data telling you?
- what have you achieved?
- what changes do you want to keep, and what do you want to get rid of?
- what becomes 'business as usual' and how?

Introduction to concepts of **Measurement for Improvement:** aims, measures, and driver diagrams.

Data diagnostics: establishing a baseline

Capacity and demand planning
Submission of mid-term data

Demonstrating improvements

Supported by calls, webinars, on-line events and Moodle online training, delivered by Measurement for Improvement experts.

Regular calls with POPS QI Associate - Regular POPS Network calls - Clinical 1:1 calls - Regular webinar series - Regular email updates - Website resources

The POPS Network

Perioperative medicine for older people

Jugdeep Dhesi, Geriatrician
Perioperative medicine for older patients undergoing Surgery (POPS)
Dept of Ageing and Health
Guy's and St Thomas' NHS Foundation Trust

POPS Perioperative medicine for Older People undergoing Surgery

Guy's and St Thomas' NHS
NHS Foundation Trust

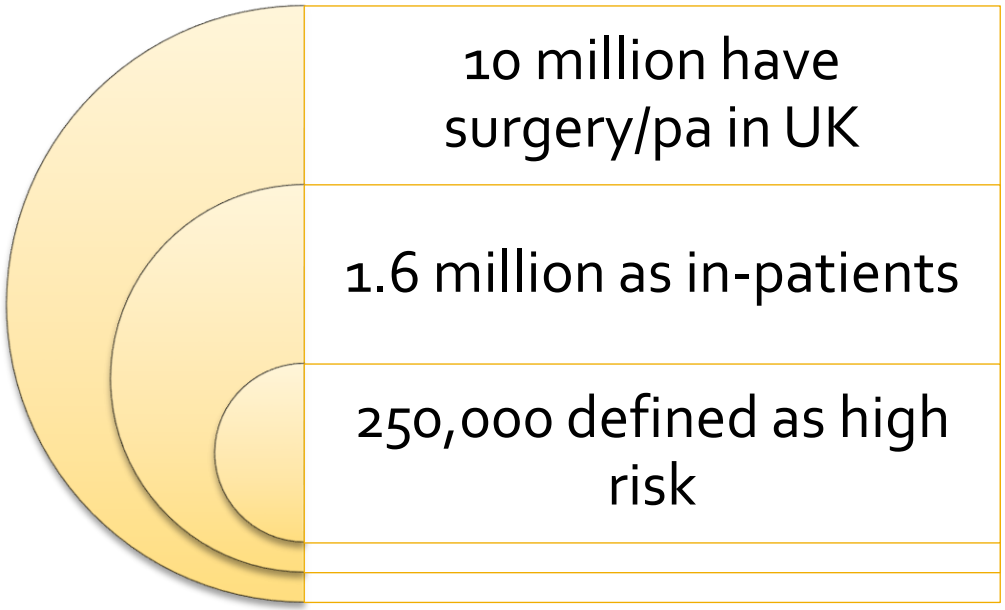
KING'S College LONDON

Centre for Perioperative Care

KING'S HEALTH PARTNERS

BGS British Geriatrics Society
Improving healthcare for older people

Where do we even start?!



Clinician reported outcomes

- Morbidity
- Mortality

Patient reported outcomes

- Recovery
- Experience, satisfaction
- Regret

Process related outcomes

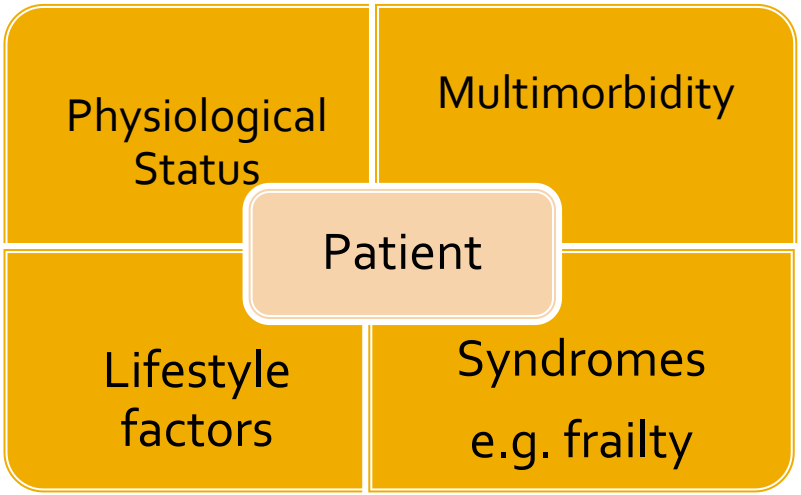
- LOS, readmissions
- Harm and complaints
- Cost to informal and/or formal sectors

Risk related to procedure and to patient

Procedure specific
Low risk
Intermediate risk
Major
Complex

Site of surgery
Intra-cavity
Non-cavity

Timing
Elective
Expedited
Emergency



Socio-economics

Disability

Recognised
versus
Unrecognised disease/syndromes

Perioperative care for 'high risk' patients

Stage of periop pathway	What should we do?
Pre-op Assessment	Assess of severity of known conditions Screen for undiagnosed issues Assess severity of newly diagnosed conditions
Pre-op Optimisation	Optimise comorbidities (eg diabetes) Optimise multimorbidity (eg PD and IHD) Optimise multifactorial conditions (eg frailty) Modify lifestyle related risk factors (eg smoking, alcohol, BMI)
Pre-op Shared decision making	Quantify risk using appropriate tools Employ Benefits, Risks, Alternatives, do Nothing approach

Perioperative care for 'high risk' patients

Stage of periop pathway	What should we do?
Pre-op Planning of hospital stay	Consider day case or admission Be clear about admission; where & when including place and day of week Plan site of postoperative care; ward, enhanced care, level 2/3
Postoperative management	Identify anticipated complications early Use EB approaches for postop medical complications (eg AF, ACS, HAP, delirium) Proactively set realistic rehabilitation goals Ensure timely, safe, effective discharge Provide effective handover to community for LTC mx

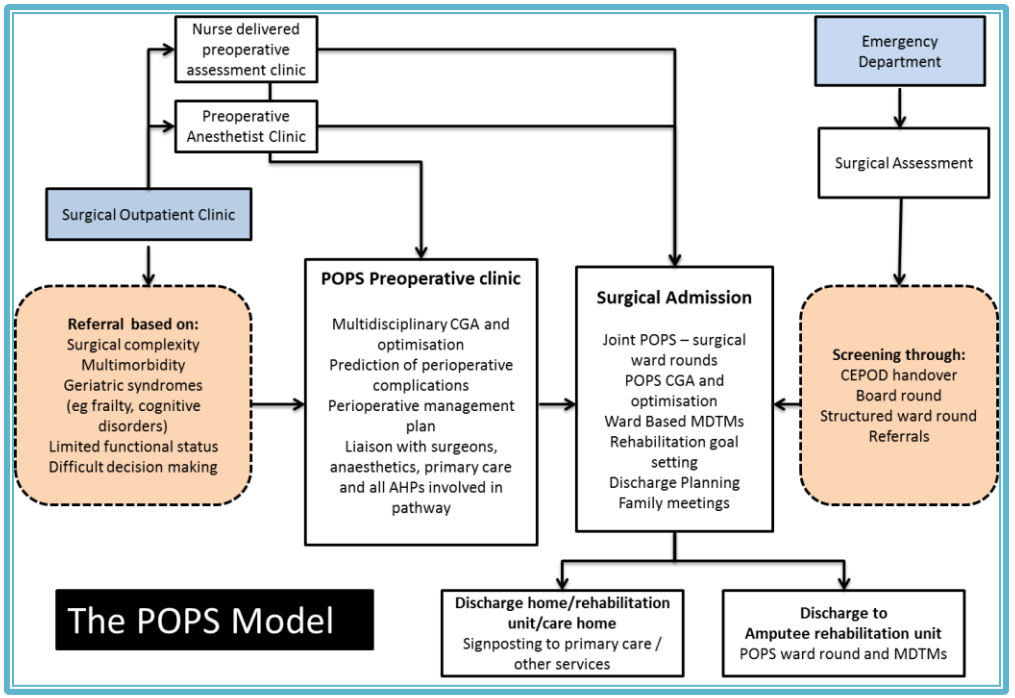
Can such approaches be put into practice?

Variety of approaches

- Traditional
- Co-management
  - Physician (eg POPS)
  - Anaesthetic (eg Exeter)
  - Hospitalist (eg US)

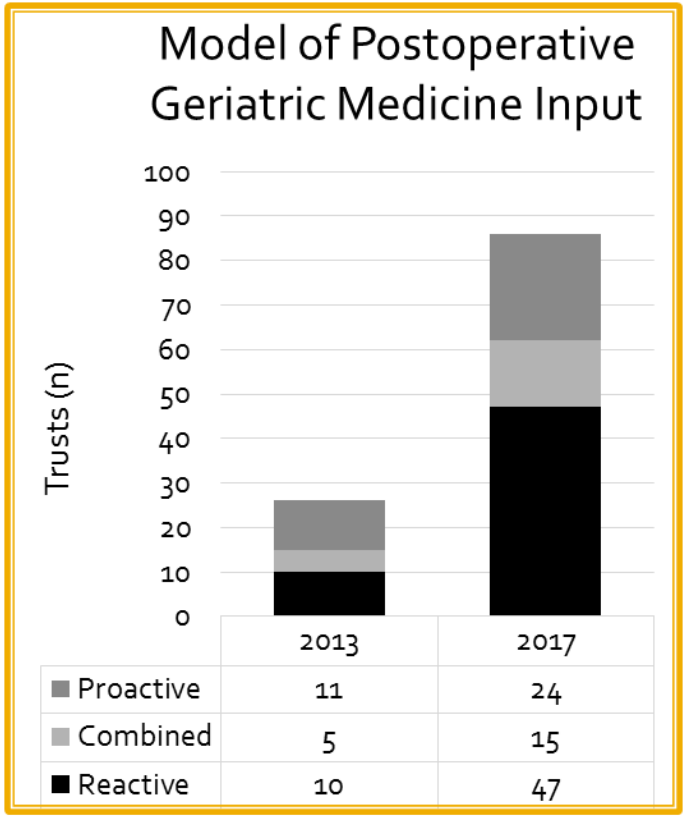
Case studies

www.CPOC.org.uk



Clearly innovation in perioperative care is happening in the UK…

- Response rate 127 of 152 NHS hospitals (88%)
- Preoperative clinics= 37
  - 20 existing clinics
  - 14 dedicated ger med
  - 3 jt clinics (anaes & ger med)
- Increase in
  - joint meetings
  - joint guidelines
  - surgical directorate funding



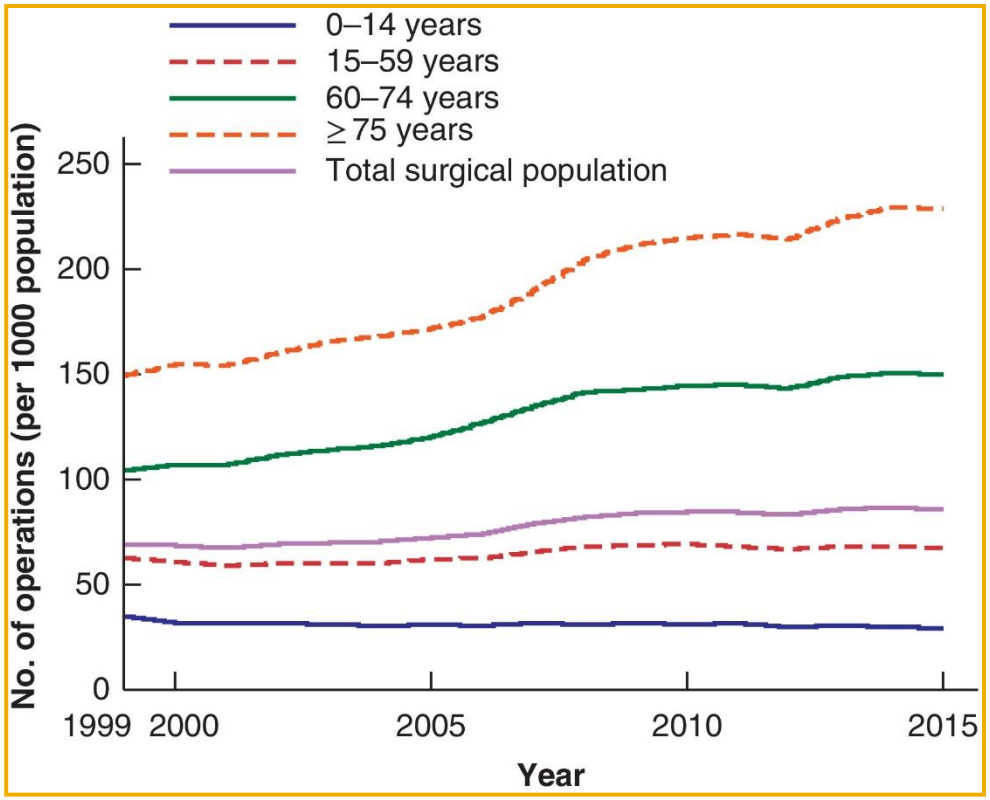
Partridge Age and Ageing 2014, Joughin et al Age & Ageing 2019

…and we are addressing change at system-level …

Aspect	Consideration	What is happening?
Pathway & Ownership	'Surgery is a punctuation' Individual *versus t*eam	Building across organisations to develop necessary culture, behaviours
Clinical guidelines	Specialty/professional *versus* patient centred	e.g. Diabetes Anaemia Frailty
Education and training	Curricula Resources	Work with HEE - curriculum, resources
Workforce	Insufficient Alternative workforce	Developing the workforce - Transdisciplinary - ACP
Evaluation	QI/IS +/- traditional research	Linking with national audit/big data (GIRFT, PQIP, NELA/NHFD etc)

…but we need this to happen at pace…

Twice as many people aged over 65 years have surgery compared to those under 65 years



Fowler et al, BJS 2019 : 1012-1018

…particularly now!

5 million on the waiting lists

- High volume low complexity
- Low volume high complexity

Need to turn ‘waiting lists’ into ‘preparation lists’

- Assessment
- Optimisation
- Shared decision making
- Planning
- Postoperative care

In this context, why is the POPS Network useful?

1. Support and test systematic rollout at a 'small' number of sites
   - Through provision of 'hard' resources, coaching and mentoring, advice on measurement for improvement
   - Learn what works and what doesn't

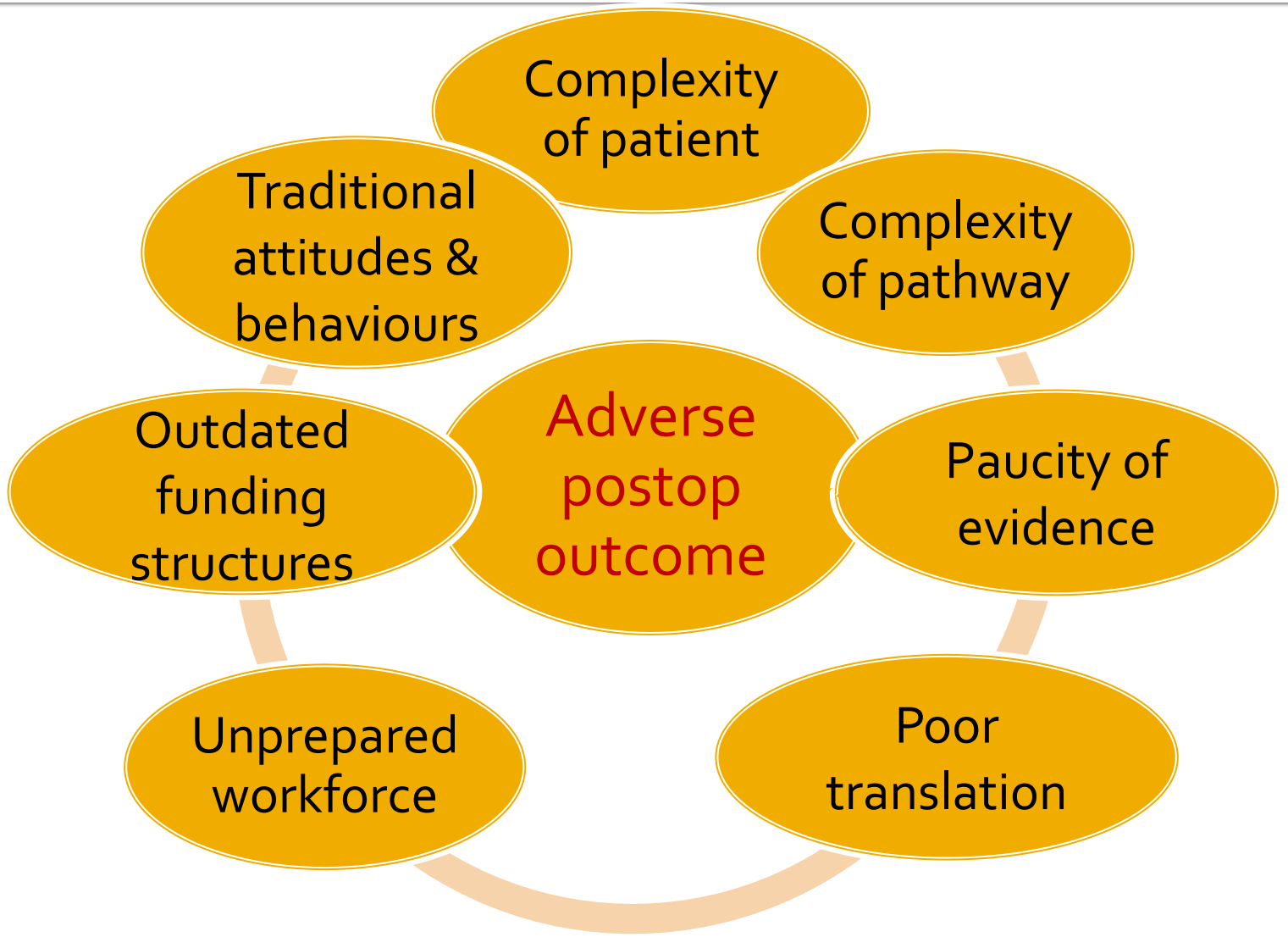
2. Support early adopters to become regional centres
   - Learn from stage 1 to adapt the network to the needs of other NHS units
   - Build expertise and capacity to support stage 3
   - Engage teams in national work

3. Support systematic scale up/spread/roll out
   - At the speed at which it is required!!

What's happened so far and the questions arising?

Questions	Possibilities
Which population should we start with?	Surgical specialty (GI, vascular, urology), Pathology (cancer/non cancer) Admission route (elective/emergency)
Within those areas, how should we segment the population?	Age, frailty, multimorbidity, polypharmacy, SORT/ASA
What should be the KPIs?	Clinician reported Patient reported Process related
What is the required workforce?	Right now to deliver 6 month project In the future to deliver the service
What is the required knowledge?	Perioperative medicine Implementing change Measuring impact

The next steps…



Liverpool POPS

Dr Mark Johnston

Liverpool University Hospitals
NHS Foundation Trust

Proactive Care for Older Patients Requiring Surgery (POPS)

LUHFT (RLB Site)

Dr Mark Johnston (Consultant Geriatrician)
POPS/OncoGeriatrics

Liverpool University Hospitals
NHS Foundation Trust

Our Service

2.0 WTE Band 7 CNS POPS Nurses

0.6 WTE Consultant Geriatrician (3) Time

3 Pillars of focus:

- Decision Making
- Optimisation
- Peri-operative care

KPI's:

1) 80% of Inpatients reviewed within 72hrs
2) 90% of Pre-op referrals to be seen within 2 weeks
3) Reduction in reactive Cons-Cons referrals from surgery

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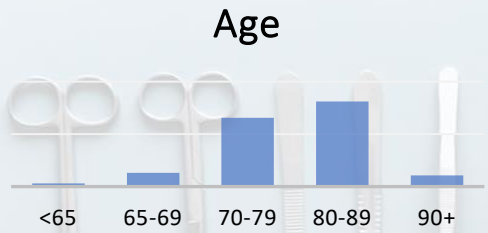
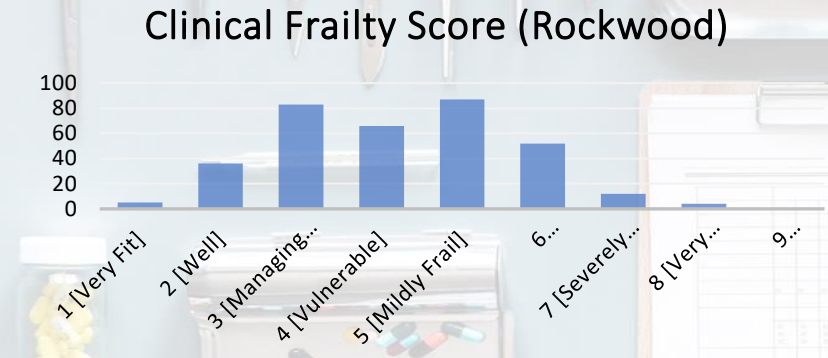
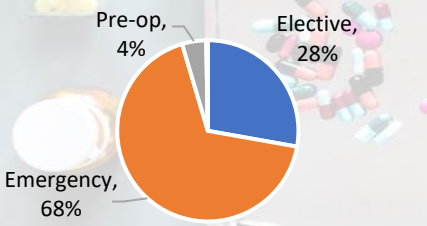
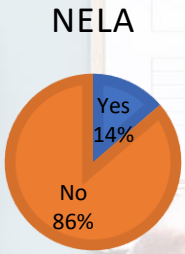
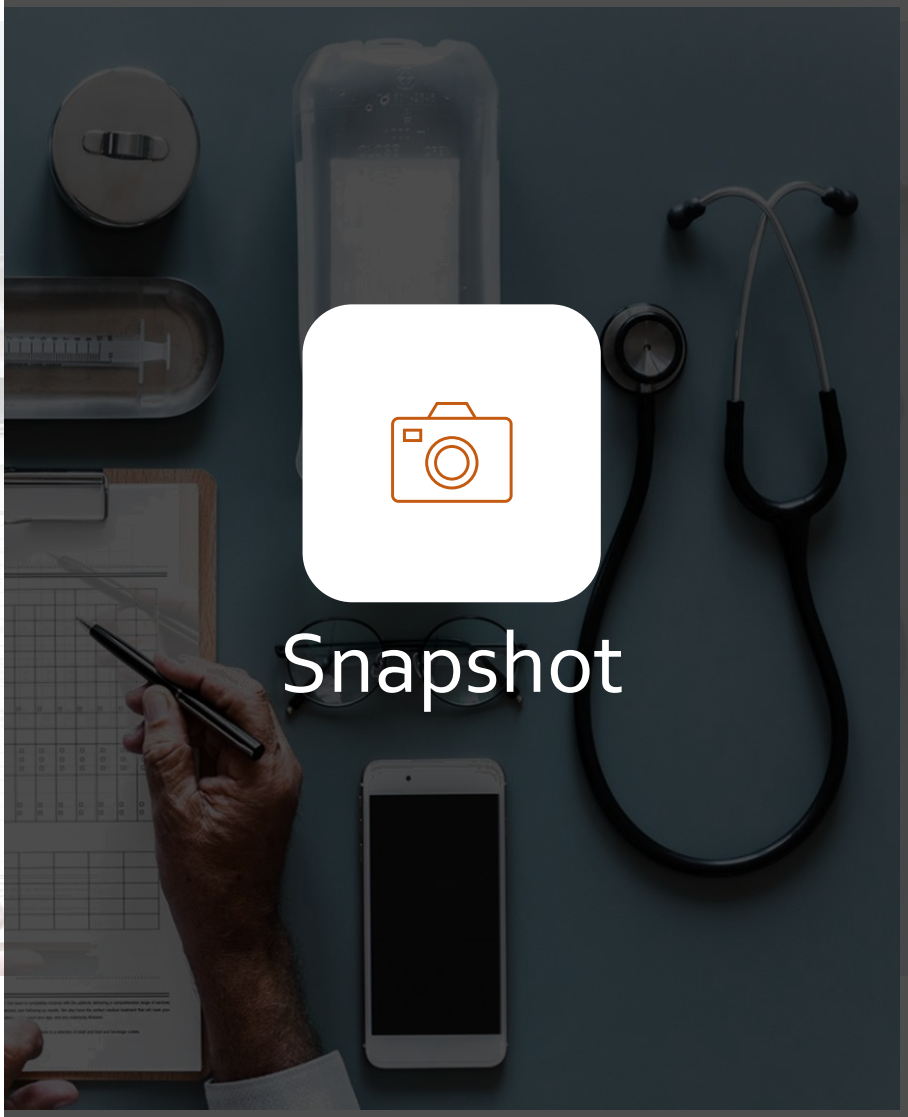






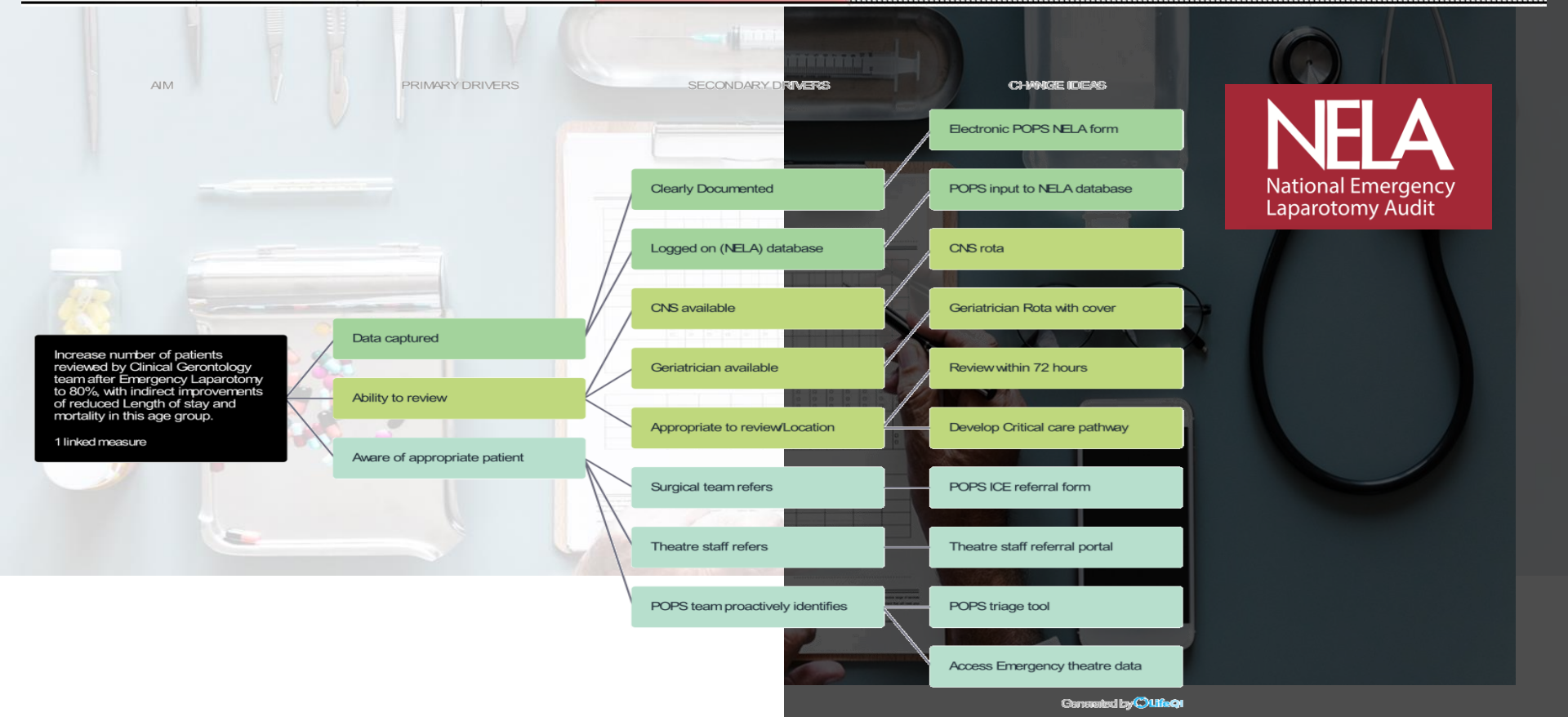




Snapshot

Liverpool University Hospitals
NHS Foundation Trust

NELA Report (Year	Date range	Hospital Site	Total Cases	Assessed by elderly medicin	Post op LoS (Median)	Post op LoS (Mean)	Adjusted Mortality rate (%
6	Dec 2018-Nov 2019	RLB	164	90	10	15.7	7.3%
5	Dec 2017-Nov 2018	RLB	144	77.4	13.8		11.60%
4	Dec 2016-Nov 2017	RLB	135	31.7	12.7		9.40%
3	Dec 2015-Nov 2016	RLB	144	43.3	13		11.10%
2	Dec 2014-Nov 2015	RLB	190	25	14.4		10.10%
1	Dec 2013-Nov 2014	RLB	181	9			



NELA
National Emergency Laparotomy Audit

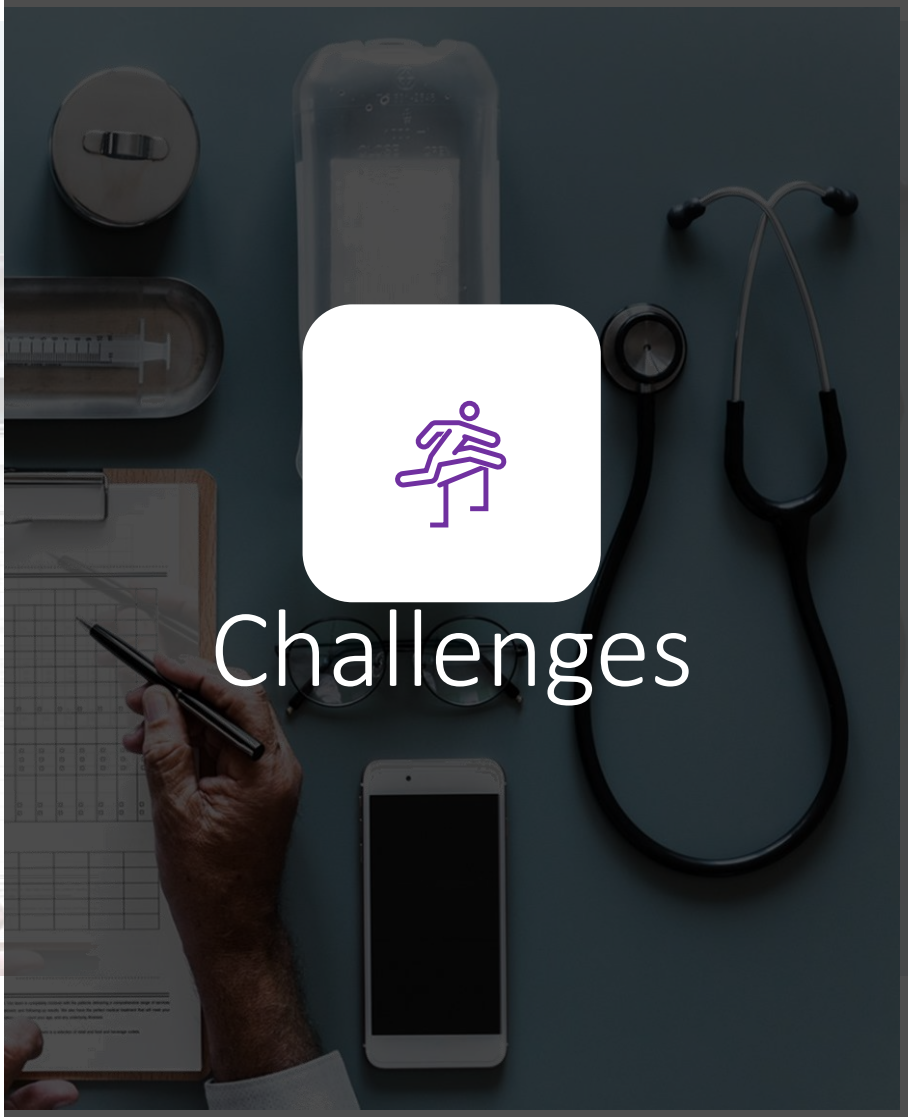
Liverpool University Hospitals
NHS Foundation Trust

Change Management

Business Intelligence

Project Management

Resource Management



Challenges

Liverpool University Hospitals
NHS Foundation Trust

Pre-op Growth

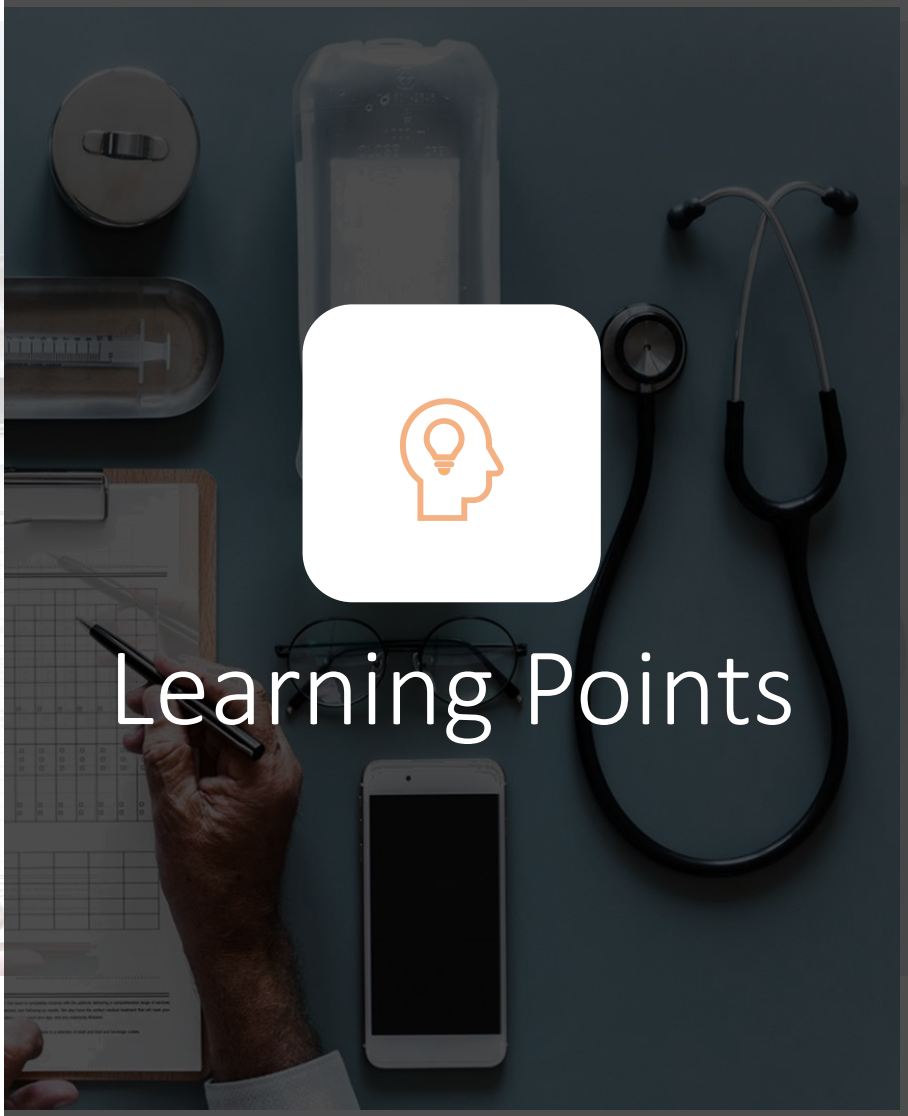
Complex MDT

Pathways

Onco-Geriatric Integration

The Future

Liverpool University Hospitals
NHS Foundation Trust



Learning Points

- Pushing on open doors
- Willingness to visit all clinical areas
- Ambassadorial role
- Focus on all 3 pillars
- Resource is precious, invest wisely
- NELA is a great starting position
- Significant appetite to develop this

Liverpool University Hospitals
NHS Foundation Trust

Thank you

Dr Mark Johnston
Mark.Johnston @liverpoolft.nhs.uk
0151 706 2000 (PA Linda Evans)

Salford POPS

Angeline Price

NHS
Salford Care Organisation
Northern Care Alliance NHS Group

Royal College of Nursing

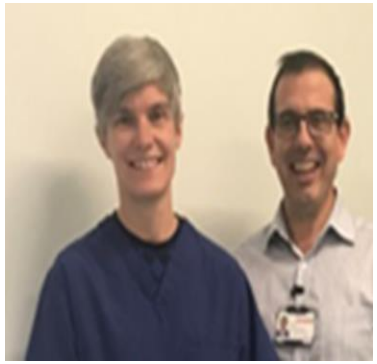
BGS

POPS Network Launch Event

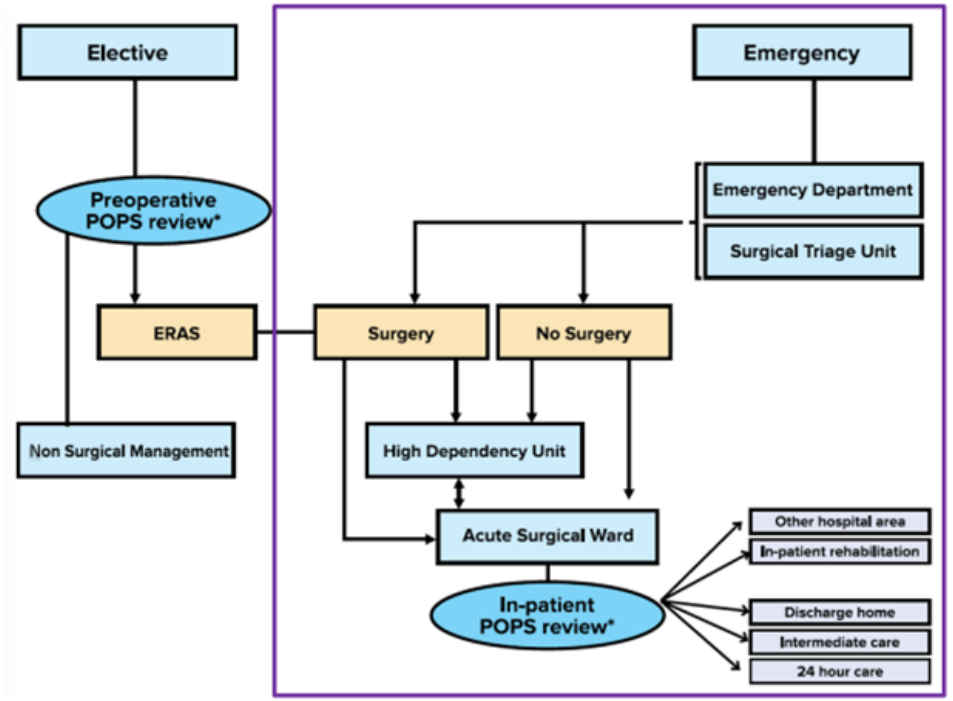
Angeline Price
Advanced Nurse Practitioner
Salford Royal Hospital

@angeline_price

POPS-GS@Salford 2014-October 2018



Elective/Emergency in hospital



4 DCC + 1 SPA sessions = 20 hours/week

(including cover, holidays, …)

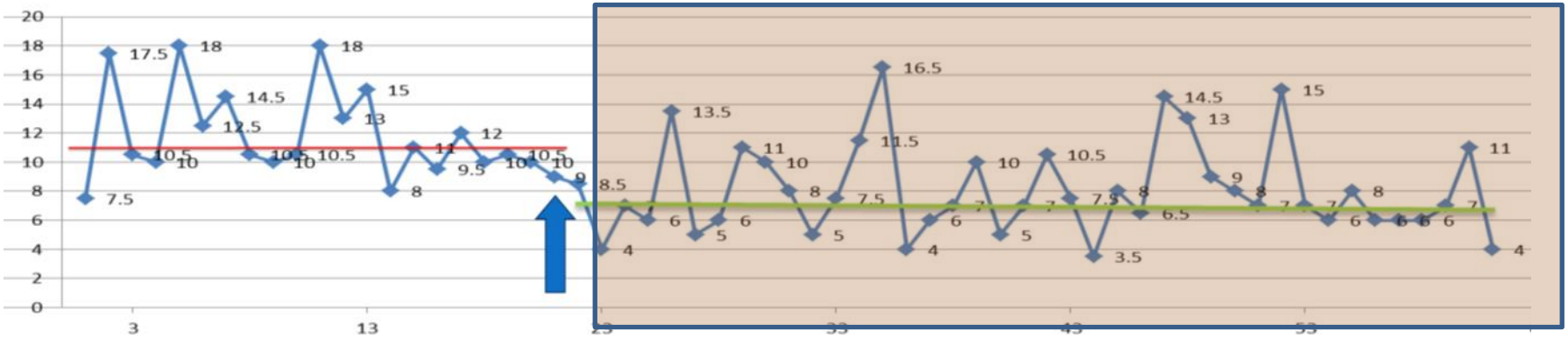
Improving surgical outcomes (Salford POP-GS)

>2000 patient-episodes

8th September 2014 – COVID-19 Pandemic

Before February 1st
11 Median

After February1st
7 Median



Improving surgical outcomes (Salford POP-GS)

- ✓ Patient and staff satisfaction
- ✓ Reduced calls to medical registrar
- ✓ Reduced referrals Cardiology, gastro, endocrine
- ✓ Improved coding (recognition of complications)
- ✓ Improved quality of discharge summaries

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NELA
National Emergency Laparotomy Audit

Achilles heel

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National Emergency Laparotomy Audit

Achilles heel

Only 28.8% of frail patients over 65 had geriatrician input

What do we do differently?

Advanced Practitioner:

0.5WTE

5 sessions spread across Mon-Fri

Flexibility according to need

Cost effective

What is advanced practice?

Advanced clinical practice is delivered by experienced, registered health and care practitioners. It is a level of practice characterised by a high degree of autonomy and complex decision making. This is underpinned by a master's level award or equivalent that encompasses the four pillars of clinical practice, leadership and management, education and research, with demonstration of core capabilities and area specific clinical competence.

- Experienced clinician > 5 years post-registration
- Critical skills in assessment, diagnosis, intervention
- Decision making in complex situations
- Multi-agency working

Definition of advanced level practice

- High degree of **autonomy** and **complex decision making**

- Analysis and synthesis of complex problems across a range of settings**,** enabling innovative solutions to enhance people's experience and improve outcomes

My role at salford

- Proactive identification of patients
- Initial assessment – undertake CGA
- Targeted geriatrician input
- Ongoing review
- Troubleshooting
- MDT meetings – complex discharge planning
- Education / QI projects

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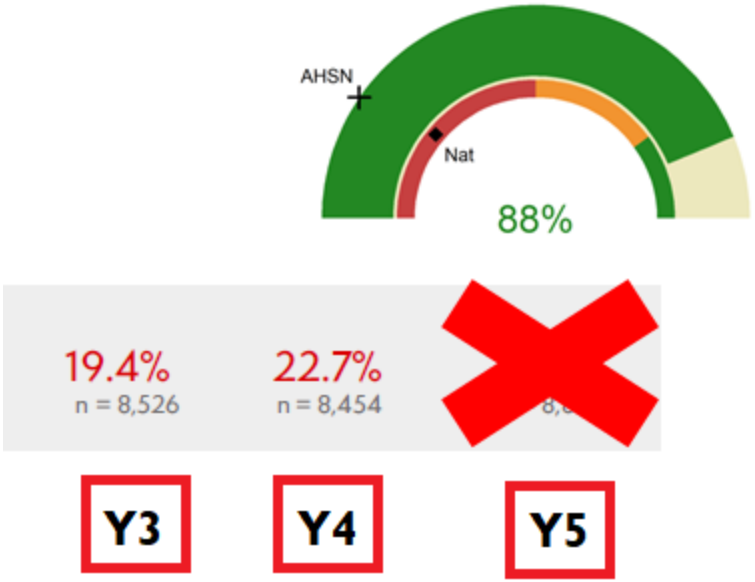
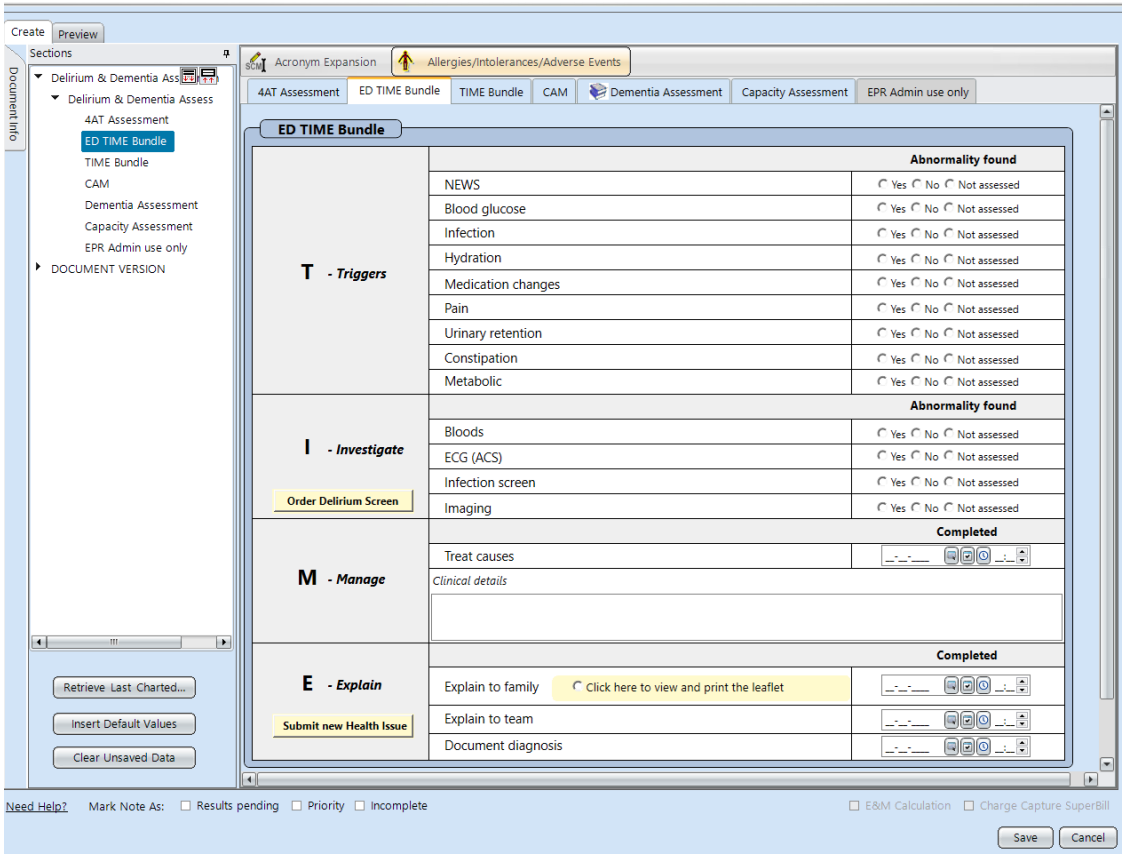


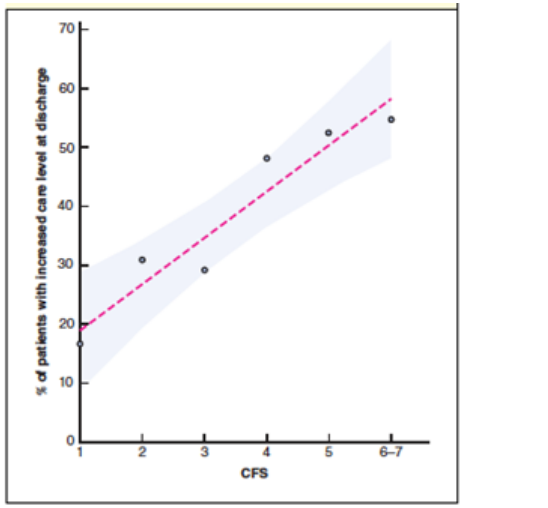
Success!

- **Delirium identification and timely management**



MDT working

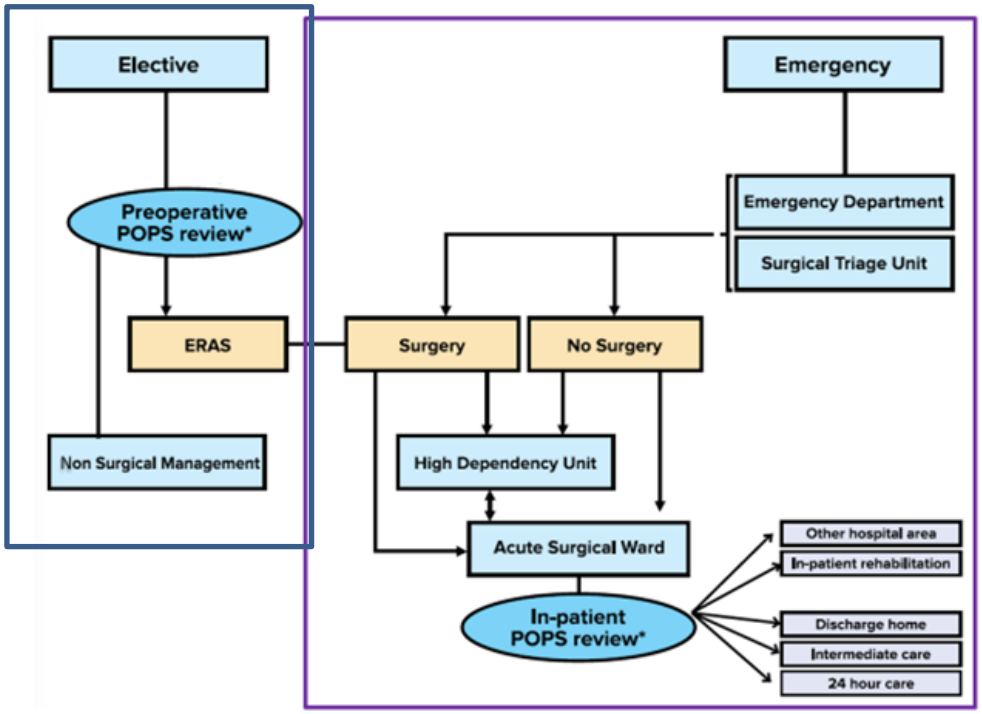
- Local NELA steering group
- MDT working group
  - Physio
  - OT
  - Dietician
  - Surgical ACP
  - CNS specialist nurses/ward nurses
  - Palliative Care Team / District Nurses



Increased dependence at discharge

Service expansion

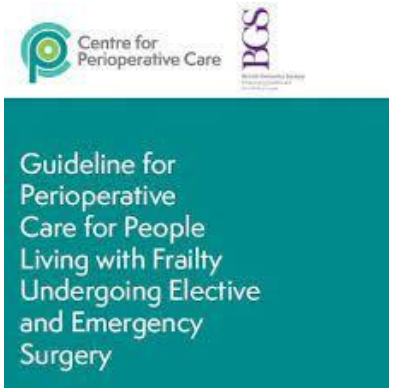
- Colorectal 2 week wait
- Upper GI High risk
- Urology Test of Change



- Healthier together
  - Service Reestablishment/ consolidation
  - Amalgamation of in-reach services
  - Quality Improvement

Royal College of Nursing

- Perioperative Forum Deputy Chair
- Re-launch – expansion!
- Re-think what ‘Perioperative’ means
- Guidelines .. Anaemia, diabetes, Frailty!
- Conference invitations



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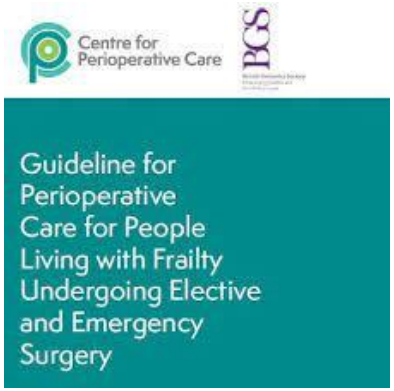


NELA
National Emergency Laparotomy Audit

EMERGENCY LAPAROTOMY & frailty
ELF

Saving lives, Improving lives

Patient and People Focus | Accountability | Continuous Improvement | Respect

MANCHESTER 1824
The University of Manchester

NHS
Northern Care Alliance
NHS Group

The impact of emergency laparotomy for older people living with frailty

Angeline Price
Advanced Nurse Practitioner
Salford Royal Hospital

STRENGTHS

- Existing service upon which to develop
- Respected by colleagues
- Collaborative working
- ACP/Consultant Geriatrician delivered
- Patient/Staff satisfaction
- Financial benefits
- Aligned with Trust objectives

WEAKNESSES

- Reliant on 3 individuals
- Increasing demand
- Medical pressures/priorities (COVID-19)
- Staff changeover
- Frailty/Delirium identification/management
- Data gathering
- Longer term sustainable funding/service

OPPORTUNITIES

- Increasing demand
- NELA
- 2WWL CR
- High risk UGI MDT initiatives
- Healthier Together
- Research/Publications
- Career progression

THREATS

- Staff retention/deployment
- Snowballing demand
- Clinical priorities elsewhere
- Conflicting priorities/vision
- Financial pressures
- Territorialism/defensiveness
- Complacency/ change fatigue

Questions and Comments

Cardiff POPS

Dr Nia Humphry

Case Study from a Cohort One site: Cardiff

February 2022

Dr Nia Humphry
Consultant Perioperative Geriatrician

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

POPS
PERIOPERATIVE CARE OF OLDER PEOPLE UNDERGOING SURGERY

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Cardiff and Vale University Health Board

The Team

Nia	**Consultant Perioperative Geriatrician (General Surgery)**
Nicki	**(NELA) Nurse practitioner**

The Team

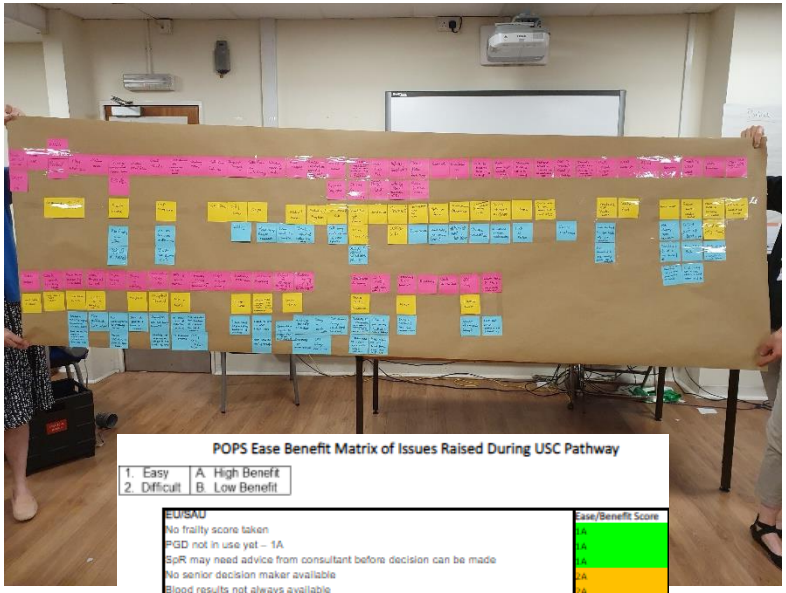
- ✓ Multidisciplinary
- ✓ In-house improvement / data support

Nia	**Consultant Perioperative Geriatrician (General Surgery)**
Nicki	**(NELA) Nurse practitioner**
Rachel	**Physician Associate (joined Nov 2021)**
Chris	Consultant Colorectal Surgeon & CD Emergency General Surgery
Margaret	Consultant Anaesthetist & Frailty Lead for Anaesthetics
Jo McL / Mererid	Physiotherapists
Martin / Lauren	Occupational Therapists
Dean	Pharmacist
Jo H / Huw	Service Improvement Managers
Lewis	Service Manager, Surgery Clinical Board
Steve	Dietician
Munawar	Consultant in Emergency Medicine & Frailty Lead for ED
Sandra Watts	Practice Development Nurse, General Surgery
Jyothi Srinivas	Consultant Anaesthetist, POAC Representative

Aims: Long-term
To develop clear, well-resourced pathways, to improve the care of older surgical patients living with frailty • All receive CGA • Elective and emergency setting

Aims: Short-term (6 months)	
All patients 65+ admitted under general surgery are assessed for frailty	Emergency
All patients 65+ *and* frail undergo a Comprehensive Geriatric Assessment	
Improve patient pathway for those undergoing emergency laparotomy	

✓ Strategic priorities of organisation
✓ Consult wider team

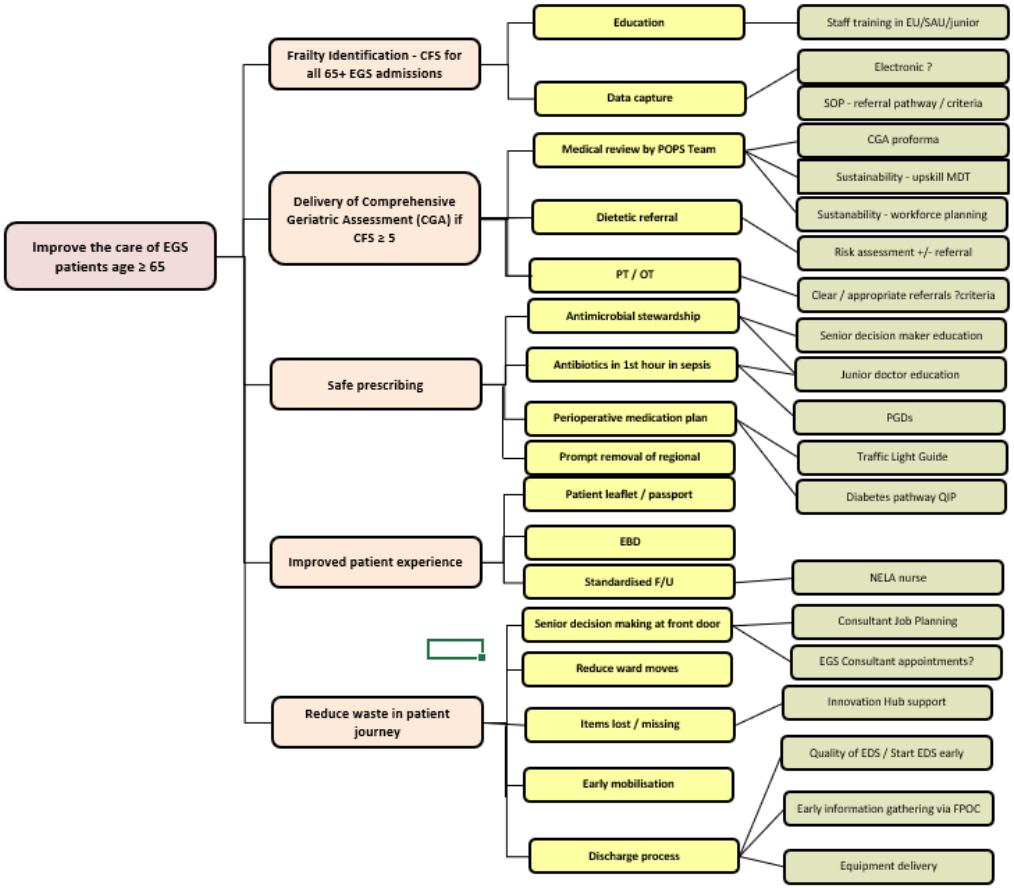


POPS Ease Benefit Matrix of Issues Raised During USC Pathway

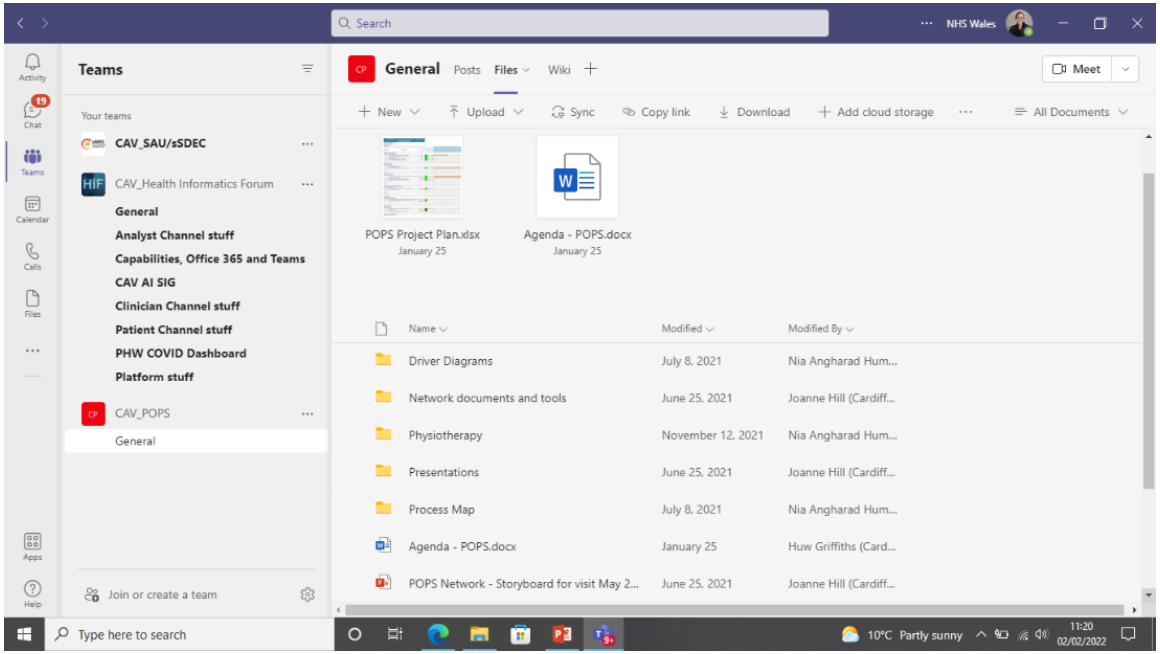
1. Easy	A. High Benefit
2. Difficult	B. Low Benefit

	Ease/Benefit Score
EU/SAU	
No frailty score taken	1A
PGD not in use yet – 1A	1A
SpR may need advice from consultant before decision can be made	1A
No senior decision maker available	2A
Blood results not always available	2A
Delays for imaging	2A
Paper requests for radiology	2A
Delays for imaging results reporting	2A
Pre-op and surgery	
Peri-op med plans/decision	1A
Items lost or missed	1A
Bed booking process – duplication	2A
Availability to consent out of hours	2A
Pre-op delays due to discussions required with patient/family	2A
Theatre availability	2A
Consultant surgeon availability	2A
Lack of porters	2A
Can be hard to get hold of consultant mobile	2A
Senior anaesthetist not always available (OOHs)	2A
Post op	
Not always space in recovery	2A
Anaesthetist stuck if no nurse available	2A
Long stay in recovery if there is no bed available on the ward	2A
No ITU bed	2A
Nurse in charge does not always know which ward to admit to	2A
Admitted to ward	
Patient not always admitted on to WCWS in real time (OOHs)	1A
Delay in removing regional anaesthesia – anti ERAS	1A
Patient not mobilised post op (still in bed)	1A
No consideration for frailty score	1A
Paper system POPS – manual data entry	1A
Physio/OT are not always required but still receive a referral	1A
Clarity of physio/OT referral – what is need/question	1A
No clear mode of POPS referral (reactive)	1A
No standard POPS proforma	1A
POPS pick up patients from handover/theatre list/NELA website	1A
Is the patient always referred to dietetics if needed?	1A
Pain team review regional anaesthesia but not PCA	2A
Not all patients have a review	2A
There is only one Nia and Nicki	2A
Discharge planning	

- ✓ Face to face
- ✓ Driver diagram will evolve



- ✓ Regular meetings
  - Agenda
  - Project plan (?)
  - Actions log
- ✓ Teams channel



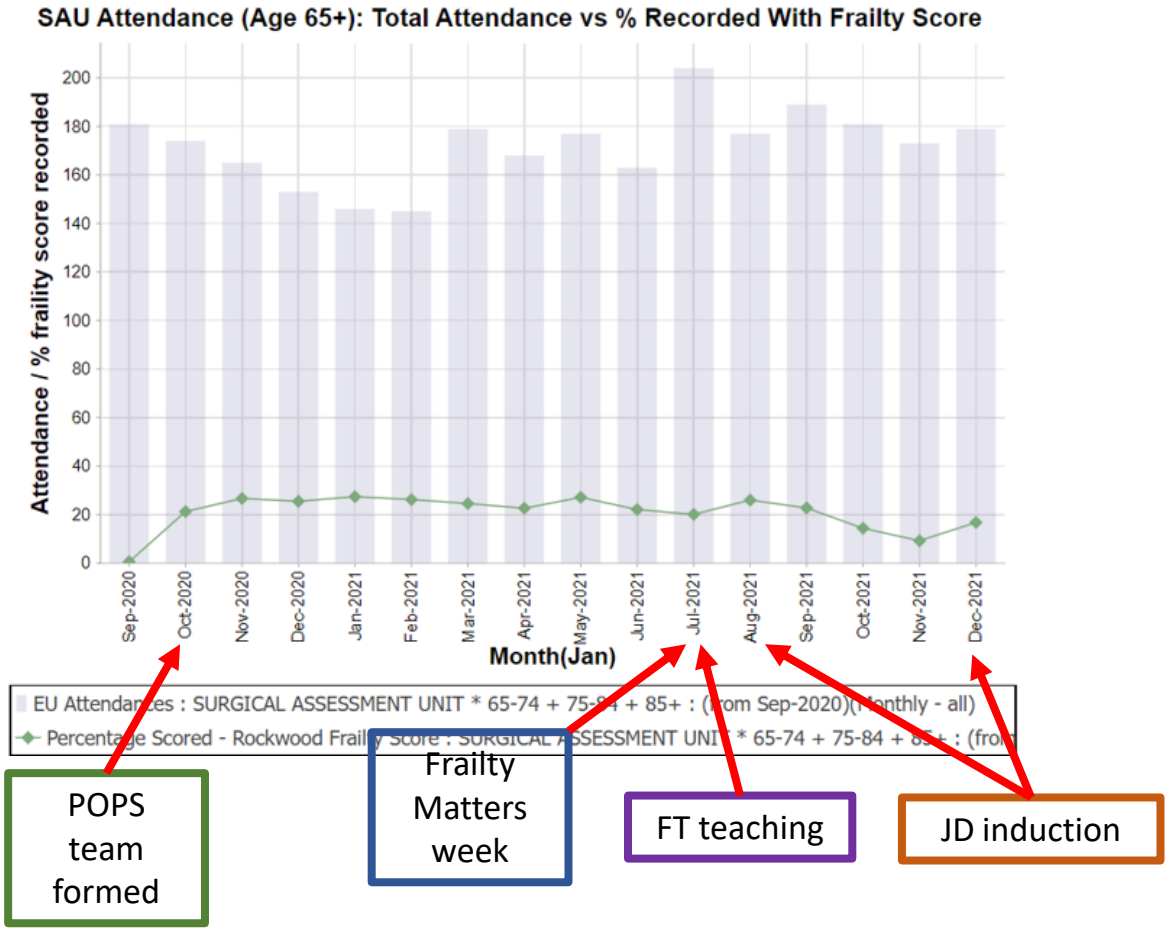
Workstreams

Frailty Identification	Delivering CGA	Safe prescribing	Patient experience	Reducing waste
• Audit of inpatients / current practice • Staff education	• Referral pathway • Proforma • Identity – logo, posters • Nutrition risk assessment • Expansion into POAC	• Pain pathway EmLap • Traffic light guide • Abx 1st hour EmLap PGDs	• Memory link worker • Lost property • NELA follow-up nurse business case	• Delirium screening day 1 post op

Workstreams

Frailty Identification	Delivering CGA	Safe prescribing	Patient experience	Reducing waste
• Audit of inpatients / current practice • Staff education • New sSDEC proforma	• Referral pathway • Proforma • Identity – logo, posters • Nutrition risk assessment • Expansion into POAC	• Pain pathway EmLap • Traffic light guide • Abx 1st hour EmLap PGDs	• Memory link worker • Lost property • NELA follow-up nurse business case	• Delirium screening day 1 post op

Frailty Identification (front door)



This week…

sSDEC Admission Proforma

sSDEC Surgical Same Day Emergency Care

GIG CYMRU NHS WALES — Bwrdd Iechyd Prifysgol Caerdydd a'r Fro / Cardiff and Vale University Health Board

General Surgery ☐ Urology ☐ Vascular ☐ ENT ☐ MaxFax ☐ Ophthalmology ☐

DATE: _____ TIME: _____ CONSULTANT: _____

ADDRESSOGRAPH	TELEPHONE: _____ MOBILE: _____ MARITAL STATUS: _____ RELIGION: _____ COVID VAX: 1☐ 2☐ 3☐ DATE: _____ GP NAME: _____ ADDRESS: _____ TELEPHONE: _____
NEXT OF KIN: _____ ADDRESS: _____	RELATIONSHIP: _____ TELEPHONE: _____

METHOD OF REFERRAL: ED ☐ HC ☐ GP ☐ Allergies: .....

Presenting Complaint: ..... Patient Age: .....

..... Occupation: .....

Learning Difficulties / Autism? Yes / No Dementia? Yes / No

Time of observations:		HEIGHT:	WEIGHT:
PULSE:	BP:	RESP. RATE:	TEMP:
O_2 SATS:	On: O_2	AVPU: A V P U	PAIN SCORE:
NEWS:	GLUCOSE:	NAUSEA: YES / NO	BMI:

IF NEWS >3 OR ABOVE, THEN ESCALATE

INVESTIGATIONS SENT					
FBC:		CRP:		URINE DIP: MSU SENT: YES / NO	
U&E:		AMYLASE:		β-HCG:	
LFT:		GROUP & SAVE:		CLOTTNG:	
BLOOD CULTURE:		ECG:		LACTATE:	

IF NEWS >3 AND THIS PATIENT HAS ACUTE ABDOMINAL PAIN / DISTENSION, THIS PATIENT IS AT RISK FOR INTRAABDOMINAL SEPSIS REFER TO SEPSIS 6 TOOL ON PAGE 5 (and record on EU workstation - Sepsis Star)

PRESCRIBE ANTIBIOTICS ON PAGE 10 OR ON DRUG CHART - TAZOCIN 4.5g plus GENTAMICIN 6mg/kg
Take culture and start antibiotics.

For penicillin allergy please consult MicroGuide.

Social History:

Activities of daily living:
☐ Independent ☐ Residential home ☐ Carers (_____x/day) ☐ Nursing home

Mobility:
☐ Independent ☐ Frame ☐ Stick ☐ Wheelchair

Smoking:
☐ Yes ☐ No ☐ Ex **Exercise tolerance:** _____

If yes, give brief interventions and offer NRT if they are inpatients - please tick if accepted ☐

Alcohol:
☐ Yes ☐ No ☐ Ex
Units/week: _____

Drug Abuse:
Yes ☐ No ☐ Ex ☐
Details: _____

If yes, you MUST complete full audit-C, Appendix 1

History of falls: ☐ Yes ☐ No

Registered Blind: ☐ Yes ☐ No **Severe hearing loss:** ☐ Yes ☐ No

Clinical Frailty Score (over 65s):
N.B. Should be based on activity over last 14 days. N/A in stable long term physical or learning difficulties.

CLINICAL FRAILTY SCALE

1 **VERY FIT** — People who are robust, active, energetic and motivated. They tend to exercise regularly and are among the fittest for their age.

2 **FIT** — People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g., seasonally.

3 **MANAGING WELL** — People whose **medical problems are well controlled**, even if occasionally symptomatic, but often are **not regularly active** beyond routine walking.

4 **LIVING WITH VERY MILD FRAILTY** — Previously "vulnerable," this category marks early transition from complete independence. While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up" and/or being tired during the day.

5 **LIVING WITH MILD FRAILTY** — People who often have **more evident slowing**, and need help with **high order instrumental activities of daily living** (finances, transportation, heavy housework). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation, medications and begins to restrict light housework.

6 **LIVING WITH MODERATE FRAILTY** — People who need help with **all outside activities** and with **keeping house.** Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **LIVING WITH SEVERE FRAILTY** — **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~6 months).

8 **LIVING WITH VERY SEVERE FRAILTY** — Completely dependent for personal care and approaching end of life. Typically, they could not recover even from a minor illness.

9 **TERMINALLY ILL** — Approaching the end of life. This category applies to people with a **life expectancy <6 months**, who are **not otherwise living with severe frailty.** (Many terminally ill people can still exercise until very close to death.)

SCORING FRAILTY IN PEOPLE WITH DEMENTIA

The degree of frailty generally corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

In **very severe dementia** they are often bedfast. Many are virtually mute.

DALHOUSIE UNIVERSITY
www.geriatricmedicineresearch.ca

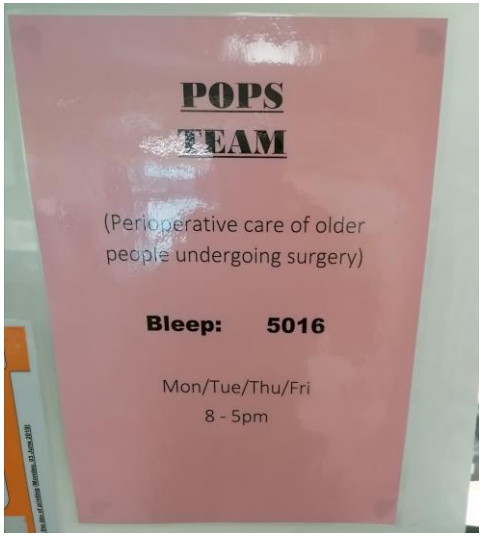
Clinical Frailty Scale ©2005–2020 Rockwood, Version 2.0 (EN). All rights reserved. For permission: www.geriatricmedicineresearch.ca
Rockwood K et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005; 173:489–495.

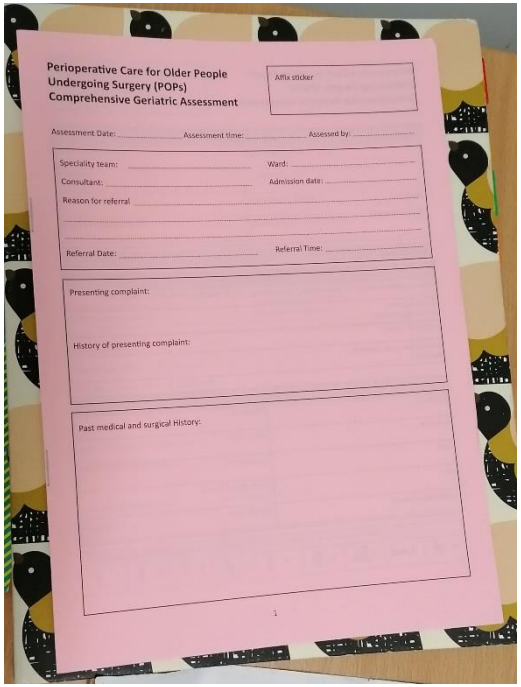
Four-point abbreviated mental score (compulsory if >65 years):
Place ☐ D.O.B. ☐ Age ☐ Year ☐
If one point incorrect, please complete full 4 AT assessment (Appendix 2).

Remember dementia is CFS 5+

Clinical Frailty Score = **(POPS referral if ≥5)**

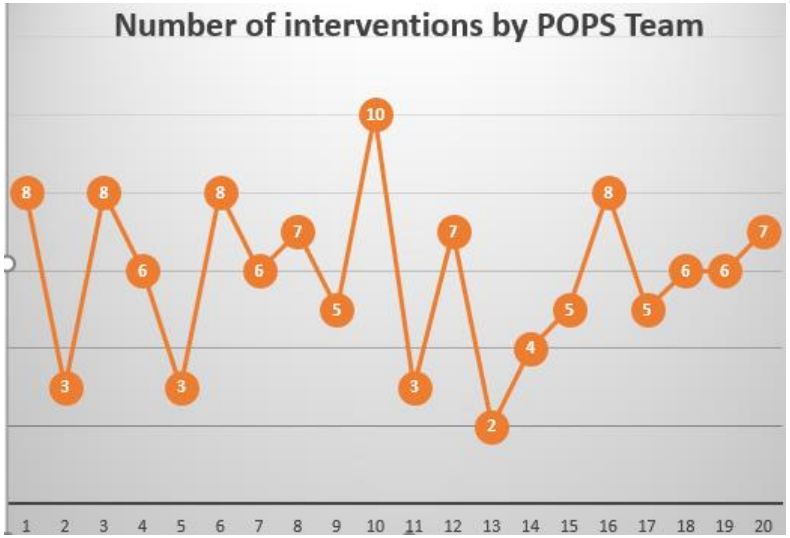
CGA Delivery

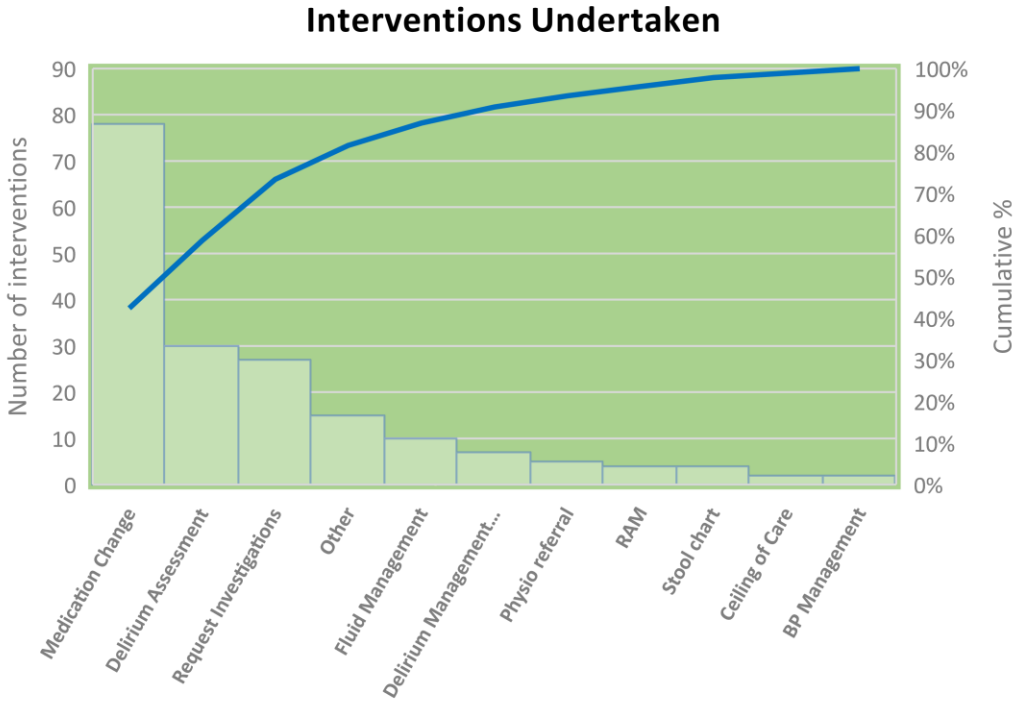




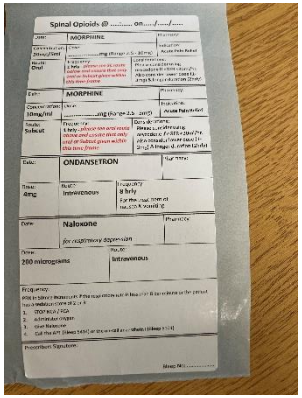
POPS

PERIOPERATIVE CARE OF OLDER PEOPLE UNDERGOING SURGERY


Number of interventions by POPS Team
8 3 8 6 3 8 6 7 5 10 3 7 2 4 5 8 5 6 6 7
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20


Interventions Undertaken
Number of interventions
Cumulative %
0 10 20 30 40 50 60 70 80 90
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
Medication Change
Delirium Assessment
Request Investigations
Other
Fluid Management
Delirium Management...
Physio referral
RAM
Stool chart
Ceiling of Care
BP Management

Safe Prescribing



2 weeks data collection

NELA over 65s

6 patients
- all prescribed Tramadol
- OOH + NBM / Pain team / stickers
- PCA - CFS 7, dementia

Working group formed – pathway / new stickers (February)

Postoperative pain management in the emergency laparotomy patient over 65

- All emergency laparotomy patients should return to the ward with rectus sheath catheters or an epidural.
- If the patient has not had an epidural, they should have a morphine/ fentanyl PCA.
- All patients should receive regular paracetamol.

Our analgesia guidelines aim to limit the use of opiates /tramadol in our older emergency laparotomy group, as they are associated with delirium in this group of patients.

1. **Managing moderate/severe pain shortly after surgery**

If the patient is in **moderate / severe** pain shortly after surgery, do they have a PCA?

Yes	No
Encourage use, if demand greater than delivered, may need to increase dose, contact pain team for advice.	May need PCA. If the patient may find it difficult to use a PCA, prescribe subcutaneous (sc) morphine 2.5-5mg PRN maximum hourly. Ensure sc butterfly infusion catheter is placed.

2. **When the patient no longer needs IV morphine/fentanyl**

When the patient no longer needs iv opiates, are they absorbing enterally?

Yes

Continue regular paracetamol and prescribe oramorph for breakthrough pain. Dose 2.5-10mg 2 hourly (start low in older/frailer patients).
In patients with renal impairment (CrCl<30ml/hour) prescribe Oxycodone 1 - 2.5mg 2 hourly.

Opiate toxicity

Ensure Naloxone 200 mcg iv PRN always prescribed with opiates, in case of opiate toxicity.

No

Consider **Clinical Frailty Scale score** (see score sSDEC admission page 2/15)

CFS 1-3 Not frail	CFS 4 Vulnerable	CFS 5-9 Frail
Has the patient had any side effects with tramadol? **No:** prescribe Tramadol PRN at 50mg QDS and titrate cautiously to max dose 100mg. **Yes:** prescribe sc morphine 2.5-5mg hourly PRN	Has the patient had any side effects with tramadol? **No:** prescribe Tramadol 25mg QDS PRN. **Yes:** prescribe sc morphine 2.5-5mg hourly PRN	**Do not prescribe tramadol** Prescribe sc morphine 2.5-5mg hourly PRN

LIMIT EXPOSURE TO OPIATES AND TRAMADOL, AS PAIN IMPROVES CONSIDER DEPRESCRIBING DAILY.
AIM TO DISCHARGE ALL PATIENTS OFF TRAMADOL AND ON MINIMAL OPIATES (CODEINE/ ORAMORPH) FOR A LIMITED TIME ONLY.

Contact details: 8am- 8pm Acute Pain team Bleep 5414. Out of hours on call anaesthetist Bleep 5101

Reflection

Aims: Short-term (6 months)	
All patients 65+ admitted under general surgery are assessed for frailty	✗
All patients 65+ *and* frail undergo a Comprehensive Geriatric Assessment	✗
Improve patient pathway for those undergoing emergency laparotomy	✓

Emergency

Top Tips!

The Team:
- Cast the net wide
- In-house innovation / data support – ask!

Your Aims:
- Strategic priorities
- Consult your team

Getting started:
- Process mapping – face to face
- Establish regular meetings - keep actions log
- Teams channel

During the network:
- Keep focused on your aims, but learn from others
- Simple data can demonstrate a lot

nia.humphry@wales.nhs.uk

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Cardiff and Vale University Health Board

POPS

PERIOPERATIVE CARE OF OLDER PEOPLE UNDERGOING SURGERY

Measurement for Improvement

Matt Tite

Starting our measurement Journey

Feb 2022

Matt Tite

In the next 15 minutes…

- Introduce our approach to measurement
- Tell you about the measurement offer
- Start our measurement journey
  - Aim statements
- Set some homework

POPS Measurement Journey

Launch Event (Part 1: 03/02/22): Setting the Aim and understanding the scope using process mapping

Launch Event (Part 2: 17/02/22): Driver diagram development session and the 7 steps to measurement

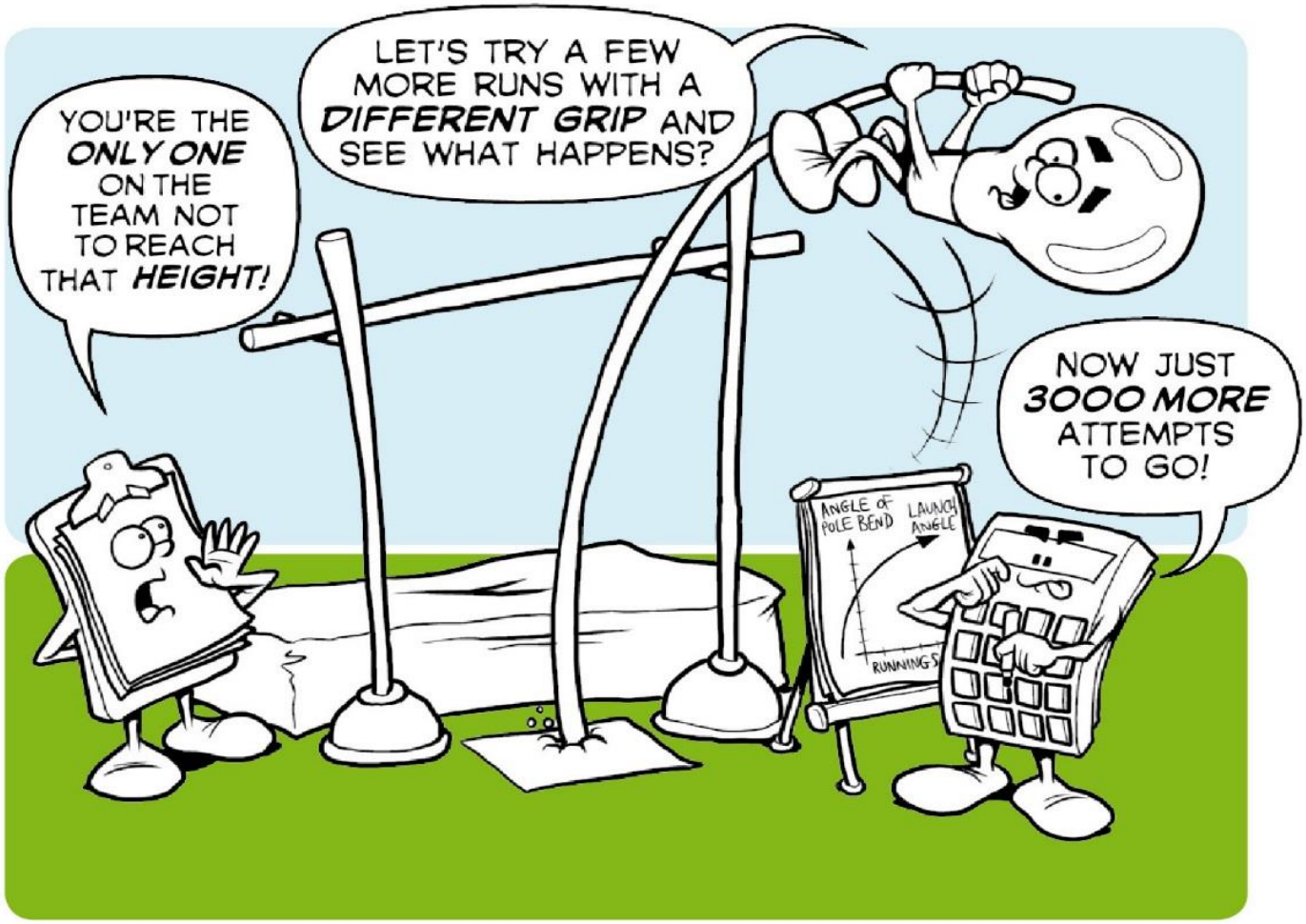
Measurement Masterclass (24/02/22): Measurement for Improvement knowledge, how and what to measure

- Measurement for improvement & Shared Decision making
- Measurement for improvement & Experienced Based Design

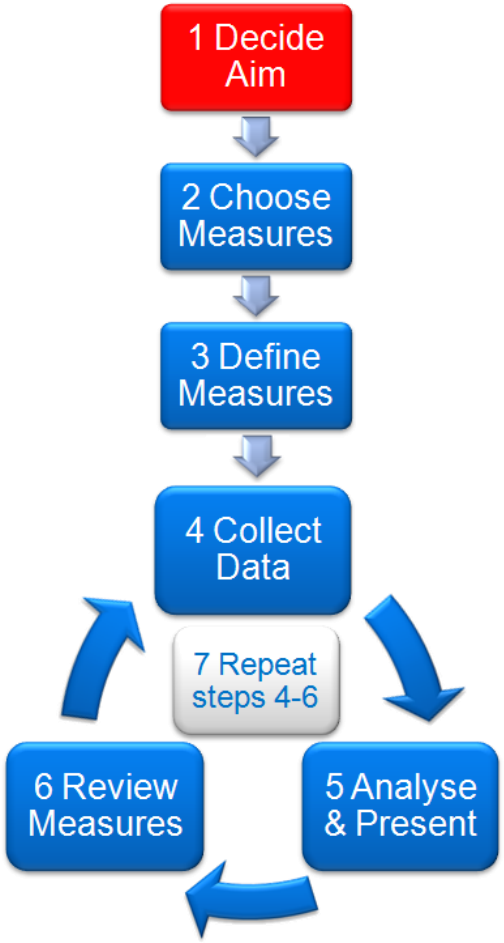
Your Measurement visit

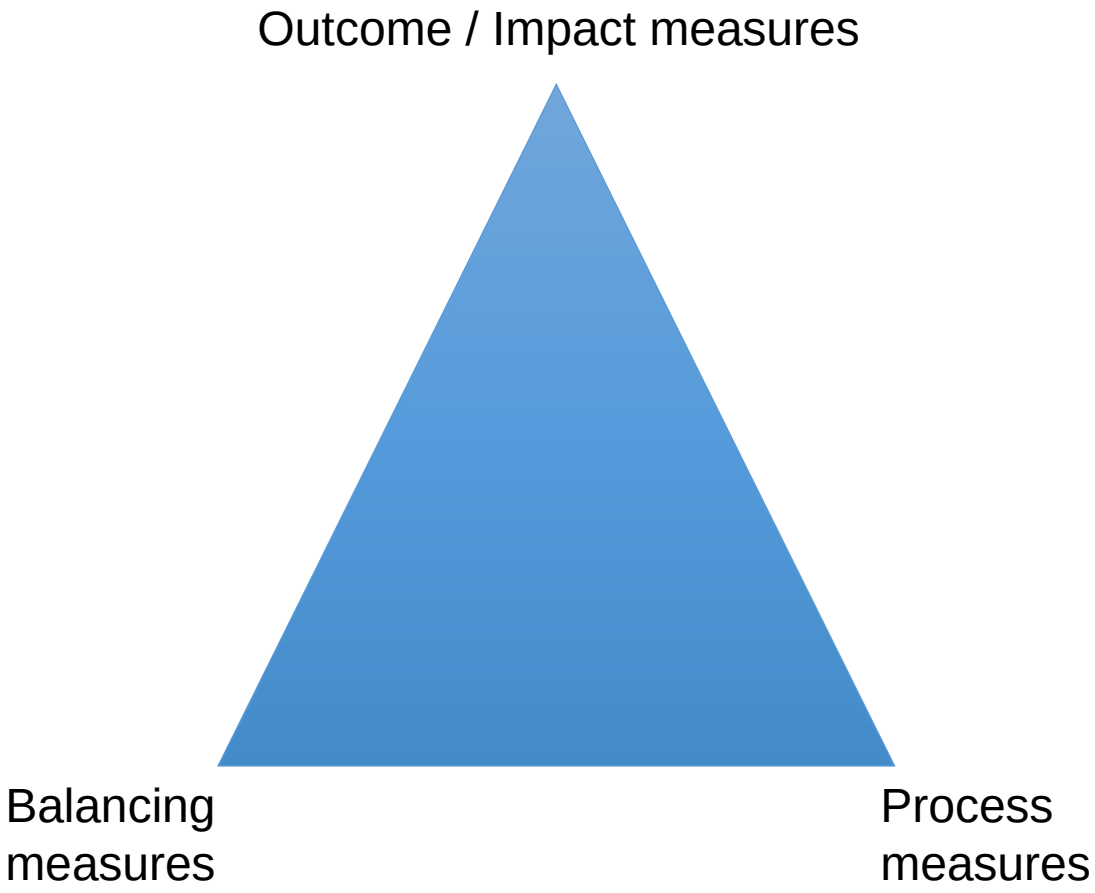
Mid National Event: Share your working data and the tools you are using for data collection

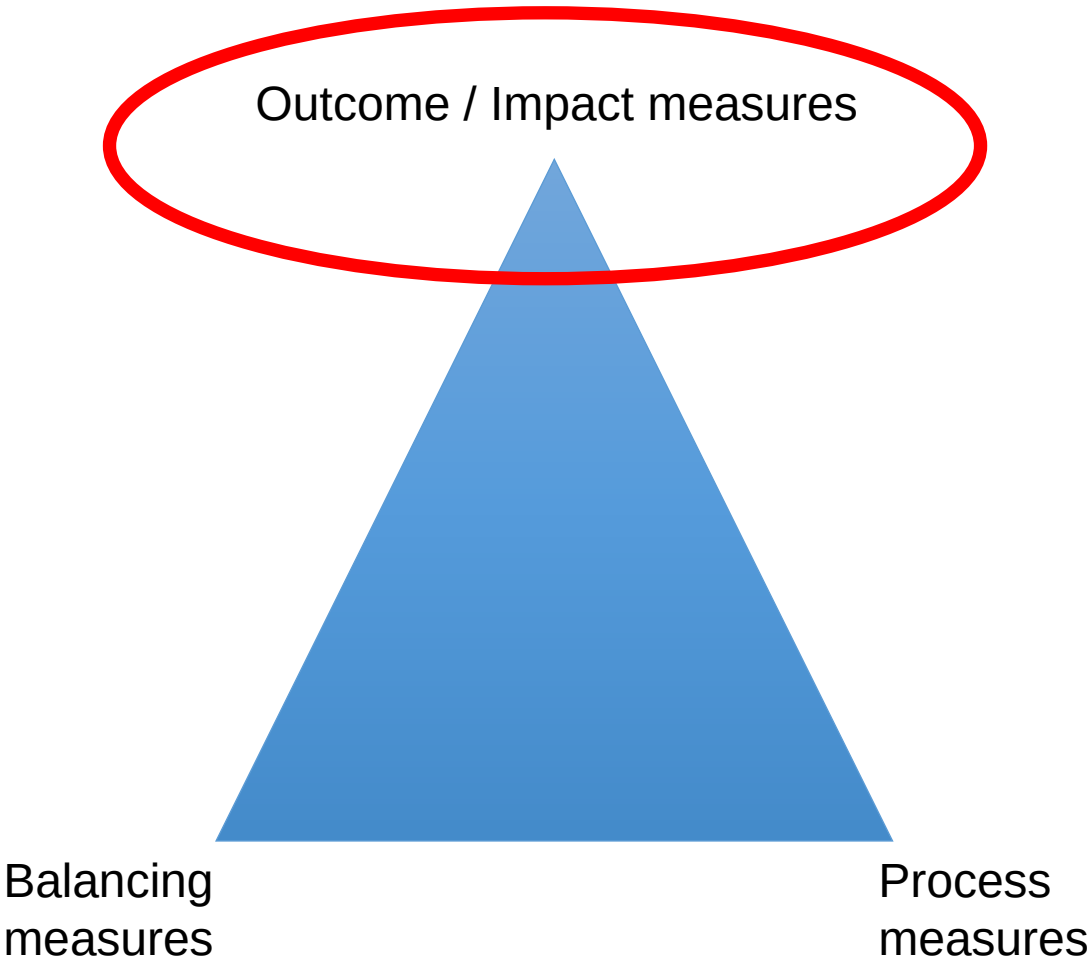
Final National Event (04/08/2022): Your charts

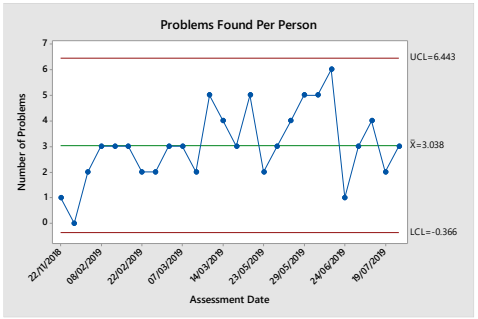

YOU'RE THE ONLY ONE ON THE TEAM NOT TO REACH THAT HEIGHT!
LET'S TRY A FEW MORE RUNS WITH A DIFFERENT GRIP AND SEE WHAT HAPPENS?
NOW JUST 3000 MORE ATTEMPTS TO GO!
ANGLE OF POLE BEND
LAUNCH ANGLE
RUNNING S

The 7 steps to measurement

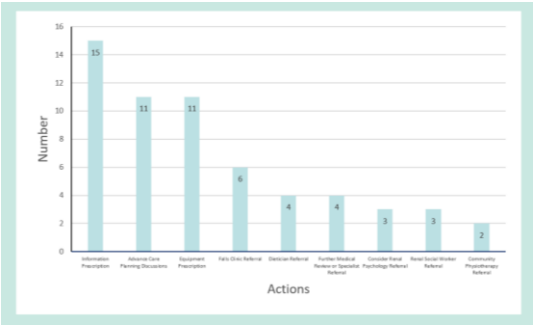


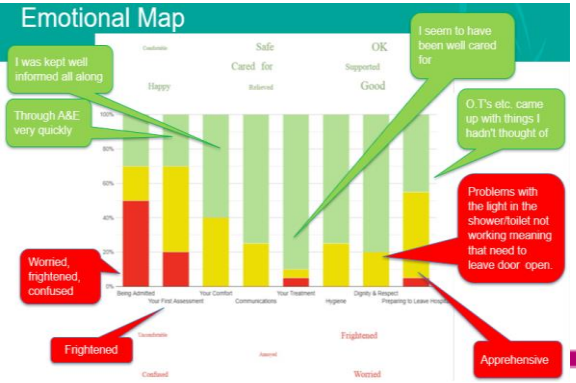

Outcome / Impact measures
Balancing measures
Process measures


Outcome / Impact measures
Balancing measures
Process measures



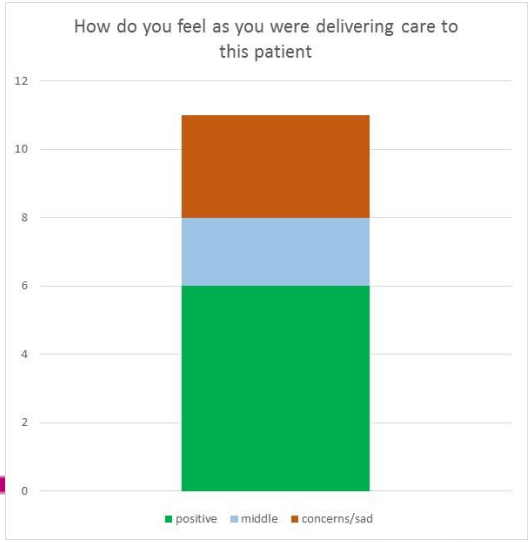
Data / Graphs





Patient Perspective

Staff Perspective



What shall we measure?

Activity 1 : Where are you wanting to go?

For your POPS service, what would ‘Perfect’ look like?

Open a blank email

Write in your sentence

Sent it to your project lead

Where are you wanting to go?

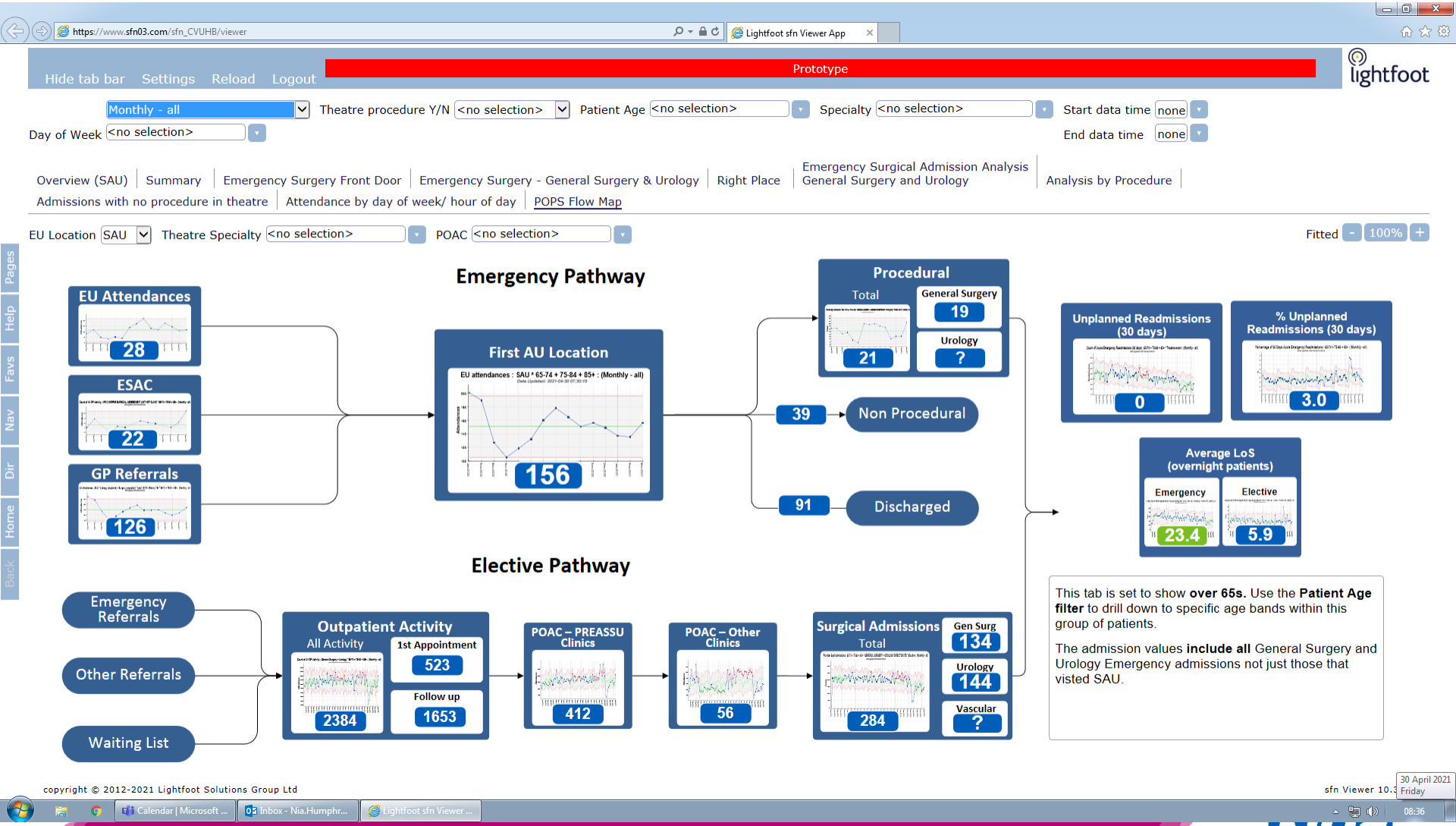
Homework

Work as a team – have you written the same things?

If so, see if you can create an aim statement

Bring your combined aim statement to driver diagram session 17 February 2022

Our Pathway Map



Homework (Part 2)

Can you create a functional map:

- Where do your patients come from
- What are the stages that they currently go through
- Has C19 changed the process?

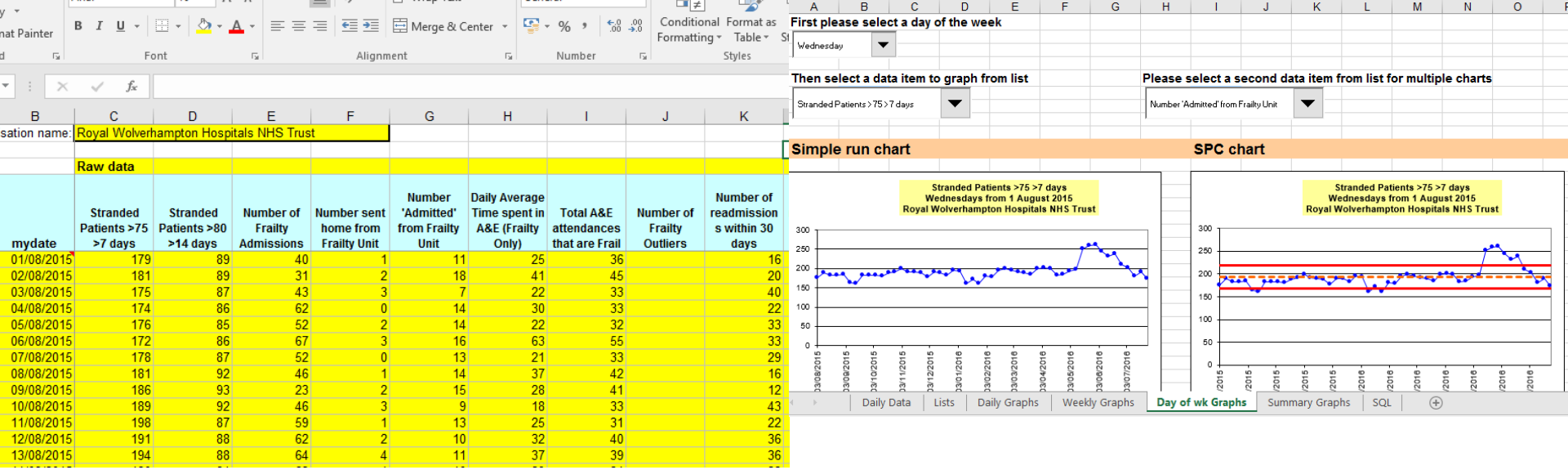
Bring your functional map to driver diagram session – 17 February 2022

Measurement and analysis support

- A Measurement for Improvement workshop
- A measurement visit
- An interactive measurement guide
- Webinars
- Telephone support
- SPC tools

Five Measurement Challenges

1. Are you clear on your aim?
2. Have you selected the right measures to quantify the benefits?
3. Are you tracking the right patient groups - how do you identify these?
4. Can you map and quantify the flow of frail patients through your system?
5. Will you be able to demonstrate the impact of implementing your improvements?

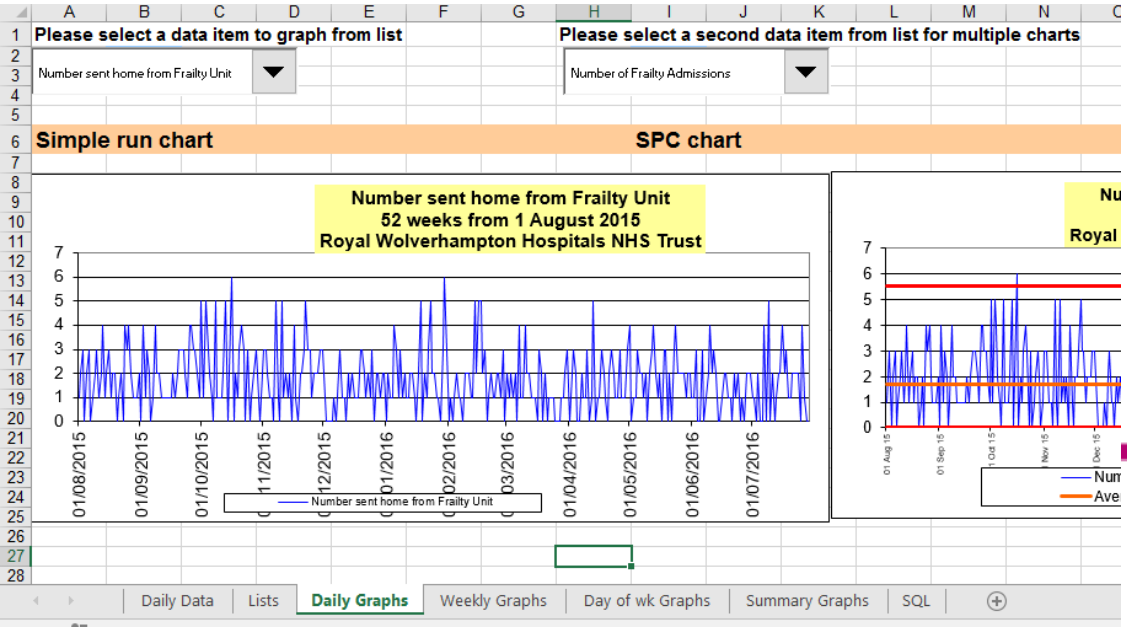


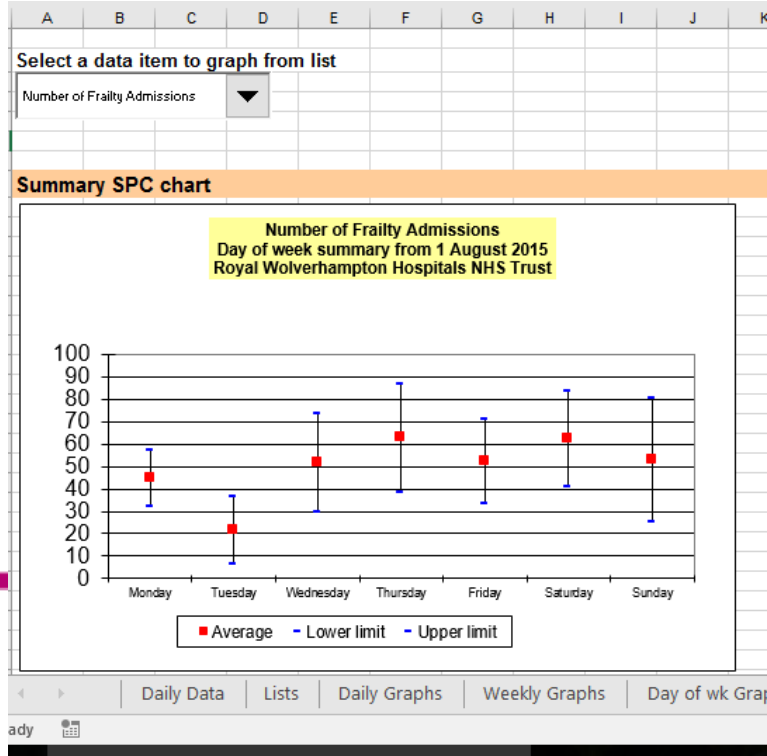
sation name: Royal Wolverhampton Hospitals NHS Trust

Raw data

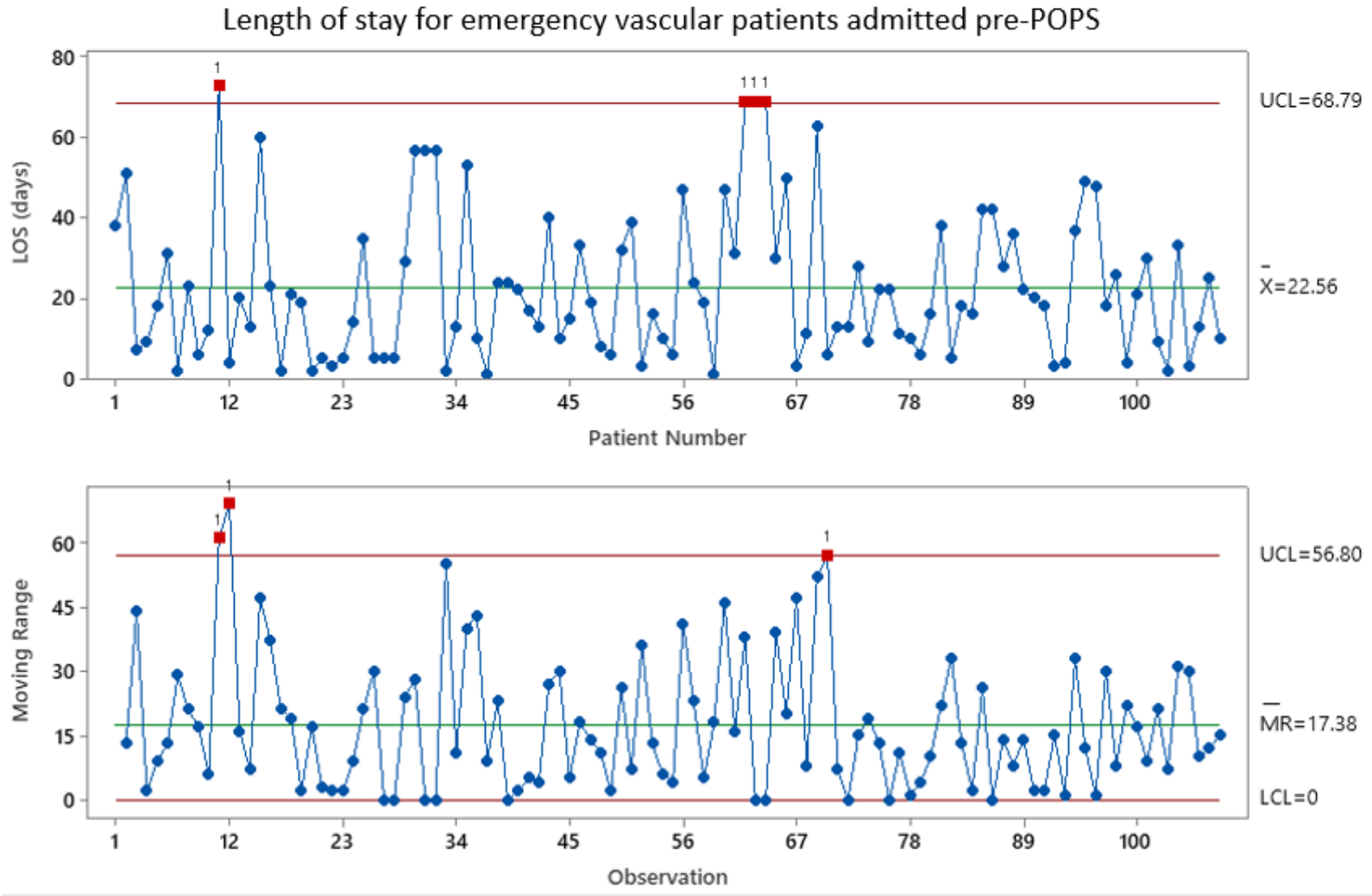
mydate	Stranded Patients >75 >7 days	Stranded Patients >80 >14 days	Number of Frailty Admissions	Number sent home from Frailty Unit	Number 'Admitted' from Frailty Unit	Daily Average Time spent in A&E (Frailty Only)	Total A&E attendances that are Frail	Number of Frailty Outliers	Number of readmissions within 30 days
01/08/2015	179	89	40	1	11	25	36		16
02/08/2015	181	89	31	2	18	41	45		20
03/08/2015	175	87	43	3	7	22	33		40
04/08/2015	174	86	62	0	14	30	33		22
05/08/2015	176	85	52	2	14	22	32		33
06/08/2015	172	86	67	3	16	63	55		33
07/08/2015	178	87	52	0	13	21	33		29
08/08/2015	181	92	46	1	14	37	42		16
09/08/2015	186	93	23	2	15	28	41		12
10/08/2015	189	92	46	3	9	18	33		43
11/08/2015	198	87	59	1	13	25	31		22
12/08/2015	191	88	62	2	10	32	40		36
13/08/2015	194	88	64	4	11	37	39		36

Use the measurement tool….

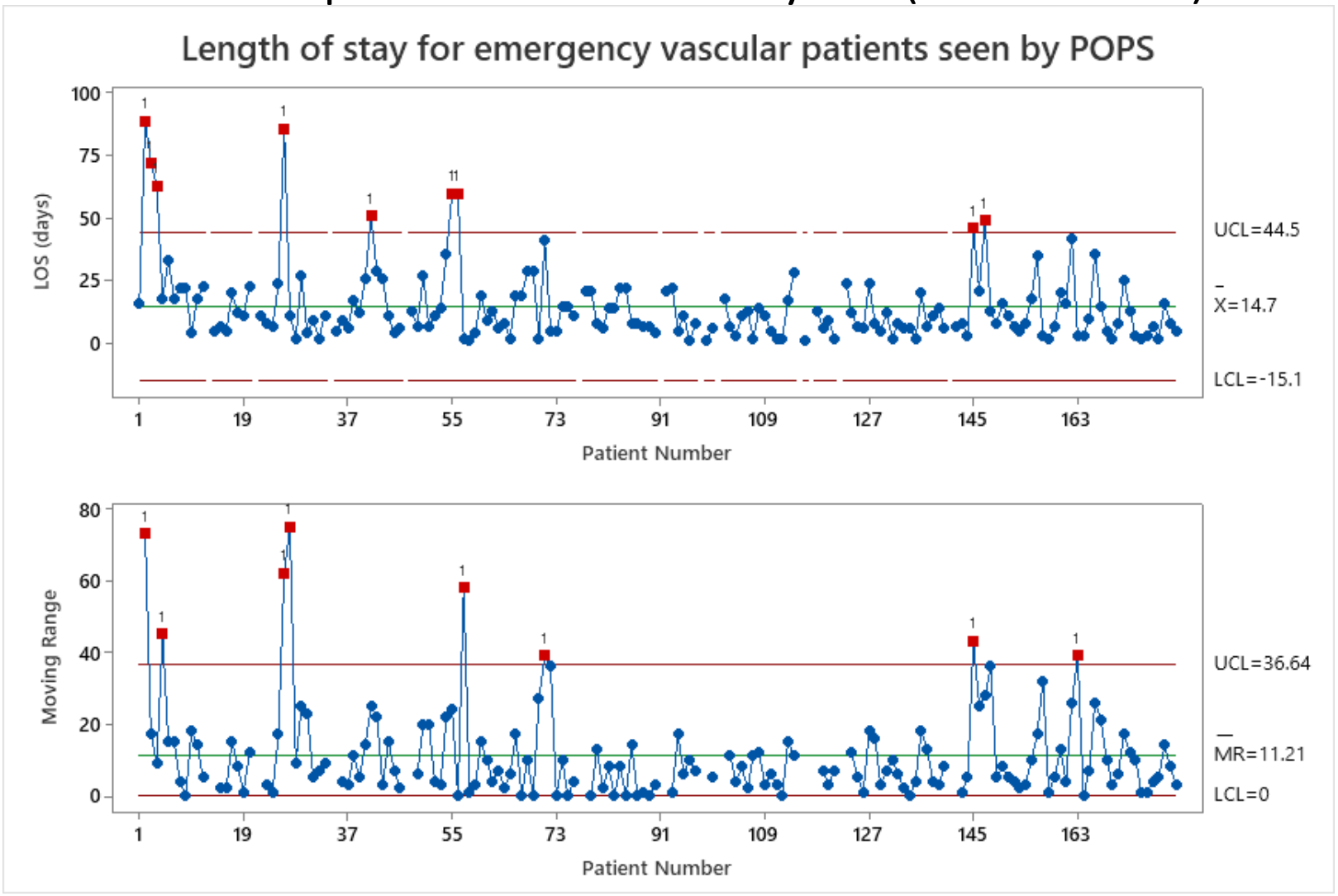




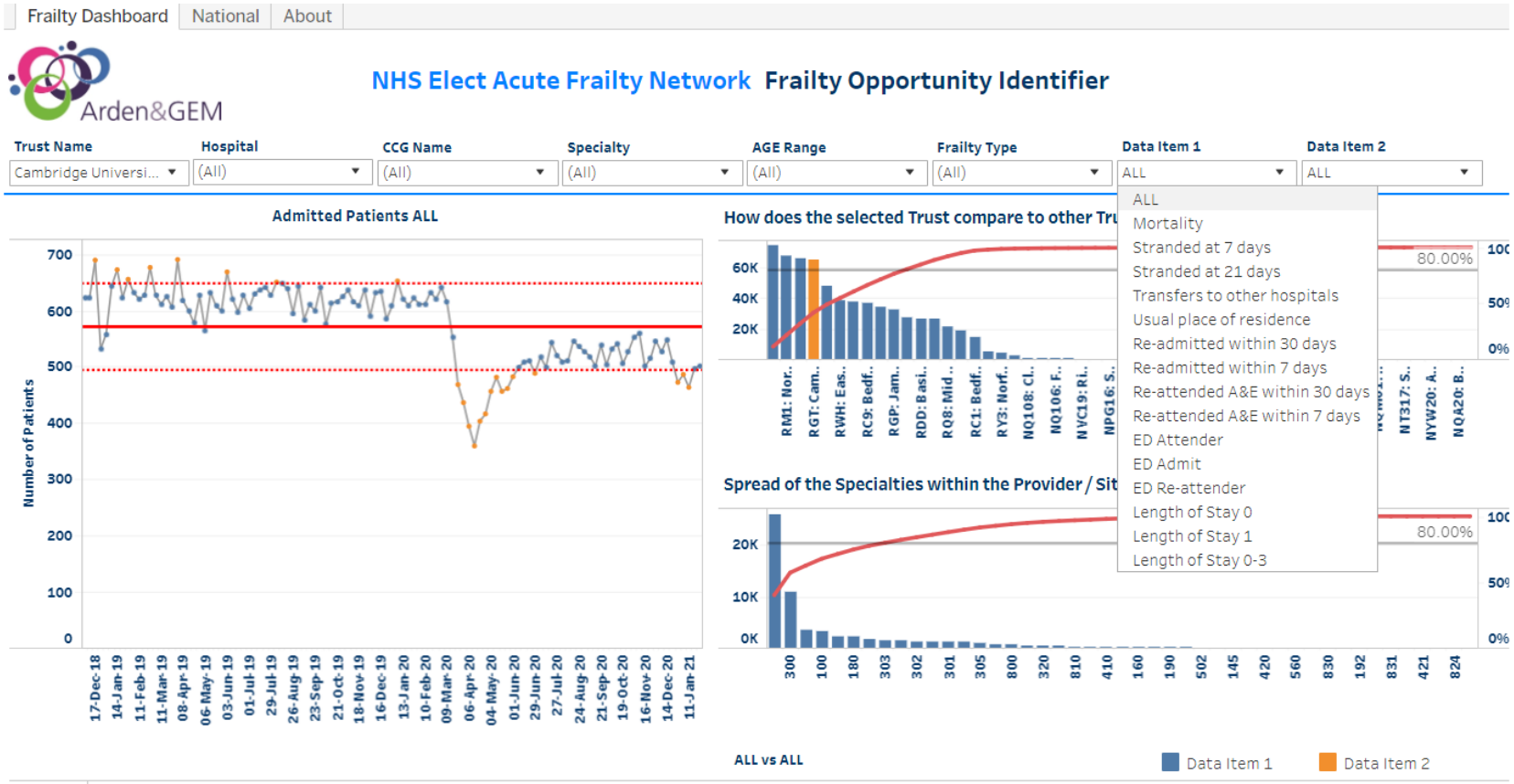
Examples of SPC analysis (East Kent)



Examples of SPC analysis (East Kent)



Frailty Opportunity Identifier



To get your own login..

https://apps.model.nhs.uk/register

https://ncdr.england.nhs.uk/Account

www.youtube.com

Using the Online Frailty Opportunity Identifier Tool

Wants and Offers

Lisa Godfrey

Want's and offer's

- Think about what you 'want' to know about POPS and the knowledge you have to 'offer' about developing POPS services.

- Using Slido, we'll ask you two questions:

  - **WANTS** - What areas would you like support with? For example, support with data analysis, developing business cases, workforce, internal/external relationships.

  - **OFFERS** - What have you done that you would be happy to share with others? (*make sure you also include your name and organisation as we may ask you to share your offer in the next session on 17 February)*

www.sli.do #POPS2LAUNCH1

World Café on 17 February

Summary and closing remarks

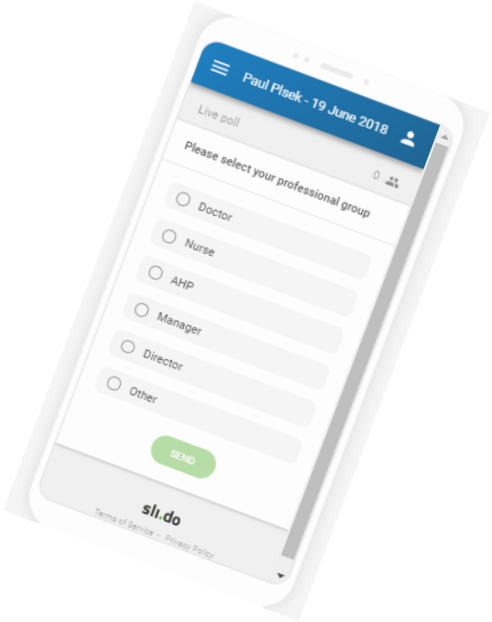
Dr Jugdeep Dhesi

Next steps

As a team think about the following:

- Ensure you've identified core members of your team e.g. your Exec Sponsor, Analyst, Project Manager etc.
- Access the POPS website www.popsolderpeople.org and let us know what content would be useful.
- Access the POPS Toolkit on the website.
- Get the date for your virtual site visit in your diary (if applicable)
- Co-ordinate with us to schedule the date for your virtual measurement site visit.
- Register for the next session on 17 February – 09:00 to 12:00, and the Measurement Masterclass on 24 February – 09:00 to 12:00.

sli.do



Open a browser on any laptop, tablet or smartphone

- Go to **www.sli.do** or scan the QR code below
- Enter the event code **#POPS2Launch1**
- Use the polls to give us feedback about the day

Think about the support you want/need and let the programme team know at

networksinfo@nhselect.org.uk