# *Perioperative Care for Older People undergoing Surgery The (POPS) Network*

August 2021

Programme
Core Session

# Agenda

| | |
|---|---|
| **09:00** | |
| | **Welcome and introduction to the day** **Dr Jugdeep Dhesi** POPS Network Clinical Lead |
| | **What should we do about the Workforce? Part One** **Angeline Price**, ANP, Salford Royal NHS FT, **Jason Cross**, ANP, Guy's and St Thomas' NHS FT and **Dr Mevan Gooneratne**, Consultant, Barts Health NHS Trust |
| | **Perioperative Services in Emergency Services** **Dr Magda Sbai**, Consultant, Guy's and St Thomas' NHS FT, **Dr Deepa Rangar**, Consultant, Royal Infirmary Edinburgh, NHS Lothian and **Dr Mark Johnston**, Consultant, Liverpool University Hospitals NHS FT |
| **BREAK (10 mins)** | |
| | **Update from each site** An opportunity to hear from each of our Network sites about their progress to date. |
| | **Summary and Next Steps** **Dr Jugdeep Dhesi,** POPS Network Clinical Lead |
| **11:00** | **CLOSE** |

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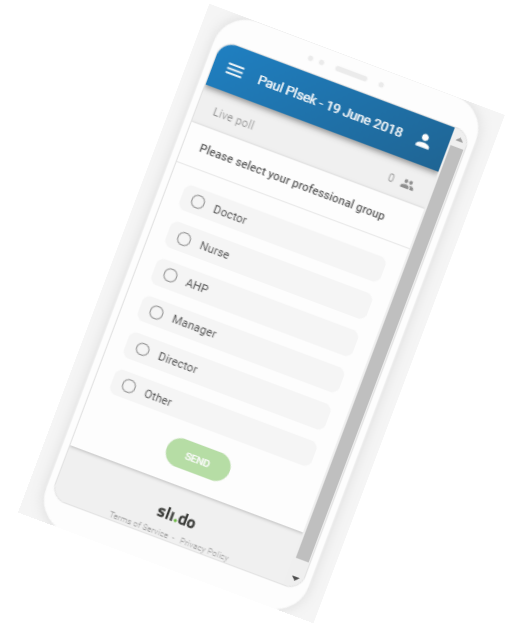



Open a browser on any laptop, tablet or smartphone

- Go to **sli.do.com** or scan the QR code below
- Enter the event code **#POPSCore3**
- Use the polls to give us feedback about the day

# What should we do about the Workforce? Part One

**Dr Mevan Gooneratne, Jason Cross and Angeline Price**

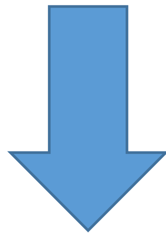
# What skillset is needed?
# Who can deliver it?
# What does this look like in practice?

Jason Cross

Advanced Nurse Practitioner

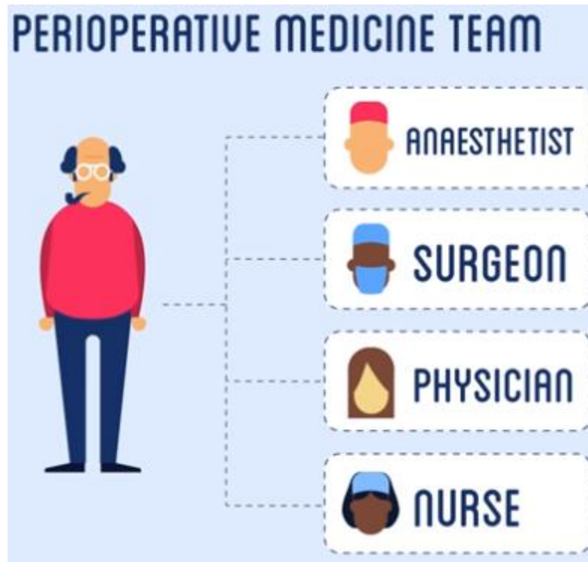
# The problem…

- Training gap
- Need to upskill our current workforce



- Not realistic to throw more staff at the problem
- Be creative with our business planning.

# Not all services are the same?..



Who?

- Anaesthetist led and delivered
- Geriatrician led and delivered
- (Hospitalist led and delivered)

When?

- Preoperative only
- Postoperative only
- Whole pathway

*Braude FHC Journal 2016*

# What skillset is needed?

- whole pathway expertise
- knowledge and skills in comprehensive assessment
- case management

- Do we need a new perioperative specialist?

  Or

- Upskill staff we have

  Or

- Both

# Who can deliver it?  - Physicians Associates

- Physician Associates
  - USA model with recent development of own faculty /linked to Royal College of Physicians/two year training programmes
  - In UK part of the Medical Associate Professions group
  - 37 colleges now providing training (undergrad and MSc)
  - Permanent members of medical  / surgical team
  - Assessment and management of patients

1. physician associates (PAs)
2. anaesthesia associates (AAs) – known as physician's assistants (anaesthesia) prior to 2019
3. surgical care practitioners (SCPs)
4. advanced critical care practitioners (ACCPs).

- Limitations
  - Cannot prescribe/limits on investigations can order/start as dependant practitioners
  - Few training places (though increasing yearly)
  - Expensive!  (band 7)
  - Some limited evidence at present into impact on care

# Who can deliver it? - Allied Health Professionals

- Occupational Therapist and Physiotherapist
  - Improvements in quality of life
  - Decrease in hospital admissions

- Pharmacists
  - Improved drug knowledge and compliance
  - no effect on reducing mortality or hospital admissions
    - But likely do impact on reduction of drug related harm – anecdotal

*Graff et al., 2008; Knapp et al.,2010, Yoon et al,. 2007*

# Who can deliver it ? - Nurses

- Case management
  - Comprehensive assessment
  - Care planning and implementation
  - Diagnostic reasoning
- Specialist education/career pathway
  - Advanced assessment skills/Prescribing
- Evidence of benefit
  - Limited in surgical care of older people
  - In-hospital – reduced discharges to institutional care
  - Transitional care – reduced readmission
  - Long term care – Reduction mortality and readmission. Increased satisfaction and function

*J C Morilla-Herrera, International Journal of Nursing Studies, 2016*

# And for POPS@GSTT, this model works…

- Varied nursing background/skills
- Nurses attached to a specific specialty
- Clinic and inpatient liaison/own caseload of patients utilising CGA
- Clinical governance

# Typical Day/scope of practice

| 7am | EGS/liaison handover | 12 noon – 3pm | Clinic<br>▪ CGA<br>▪ ERP |
|---|---|---|---|
| 7.30am | Ward handover (nursing) | | |
| 7.45am- 12 noon | Patient reviews<br>▪ Ward round<br>▪ MDM<br>▪ Data entry | 3pm | Ward reviews<br>▪ Admin<br>▪ MDT working<br>▪ Family liaison |

# Typical Day / scope of practice

| | Noon – 3pm | Clinic<br>▪ CGA<br>▪ ...P |
|---|---|---|

▪ Data entry

Proactive identification of patients
CGA on the ward
Teaching/ward/formal
Leading family meetings
Case management
Link to other specialist teams

# Underpinned with…

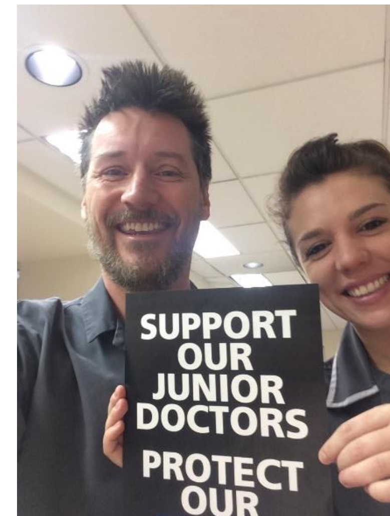
**Support**
- Joint appraisals
- Encouragement to develop practice

**Cohesive team working**
- Approachable
- Contactable

**Shared responsibility**
- MDM
- Joint decision making

# Retaining and evolving the role...

- **Knowledge**
  - Advanced assessment skills
  - Prescribing
- **Hands on skills**
  - Ward liaison/communication
  - Flexibility/cross cover
- **Responsibility/autonomy**



# Capability framework

Capability framework for practitioners working in perioperative medicine – Summary

| | Band 5 | Band 6 | Band 7 | Band 8A |
|---|---|---|---|---|
| Educational requirements / Qualifications | • Registered practitioner | • (band 5 criteria plus)<br>• Mentorship<br>• 2 years post graduate experience | • (all band 5 & 6 criteria plus)<br>• Advanced assessment and physical examination skills course<br>• Non-me | • (all band 5-7 criteria plus)<br>• Post graduate qualification at MSc level to include evidence of |
| | | | | |
| Clinical/direct care practice | • 80-100% of work is patient facing<br>• Holistic care of a complex patient group with direct senior supervision<br>• Work within scope of practice | • 70% of clinical work is patient facing<br>• own caseload with supervision from a nominated senior | • 70% clin manage<br>• Complex own cas nominat | |
| Leadership and collaborative practice | • Act as a role model for junior members of staff to promote quality patient care<br>• Manage a team under supervision from a senior<br>• Work as a member of and communicate with the MDT | • Participate in local leadership initiatives, advocating and disseminating standards to local services | • Participa bodies, dissemi services<br>• Acting u their abs<br>• Provides junior te | |
| Improving quality and developing practice | • Be aware of local quality improvement projects and highlight areas for potential improvement to seniors<br>• Critically appraise own practice | • under supervision, leading on local quality improvement audits and programmes<br>• implement changes within the department to improve quality and support junior team development | • Participa and audi | |
| Developing self and others. | • Actively seek development reviews, opportunities and feedback from seniors and teammates<br>• Present at a team level<br>• Take an active role in student development<br>• Promote public health initiatives when interacting with patients and family | • Contribute to staff appraisals<br>• Presentation at local levels<br>• Proactively seek development opportunities for self and team | • Contribu educatio subordin<br>• Presenta level | |

POPS Perioperative medicine for Older People undergoing Surgery

Perioperative nursing / POPS specialty specific competencies – Practitioner band 6 to 8

| | Band 5 | Band 6 | Band 7 | Band 8A |
|---|---|---|---|---|
| Assessment pathways and models of care | | • Experience of or working within perioperative pathway including pre-assessment clinic | • Can describe variances in different models of care and perioperative pathways | • Lead on pathway and service development<br>• Expert knowledge of perioperative pathway. |
| Theories of ageing | | • Recognises differences of ageing on impact to general health<br>• Evolving knowledge of issues that affect health and ageing | • Able to articulate both biological and psychosocial theories of ageing | • Expert knowledge that is transferred into practice and influences assessment and planning of care. |
| Comprehensive geriatric assessment | | • Understanding of nursing / ADL holistic assessment and the evidence of CGA in management of older patients | • Demonstrates an understanding of the components and theory of comprehensive geriatric assessment. Applies this into practice to develop individualised care plans. | • Presenting nationally and locally on perioperative CGA. Contributing and leading on study / research into benefits of CGA in the patient group living with frailty and/or multi morbidity |
| Cognitive impairment | | • Basic knowledge on delirium and dementia with signposting to relevant guidance and management strategies. Undergone local mandatory training | • Recognises impact of deteriorating cognitive function on health, including capacity to consent. Able to employ strategies to assess and reduce resulting risks (delirium, functional decline, worsening cognitive decline<br>• Can appropriately assess and apply local guidance for deprivation of liberty safeguarding issues. | • Leading on strategies and education programmes to highlight cognitive, capacity and deprivation of liberty issues pertaining to those who access POPS service. Presenting locally and nationally to educate and inform wider audience. |
| Multimorbidity | | • Recognition of the impact of age on health with an understanding of the interaction how multiple health issues change health management. | • Able to assess and manage recognised and unrecognised disease. Understanding the interaction of multi-morbid disease in the perioperative setting and able to plan individual care utilising local and national guidance. | • Is an expert in how the accumulation of disease impact on short and long term health of a person accessing perioperative expertise. Leads on education and strategies, linking with national organisations (AAGBI / AAA / RCN to influence the national agenda. |
| Understanding Frailty | | • Recognition of frailty with use of appropriate scoring and assessment. Able to explain how frailty impacts health trajectory. | • Knowledge of the frailty syndromes, assessment tools to highlight frailty and how frailty impacts on mortality and post-operative outcomes.<br>• Is able to initiate strategies to influence frailty progression | • Expert in frailty syndromes and their impact in the perioperative setting. Able to detail and implement strategies to affect the trajectory of frailty.<br>• Taking a lead both nationally and locally on education in frailty within the POPS arena |

- Capability framework from band 6 to 8
- Drawn from POPS@GSTT experience
- Foundation of POPS education module and KCL higher award
- Can be used as template for own bespoke education programme

# Core module

- GSTT - Taught 2 day classroom/virtual course - 20 hours CPD/WBL
- POPS online module (hosted by BGS £150) – 40 hours CPD/WBL

POPS nurses course - Timetable for taught sessions (counts towards 20 hours of practice)

Day 1

| 8.30 to 9am | 9am -10.15am | 10.15 – 11.30am | 11.30 – 12.45 | 12.45 – 2pm | 2 – 3.15pm | 3.15 – 4.30pm | 4.30 to 5pm |
|---|---|---|---|---|---|---|---|
| Registration and welcome | Perioperative pathways of care | Theories of ageing | Comprehensive geriatric assessment | Lunch | Condition management | Condition management | End of day summary |
| Detail / (attached to learning outcome) | (LO1) | (LO2) | (LO3) | KCL work based learning | (LO7) | (LO7) | Allocation of topics for |
| Delivered by | | | | | | | |

Day 2

| | 9am -10.15am | 10.15 – 11.30am |
|---|---|---|
| Registration | Understanding Frailty | Muiltmorbidity |
| Detail / (attached to learning outcome) | (LO4) | (LO5) |
| Delivered by | | |

British Geriatrics Society
Improving healthcare for older people

Coronavirus | Topics | Events | Policy & Media | Resources | BGS groups | About | Members directory

Home > Perioperative Care of Older People Undergoing Surgery

## Perioperative Care of Older People Undergoing Surgery

### Course overview

It is increasingly recognised that there is a need to have geriatric medicine input in surgical pathways for older people to improve patient outcomes & experiences. Since 2016 perioperative medicine for older people is included in the optional higher level competency grid for the Geriatric Medicine Curriculum. However the introduction of geriatric medicine specialists into complex surgical environments is highly challenging and evidence of successful service developments is sparse. With the increased pressure on budgets, making the case for funding to develop new services without robust evidence is also difficult.

This elearning course, designed by the growing group of dedicated clinicians, from across geriatric medicine, surgery and anaesthetics, will present case studies and lessons learned when developing services and gathering evidence for the effectiveness of structured elderly medicine input into surgical care pathways for older people.

All members of the MDT are encouraged to participate; nurses, therapists, anaesthetists and surgeons. The course ranges from practical advice and guidance regarding the perioperative management of the complex older surgical patient, whilst also hearing first hand experiences and advice on the set up and day to day running of a surgical-geriatric liaison service.

Get this module

Full Module with CPD

Content Only

Become a member

**Learning outcomes**

**Management of the older / more complex surgical patient**

**LO3. Comprehensive geriatric assessment**

**Learning outcome**

The practitioner will be able to describe the benefits of the application of, and be able to deliver a comprehensive geriatric assessment (CGA)

**Knowledge**

- Have an understanding of the components of CGA
- Able to give evidence of benefit of CGA in the older patient and surgical environment, citing relevant research and study.
- Able to detail what additional assessments are required to enhance CGA in the surgical / perioperative pathway.

**Evidence**

**Essential**

- Classroom session
- Online module (BGS)

**Optional (KCL)**

- Portfolio or essay evidence

***Other sources of information***

https://www.bgs.org.uk/topics/cga-in-acute-settings
https://www.youtube.com/watch?v=ni2FaEboCZU
https://www.ncbi.nlm.nih.gov/pubmed/28198997

**Skills**

- Demonstrates an understanding of the components and theory of comprehensive geriatric assessment.
- Ability to articulate what CGA is to patients and other service providers
- Applies CGA into their practice to develop individualised care plans.
- Integration and able to undertake a CGA in an outpatient setting / clinic
- MDT case presentation
- Uses CGA methodology for ward based care planning.

CPD = Continuous professional development
WBL = Work based learning
BGS = British Geriatric Society

# Developing Advanced Clinical Practitioners for Acute Frailty: using the skills and capabilities frameworks


Angeline Price

Advanced Clinical Practitioner

Salford Royal Foundation NHS Trust

Salford Care Organisation
Northern Care Alliance NHS Group

@angeline_price

Elect

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

# 3 key themes

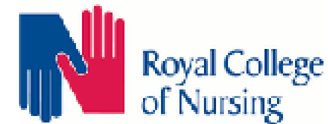
- Individual
- Training
- Opportunity

# My Background

- Registered Nurse 2009
- Specialist Nurse 2014
- Trainee ACP 2016
- **ACP Oct 2018**

# My Current Role – 2 years in

- 2ww colorectal frailty service
- National Emergency Laparotomy Audit
- Clinical audit + QIP lead
- Education local and national
- Research - COPE, ELF2
- Publications x 20
- Committee positions- BGS, RCN

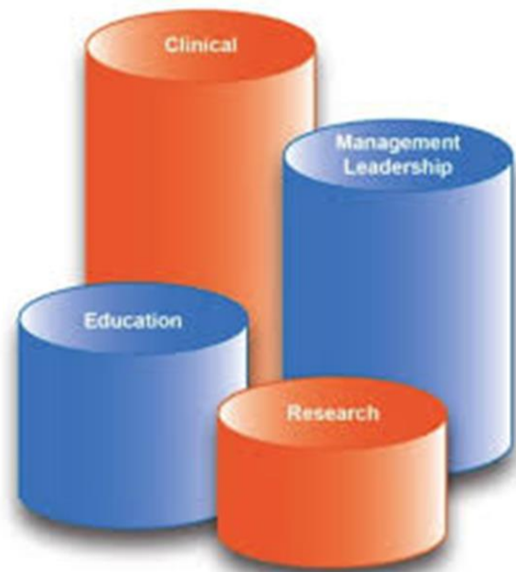


# The Individual

- Experienced clinician ~ 5 years
- Ability to study at Level 7
- 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
- **Think about your talent pool**

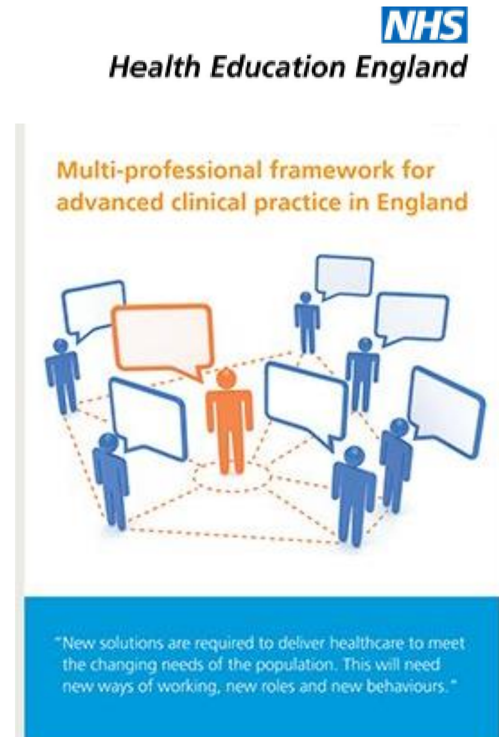
# Training

- MSc programme: 2-3 years
- Engaged supervisor
- Protected study time
- Opportunities across the **Four Pillars o**
  **Advanced Practice**



# Training

- MSc programme: 2-3 years
- Engaged supervisor
- Protected study time
- Four Pillars of Advanced Practice




**RCP/HEE Core Competencies Framework – imminent**

# Opportunity

- Governance systems that support ACP
- Organisational buy-in
- Ongoing CPD time ~ 80/20 split
- Access to non-clinical CPD
- Appropriate supervision

**Multi-professional consultant-level practice capability and impact framework**

Recognising the benefit of 'boundary pushing'

# 3 key themes

- Individual
- Training
- Opportunity

# POPS goes the pre-op


Dr Mevan Gooneratne

Consultant Anaesthetist

The Royal London Hospital


NHS Barts Health NHS Trust

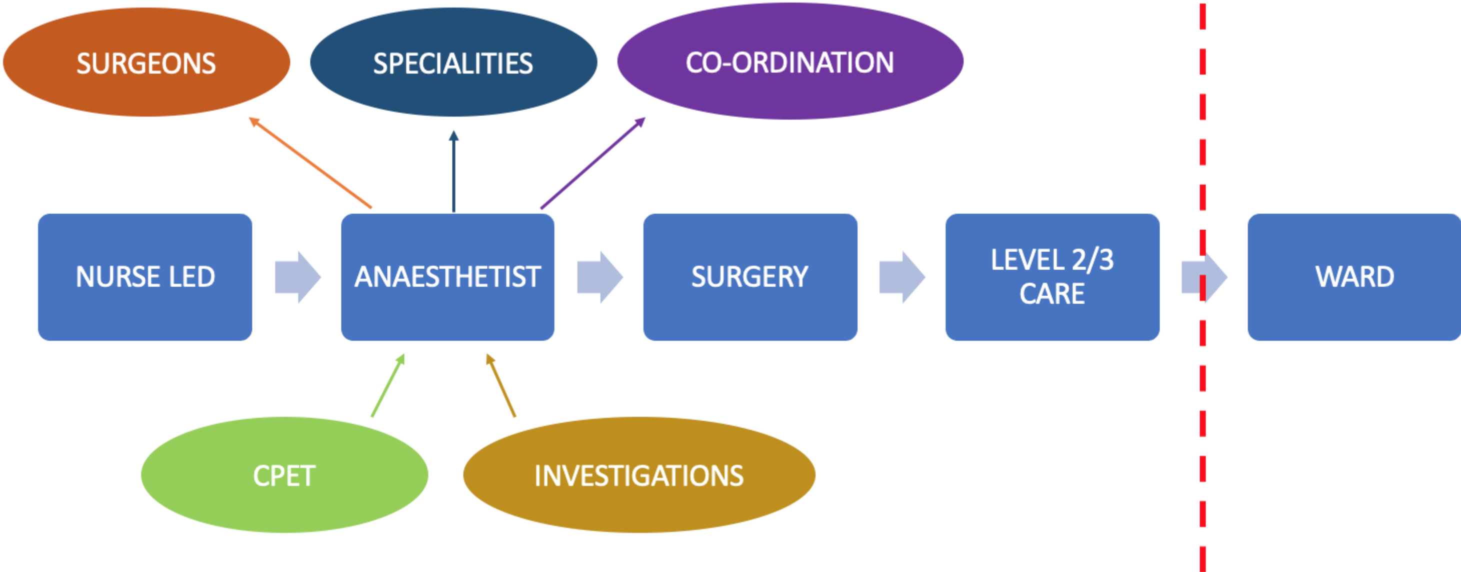
NHS Elect

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

# Objectives

- POPS experience
- Challenges
- Interventions & Innovations
- New model of care
- Advantages & Disadvantages
- Ambition

# Classic anaesthetic pre-assessment (PAC)



GERIATRIC MEDICINE

INVESTIGATIONS

ALLIED HEALTH CARE

**POPS EXPERIENCE**

COMMUNICATION

MULTIMORBIDITY

PRIMARY CARE

# CGA v anaesthetic led PAC

**CGA**

MULTIMORBIDTY
SOCIAL CARE
PRIMARY CARE
POST-OP CARE
ONE STOP
MEDICAL OPTIMISATION
NEW DIAGNOSES

PREHABILITATION
FITNESS
ASSESSMENT
SHARED DECISION
MAKING
RISK ASSESSMENT

**ANAESTHESIA**

MODALITY
INTERVENTIONS
CPET
CO-ORDINATION
ANAESTHETIC OPTIMISATION
PACU /HDU / ICU

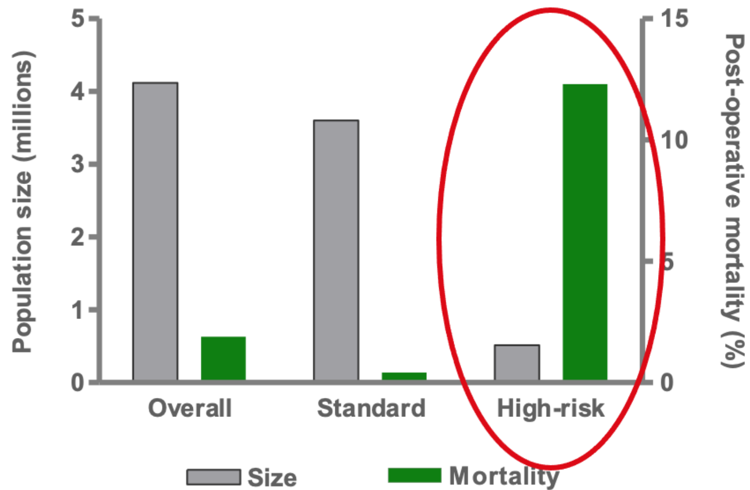
# Can we implement CGA into our PAC model?

- Cultural change
- Funding
- Demographic
- Capacity
- Gerontology support

# Empowering Nurses

- Past Medical / Surgical History (15 min/prepping)
- Social History (10 min)
- MOCA (15 min)
- Frailty (10 min)
- Bloods (10 min)
- Swabs (10 min)
- Exercise Test (15-20 min)
- Further test, e.g. spirometry (15 min)

# Maximising Resources




*Pearse et al. Crit Care 2006; 10: R81.*

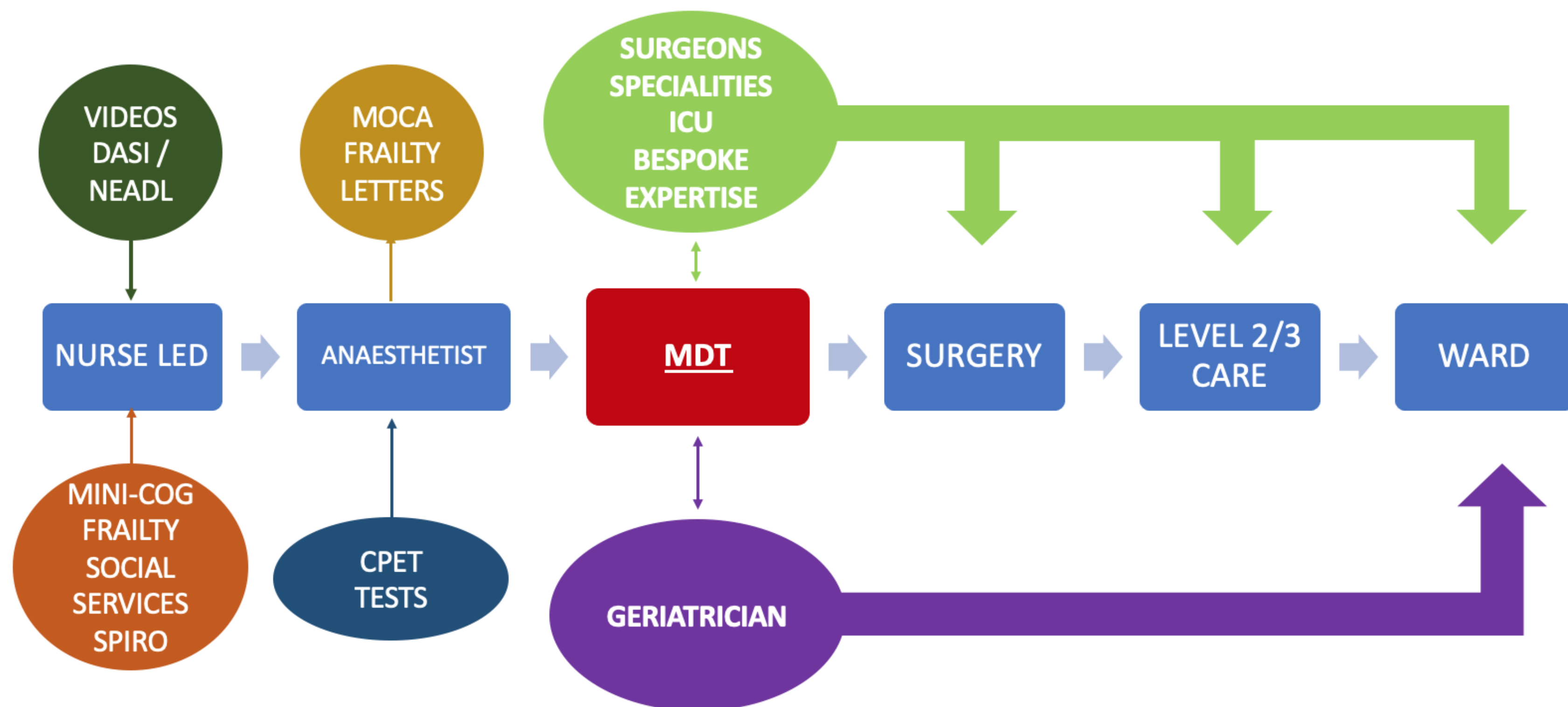
**Anaesthetic Assessment**

- SDM
- Vigilance
- Letters
- Optimisation

# MDT

- Surgeons
- Cardiologist (0.5 PA)
- Respiratory physician (0.5 PA)
- Geriatricians (6 PAs)
- Anaesthetists
- Renal physician

# New hybrid model of care



# Hybrid Model

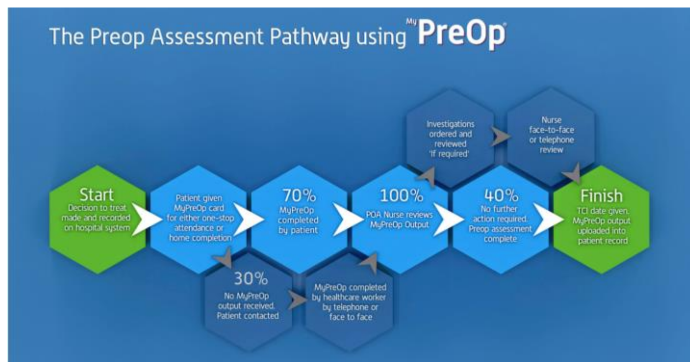
## Advantages

- Cost efficient/Targeted
- Maximise resources/expertise
- Increase consultant capacity
- Empower nurses
- ‘1 stop shop’
- Mimics POPS/MDT
- More palatable!

## Disadvantages

- Evidence base limited
- PAs
- Limited expansion
- Reproducibility elsewhere
- Capacity

# Innovation & capacity




Explain my Procedure

Select your procedure:

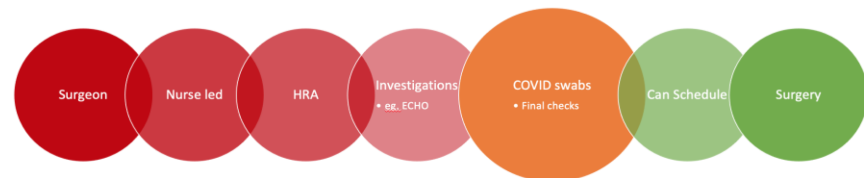
Perioperative Risk Assessment

Day of Surgery

Gynaecological Cancer Surgery

General Anaesthesia

Epidural and Spinal



# Co-ordination and data collation

Home Patient Clinic User Review Management Library Tools Help

WH527401 30/05/19

Consultant: Operation date: dd/mm/yyyy Operation: Traffic-light - convert to cols layout & reduce padding

Information POA 1 POA 2 POA 3 Actions Recent results HRA Notes Leaflets

| POA | Biochem | Haematology | Cardiology | Micro |
|---|---|---|---|---|
| CPET | BNP | Coag | ECG | COVID |
| EFS | Bone | FBC | Echo | MRSA |
| GP request | Iron | G&S | **Respiratory** | **Referrals** |
| HRA | LFTs | iv Iron | POASpirometry | Cardiology |
| iv Iron | U&Es | | | Renal |
| Refer MDT | | | | Haematology |
| Mini-COG | | | | Respiratory |

**Plan / Outstanding Issues:**

1. ECHO
2. Geriatrician input, especially with regards to capacity ability to weigh up significance of surgery
3. Cardiology / Geriatrician review to establish appropriate AF management
4. To be discussed at MDT with geriatric, neurosurgical and anaesthetic and PAC input.
5. Establish as to whether anaemia fully investigated or secondary to chronic disease (renal disease)

**Outcome:**

| | |
|---|---|
| Fit for surgery | Not at present |
| Outstanding investigations | ECHO |
| Drugs to be omitted prior to surgery | ACE if proceed to surgery |
| Other instructions | To be listed for MDT |

# Summary

Dr Frances Parsons
Perioperative Fellow,
The Royal Marsden and
Royal London Hospital
francesparsons88@gmail.com

Dr Ching Ling Pang
Consultant Anaesthetist,
The Royal London Hospital

## CREATING CAPACITY IN A CRISIS

The COVID-19 pandemic has had a significant impact on the ways in which our hospitals and services run. The need to provide elective cancer surgery during this period has necessitated many changes to the way we work, and this has produced unanticipated benefits. In this article we discuss the way our pre-assessment clinic (PAC) at the Royal London Hospital (RLH) has adapted to reintroduce safe and timely elective surgery when faced with staff shortages and the risk of infection to patients and staff. While the pandemic has significantly impacted on service delivery in other clinical areas, in pre-assessment it has resulted in a more self-sufficient and efficient service.

# Questions and Comments

# *Perioperative services in emergency services*

**Dr Mark Johnson, Dr Deepa Rangar and Dr Magda Sbai**

# Interventions needed and who can deliver them

Magda Sbai,
Perioperative medicine for older people undergoing surgery, POPS,
Dept of Ageing and Health,
Guy's and St Thomas' , London

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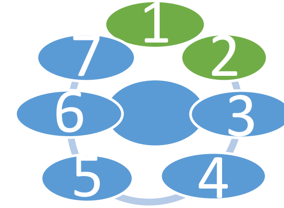
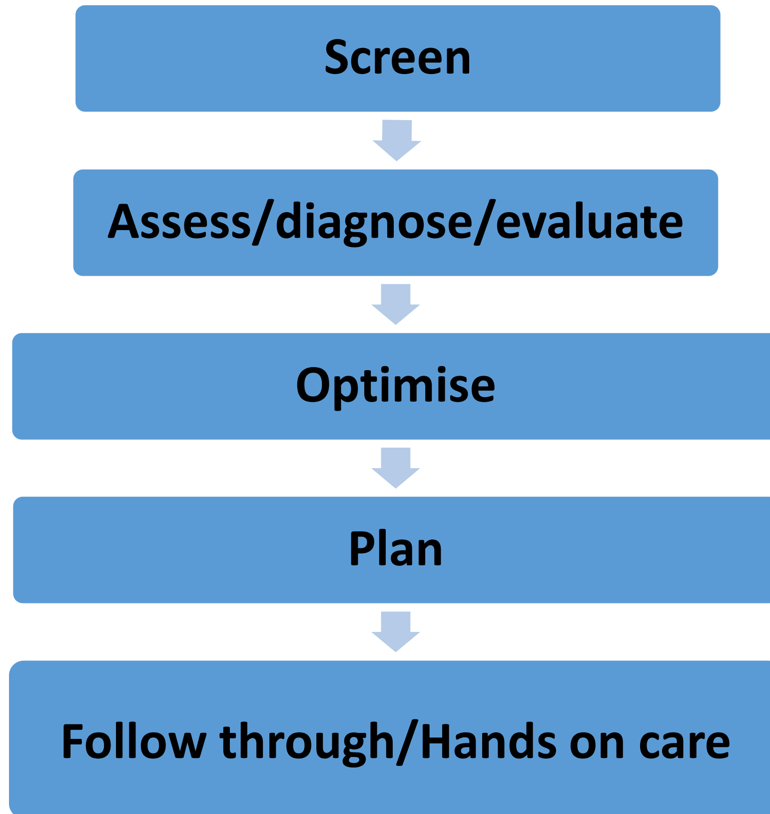
## What is needed…

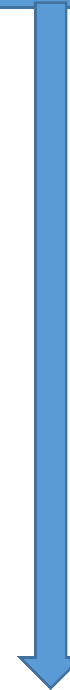
- Holistic, multidimensional, multidisciplinary assessment
- Formulation of
  - a list of needs and issues
  - an individualised but coordinated care & support plan
  - tailored to an individual's needs, wants & priorities

...in a complex pathway, needs an underpinning methodology...

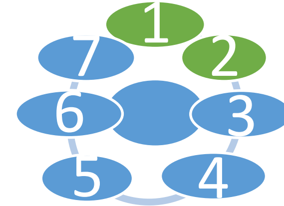



SDM



# …CGA and optimisation…




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

Clinical practi…

Compre…

trials

A.E Stuck, …

Targeted
Objective tools
Multidomain
Hands on
Follow through

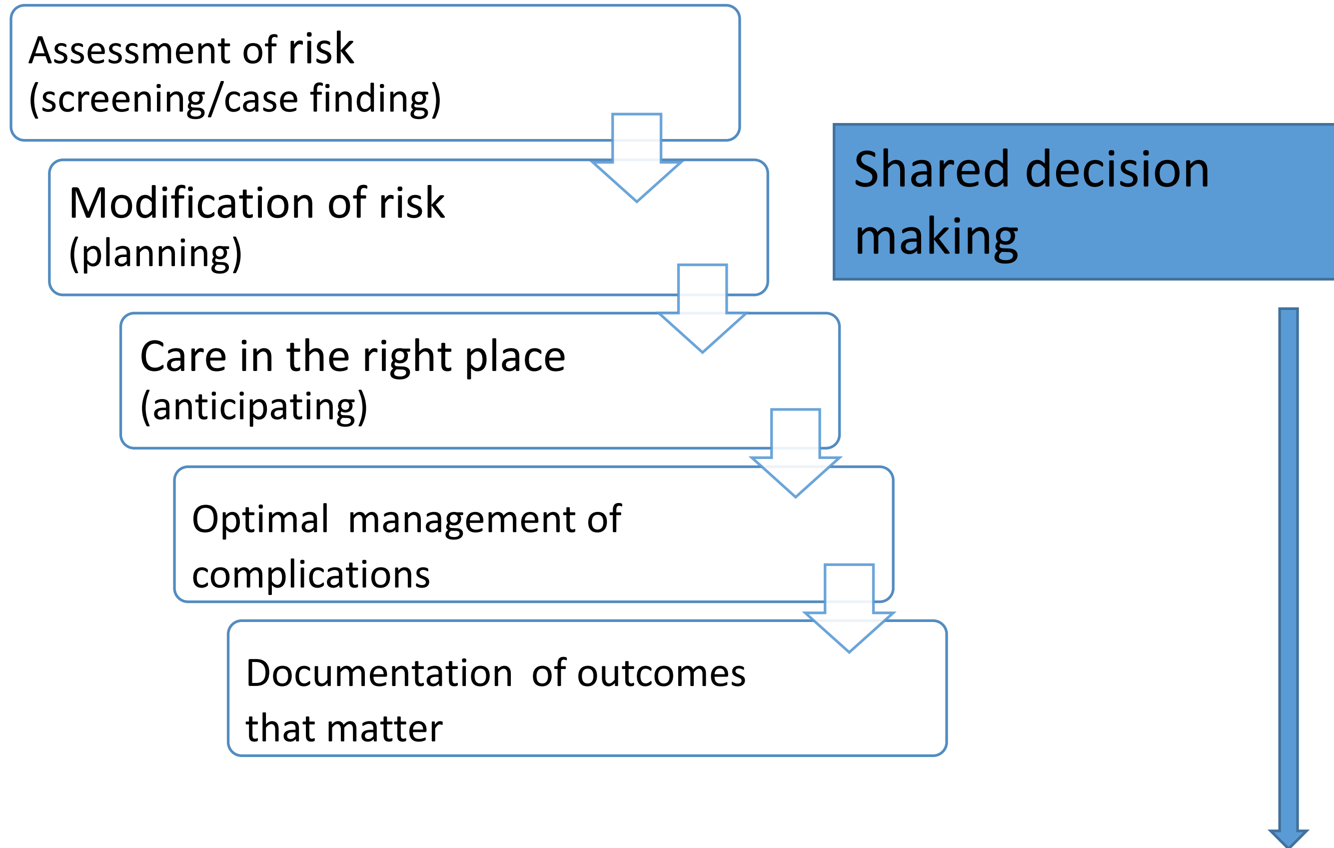
…F PUBLIC HEALTH, OXFORD

Cochrane
Library
Cochrane Database of Systematic Reviews

…rehensive geriatric assessment for older adults
…tted to hospital (Review)

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

# …and can be used in the pathway

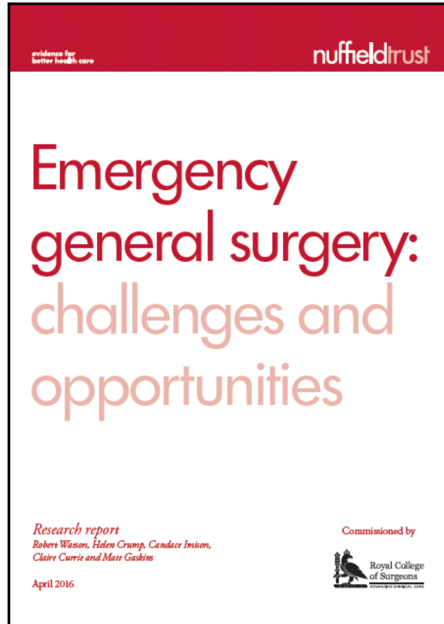


# So, essentially it's a team approach…

Right team at the right time in the right place

- Preoperatively
  - Screening, assessment and investigation
  - Optimisation
  - Shared decision making (Advanced care planning)
- Intraoperatively
  - Timely, tailored surgical and anaesthetic care
  - Right destination
- Postoperatively
  - Proactive identification & standardised mx of comps
    - Surgical, medical, rehabilitation and discharge planning

# …as discussed in numerous reports




- ‘Routine daily input from medicine for older people should be available to elderly patients undergoing surgery and is integral to inpatient care pathways in this population’ *An Age Old Problem 2010*

- ‘Geriatricians play a key role in helping to evaluate and manage risk and promoting shared decision approaches. Effective MDT working to bring together physician, surgeon, anaesthetist and geriatrician is critical’ *Access All Ages 2012*

- ‘Geriatricians should work more closely alongside teams both inside and outside hospital’ *RCS Nov 2014*

# Impact suggested by big data

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

# Recommendations from NELA

| | | |
|---|---|---|
| | emergency laparotomy | |
| **Elderly Care** | | |
| 5.11 | **Commissioners, Provider Executive Boards and Medical Directors:** scope requirements for Elderly Care input into patients undergoing emergency laparotomy, based on estimation of emergency surgical caseload, and work to address any shortfall | April 2019 |
| 5.12 | **Clinical Directors from Elderly Care, Surgery, Anaesthesia, Intensive, local NELA leads, Multidisciplinary clinical teams:** develop and agree multidisciplinary care pathways that define when input from Elderly Care should be sought | Pathways to be in place by April 2019 in anticipation of Best Practice Tariff |
| 5.13 | **Local NELA leads, multidisciplinary clinical teams:** Ensure patients over the age of 70 have frailty, nutritional status, cognitive function and functional impairment assessed to inform decision-making and highlight those that may benefit from perioperative input by Elderly Care teams. Ensure these are embedded in clinical pathways | Pathways to be in place by April 2019 in anticipation of Best Practice Tariff |
| 5.14 | **Multidisciplinary clinical teams:** ensure that NELA data on input by Elderly Care teams is reviewed at regular multidisciplinary governance meetings | Commence from next governance meeting (by January 2019 at the latest) |
| 5.15 | **NELA:** share information on hospitals who perform well for Elderly Care input | December 2018 |
| 5.16 | **NELA:** collaborate with the British Geriatric Society to raise awareness of emergency laparotomy in older people | April 2019 |

# …although of course surgical expertise is central!!!...

ASA PAPER

## Patients With Adhesive Small Bowel Obstruction Should Be Primarily Managed by a Surgical Team

*Christopher T. Aquina, MD, MPH,[*] Adan Z. Becerra, BA,[*] Christian P. Probst, MD, MPH,[*] Zhaomin Xu, MD,[*] Bradley J. Hensley, MD, MBA,[*] James C. Iannuzzi, MD, MPH,[*] Katia Noyes, PhD, MPH,[*] John R. T. Monson, MD,[*†] and Fergal J. Fleming, MD[*]*

(Ann Surg 2016;264:437–447)

# …and POPS involved/leading on…

Preoperative care (inc conservative management)

- Medical optimisation
  - Fluids, AKI, delirium, sepsis, drug management
- Communication with patient/carers
  - Capacity, consent, shared decision making
  - Advance care planning – ceilings of care
- Communication across teams to optimise mx
  - Focus on reducing risk of predictable comps
  - Ensuring proactive approach to diagnosis & mx

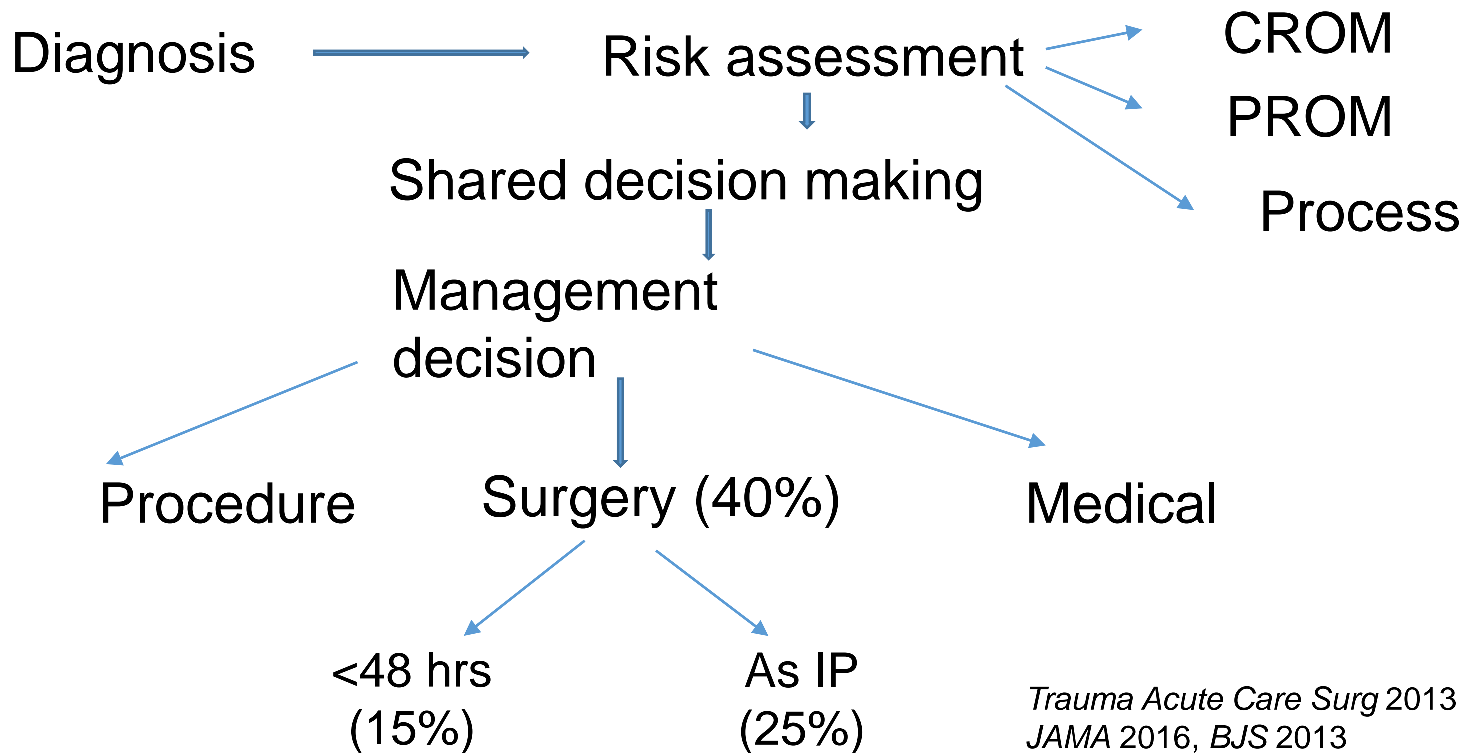
# …and delivering hands on postop care

## Ensuring continuity of postoperative care

- Medicine
- Rehabilitation
- Discharge planning
  - POC, ICT, care home
- Communication
  - Patient
  - Family/carers
  - Primary/community care

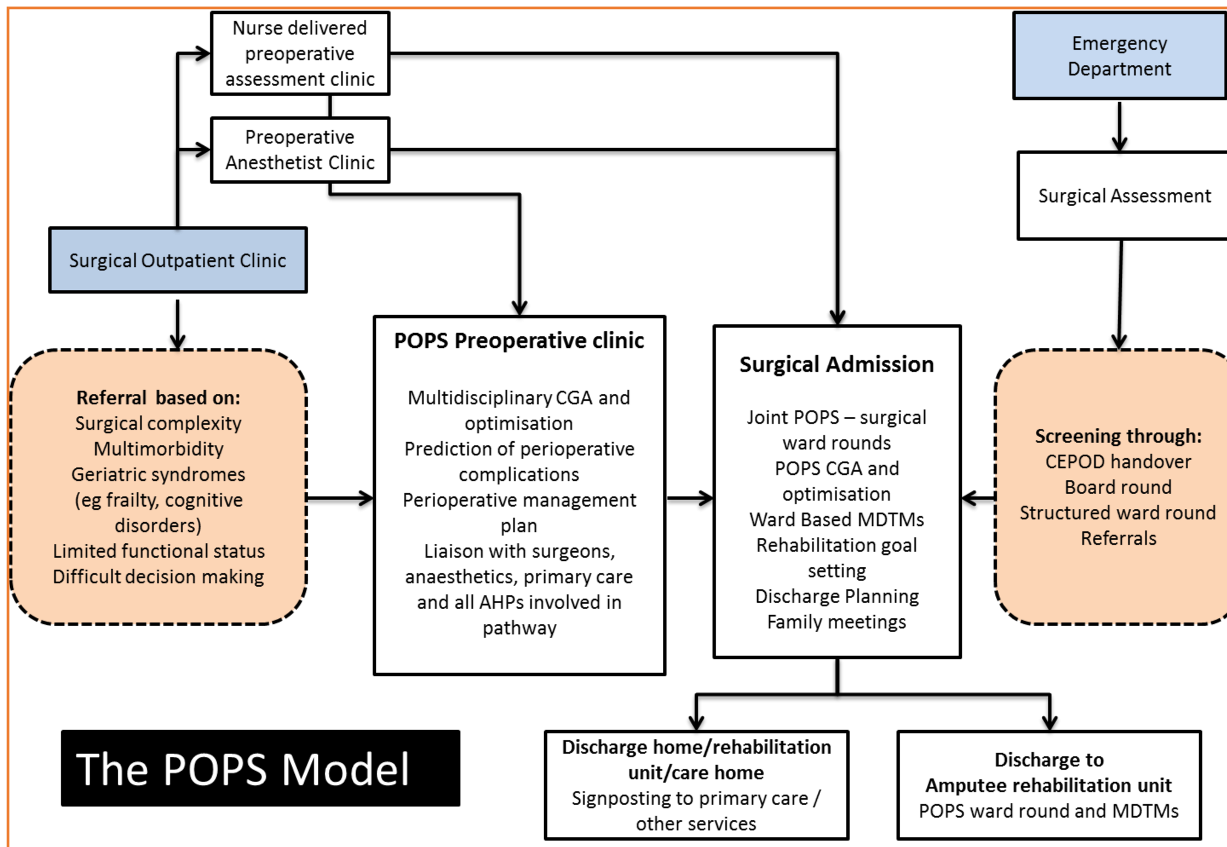
Nursing handover
Surgical handover
Joint ward rounds
MDTMs
Physical presence

# A collaborative approach…




*Trauma Acute Care Surg* 2013
*JAMA* 2016, *BJS* 2013

# In practice; the POPS model at GSTT for emergency surgical patients…



# Where to start

| Issue | Tool |
| --- | --- |
| Frailty | CFS, EFS |
| Cognitive status | 4AT, MoCA |
| Nutritional status | MUST |
| Functional status | Care needs, Barthel, NEADL |

- Guidelines
- Pathways
- Joint morbidity/mortality meetings
- QI methodology
- Funding (board meetings, stories)

# Challenges in establishing CGA in perioperative medicine

A complex undertaking requiring

- collaboration across specialties and disciplines
- whole system reorganisation (cultural change)
- upfront funding

It can be done but raises one important question:

- do we have necessary trained workforce?

# What do we really need in our workforce?

- whole pathway expertise
- knowledge and skills in compressive assessment
- case management

- Do we need a new perioperative specialist?

Or

- Upskill staff we have

Or

- Both

# The challenge –addressing the workforce

| | |
|---|---|
| FY | • Modular training programme<br>• From contemplation to recovery |
| Specialist | • Curriculum<br>• OOPE/T GSTT, DGT, EKHT, Oxford, Bristol, Taunton, Salford, Edinburgh & more<br>• Research/QI/IS/Darzi fellows |
| National/ International | • E-learning modules<br>• MSc<br>• POPS conference |

# Who else can do this?

- National approach to alternative workforce
  - Allied health professionals
  - Physicians associates
  - Nurses

# Allied health professionals

- OT and physiotherapist
  - Improvements in quality of life
  - Decrease in  hospital admissions

- Pharmacists
  - Improved drug knowledge and compliance
  - no effect on reducing mortality or hospital admissions
    - But likely do impact on reduction of drug related harm – anecdotal

*Graff et al., 2008; Knapp et al.,2010, Yoon et al,. 2007*

# Physicians associates

- Physician associates
  - USA model with recent development of own faculty / linked to royal college of physicians / two year training programmes
  - In UK part of the medical associate professions group
  - 37 colleges now providing training (undergrad and MSc)
  - Permanent members of medical / surgical team
  - Assessment and management of patients

1. physician associates (PAs)
2. anaesthesia associates (AAs) – known as physician's assistants (anaesthesia) prior to 2019
3. surgical care practitioners (SCPs)
4. advanced critical care practitioners (ACCPs).

- Limitations
  - Cannot prescribe / limits on investigations can order / start as dependant practitioners
  - Few training places (though increasing yearly)
  - Expensive! (band 7)
  - Some limited evidence at present into impact on care

# Clinical nurse specialist / advanced nursing practice

- Case management
  - Comprehensive assessment
  - Care planning and implementation
  - Diagnostic reasoning
- Specialist education / career pathway
  - Advanced assessment skills / Prescribing
- Evidence of benefit
  - Limited in surgical care of older people
  - In-hospital – reduced discharges to institutional care
  - Transitional care – reduced readmission
  - Long term care – Reduction mortality and readmission. Increased satisfaction and function

*J C Morilla-Herrera, International Journal of Nursing Studies, 2016*

# What do Peri-operative Emergency Services look like in practice?

Deepa Rangar
Clinical Lead for POPS
Royal Infirmary Edinburgh

# POPS

## Proactive care of Older People in Surgery

**Refer if**
>70 years old
**AND has ANY of the following:**
Delirium / Dementia
Frequent falls
Multimorbidity
Peri-operative medical complications
Nursing or residential home resident
Polypharmacy
End of life care
Need for rehab bed

**POPS**
**07811025912**
**M-F 9-5**

Royal Infirmary Edinburgh
108 surgical beds
- General surgery
- Vascular surgery
- UGI/HPB

- Emergency Pathway only at present
- Developing pre-assessment frailty pathways in collaboration with anaesthetics.

POPS team
- 6 PA consultant time MOE
- 1 Band 6 POPS Nurse Practitioner
- 2 MOE Clinical Fellows

# Evolution of POPS in RIE

- Reactive to pro-active
- Expansion of team (ELHF grant) for 12 month pilot POPS Nurse Practitioner
- Closer working and appreciation of specialty-specific skills (surgeons/anaesthetists)
- Surgical directorate now funding MOE consultant PAs, Clinical Fellows and POPS NP

Hospital Electronic Frailty Index (HEFI) identifies Frail Older Person in RIE 105/106/107

Ward teams identify Frail Older Person who may benefit from specialist MOE input/CGA

**Patient Identification**

Refer to POPS Team:
1) Verbally to POPS NP/CF
2) POPS Mobile 07811025912
3) POPSRIE@nhslothian.scot.nhs.uk

POPS NP/CF complete initial MOE assessment Monday –Friday 9am-5pm

**Patient Review**

Daily patient review with twice weekly Consultant Ward Round (TUESDAY/FRIDAY); weekly MDTM Tuesday 2pm

**Specialist Senior MOE assessment**

Therapy assessment – PT/OT

**Safe Discharge Pathway**

Home with home-based rehabilitation

Bed-based rehabilitation in 105/106/107 or downstream bed

Transfer to RIE MOE Wards in exceptional circumstances

# Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

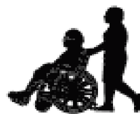
2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – 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 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People 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 **Severely Frail** – **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 **Very Severely Frail** – Completely dependent, approaching the 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 evidently frail.**

**Scoring frailty in people with dementia**

The degree of frailty 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.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

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# Hospital EFI (RIE)

- Cumulative score generated from nursing admission questionnaires
- Incorporates MUST, 4AT, continence, mobility, dependency
- NOT validated in surgical population
- Useful screening tool
- Also verbal referrals
- Testing POPS presence at morning surgical rapid run downs

# Outcomes

- LOS Surgical wards 16.4 days to 10.3 days
- LOS Hospital/rehab 29 days to 16 days
- 30 day mortality 16.5% to 3.9%

Great communication and advice from the team. Very thorough and great support with medical management

Easier referrals with POPS team being present on the wards all the time. Great inter-speciality communication.

Communication with families has been much improved thanks to POPS.

POPS has been a great support for the patients. It's nice to know other issues are being looked after and not just surgical

Very helpful, good thorough reviews and early implementation with discharge planning.

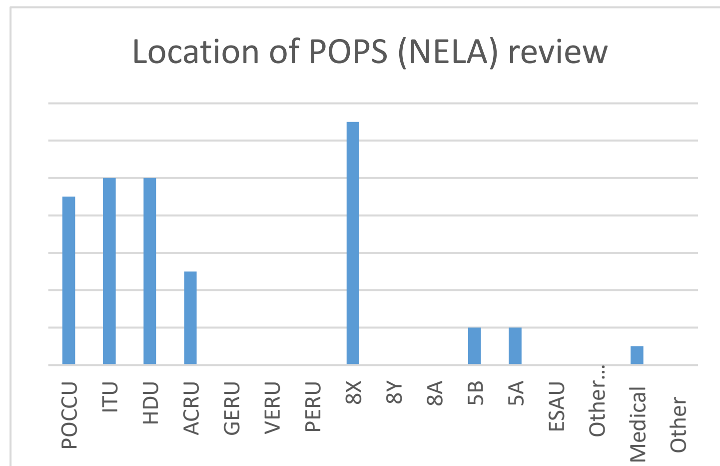
# Challenges…and advice!

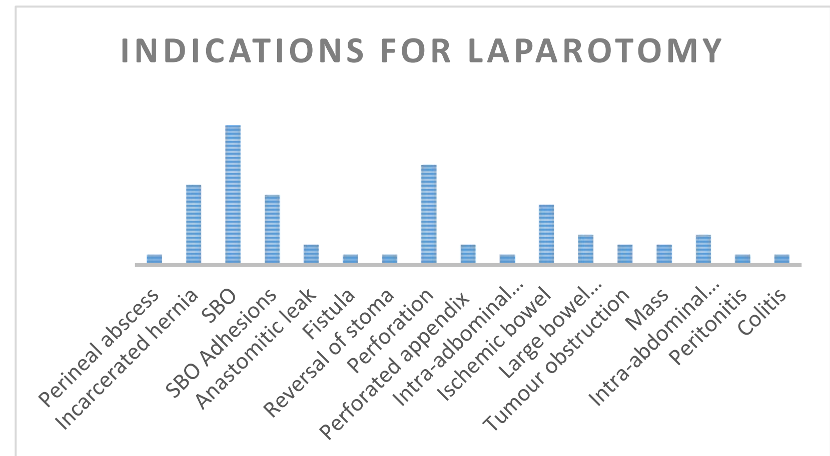
- Understanding culture of surgical units
- Culture shift
- Mutual respect and understanding of specialty specific skills
- Engaging junior doctors and registrars
- Be creative with funding
- Marathon not a sprint!!

# How to Link this into NELA

Dr Mark Johnston,
Peri-operative care for Older Patients requiring Surgery
Department for Medicine for Older People
Royal Liverpool University Hospital

| 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 | | | |




Pre-op?

| AIM | PRIMARY DRIVERS | SECONDARY DRIVERS | CHANGE IDEAS |
|---|---|---|---|
| Increase number of patients reviewed by Clinical Gerontology team after Emergency Laparotomy to 80%, with indirect improvements of reduced Length of stay and mortality in this age group.<br><br>1 linked measure | Data captured | Clearly Documented | Electronic POPS NELA form |
| | | Logged on (NELA) database | POPS input to NELA database |
| | Ability to review | CNS available | CNS rota |
| | | Geriatrician available | Geriatrician Rota with cover |
| | | Appropriate to review/Location | Review within 72 hours |
| | | | Develop Critical care pathway |
| | Aware of appropriate patient | Surgical team refers | POPS ICE referral form |
| | | Theatre staff refers | Theatre staff referral portal |
| | | POPS team proactively identifies | POPS triage tool |
| | | | Access Emergency theatre data |

Generated by

# Questions and Comments

# Site updates

Dr Jugdeep Dhesi

# *Update from sites*

We now have the opportunity to hear from each of our Network sites in turn, sharing your aims and progress so far.

We would love to hear what you have managed to achieve so far

Try to focus on the progress you are making or challenges you are facing - it does not matter how big or small there is always something to learn.

Each team has three minutes for their update.

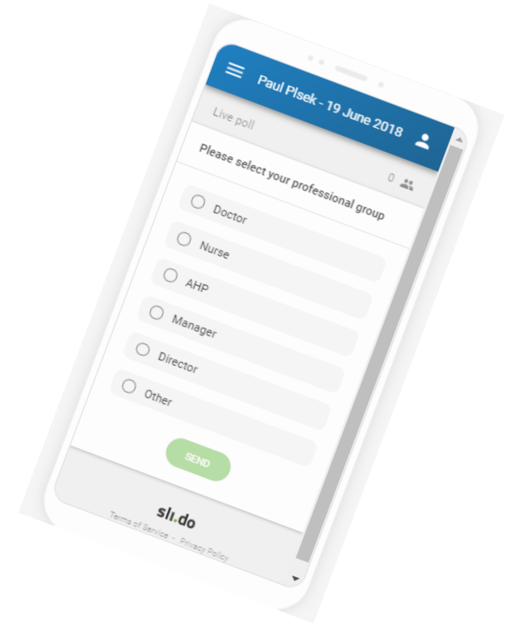
# *Summary and closing remarks*

**Dr Jugdeep Dhesi**

## *Next steps*

- Access the POPS website www.popsolderpeople.org and let us know what content would be useful.
- Share any content or resources you have that you think others would find useful.
- The password for the pages in the Members Area is **POPSNetwork2021**
- Access the POPS Toolkit at the website.
- Register for the next Core Event on **Thursday 9 September** from 9am to 11am: https://events.nhselect.nhs.uk/index.php/events/pops-cohort-one-core-session-september-2021/

sli.do




Open a browser on any laptop, tablet or smartphone

- Go to **sli.do.com** or scan the QR code below
- Enter the event code **#POPSCore3**
- 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**