Perioperative Care for Older People undergoing Surgery
The (POPS) Network
Cohort Two
Core Event

May 2022

Agenda

09:00	Welcome and introduction to the day **Dr Jugdeep Dhesi** Clinical Lead, POPS Network
	Using CPOC BGS Frailty guidance to support change **Dr Jude Partridge** POPS Consultant, GSTT
	How to identify 'at risk' patients early in the pathway **Dr James Prentis** Consultant, Newcastle
	Case study: changing the waiting list to a preparation list **Dr Rachael Barlow,** Clinical Lead Prehabilitation, Cardiff
	BREAK
	Your measurement journey so far **Matt Tite** Director, NHS Elect
	Networking session **All**
	Summary and Next Steps **Dr Jugdeep Dhesi** POPS Consultant, GSTT and POPS Network Clinical Lead
11:30	**CLOSE**

Housekeeping

Silence is golden, unless you want us to hear you

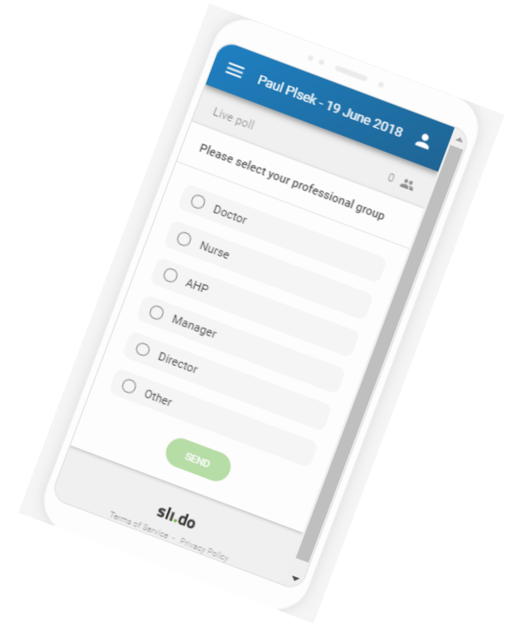
Please turn off your camera during presentations

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

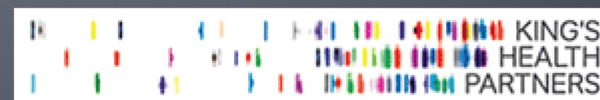
- Go to **www.sli.do** or scan the QR code below
- Enter the event code **#POPS2-MAY**
- Use the polls to give us feedback about the day

Using CPOC BGS Frailty guidance to support change

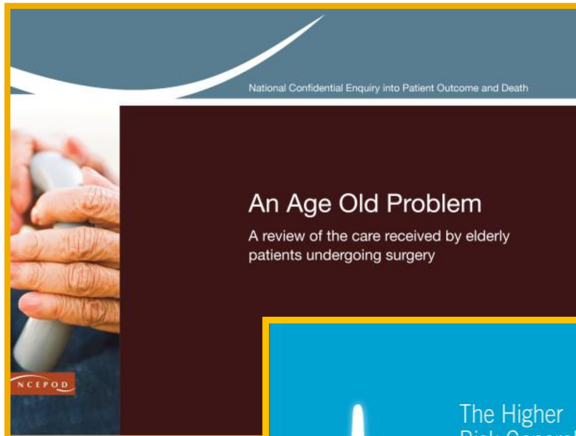
Dr Jude Partridge, POPS Consultant, GSTT

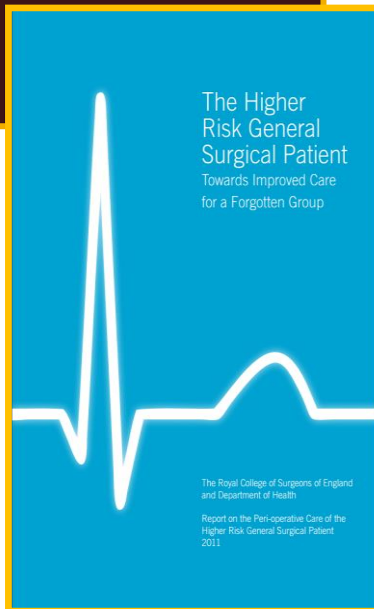
Evidence supporting the development of POPS services for older surgical patients; using CPOC BGS frailty guidance to support change

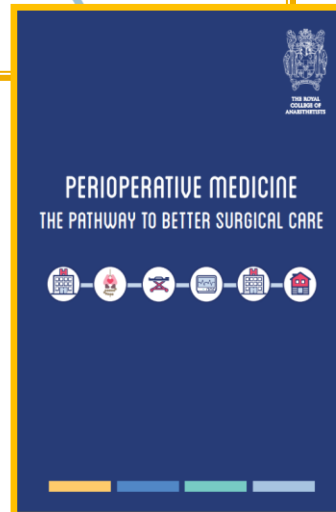
Jude Partridge
Geriatrician
Guy's and St Thomas' NHS Foundation Trust
Hon Senior Lecturer
King's College London

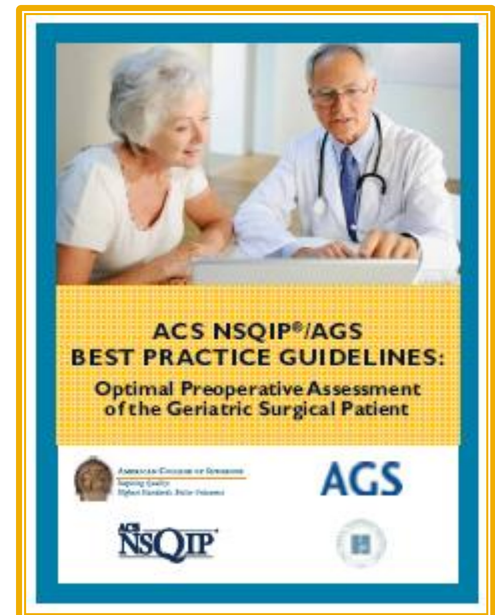


Reports and guidelines



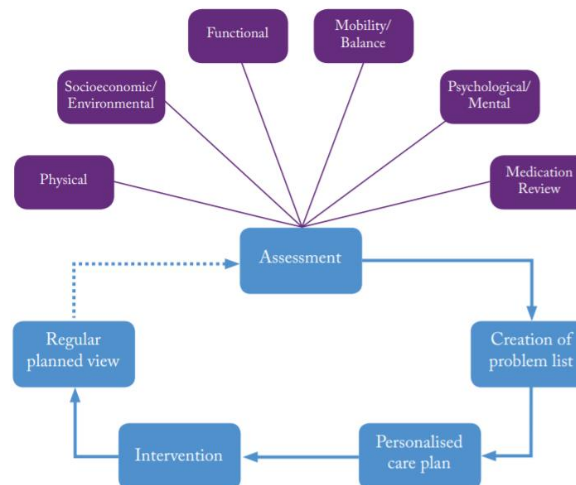






Advocating the use of Comprehensive Geriatric Assessment (CGA)

A multidimensional, multidisciplinary process that identifies medical, social and functional needs prompting the development of an evidence based, integrated and individualised care plan to meet those needs.



https://www.bgs.org.uk/resources/

What is the evidence for CGA?
… in medical patients…

30% higher chance of being alive and in own home
NNT 13 (OR 1.31, CI 1.15-1.49)

Originally published as Volume 2, Issue 8878

Clinical practice

Comprehensive
trials

DEPARTMENT OF PUBLIC HEALTH, OXFORD

Ju

Pr

Does inpatie
assessment
adults admit

Cochrane
Library

Cochrane Database of Systematic Reviews

Comprehensive geriatric assessment for older adults admitted to hospital (Review)

Ellis G, Gardner M, Tsiachristas A, Langhorne P, Burke O, Harwood RH, Conroy SP, Kircher T, Somme D, Saltvedt I, Wald H, O'Neill D, Robinson D, Shepperd S

...in hip fracture...

Cochrane Database of Systematic Reviews

CGA in hip fracture results in;
- Reduced mortality rates
- Fewer discharges to higher level of care
- Reduced total cost

Comprehensive geriatric assessment for older people admitted to a surgical service (Review)

Eamer G, Taheri A, Chen SS, Daviduck Q, Chambers T, Shi X, Khadaroo RG

8 RCTs comparing CGA with usual care
- 7 in hip fracture patients
- 1 in elective surgical oncology

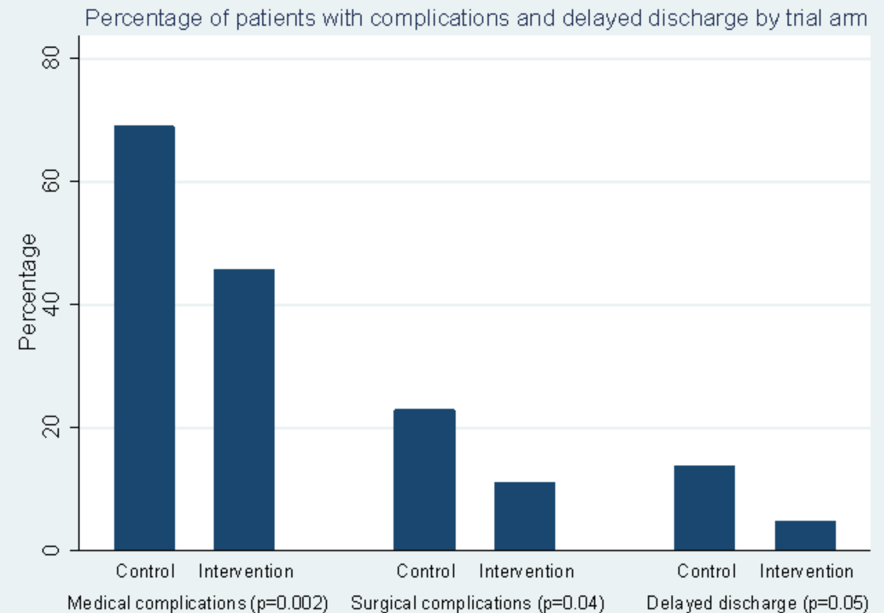
…in elective arterial surgery…

BJS

Randomized clinical trial

Randomized clinical trial of comprehensive geriatric assessment and optimization in vascular surgery

J. S. L. Partridge[1,3], D. Harari[1,3], F. C. Martin[1,3], J. L. Peacock[3], R. Bell[2], A. Mohammed[1] and J. K. Dhesi[1,3]



...and in terms of postoperative ward care in emergency patients...

J Am Med Dir Assoc. 2021 Oct 29;S1525-8610(21)00903-8. doi: 10.1016/j.jamda.2021.09.037. Online ahead of print.

Geriatric Comanagement of Older Vascular Surgery Inpatients Reduces Hospital-Acquired Geriatric Syndromes

Janani Thillainadesan [1], Sarah J Aitken [2], Sue R Monaro [3], John S Cullen [4], Richard Kerdic [5], Sarah N Hilmer [6], Vasi Naganathan [4]

Affiliations + expand

PMID: 34756839 DOI: 10.1016/j.jamda.2021.09.037

- Reductions in hospital-acquired geriatric syndromes
  - Delirium
  - Cardiac complications
  - Infective complications
- Benefits also demonstrated in frail subgroup

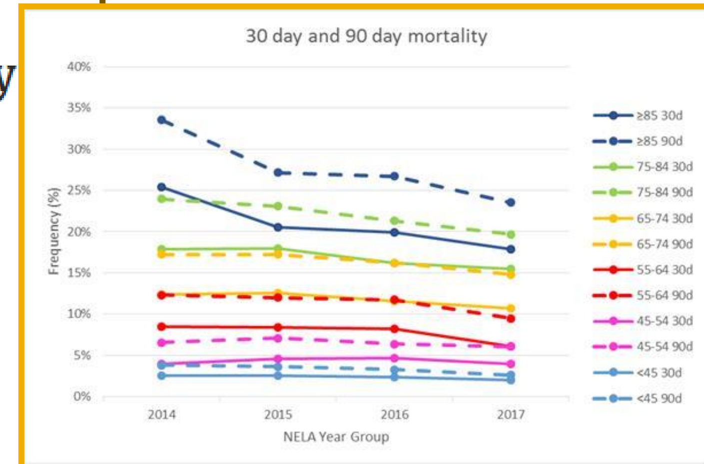
...also supported by big data studies...

EDITOR'S CHOICE

Older patients undergoing emergency laparotomy: observations from the National Emergency Laparotomy Audit (NELA) years 1–4 FREE

Rachel M Aitken, Judith S L Partridge, Charles Matthew Oliver, Dave Murray, Sarah Hare, Sonia Lockwood, Nick Beckley-Hoelscher, Jugdeep K Dhesi

Age and Ageing, Volume 49, Issue 4, July 2020, Pages 656–663,
https://doi.org/10.1093/ageing/afaa075
Published: 02 June 2020 **Article history ▾**



Organisational factors and mortality after an emergency laparotomy
Oliver et al, BJA 2018

Postoperative geriatric medicine review was associated with substantially lower mortality in older patients
OR 0.35; 95% CI:0.29-0.42

...with cost effectiveness...

- Number of investigations
- Number of consultations
- Number of meds
- Duplication of work
- Late cancellations
- Length of stay
- Medical Spr calls
- Readmissions
- Informal/formal social care

Age and Ageing 2021; 1–8
doi: 10.1093/ageing/afab094
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RESEARCH PAPER

Preoperative comprehensive geriatric assessment and optimisation prior to elective arterial vascular surgery: a health economic analysis

Judith S. L. Partridge[1,2,†], Andrew Healey[3,†], Bijan Modarai[4,5], Danielle Harari[1,2], Finbarr C. Martin[2], Jugdeep K. Dhesi[1,2,6]

Cochrane Database of Systematic Reviews

Comprehensive geriatric assessment for older people admitted to a surgical service (Review)

Eamer G, Taheri A, Chen SS, Daviduck Q, Chambers T, Shi X, Khadaroo RG

CGA is a cost-effective substitute for standard preoperative care in elective arterial surgery
Mean total pre- and postoperative healthcare utilisation costs ~£1,165 lower for CGA patients

CGA after hip fracture showed reduced total cost

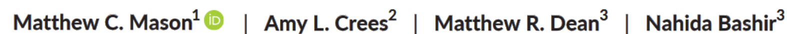
…acknowledging results are mixed

Received: 12 February 2018 | Accepted: 29 March 2018
DOI: 10.1111/ijcp.13096

ORIGINAL PAPER

WILEY THE INTERNATIONAL JOURNAL OF CLINICAL PRACTICE

Establishing a proactive geriatrician led comprehensive geriatric assessment in older emergency surgery patients: Outcomes of a pilot study



Original article doi:10.1111/codi.13785

Preoperative geriatric assessment and tailored interventions in frail older patients with colorectal cancer: a randomized controlled trial

N. Ommundsen*†, T. B. Wyller*†, A. Nesbakken*‡§, A. O. Bakka*¶, M. S. Jordhøy***, E. Skovlund†† and S. Rostoft*†

*Institute of Clinical Medicine, Oslo University Hospital, Oslo, Norway, †Department of Geriatric Medicine, Oslo University Hospital, Oslo, Norway, ‡Department of Gastrointestinal Surgery, Oslo University Hospital, Oslo, Norway, §K.G. Jebsen Colorectal Cancer Research Centre, Oslo University Hospital, Oslo, Norway, ¶Department of Digestive Surgery, Akershus University Hospital, Lørenskog, Norway, **The Cancer Unit, Innlandet Hospital Trust, Hamar, Norway, and ††Department of Public Health and Nursing, NTNU, Norway

Received 11 November 2016; accepted 26 April 2017; Accepted Article online 26 June 2017

Abstract

Age and Ageing 2019; **48:** 643–648
doi: 10.1093/ageing/afz025
Published electronically 22 March 2019

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Can comprehensive geriatric assessment be delivered without the need for geriatricians? A formative evaluation in two perioperative surgical settings

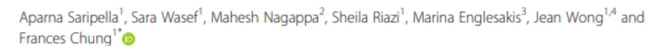
David Kocman[1], Emma Regen[1], Kay Phelps[1], Graham Martin[2], Stuart Parker[3], Thomas Gilbert[4], Simon Conroy[1]

Saripella *et al. BMC Anesthesiology* (2021) 21:127
https://doi.org/10.1186/s12871-021-01337-2

BMC Anesthesiology

RESEARCH ARTICLE Open Access

Effects of comprehensive geriatric care models on postoperative outcomes in geriatric surgical patients: a systematic review and meta-analysis



...acknowledging results are mixed

Received: 12 February 2018 | Accepted: 29 March 2018
DOI: 10.1111/ijcp.13096

ORIGINAL PAPER

WILEY THE INTERNATIONAL JOURNAL OF CLINICAL PRACTICE

Establishing a proactive geriatrician led comprehensive geriatric assessment in older emergency surgery patients: Outcomes of a pilot study

Matthew C. Mason[1] | Amy L. Crees[2] | Matthew R. Dean[3] | Nahida Bashir[3]

Original article doi:10.1111/codi.13785

Preoperative geriatric assessment and tailored interventions in frail older patients with colorectal cancer: a randomized controlled trial

N. Ommundsen*†, T. B. Wyller*†, A. Nesbakken*‡§, A. O. Bakka*¶, M. S. Jordhøy*, E. Skovlund†† and S. Rostoft*†**

*Institute of Clinical Medicine, Oslo University Hospital, Oslo, Norway, †Department of Geriatric Medicine, Oslo University Hospital, Oslo, Norway, ‡Department of Gastrointestinal Surgery, Oslo University Hospital, Oslo, Norway, §K.G. Jebsen Colorectal Cancer Research Centre, Oslo University Hospital, Oslo, Norway, ¶Department of Digestive Surgery, Akershus University Hospital, Lørenskog, Norway, **The Cancer Unit, Innlandet Hospital Trust, Hamar, Norway, and ††Department of Public Health and Nursing, NTNU, Norway

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Can comprehensive geriatric assessment be delivered without the nee... A formative evaluation in... surgical settings

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Saripella *et al. BMC Anesthesiology* (2021) 21:127
https://doi.org/10.1186/s12871-021-01337-2

BMC Anesthesiology

RESEARCH ARTICLE Open Access

Check for updates

Effects of comprehensive geriatric care models on postoperative outcomes in geriatric surgical patients: a systematic

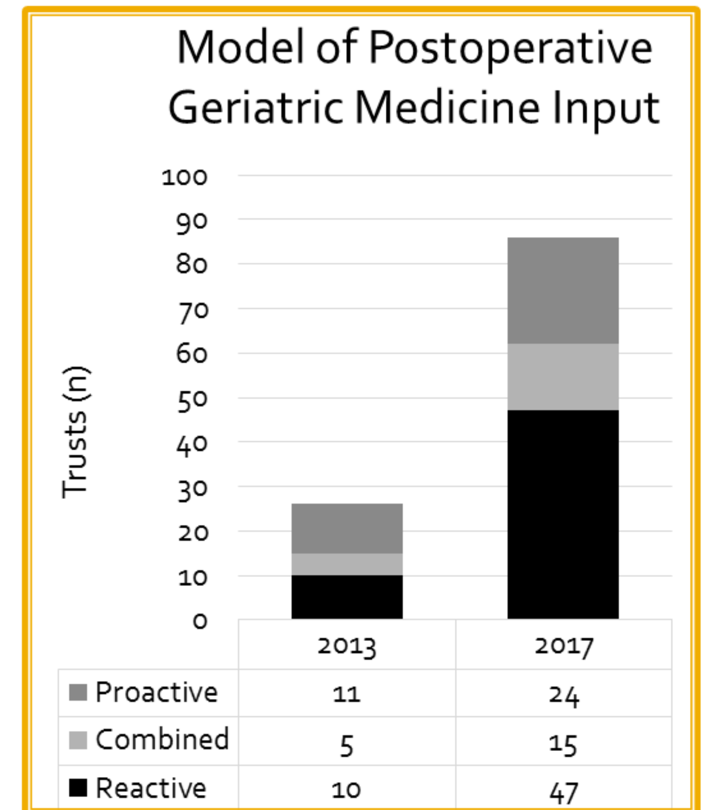
Mixed results

Concerns about power, methodology

Often due to a lack of fidelity to CGA

POPS services are being established

- Serial surveys 2014-2019
- Increase in whole pathway services
- Increase in
  - joint meetings
  - joint guidelines
  - surgical directorate funding



	2013	2017
Proactive	11	24
Combined	5	15
Reactive	10	47

Joughin et al Age & Ageing 2019

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- Serial surveys 2014-2019
- Increase in whole pathway services
- Increase in
  - joint meetings
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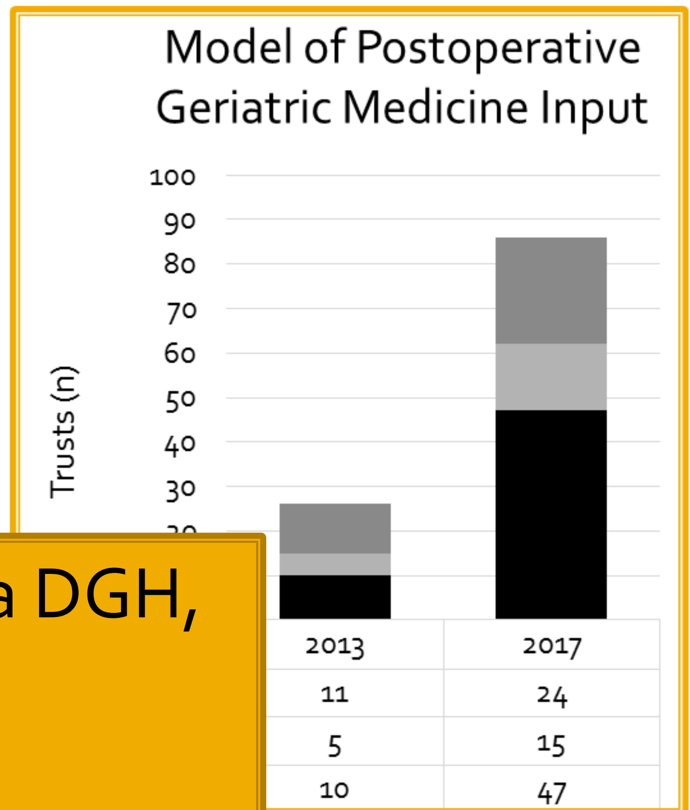


al Age & Ageing 2019

"we want to but it cant be done at a DGH, because we don't have...
- the workforce
- the money"

...at district general hospitals as well as at teaching hospitals

ORIGINAL RESEARCH Clinical Medicine 2021 Vol 21, No 6: e608–14

Establishing a perioperative medicine for older people undergoing surgery service for general surgical patients at a district general hospital

Authors: Ruth de Las Casas,[A] Catherine Meilak,[B] Anna Whittle,[B] Judith Partridge,[C] Jacek Adamek,[D] Euan Sadler,[E] Nick Sevdalis[F] and Jugdeep Dhesi[G]

Scaling up perioperative medicine for older people undergoing surgery (POPS) services; use of a logic model approach

Authors: Emily V Jasper,[A] Jugdeep K Dhesi,[B] Judith SL Partridge[C] and Nick Sevdalis[D]

> Future Healthc J. 2018 Jun;5(2):108-116. doi: 10.7861/futurehosp.5-2-108.

Embedded geriatric surgical liaison is associated with reduced inpatient length of stay in older patients admitted for gastrointestinal surgery

David Shipway [1], Louis Koizia [2], Nick Winterkorn [2], Michael Fertleman [3], Paul Ziprin [4], Krishna Moorthy [5]

Affiliations + expand

PMID: 31098544 PMCID: PMC6502563 DOI: 10.7861/futurehosp.5-2-108

Free PMC article

"we want to but it cant be done at a DGH, because we don't have...
- the workforce
- the money"

With 'buy in' from different professional stakeholders in the perioperative pathway…

J Surg Educ. Jul-Aug 2015;72(4):641-7. doi: 10.1016/j.jsurg.2015.01.019. Epub 2015 Apr 15.

Do surgical trainees believe they are adequately trained to manage the ageing population? A UK survey of knowledge and beliefs in surgical trainees

D J H Shipway [1], J S L Partridge [2], C R Foxton [3], B Modarai [4], J A Gossage [5], B J Challacombe [6], C Marx [7], J K Dhesi [8]

Affiliations + expand

PMID: 25887505 DOI: 10.1016/j.jsurg.2015.01.019

Partridge *et al. Perioperative Medicine* (2020) 9:3
https://doi.org/10.1186/s13741-019-0132-0

Perioperative Medicine

RESEARCH Open Access

Check for updates

The emerging specialty of perioperative medicine: a UK survey of the attitudes and behaviours of anaesthetists

J. S. L. Partridge[1,2*], A. Rogerson[3], A. L. Joughin[4], D. Walker[5], J. Simon[6], M. Swart[7,8] and J. K. Dhesi[1,9]

ORIGINAL RESEARCH Clinical Medicine 2021 Vol 21, No 2: e192–7

Towards integrated perioperative medicine: a survey of general practitioners' attitudes, beliefs and behaviours regarding perioperative medicine for older people

Authors: Tessa O'Halloran,[A] Jessie Colquhoun,[B] Gerard Danjoux,[C] Judith SL Partridge[D] and Jugdeep K Dhesi[E]

...and now recommended by CPOC – BGS guidelines

Guideline for Perioperative Care for People Living with Frailty Undergoing Elective and Emergency Surgery

September 2021

CPOC – BGS perioperative frailty guideline

Guideline for Perioperative Care for People Living with Frailty Undergoing Elective and Emergency Surgery

Frailty Pathway

Emergency admission

Assess and document frailty (CFS).

Consider atypical presentations of surgical pathology associated with frailty.

Obtain timely collateral history.

Establish presence of ACD, ADRT, DNAR decisions and LPA for health and welfare, and agree treatment escalation plan.

Refer to perioperative frailty team/other services for optimisation, or use frailty intervention tool.

Assess, document and modify risk factors for delirium.

Undertake SDM and consider involving relatives and/or carers.

Follow emergency care pathways.

Primary care referral for elective surgery

Start SDM including discussion about non-surgical options.

Make Every Contact Count; medical and lifestyle optimisation.

Referral to include:

- frailty score (CFS/eFI)
- presence, severity and management of comorbidities
- presence of ACD, ADRT, DNAR decisions and LPA for health and welfare.

Surgical and preoperative assessment out-patient services

Use information from primary care.

Reassess and document frailty.

Refer to perioperative frailty team/other services for optimisation, or use frailty intervention tool.

Establish and review existing ACD, ADRT, DNAR decisions and LPA for health and welfare, and agree treatment escalation plan.

Undertake SDM including discussion about non-surgical and palliative surgical options.

Consider involving relatives and/or carers.

Plan admission and discharge.

In theatre and recovery

Consultant surgeon and anaesthetist involvement for high-risk cases.

Identify frailty and co-existing conditions at the WHO team briefing.

Employ strategies for positioning and moving cogniscent of frailty.

Ensure physiological homeostasis cognIscent of frailty.

Informed by frailty status and agreed treatment escalation plans, anticipate postoperative care requirements and setting, and review again at the end of surgery.

Surgical wards providing care for emergency and/or elective patients

Assess and document frailty.

Anticipate, prevent, and treat:

- delirium
- pain
- medical and surgical complications
- hospital acquired deconditioning.

Review treatment escalation plans.

Promote recovery and timely discharge:

- review discharge plans
- regular multidisciplinary team meeting
- proactive communication with patients and consider involving relatives and carers.

Transfer of care to the community

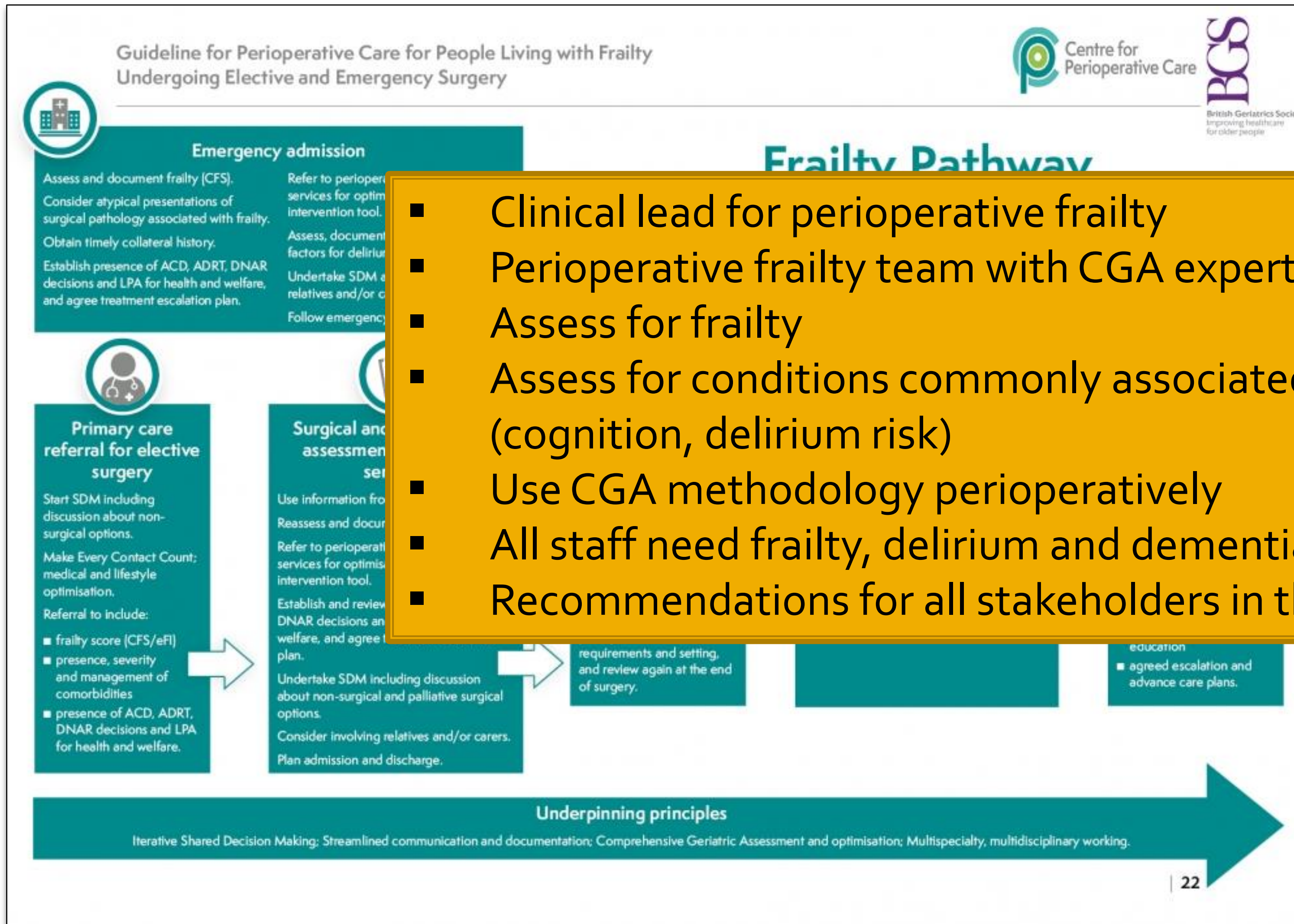
Ensure timely and comprehensive written discharge information to patient and GP, including:

- diagnoses
- treatment (operative and/ or non-operative)
- complications
- continuing medical and/ or functional impairments
- medication changes
- follow up plans and referrals
- safety-net advice and points of contact
- patient and carer education
- agreed escalation and advance care plans.

Underpinning principles

Iterative Shared Decision Making; Streamlined communication and documentation; Comprehensive Geriatric Assessment and optimisation; Multispecialty, multidisciplinary working.

CPOC – BGS perioperative frailty guideline



- Clinical lead for perioperative frailty
- Perioperative frailty team with CGA expertise
- Assess for frailty
- Assess for conditions commonly associated with frailty (cognition, delirium risk)
- Use CGA methodology perioperatively
- All staff need frailty, delirium and dementia training
- Recommendations for all stakeholders in the pathway

Provides useful metrics

Guideline for Perioperative Care for People Living with Frailty
Undergoing Elective and Emergency Surgery

Recommendations for quality improvement and metrics

The clinical lead for (perioperative) frailty should support implementation of this guideline, through local quality improvement programmes. This will require:

- patient and public involvement in co-design/co-production
- identification of local key performance indicators based on the metrics below
- collaboration with local data analysts/informatics to support robust data collection (ideally through linkage with existing datasets, for example Getting it Right First Time, Perioperative Quality Improvement Programme, National Hip Fracture Database, National Emergency Laparotomy Audit)[12,14,50,125]
- local measurement using a time series approach (eg statistical process control charts)
- local collaborative, interdisciplinary audit/morbidity/mortality meetings to review the data and inform quality improvement programmes.

To support measurement for improvement the following metrics may be used:

Metrics to support development of clinical pathway

- Number/proportion of patients with documentation of frailty
- Number/proportion of patients with frailty referred to perioperative frailty services for Comprehensive Geriatric Assessment and optimisation (CGA) or pharmacy services
- Number/proportion of patients with frailty, in whom a non-operative approach is taken, who are referred to perioperative frailty services or palliative care for ongoing conservative treatment
- Number/proportion of patients with frailty in whom an assessment of cognition is documented
- Number/proportion of patients living with frailty who have documentation of shared decision making
- Number/proportion of patients living with frailty who have documentation of treatment escalation plans and advance care plans.

Metrics to measure process

- Hospital guideline for prevention and management of delirium applicable to the perioperative setting.
- Length of hospital stay in patients with CFS≥5
- Percentage of patients with LOS > 21 days with CFS≥5 (superstranded)
- Place of discharge from hospital

Provides useful metrics

Guideline for Perioperative Care for People Living with Frailty
Undergoing Elective and Emergency Su[rgery]

Recommendations for quality i

The clinical lead for (perioperative) frailty should s
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Metrics to support development of clinical pa

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- Number/proportion of patients with frailty, in w referred to perioperative frailty services or palli
- Number/proportion of patients with frailty in w
- Number/proportion of patients living with frailt
- Number/proportion of patients living with frail plans and advance care plans.

Metrics to measure process

- Hospital guideline for prevention and managem
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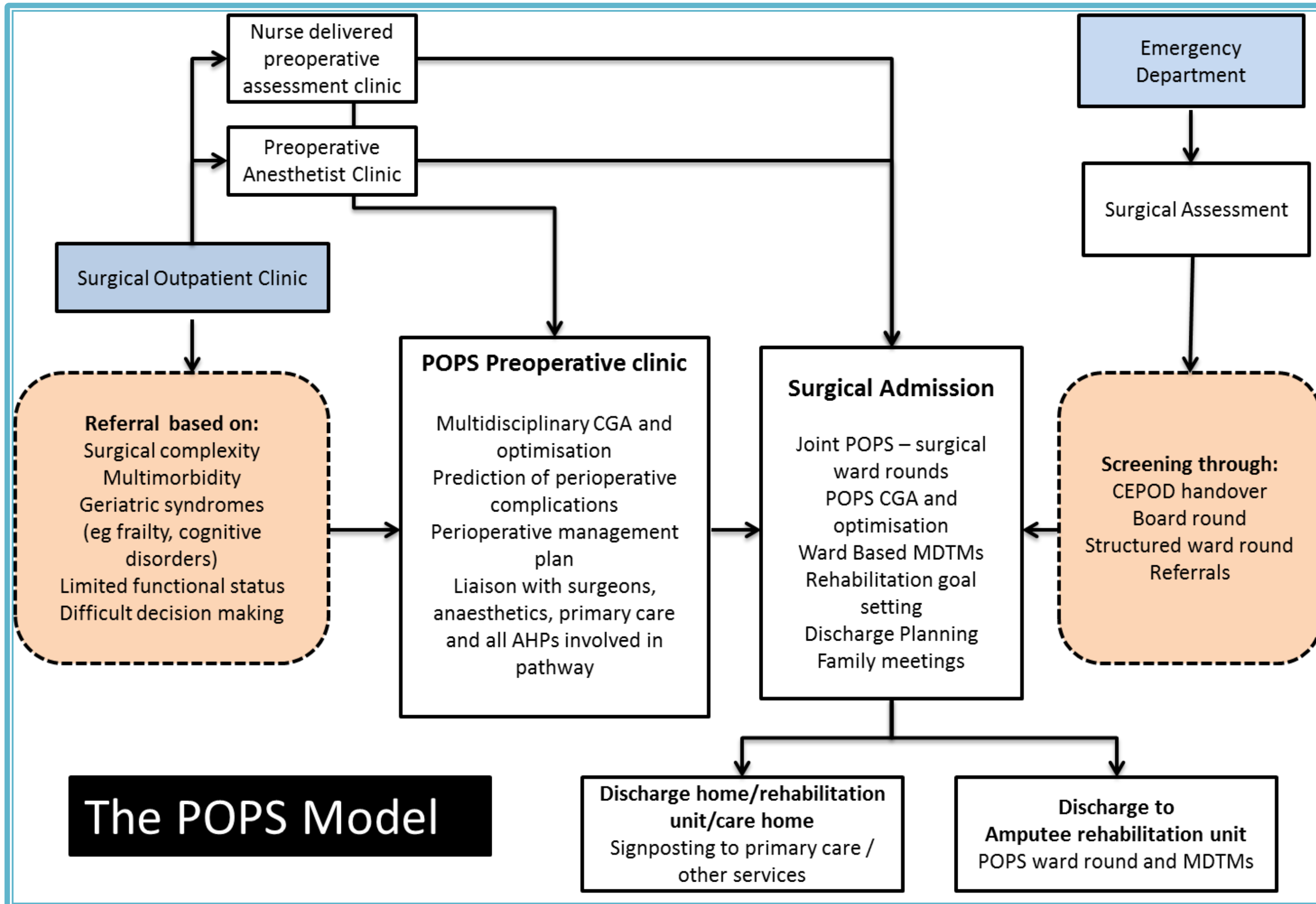
- Percentage of patients with LOS > 21 days with CFS≥5 (superstranded)
- Place of discharge from hospital

- Proportion of patients in whom frailty is assessed perioperatively
- Proportion of patients living with frailty who have a TEP/ACP documented?
- Availability of a POPS team
- LoS, place of discharge
- Satisfaction with SDM
- Decisional regret

The POPS model



How to identify 'at risk' patients early in the pathway

Dr James Prentis, Consultant, Newcastle

Newcastle Prehab/Waiting well

Dr James Prentis

Social prescribing

- Nebulas term
- Encompasses a wide range of interventions – from community activities, link worker support, health improvement practitioner interventions and case management
- Increasing literature from primary care
- Prehab – has to be community based away from hospital setting
- Tertiary referral centre – no way we can do it
- Use to targeting the issues that are important to the community esp in respect to social deprivation

Diabetes

- Results coming in for a pilot using PCN resource to target preoperative using health improvement practitioners
- 20 patients completed or near the end of the quick pilot
- First 7 patients have had a fall in HbA1c of 9.0 range 19 – 0
- Never really thought we would get any
- Focus group
    1. Didn’t know where to go from and the phone call offering support has changed my life
    2. Novorapid down by 3/4s, stopped drinking, lost weight and feel great

Waiting well – P4

- Based on this work and dashboard
- NENC ICS embarked on supporting patients on the P4 waiting list
- Ensure we target the issues causing inequalities in our healthcare setting
- New bespoke interventions and linking into existing services

Newcastle/Northumbria CCG intervention

1. Diabetes – diabetic dietitian involvement and maintaining the health improvement practitioner intervention.
2. Opiates – not a opiate reduction intervention but supporting patients on opiates whilst waiting with link worker model.
3. Smoking cessation – referral into existing service with e-cigarettes offer specifically for this group
4. Obesity – services aren't great in the region but going to try
5. Anaemia – sponsored by Vifor to ensure anaemia targeted with oral medications before they hit preassessment allowing for IV iron

Peripheral arterial disease

- Covid proof soft touch digital intervention with health improvement practitioner support
- Pilot RCT with embedded qualitative outcomes
- 18 patients currently recruited
- Simply brilliant
- Homeless and living in his car. Maintained engagement, stopped smoking and exercise capacity increased from 58m to 280m

More plans

- AAA intervention commencing on 6th June
- QI intervention with embedded qualitative research
- Hope to enrol all AAA patients over a year period

- Just got funding for similar intervention as a pilot RCT for patients with pancreatic cancer
- Linking to dietetics as nutritional support major issue – health improvement practitioner will support the nutritional assessment

Conclusions

- It's brilliant – loving every second
- First time been able to bring in money and deliver
- Dashboard – game changer
- Waiting well – never bothered with elective surgical population and they need it now as much as cancer
- Specific interventions for major surgery about to start

Case study: changing the waiting list to a preparation list

Dr Rachael Barlow, Clinical Lead Prehabilitation, Cardiff

Break

Your measurement journey so far

Matt Tite, Director, NHS Elect

Coffee and Networking

Potential topics for conversation:

- What approach have you used to identify people for POPS services
- Which staff do the screening
- Do you use digital approaches – if not, what could you be doing/how can the network help
- What barriers/enablers have you come across
- How can you engage different specialities in screening
- How is the work going/how does it feel at the moment

Summary and closing remarks

Dr Jugdeep Dhesi

Next steps

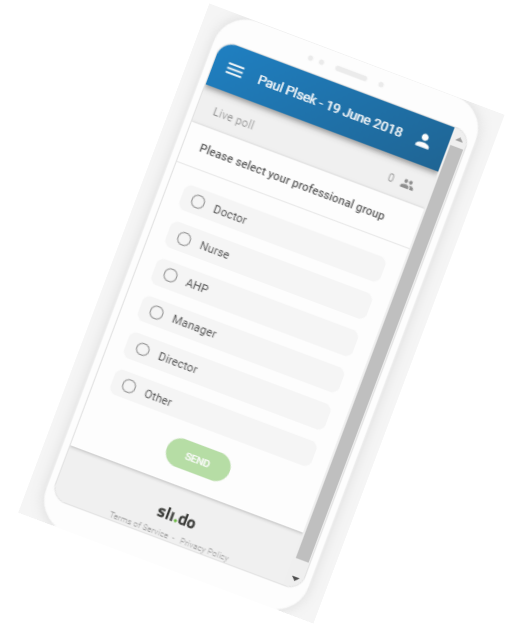
As a team think about the following:

- Access the POPS website www.popsolderpeople.org and let us know what content would be useful. The password for the pages in the Members Area is **POPSNetwork2021**
- Focus on identification, training, process and application.
- Agree measures to understand the impact of your improvements.
- As a team, review your progress with the POPS Toolkit at the website.

As always, let us know how we can help.

- **Register for the next event on 9 June at 09:00-11:30.**
- **Sign up for the upcoming webinars:**
  - ***Business Cases* on 17 May at 13:00-14:00**
  - ***Developing the pharmacy workforce to deliver perioperative care* on 27 May 12:30-13:30**

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 **#POPS2-MAY**
- Use the polls to give us feedback about the day

Improvement Networks ***www.popsolderpeople.org***

NHS Elect

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

networksinfo@nhselect.org.uk