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

October 2021

Programme Core Session

Agenda

09:00	
	Welcome and introduction to the day **Simon Griffiths**, Director, NHS Elect
	Update CPOC BGS Frailty Guideline **Dr Jugdeep Dhesi**, Consultant, GSTT & POPS Network Clinical Lead
	Measurement Update **Matt Tite**, Director, NHS Elect
	Moving your project forward **Lisa Godfrey,** Director, NHS Elect
BREAK (10 mins)	
	Case study - anaesthetists approach to delivering perioperative care **Dr Laura McGarrity**, Consultant Anaesthetist, NHS Ayrshire & Arran, **Dr Claire McCann**, ST7, London School of Anaesthesia & **Dr Sheena Hubble**, Consultant, Royal Devon & Exeter NHS Trust
	Summary and Next Steps **Simon Griffiths**
11:00	**CLOSE**

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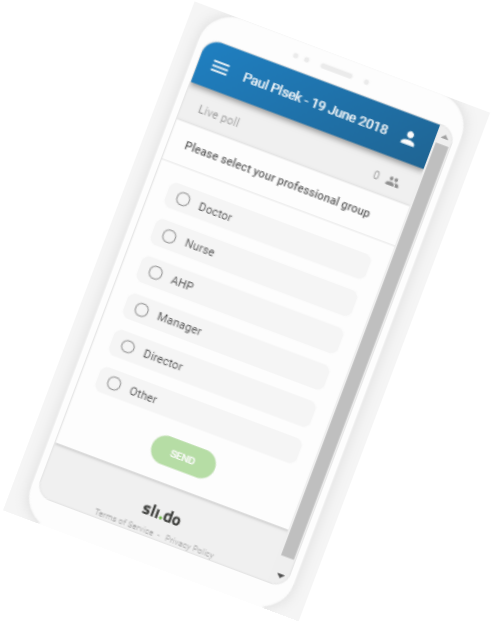
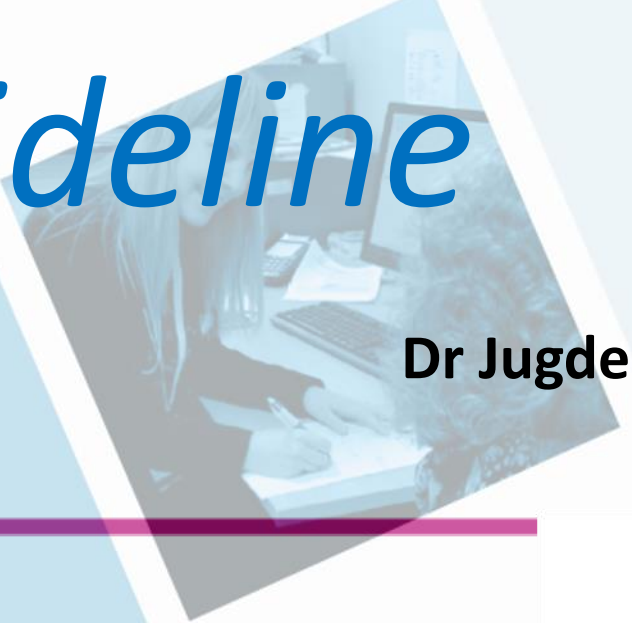


Open a browser on any laptop, tablet or smartphone

- Go to **www.sli.do** or scan the QR code
- Enter the event code **#POPSCore5**
- Use the polls to give us feedback about the day



Update to CPOC BGS Frailty Guideline

Dr Jugdeep Dhesi

Questions and Comments

Measurement Update

Matt Tite

POPS Measurement Journey

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

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

Measurement Masterclass: Measurement for Improvement knowledge, how and what to measure and an introduction to EBD

Your Measurement visit

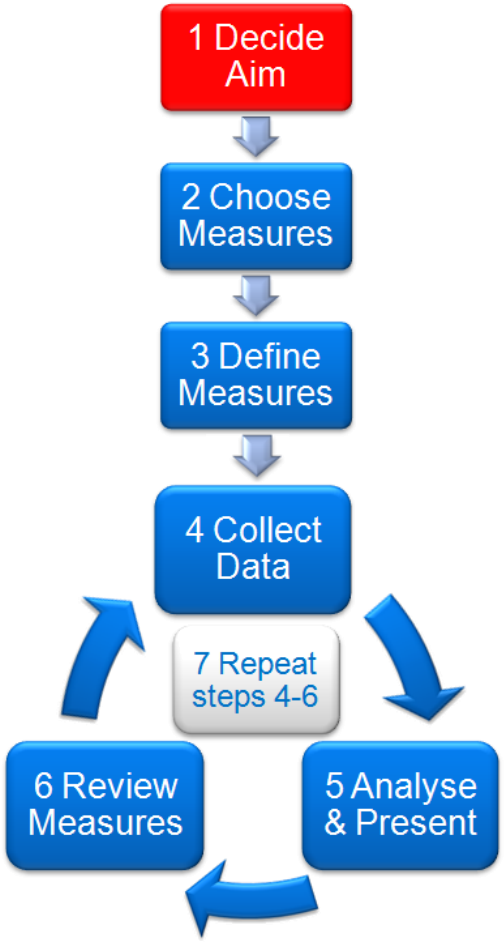
November and December Core Events: Share your working data and the tools you are using for data collection

The celebration event: Your charts

Things we have spent time learning so far…

- Aim statements
- Functional maps
- Driver Diagrams
- Outcome, process and balancing measures
- EBD
- SPC
- Pareto

The 7 steps to measurement



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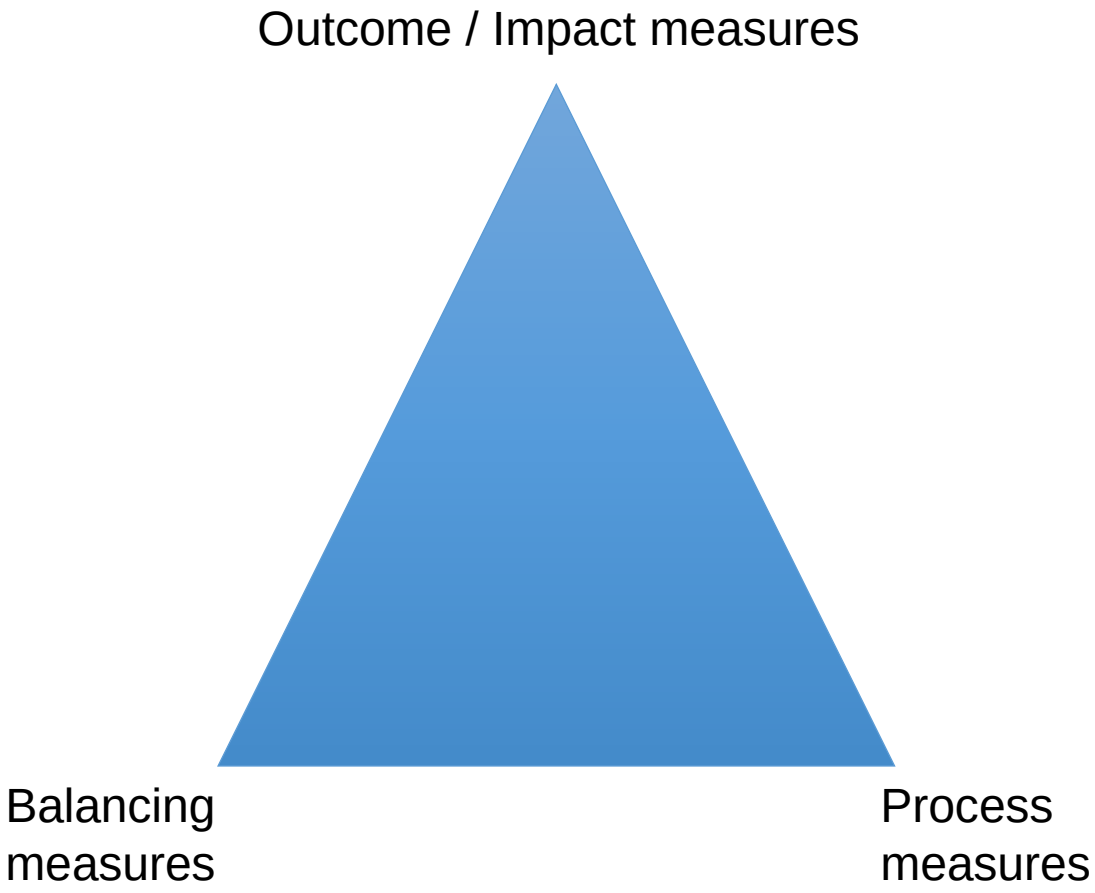
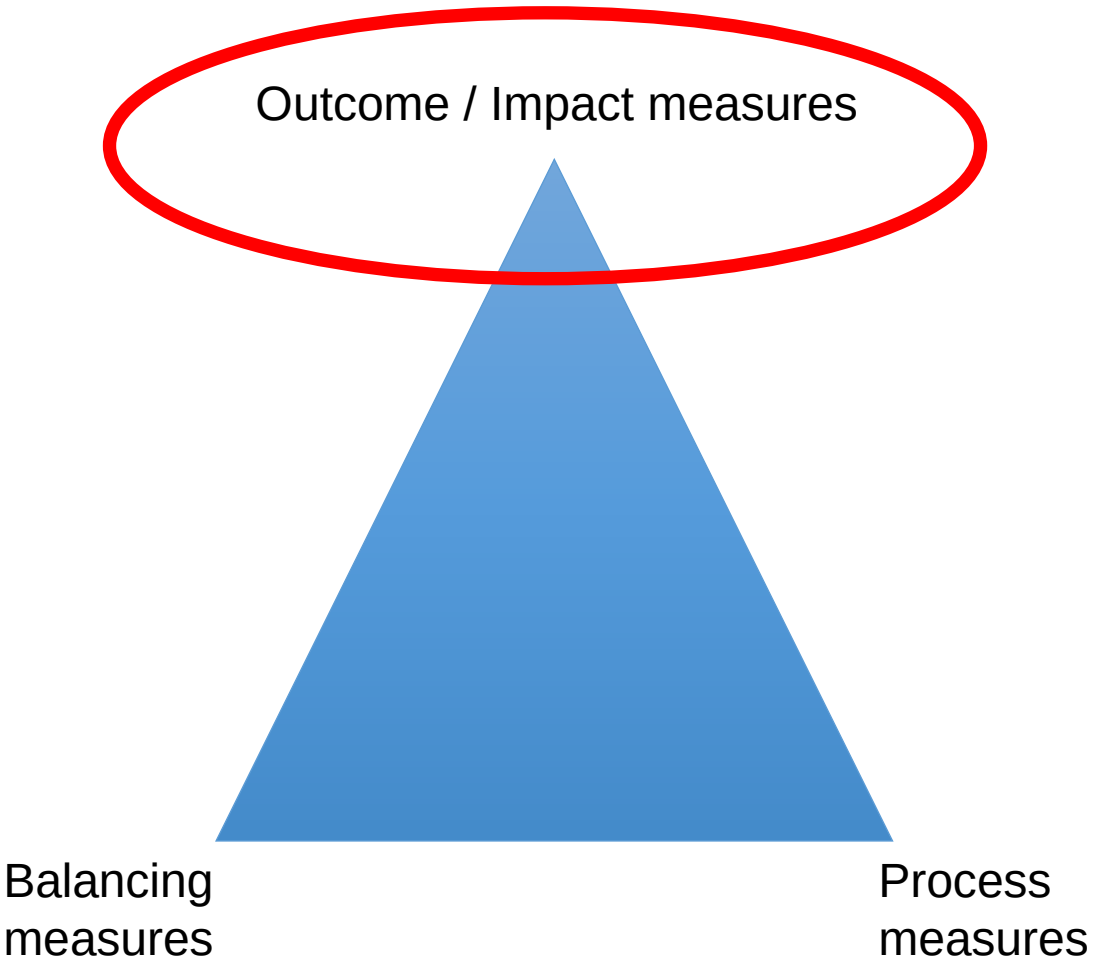

Outcome / Impact measures
Balancing measures
Process measures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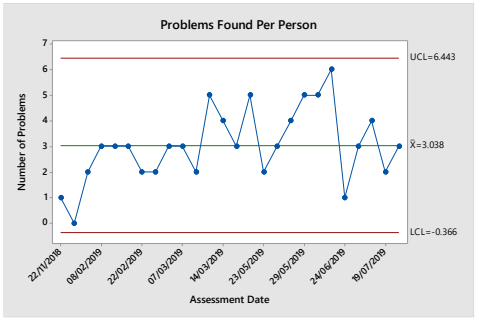
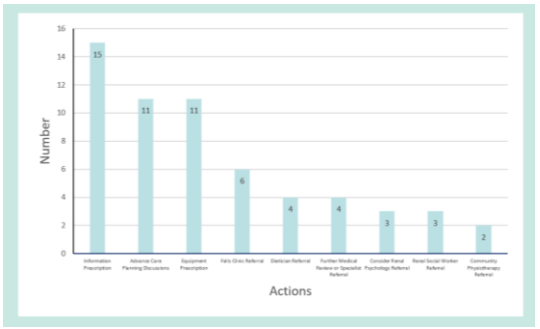
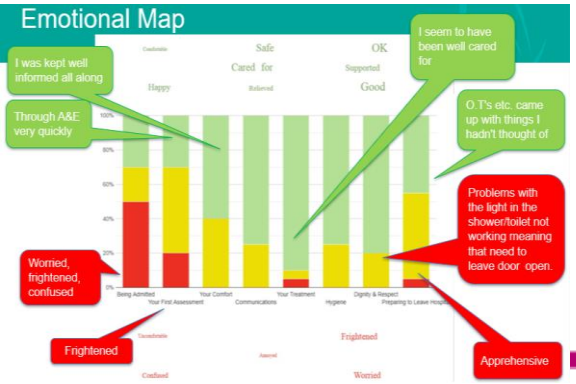


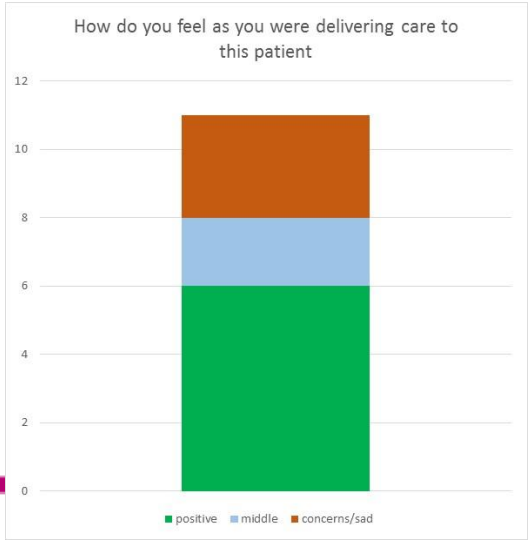


Data / Graphs

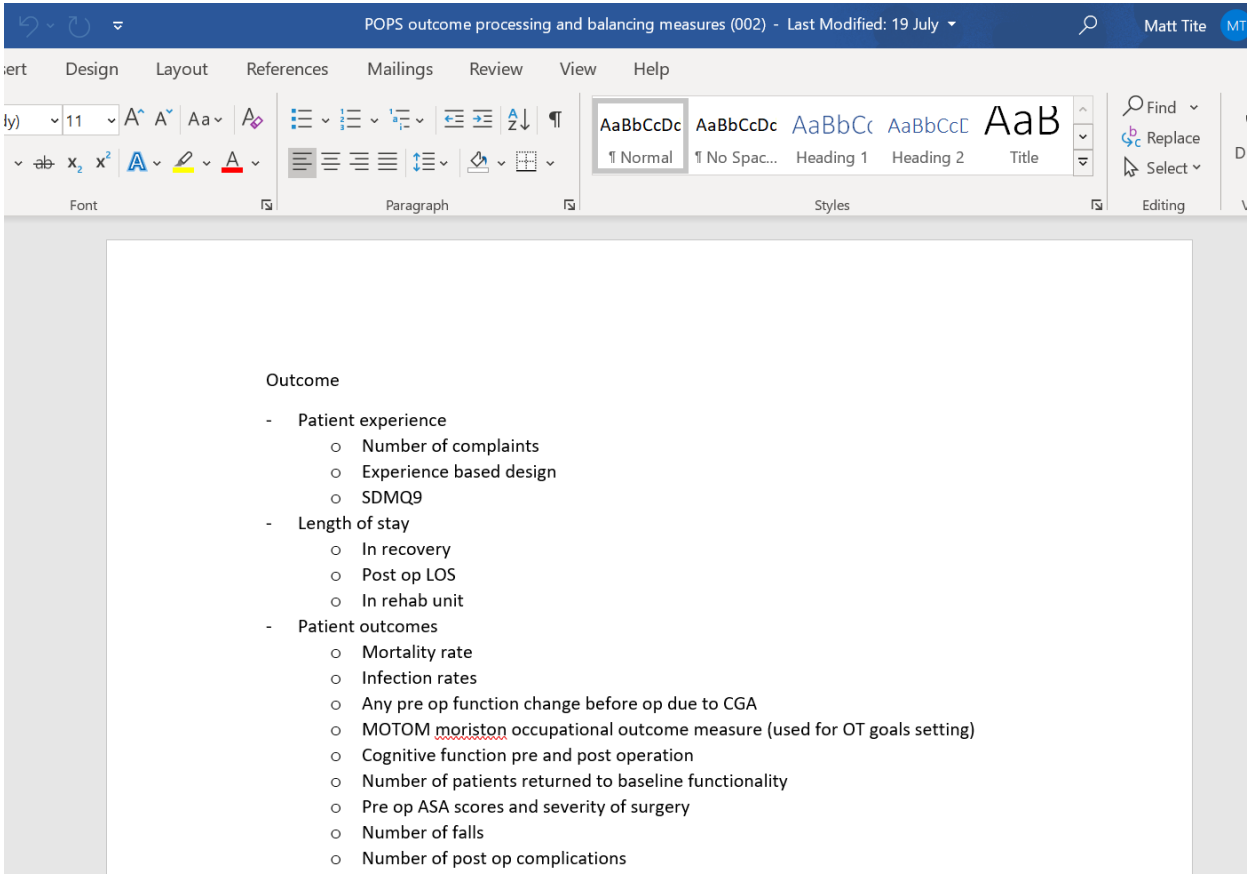


Patient Perspective

Staff Perspective



Outcome, process and balancing measures



slido

I feel we are progressing well with our Measurement for Improvement journey.

1 = Strongly Disagree
10 = Strongly Agree

ⓘ Start presenting to display the poll results on this slide.

slido

From a measurement perspective, the one thing we are really pleased about is...

ⓘ Start presenting to display the poll results on this slide.

slido

From a measurement perspective, the one thing we are really struggling with is...

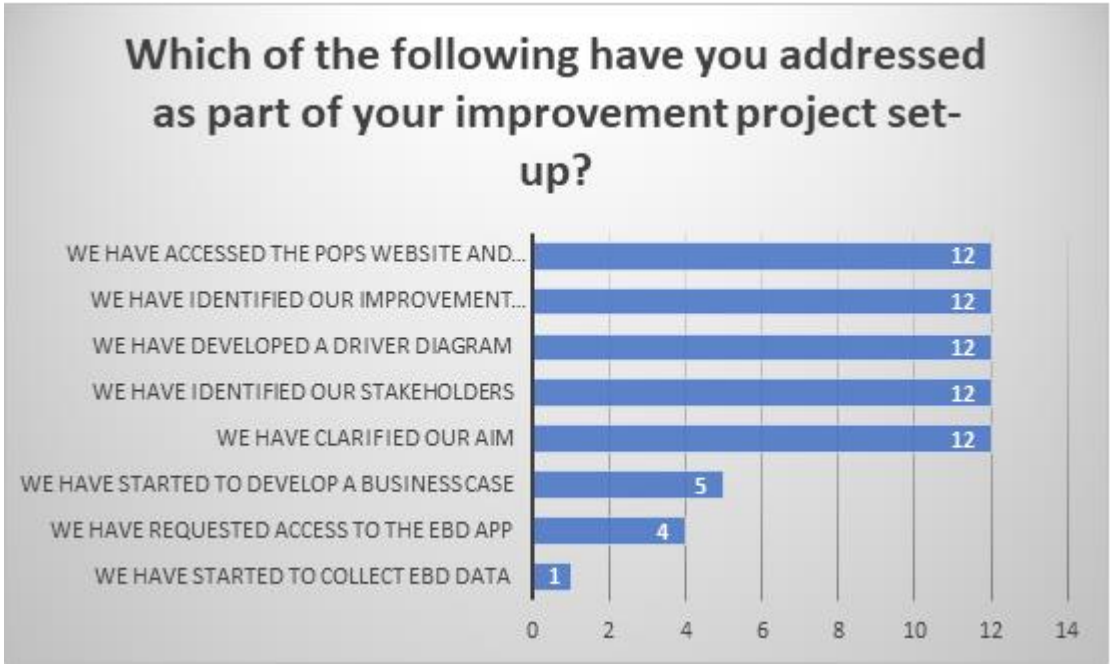
ⓘ Start presenting to display the poll results on this slide.

Moving your project forward

Lisa Godfrey

Continuing the conversation…

- At last month's Core Event we discussed:
  - where you have got to in your project planning and delivery
  - your plans for the next three months of the programme
  - what you need from us to accomplish that
- To capture this, we asked some questions on Sli.do:



What are you most proud of in the work you have done so far?

- Brought together an enthusiastic multidisciplinary team who are passionate about improving the care of older surgical patients.
- Building a relationship with ortho MDT.
- Developing an interest in the wider team in our POPS work.
- Securing funding and recruiting to develop a POPS service.
- Medicine and surgery are talking together about whole patient care.
- The enthusiasm of non-geriatricians to improve the care of our older surgical patients.
- Cross departmental working. Raising awareness of frailty identification and assessment.
- Developing a plan for joint appraisal and education plan for our CNS'.

Core Principles

- We would now like to break you into mixed groups.
- Think about the core components of the POPS Toolkit:

➢Deliver preoperative CGA and optimization through multidisciplinary working

➢Provide postoperative CGA on the surgical ward

➢Ensure ownership of patient care

➢Facilitate proactive liaison with other teams

➢Provide education and training to POPS team and key stakeholders

➢Establish governance structure and evaluation processes

➢Developing a business case

<u>In your group discuss ONE or TWO core components:</u> Where have you made progress? What are the barriers and enablers you are encountering? What support do you need?

Feedback

Case study - anaesthetists approach to delivering perioperative care

Dr Laura McGarrity, Dr Claire McCann, Dr Sheena Hubble

1. NHS Ayrshire & Arran

2. NHS Borders

3. NHS Dumfries & Galloway

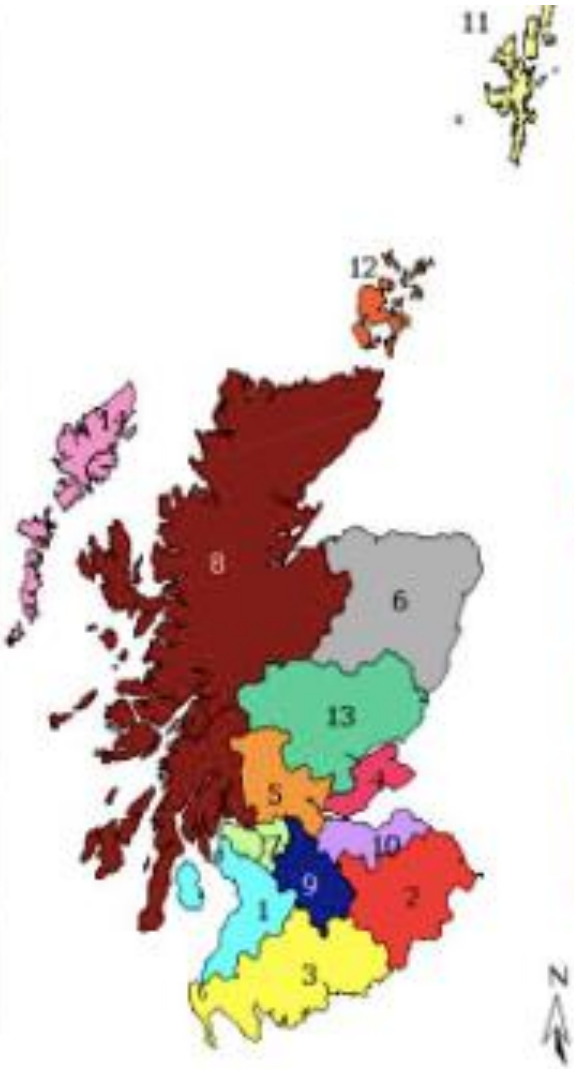
4. NHS Fife

5. NHS Forth Valley

6. NHS Grampian

7. NHS Greater Glasgow & Clyde

8. NHS Highland



9. NHS Lanarkshire

10. NHS Lothian

11. NHS Shetland

12. NHS Orkney

13. NHS Tayside

14. NHS western isles

15. Golden Jubilee National Hospital

27%

Scottish Hospitals with acute frailty unit

1.27 (0-2.27)

COTE consultant / 10,000 age >65

46% / 19%

Rates of surgical liaison

SCoOP

Comprehensive Geriatric Assessment in Secondary Care Audit (2019)

- Other unwarranted variation: AHP access, MDT review, Social work review

Centre for Perioperative Care

SurveyMonkey

57%

screen for frailty: age>65 is trigger CFS 75% 4AT 62%

8%

deliver CGA

57%

deliver SDM

21%

highlight delirium risk to post op destinations

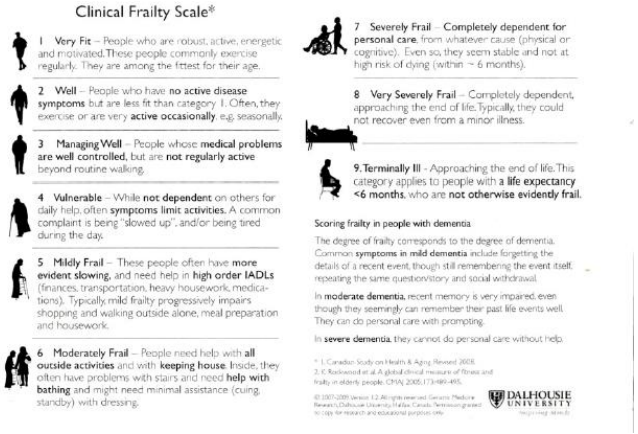
35%

Postoperative delirium toolkit

Scottish Standard – Pre op phase

- **preoperative screen & case finding**
  - **CFS / SQiD /current Dx for all age >65 referred for surgery**
  - **Edmonton>7, 4AT>0, >3delirium risk factors**
- **comprehensive geriatric assessment**
  - **major workforce deficit**
- **shared decision making discussion**

leading to consent with awareness of risk of POCD



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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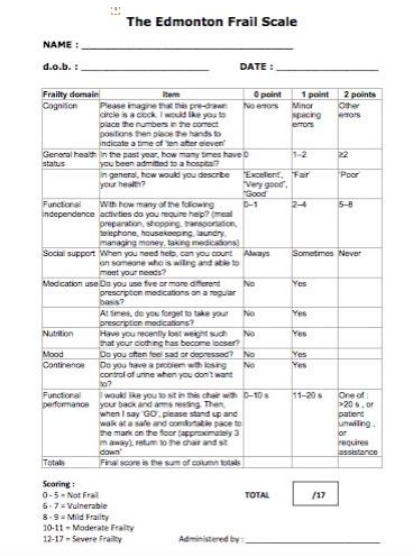


The Edmonton Frail Scale

NAME : _____

d.o.b. : _____ DATE : _____

Frailty domain	Item	0 point	1 point	2 points
Cognition	Please imagine that this pre-drawn circle is a clock. I would like you to place the numbers in the correct positions then place the hands to indicate a time of 'ten after eleven'	No errors	Minor spacing errors	Other errors
General health status	In the past year, how many times have you been admitted to a hospital?	0	1–2	≥2
	In general, how would you describe your health?	'Excellent', 'Very good', 'Good'	'Fair'	'Poor'
Functional independence	With how many of the following activities do you require help? (meal preparation, shopping, transportation, telephone, housekeeping, laundry, managing money, taking medications)	0–1	2–4	5–8
Social support	When you need help, can you count on someone who is willing and able to meet your needs?	Always	Sometimes	Never
Medication use	Do you use five or more different prescription medications on a regular basis?	No	Yes	
	At times, do you forget to take your prescription medications?	No	Yes	
Nutrition	Have you recently lost weight such that your clothing has become looser?	No	Yes	
Mood	Do you often feel sad or depressed?	No	Yes	
Continence	Do you have a problem with losing control of urine when you don't want to?	No	Yes	
Functional performance	I would like you to sit in this chair with your back and arms resting. Then, when I say 'GO', please stand up and walk at a safe and comfortable pace to the mark on the floor (approximately 3 m away), return to the chair and sit down'	0–10 s	11–20 s	One of : >20 s , or patient unwilling , or requires assistance
Totals	Final score is the sum of column totals			

Scoring :
0 - 5 = Not Frail
6 - 7 = Vulnerable
8 - 9 = Mild Frailty
10-11 = Moderate Frailty
12-17 = Severe Frailty

TOTAL /17

Administered by : _____

ACS NSQIP®

4AT

Assessment test for delirium & cognitive impairment

Patient name:
Date of birth:
Patient number:
Date:
Time:
Tester:

1 ALERTNESS — CIRCLE

Normal (fully alert, but not agitated, throughout assessment) 0
Mild sleepiness for <10 seconds after waking, then normal 0
Clearly abnormal 4

2 4AMT4

Age, date of birth, place (name of the hospital or building), current year

No mistake 0
1 mistake 1
2 or more mistakes/untestable 2

3 ATTENTION

Ask the patient: "Please tell me the months of the year in backwards order, starting at December."
To assist initial understanding one prompt of "what is the month before December?" is permitted.

Months of the year backwards

Achieves 7 months or more correctly 0
Starts but scores <7 months / refuses to start 1
Untestable (cannot start because unwell, drowsy, inattentive) 2

4 ACUTE CHANGE OR FLUCTUATING COURSE

Evidence of significant change or fluctuation in alertness, cognition, other mental function (eg, paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs

No 0
Yes 4

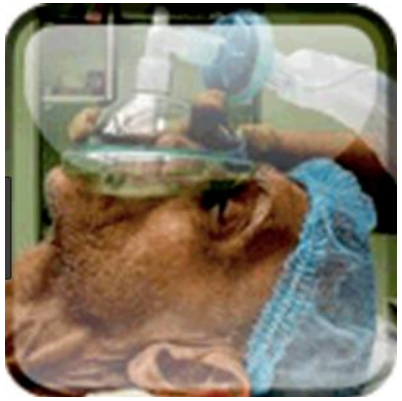
4 or above: possible delirium +/- cognitive impairment
1-3: possible cognitive impairment
0: delirium or severe cognitive impairment unlikely (but delirium still possible if AU information incomplete)

4AT SCORE

SQiD

'Do you think you have (or your relative has) been more confused in the last 6 months'

intraoperative bundle



Preoperative

- Assess risk for post operative delirium
- Avoid benzodiazepine premed
- Avoid prolonged fasting times (encourage clear fluids until 2 hours pre-op)

Anaesthesia

- Thermoregulation
- Avoid pressure effects with appropriate positioning care
- Lowest anaesthesia dose for minimum time
- Consider avoiding sedation with regional anaesthesia
- Multimodal opioid sparing analgesia
- Avoid anticholinergics

High risk

- Consider depth of anaesthesia monitoring (Age adjusted MAC, BIS)
- Consider IABP monitoring and vasopressor infusion to avoid fluctuations in BP
- Consider Goal directed fluids

Postoperative phase

- **enhanced communication with postoperative destination regards risk of POCD**
- **4AT by12noon POD1 and repeated if cognition fluctuates**
- **application of delirium toolkit when delirium occurs**

POA e-Form Demo

- preoperative screen
- **CFS / SQiD /current Dx for all age >65 referred for surgery**
- case finding
- **Edmonton>7, 4AT>0, >3delirium risk factors**

Anaesthetic training in perioperative medicine

Dr Claire McCann ST7 Anaesthetics

POPS NHS elect event Oct 21

Current model

- Minimum formal training in preassessment
- ‘High risk’ pre-op clinics based on type of surgery or cardiorespiratory risk
- Not traditionally focused on holistic risk assessment or post-op care beyond admission to ICU/HDU

2021 Curriculum learning syllabus: stage 1

Published: 04/02/2021

Perioperative Medicine and Health Promotion

Stage learning outcomes

- *Identifies clinical and social challenges that increase risk for patients undergoing surgery.*
- *Appreciates the principles of sustainability in clinical practice*

Key capabilities A to F

Key capabilities A to F

A	Explains the patient, anaesthetic and surgical factors influencing patient outcomes
B	Applies a structured approach to preoperative anaesthetic assessment of ASA 1-3 patients prior to surgery and recognises when further assessment and optimisation is required
C	Explains the effect that co-existing disease, subsequent treatment and surgical procedure may have on the conduct of anaesthesia and plans perioperative management accordingly
D	Explains individualised options and risks of anaesthesia and pain management to patients
E	Describes the importance of perioperative nutrition and fasting
F	Recognises and acts on the specific perioperative care requirements in frail and elderly patients and those with cognitive impairment

Key capabilities A to H

A	Delivers high quality, individualised perioperative care to ASA 1-4 patients for elective surgery and ASA 1-3 emergency patients, focusing on optimising patient experience and outcome
B	Liaises appropriately with other healthcare professionals to optimise patient care
C	Explains the principles of shared decision making
D	Makes appropriate plans to mitigate co-morbidities and their treatment in the perioperative period, with particular reference to less common cardiovascular, neurological, respiratory, endocrine, haematological and rheumatological diseases
E	Appreciates how integrated care pathways influence patient outcomes
F	Describes the use and limitations of common risk-scoring systems
G	Recognises when advanced physiological testing is indicated, interpreting the data to help stratify risk

Key capabilities F & G

F	Applies the principles of shared decision making about the suitability of surgery and anaesthesia with high-risk patients and colleagues
G	Evaluates information gained through preoperative assessment and applies the principles of shared decision making with the patient and multi-disciplinary team

Examples of evidence

- SLEs throughout stage of training including special interest area and experience in pre-operative assessment clinics demonstrating, for example:
  - leadership in discussion of patient care with surgical team.

Personal activities and reflections:

- courses and e-Learning: NICE guidance – shared decision making.

Examples of evidence

- SLEs throughout stage of training across range of surgical specialties including emergency surgery, obstetrics, paediatrics, neuro, cardiac and experience in pre-operative assessment clinics.

Personal activities and reflections:

- attendance at pre-operative assessment clinics
- knowledge of NICE guidance on shared decision making
- awareness of integrated care pathways in the devolved nations
- e-Learning or teaching sessions on risk scoring, cardiopulmonary exercise testing
- Final FRCA.

Suggested supervision level

- 3 - supervisor on call from home for queries able to provide directions via phone or non-immediate attendance.

Opportunities for anaesthetic and POPS collaboration

- 3 month blocks of training at SHO, junior reg and senior reg level
- Provide the training experience and perspectives / skills required
- Additional regular workforce

- Collaborate with RCOA college tutor in local dept
- Requirement to ‘sign off’ training modules on RCOA learning portfolio

Challenges

- New area of training for anaesthetics
- Not traditional model of training in the speciality
- Service provision to theatres
- Sessional work

- Desire for appropriate training to meet obvious need
- Already delivered for pain medicine in certain schools

Setting up an in-patient Perioperative service. (…An honest account).

Exeter Perioperative Medicine service ‘EX-POM’

Royal Devon and Exeter Hospital NHS Trust

Sheena Hubble FRCA MRCP DICM

2021 Ex-POM RDE Hospital

In-patient service. 150 beds.	Colorectal, UGI, Vascular, Urology, (ENT, Max-Fax)	Proactive and reactive patient list (30).	Joint surgical rounds in am to "Spread net wide"
Focussed Periop round in pm to "Spread net deep"	Opened and run dedicated Chest trauma unit, NPSA Award.	5 day per week consultant cover (excluding holidays)	7 day per week junior cover. Compliant rota.

Per week: Joint GI failure/TPN round. Complex MDT. Micro round.

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2021 Senior Team

- Lead consultant experienced Intensivist with MRCP (..in 1993!)
- Acute Medical consultant: 1 day pw
- Consultant Anaesthetist: 1 day pw (links to HRA clinic)
- Senior Care of the Elderly Nurse Consultant: 3 days pw
- 1 band 7 pharmacist: 1 day pw
- New funding for Care of the Elderly consultant: 5 PA's pw
- Recently agreed funding to join November POPS cohort!

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2021 Junior Team

- 1 Care of the Elderly ST 6-7 registrar 3 days pw (on CVA rota)
- 3 trust grade F3's
  - Minimum 2 years NHS experience, often internal.
- 1 Deanery F2
- 1 qualified Physician Assistant (PA) (works with pharmacist)
- Rotating PA students
- Anaesthetic trainee and nursing shadows

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June 2017: the Beginning…

High MET call rate and unplanned ITU admissions.	High burden on Medical Registrars, in and out of hours.	Very little bed capacity for Care of the Elderly takeover.	Inconsistent chest trauma management (180 pa).
Senior nursing dissatisfaction with medical support.	Very poor junior surgical Deanery Feedback… 'at risk'.	From June 2017 : single-handed full-time consultant	6 month Pilot. 'Home alone'.

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The Big Sell…

Ward presence and early,

Common-sense Vision Statement.

Business plan to offset cost with reduced bed days. (500K)

- Aim reduce MET calls and ITU admissions.
- Develop new MDT Chest trauma pathway to improve care of Silver Trauma.
- Improve trainee feedback to at least ‘Amber’.
- Ease ward pressures and stress.
- Proactive discharge planning to improve flow.
- Reduce ad hoc medical and geriatric referrals.

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Early Improved Outcomes

Marked reduction in MET CALLS and arrests (very soon)	Fall in NELA mortality	Reduction in Chest trauma complications. Chest Trauma Unit 2020.	Decreased mortality and LOS in Elderly pancreatitis
Improved Trainee feedback inc. medical and geriatric registrars.	Care of the elderly nurse reduced reduced geriatric referrals	Surgeons, Nurses and managers 'bought in'.	More published literature.

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How? …Enthusiasm, Smoke and Mirrors.

‘Constantly present and presenting’.	Used locum bill for the first F3.	Used COVID redeployment risk proofing to ring fence 3 F3’s	Awarded Deanery F2 for ‘good behaviour’
Early improved outcomes drove Management interest and consultant PA’s	Used WLI to generate more PA’s and holiday cover.	Won hearts and minds of Geriatric department leads.	Surgeons agreed to apportion COVID Restart money.

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Challenges.

Surgical Skepticism.	Difficult to collect data whilst at the 'coal face'.	No experience with business planning. Or 'Future proofing'.	Multiple changes of management and Goal posts.
Perennial Fiscal restraint.	Peaks and troughs of Energy.	Need a broad-based senior team as an umbrella specialty. • CGA: Computer Graphics and Analytics?? • Medical 'Bored' rounds and Oral drugs??	Visited POPS!

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Questions and Comments

Summary and closing remarks

Simon Griffiths

Next steps

- Please consider what materials your site has that could be shared as resources on the Members Area of the POPS website.
- If you are happy to share your driver diagram with other teams and have it uploaded in the Members Area please send it to networksinfo@nhselect.org.uk.
- Register for the next Core Event on **Thursday 11th November** from 9am to 11am.

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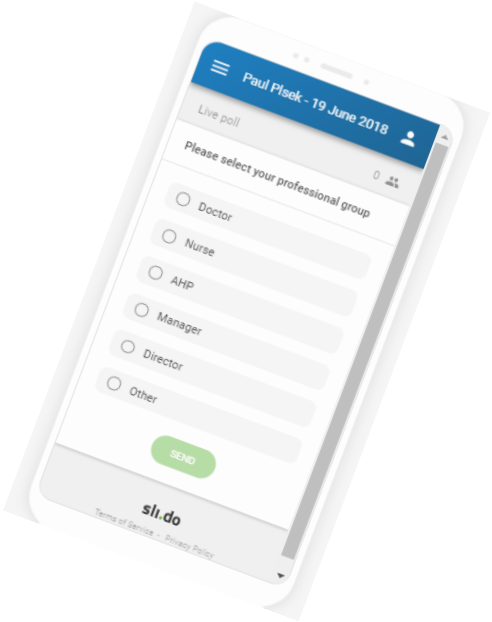

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- Go to **www.sli.do** or scan the QR code below
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- Use the polls to give us feedback about the day

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

networksinfo@nhselect.org.uk