

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

November 2021



Programme  
Core Session

# Agenda

**09:00**

**Welcome and introduction to the day** Dr Jugdeep Dhesi, Consultant, GSTT & POPS Network Clinical Lead

**Case study 'changing the waiting list to a preparation list'** Dr Rachael Barlow, Clinical Lead, Prehabilitation, Cardiff

**Mid-term data review** Matt Tite, Director, NHS Elect

**BREAK (10 mins)**

**Evidence supporting the development of POPS services for older surgical patients** Dr Jude Partridge, Consultant, POPS, GSTT

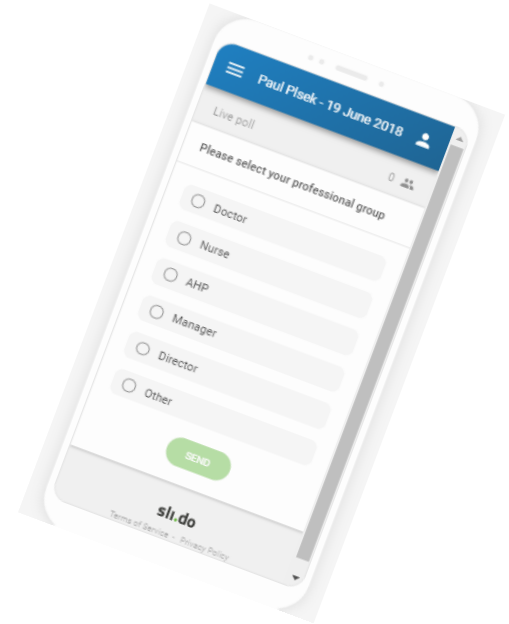
**Summary and Next Steps** Lisa Godfrey, Director, NHS Elect

**10:55 CLOSE**

# sli.do

Open a browser on any laptop, tablet or smartphone

- Go to [www.sli.do](http://www.sli.do) or scan the QR code
- Enter the event code **#POPScore6**
- Use the polls to give us feedback about the day





# *Case study – ‘Changing the waiting list to a preparation list’*

**Dr Rachael Barlow**

# Questions and Comments

# *Mid-term data review*



**Matt Tite**

# Wirral University Teaching Hospital

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# Outcome

- **Proactive identification of Inpatients with frailty**

- Criteria identified
- Referral pathway - Cerner
- ACP interaction
- Frailty Scoring
- Link to frailty scoring and develop SOP

- **Reduce incidence and severity of post-operative medical complications in surgical patients at WUTH.**

- Data set for patients with complications
  - ? EDD vs actual stay
- What are our clinical incidents relating to complications post operatively -
- What the average LOS for EGS patients over 12 months (outliers to time) - could we have predicted that at pre op ????
- Codes added following admission for delays - inclusion is >65
- Started to look at Comorbidities

- **Identify and treat post-operative medical complications early and thus reduce the impact on functional status and cognitive status**

- Identify Historical cases and review pathway and interventions for responsive service
- Group of procedures that have big enough numbers – review the data and investigate outliers for LOS above the planned “usual time”
- Emergency General team & colorectal for pathway progression and MDT approach



# Process

- **Positive Work**

- Inclusion Criteria agreed
- Medicines assessed by Senior Pharmacist within 24 hours of admission
- Falls risk assessments within medicine review

- **Development opportunities**

- Patient Pathway
- MDT clinic
- Specific medicines reviews
- Pre operative assessment/ prehabilitation

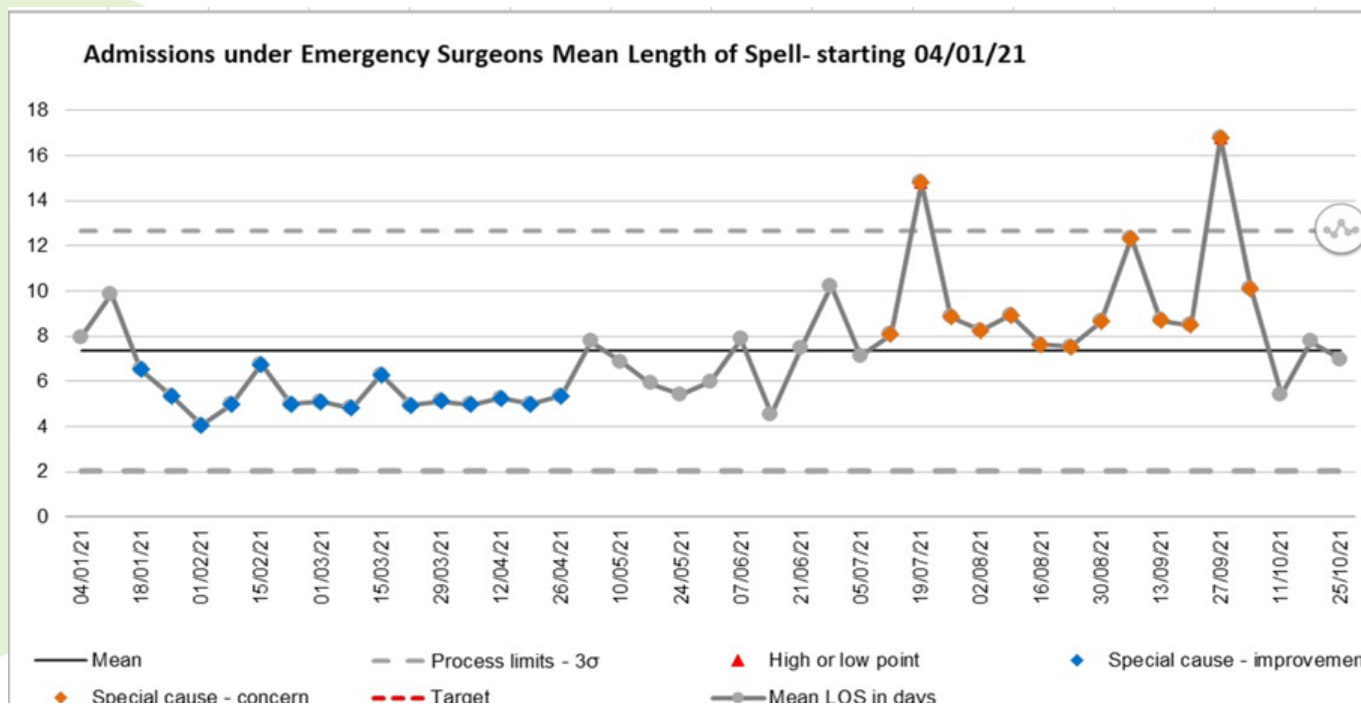
- **Next steps**

- Pathway development – link in with EGS around pathway development from surgical perspective and then move to Medics/Geriatricians/Pharmacy to get overview of the pathway
- Review Orthopaedic Pathway and diversify to EGS/Colorectal
- Virtual clinic review and set up to support MDT approach

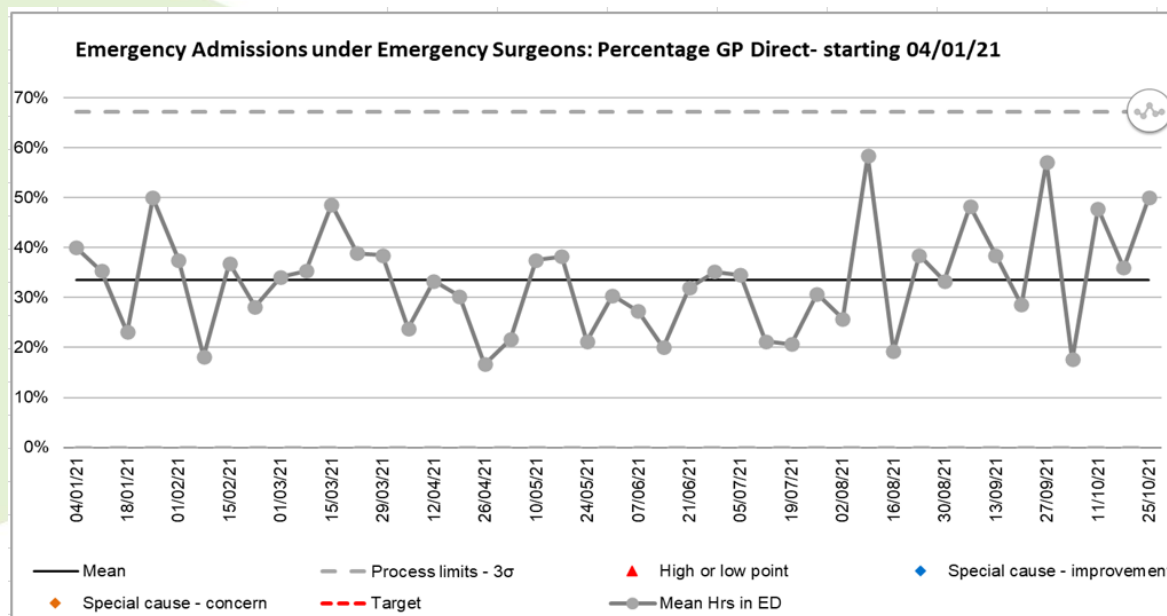
# Balancing

- **Workforce**
  - Requirements
- **Readmissions to Critical Care**
  - Data Trawl & review of admission indicators – formulate into pathway if there are any early catches
- **Return to Theatre 30 days inclusion of readmission to organisation**
- **Unplanned admissions**
  - Data vs ability to save readmissions – pathway??
- **Duplication of scores (assessments)**
  - Dementia Scoring
  - Post Op Delirium
  - ACP led assessments?
- **Pre op assessments no sooner than 4/52 before admission**
- **Establish relationships with intermediate care to facilitate early discharge**
- **Therapies input - what does this look like – wider engagement**
- **Next Steps**
  - EGS directorate to speak to IDT team for engagement into the processes - ?early interventions
  - ACP review of assessment tools to reduce duplication/streamline
  - Review of National and regional processes in the older person?
  - Data screen on 5-10 patients
  - Engage with wider therapies team

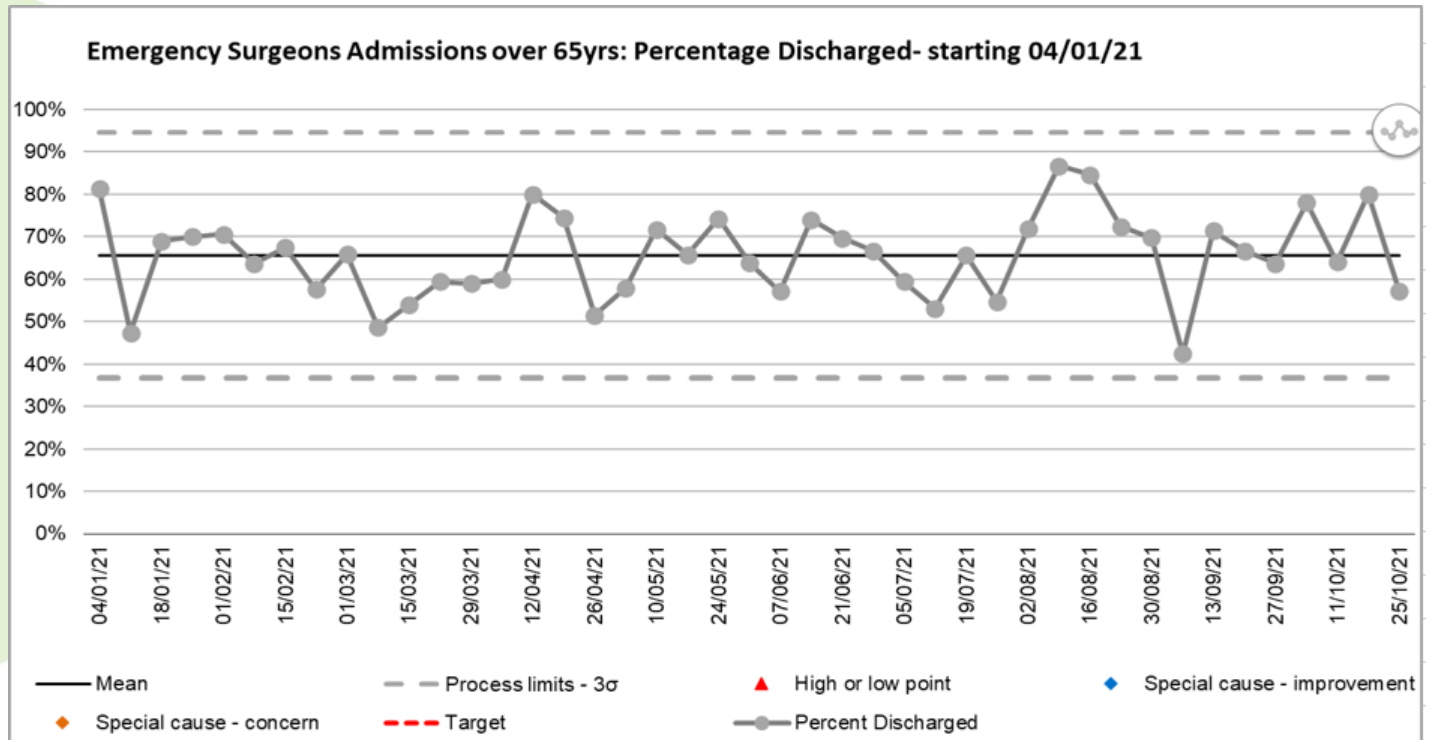
# Admissions under Emergency General Surgeons



# Direct GP Admits

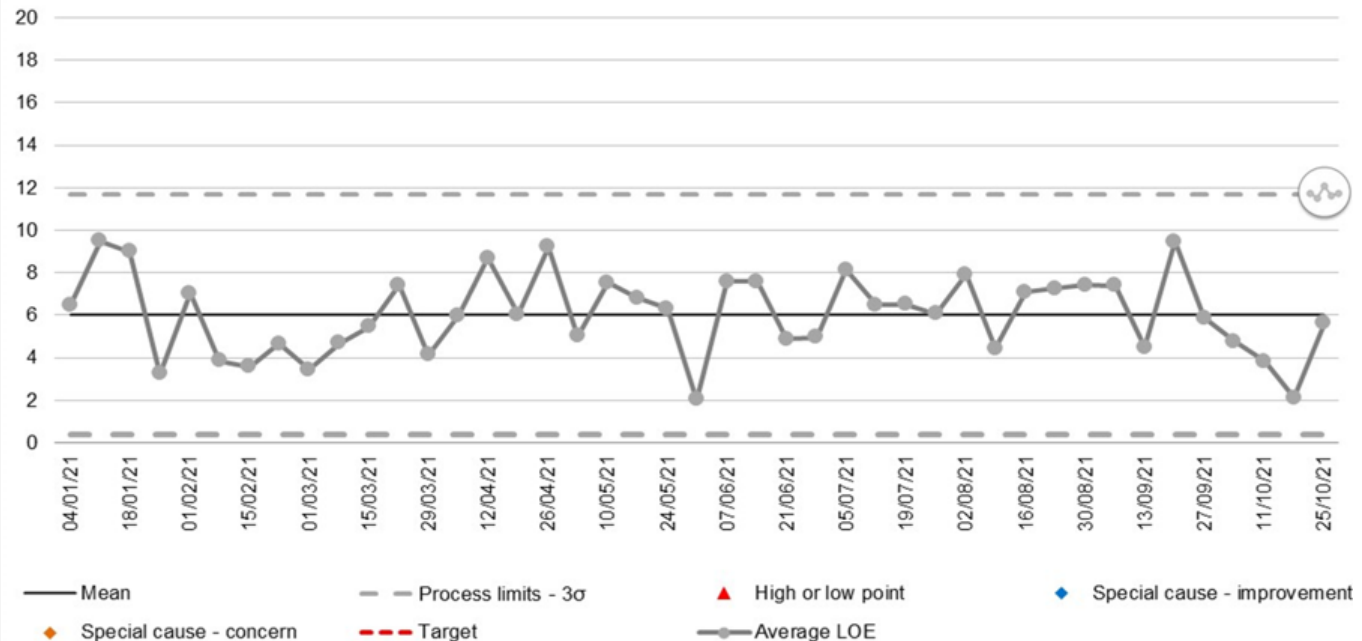


# Emergency Admissions >65yrs – discharge

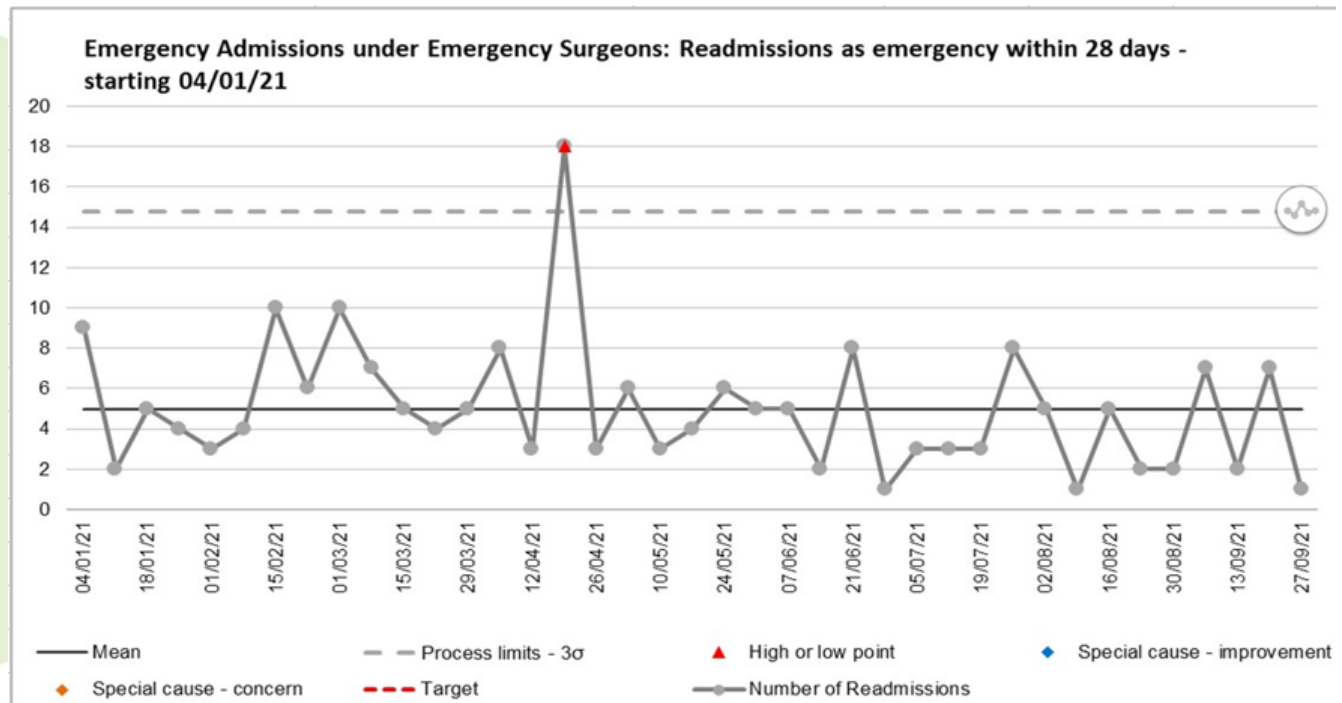


# Mean LOS under Emergency General Surgeons

Admissions under Emergency Surgeons Mean Length of Consultant Episode- starting 04/01/21



# Readmission <28 days (EGS)



# POPS Network

## University Hospital of Wales, Cardiff

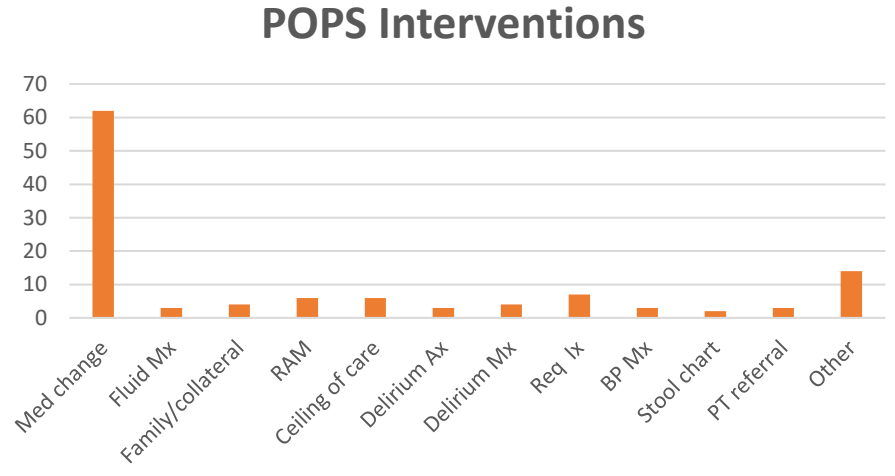
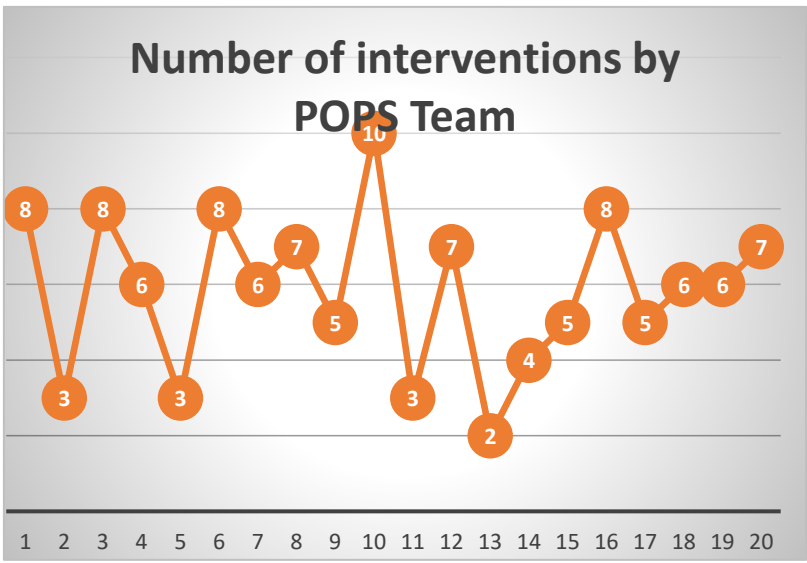
Dr Nia Humphry

Consultant Perioperative Geriatrician

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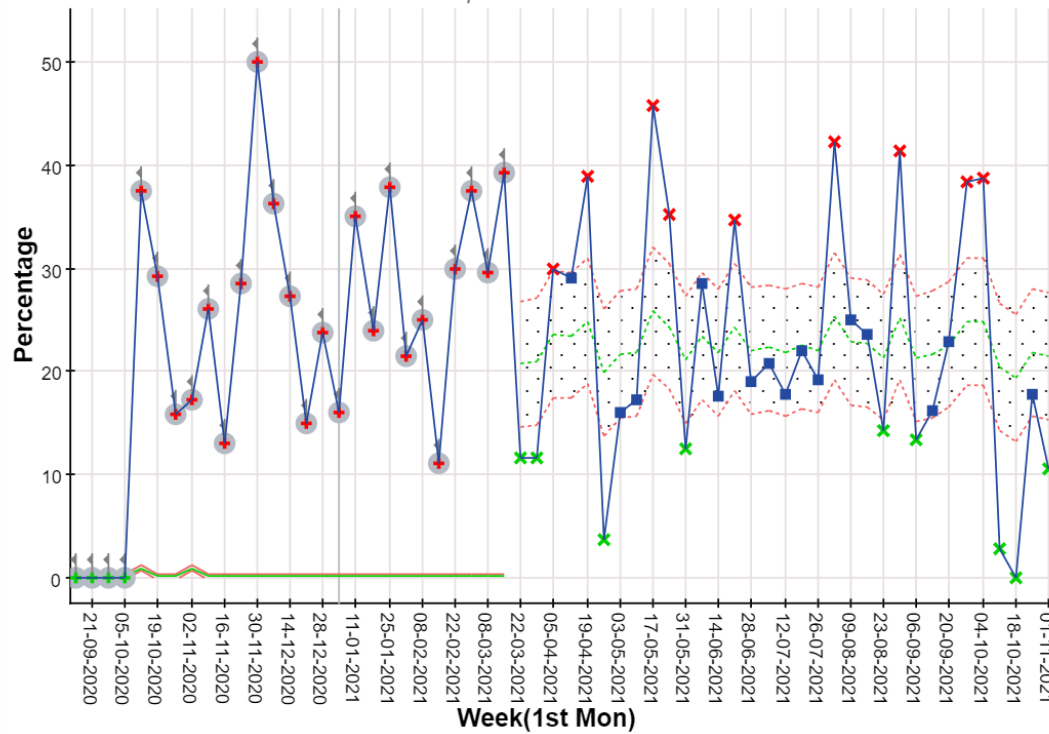
# Outcome Measures



# Process Measure

% Scored - Rockwood Frailty Score : SAU \* 65-74 + 75-84 + 85+ \* General Surgery : (Weekly - all)

Data Updated: 2021-11-09 08:00:18



# Balancing Measure

Need better capture of CFS before looking at this

Will look at readmission within 30 days (*...of over-65s with  $\geq$ CFS 5*)

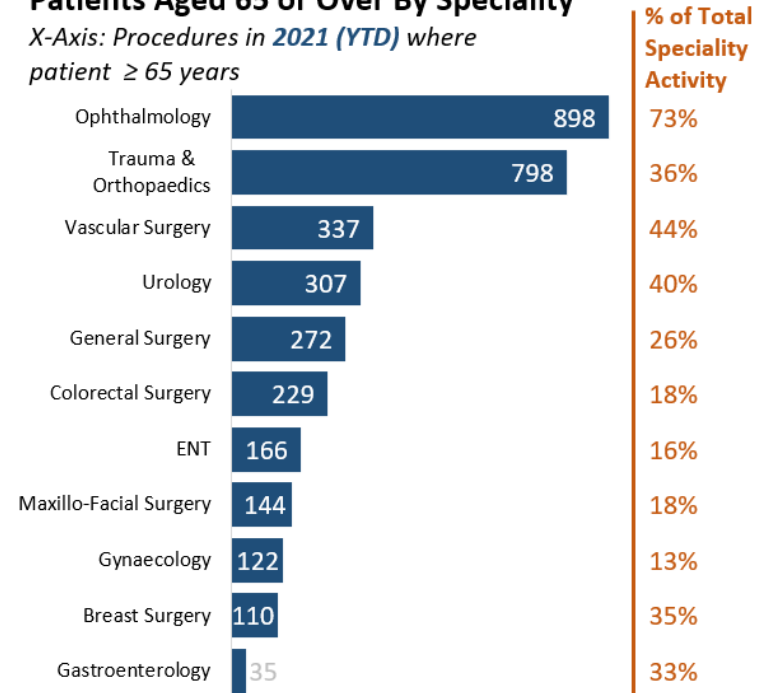
London North West University Healthcare  
PERIOPERATIVE CARE FOR OLDER PEOPLE  
UNDERGOING SURGERY (POPS) Programme  
3 of 6

## Background | LNWH has established a programme of work (POPS) to help improve quality and efficiency of care for our older surgical patients, with this pack presenting initial outcomes

- LNWH has a large number of older people – defined herein as those above 65 – undergoing surgery across all surgical specialties (See right).
- Older people, however, have an increased incidence of adverse clinician-reported, patient-reported and process-related outcomes following surgery [1].
- In recognition of this, NHS Elect have established the Perioperative medicine for Older People undergoing Surgery (POPS) programme, a national programme to promote geriatrician-led multidisciplinary input into the surgical pathway [2].
- LNWH is one of seven Trusts in the UK who have joined the POPS Network, a six-month collaborative programme of learning and development events to help support the implementation of local POPS programmes.
- This data pack shows some of the preliminary outcomes from the LNWH POPS programme

### Patients Aged 65 or Over By Speciality

X-Axis: Procedures in 2021 (YTD) where patient  $\geq 65$  years



[1] Fowler AJ, et al. *Br J Surg*. 2019 Jul;106(8):1012-1018.

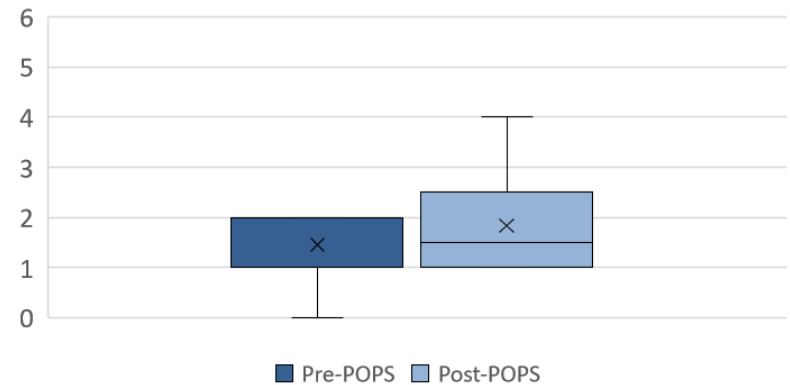
[2] Braude P et al. *BJU Int*. 2017 Jul;120(1):123-129..

## Changes in Practice | We have started two ward rounds per week in T&O wards to identify patients in need of care of elderly input which has resulted in increased transfers

- Due to limited capacity early in the programme the LNWH POPS team decided to concentrate efforts on the Trauma & Orthopaedic (T&O) pathway
- Since starting the POPS Programme the major change in practice has been to initiate a twice weekly Care of the Elderly Medicine Consultant-led Board Round
- The change in process can be seen in the increase in the median number of T&O transfers to Core of the Elderly wards for both Neck of Femur (NOF) and Non-Neck of Femur Patients (Non-NOF) --see box plots right). Pre POPS ortho rehab ward on a separate site
- The care of the elderly service have also started to engage with local data sources (e.g. TARN data) to identify further opportunities to improve care of the elderly emergency pathway as a whole cares for its elderly patients

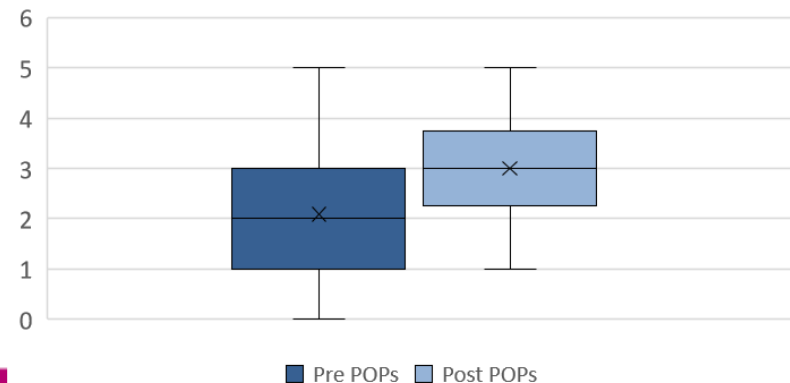
### Non-NOF Transfers to Care of Elderly Ward

Y-Axis: Transfers to Fletcher/G4 Wards per week



### NOF Transfers to Care of Elderly Ward

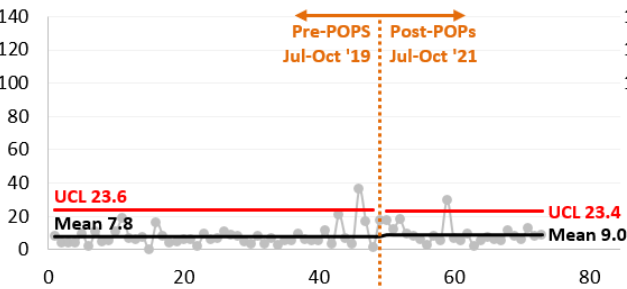
Y-Axis: Transfers to Fletcher/G4 Wards per week



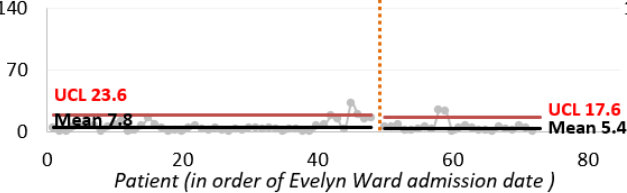
# NOF Specific Outcomes | There has been a reduction in the length of time patients are staying on the COE ward and this has translated into a reduction in the mean Total LOS

## NOF Evelyn Ward LOS

Y-Axis: Length of Stay on Evelyn Ward (days)

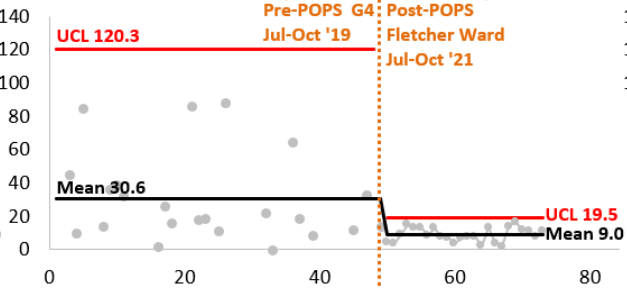


Y-Axis: Moving Range of LOS

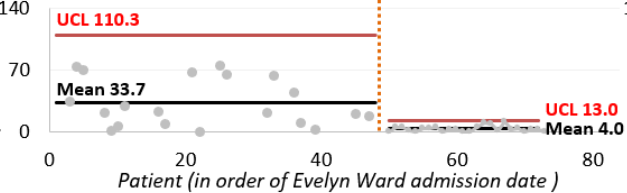


## NOF G4/Fletcher Ward LOS

Y-Axis: Length of Stay on G4 or Fletcher Ward (days)

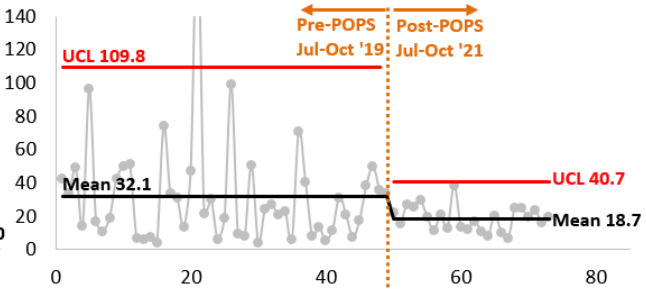


Y-Axis: Moving Range of LOS

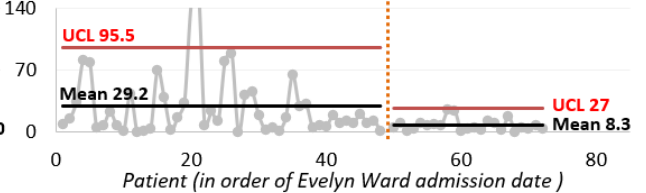


## NOF Total LOS

Y-Axis: Total Length of Stay (days)



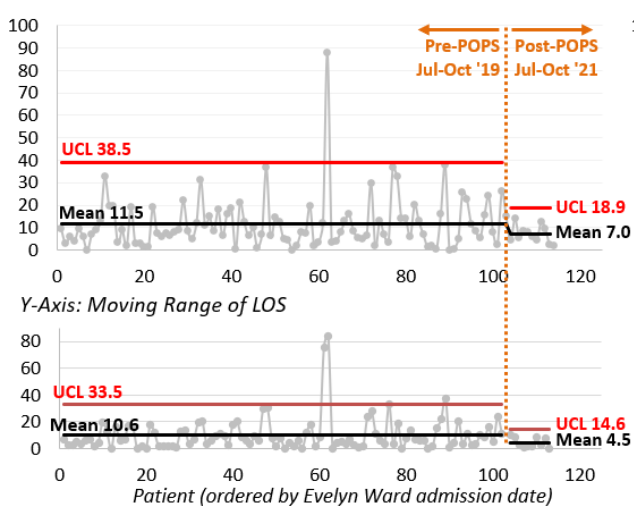
Y-Axis: Moving Range of LOS



# NON-NOF Specific Outcomes | A reduction in LOS on the Surgical Ward and on the COE ward has not translated into a reduction in total LOS – this may be to small sample numbers or a DQ issue (which we are investigating)

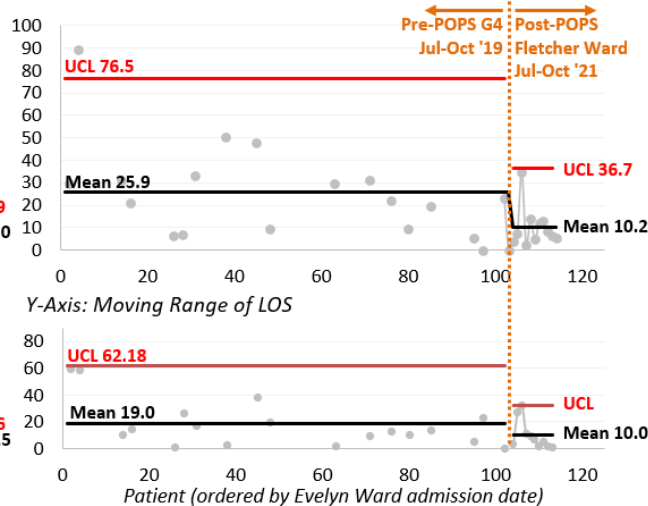
## Non-NOF Evelyn Ward LOS

Y-Axis: LOS on Evelyn Ward (days)



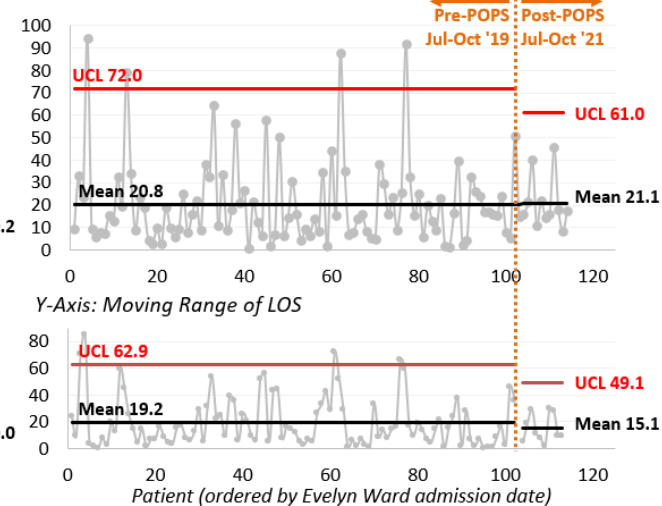
## Non-NOF G4/Fletcher Ward LOS

Y-Axis: Length of Stay on G4/Fletcher Ward (days)



## Non-NOF Total LOS

Y-Axis: Total Length of Stay (days)

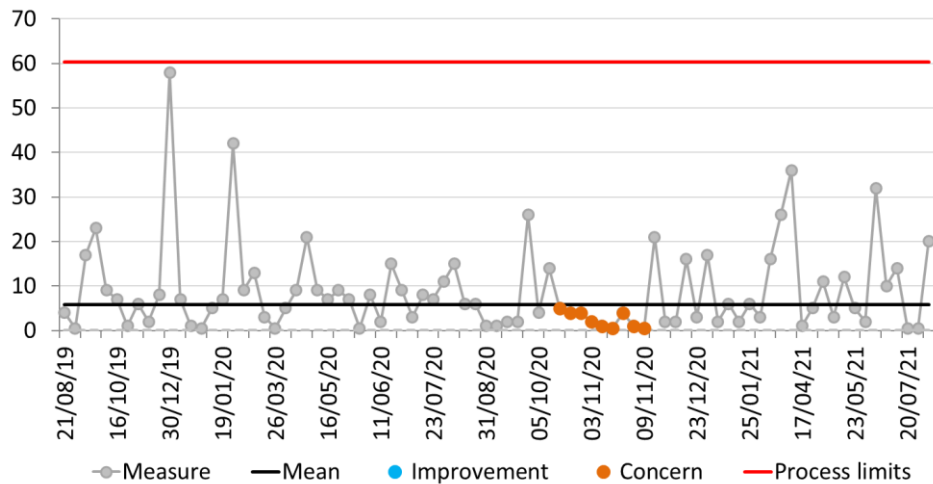




# General Outcomes | We have been investigating other outcome metrics such as falls and Pressure Ulcers

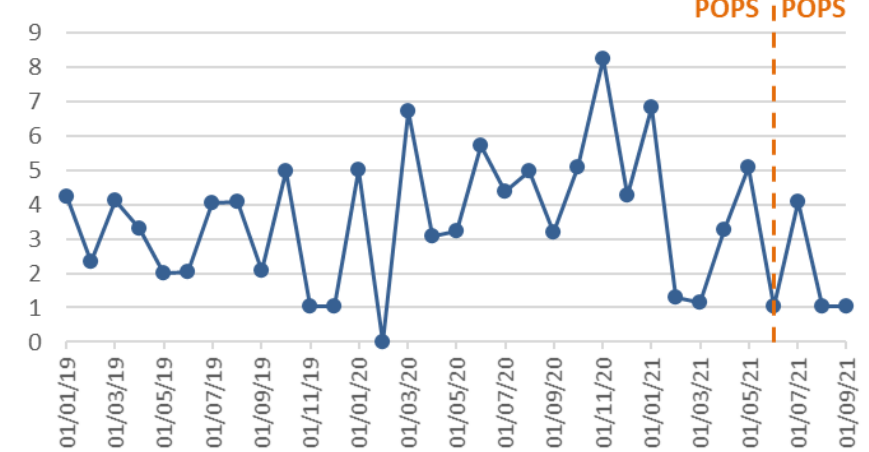
## T-SPC Chart for Falls in Evelyn Ward

Y-Axis: Days between Falls with any severity of harm



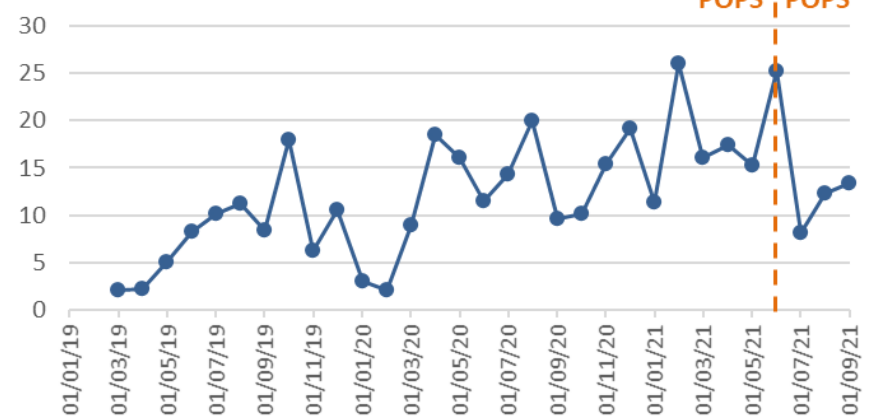
## Evelyn Ward Falls

Y-Axis: Falls per 1,000 Occupied Bed Days



## Evelyn Ward Pressure Ulcers

Y-Axis: Pressure Ulcers (Trust Acquired) per 1,000 Occupied Bed Days



# Dartford and Gravesham NHS Trust

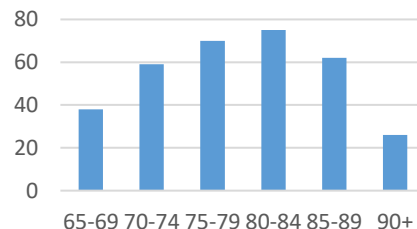
## 4 of 6

# Dartford and Gravesham NHS Trust - Indicative Numbers – Urology Elective and Non-Elective admissions

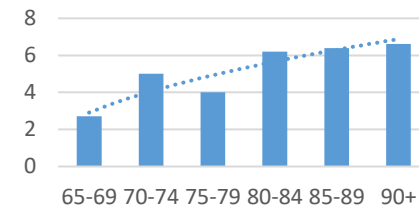
## Urology Emergencies

	All urology	Age 65 - 69	Age 70- 74	Age 75- 79	Age 80 - 84	Age 85 - 89	Age 90+
Admissions	729	38	59	70	75	62	26
LOS	3.8	2.66	5.03	4.06	6.16	6.39	6.62
Mean Comorbidity	4.9	5.6	6.42	6.86	7.40	7.79	8.23
Mean complications	0.25	0.47	0.31	0.43	0.40	0.45	0.54
Readmission	101	2	9	15	14	12	6

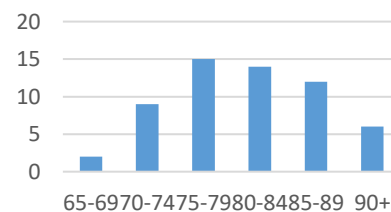
### Admissions



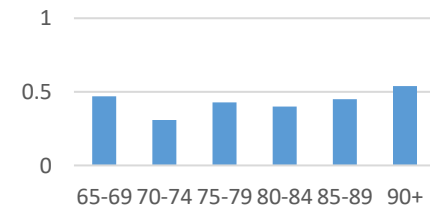
### Av. Los



### Re-admissions



### Complications - mean prevalence



## Urology Elective (Excluding 1 day admissions - to exclude day case)

	All urology	Age 65 - 69	Age 70- 74	Age 75- 79	Age 80 - 84	Age 85 - 89	Age 90+
Admissions	1017	124	158	142	144	85	21
LOS	1.92	1.76	1.82	1.46	2.31	2.93	1.71
Mean Comorbidity	5.1	4.93	5.41	5.70	5.99	6.68	6.71
Mean complications	0.06	0.06	0.05	0.09	0.06	0.18	0.0
Readmission	59	3	9	9	9	11	2

# Background

- Proof of concept (2019) General Surgery / Vascular
  - Reduction in LOS: EGS 14.18 days to 11.16 days
  - Reduction in 30 day readmission: EGS 30% to 18%
  - NELA Data EGS older seen by geriatrician ( Pre POPS 2, 8, 20% → Post POPS 98%)
  - Staff satisfaction : >80% agreed POPS improved overall care / management of medical problems / dc planning / patients' experience of the older surgical patient
- Limitations of Service
  - Single consultant delivered service (No service > 8 weeks/yr)
- Current service stretched
  - Anticipated CGA 440/yr (763 in first year, 159 in 3 months: 636 per year)
  - Clinic capacity / referrals
- 8 current Urology alerts
  - GIFT: LOS above national average
  - Day case rate ureteroscopy / TURBT / male outflow obstruction
  - GIFT: Readmission rate above national average

# Outcome measures

## Prospective Urology (elective / emergency)

- Age, Comorbidity no, CFS, Admission from, LOS, Readmission, Complications, DC destination,

## Staff satisfaction

- Staff Survey

## Patient satisfaction

- EBD, Survey, Patient event (early 2022)

## Raising profile of urology service

# Process measures

- CNS appraisal / Education framework
  - New structure for education and joint appraisal (medical and nursing) for CNS
- Capacity current issues
  - Clinic capacity /referrals

# Balancing measures

- Recruitment – expertise / training
- Capacity - Resource (Business case)

# York

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# Outcome Measures

- Average LOS
- Unplanned return to theatres
- Improved Patient Experience
  - Reduction in complaints
  - Increased compliments
- Reduction in complications
- Reduction in time to theatre
- Reduced mortality rates
- Return to normal function

# Balancing Measures

- Unplanned 30 day re-admission
- Unplanned ITU admissions
- Complications rate
- Staff experience

# Process Measures

- Time to medical review
- Time from admission to theatre
- CFS scores on admission
- Pre-op / post op assessments
  - Delirium
  - Cognition
  - Nutrition

# Cambridge

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# OUTCOME MEASURES - NHS-Elect POPS exploratory audits

- At CUH there is an established pre-operative assessment clinic for frail patients (PRIME)
- NHS-Elect POPS provided an opportunity to consider our current service in ways we had not done previously

Review of patients seen in PRIME who do not proceed to surgery  
50 case notes reviewed retrospectively.  
Reason for cancellation considered Patient/medical/surgical/more than one.

16% cancelled (after exclusions 11%)

Documented reasons for cancellation are outlined in table.1

Patient Choice (n)	Medical reason (n)	Surgical reason (n)	More than one reason (n)
8	6	10	26

Table 1. Reasons for cancellation of surgery following PRIME review

52% cancelled for more than one reason (p=0.000007)

44 (88%) had documented input into decision-making process

Plans:

Smart phrase for shared decision-making. SHARE model

## Review of patients who were cancelled on the day of surgery

Audit ongoing. 100 case notes.

Audit team has been put in place, datapull has been undertaken.

Retrospective case notes audit to review reason for day of surgery cancellations

Comparison between patients attending PRIME and those via other pathways

Are there any modifiable factors which we can identify – Patient factors, medical factors, operational factors

## Audit of day cases who convert to longer admissions

Unexpected difficulties with dataset due to coding issues

Dataset rationalised to UROLOGY cases

Mean LoS 8.5 days

55% M, 45% F

Mean Age 77.5, Mean ASA 2.85

Only 20% seen in PRIME prior to surgery

Main reasons for longer admission:

40% due to rigor/infection post-op

20% haematuria

i.e. mainly surgical issues, however:

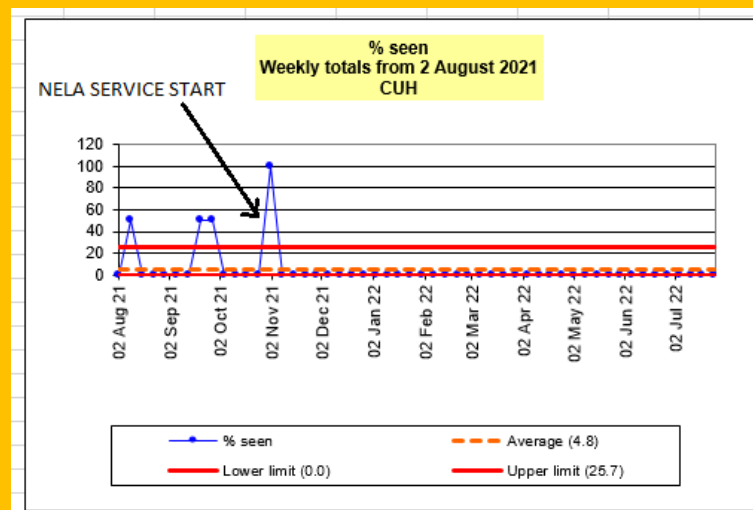
20% discharge difficulties e.g. restarting care packages/problems managing catheter at home

Possible modifiable factors in relation to discharge planning. Prompting extension of audit and retrospective comparison review

## PROCESS MEASURES

### CUH Service Development project – *NELA in-patient CGA service*

- **NHS-Elect POPS** afforded our team the chance to review our current service and discuss opportunities for significant developments.
- An existing elective workstream is in place, but the team identified a significant gap in service provision: **A post-op NELA pathway.**
- Interested clinicians were identified. Liaison with surgical and management teams was undertaken. Agreement that the pathway would be supported and valuable to the Trust overall.
- Initial audit work pre-workstream completed. Joint presentation meetings with surgeons and geriatricians booked going forward.
- **Only 12% of NELA patients seen by a geriatrician prior to project initiation.**
- Main hurdle in service provision identified – **real time case identification.**
- This issue held up development significantly.
- Different referral pathways/approaches tried in collaboration with surgical team.
- A real-time dashboard approach was developed.
- NELA patients now identified by the geriatricians on the day after their surgery.
- **NELA geriatrician review service initiated 1.11.21**
- Ongoing real-time audit of NELA reviews – to assess proportion of patients seen
- **Since start of service 100% of eligible patents have been reviewed**
- Ongoing audit work will review quality indicators such as:
  - Proportion of patients with CFS/CPR discussions, complication rates, discharge discussions
  - medications reviews, cognitive assessments, nutrition and mobility assessments
- We will also compare significant indicators such as:
  - Mortality rates, Length of stay



## Balancing Measures – CUH staff and patient surveys

- Experience based design - We have previously sought feedback from patients and staff about our MDT Elective pre-op assessment clinic

'My sheer 'horror and worry' re: anaesthetic and physical status was completely acknowledged. Am now completely confident re: surgery. Thank you very much!!'

'Very comprehensive and a great boost in my confidence in the team'

- We are utilising the NHS-Elect staff survey to undertake a review of staff experience and feedback
- A similar patient and carer survey is also being undertaken by the clinic team – aiming 30 to 50 responses
- We hope that the responses will help us refine the clinic service and identify areas we can improve

# Questions and Comments





# *Evidence supporting the development of POPS services for older surgical patients*

**Dr Jude Partridge**

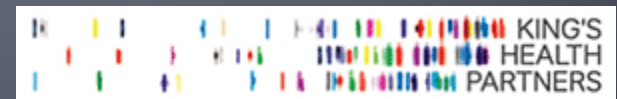
# Evidence supporting the development of POPS services for older surgical patients

Jude Partridge

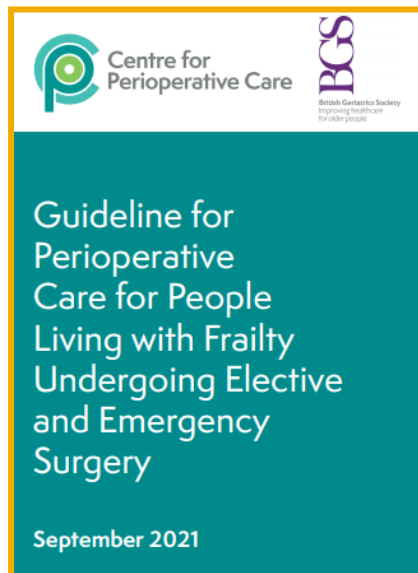
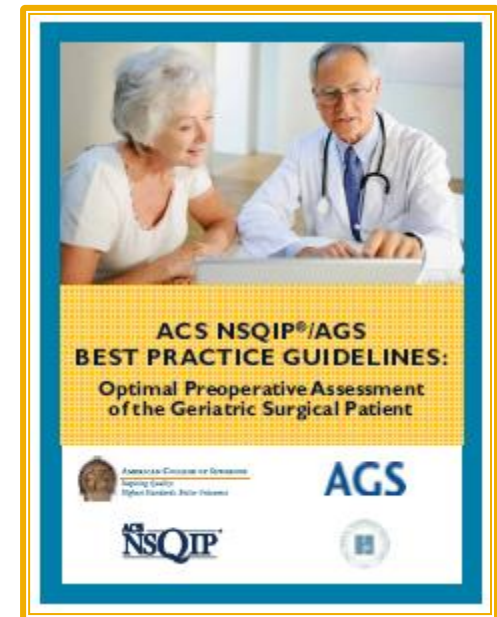
Perioperative care of Older People undergoing Surgery (POPS)

Department of Ageing and Health

Guy's and St Thomas' , London



# Reports and guidelines



# CGA has an evidence base in medical patients



UNIVERSITY OF  
OXFORD

DEPARTMENT OF PUBLIC HEALTH, OXFORD

June 2012– Evidence Summary of a Cochrane Effective  
Practice and Organisation of Care group systematic review

**Does inpatient comprehensive geriatric  
assessment improve care for frail older  
adults admitted to hospital ?**



**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

# CGA has an evidence base in medical patients



UNIVERSITY OF  
OXFORD

DEPARTMENT OF PUBLIC HEALTH, OXFORD

June 2012– Evidence Summary of a Cochrane Effective  
Practice and Organisation of Care group systematic review

Does inpatient comprehensive geriatric  
assessment improve care for frail older  
adu

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



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

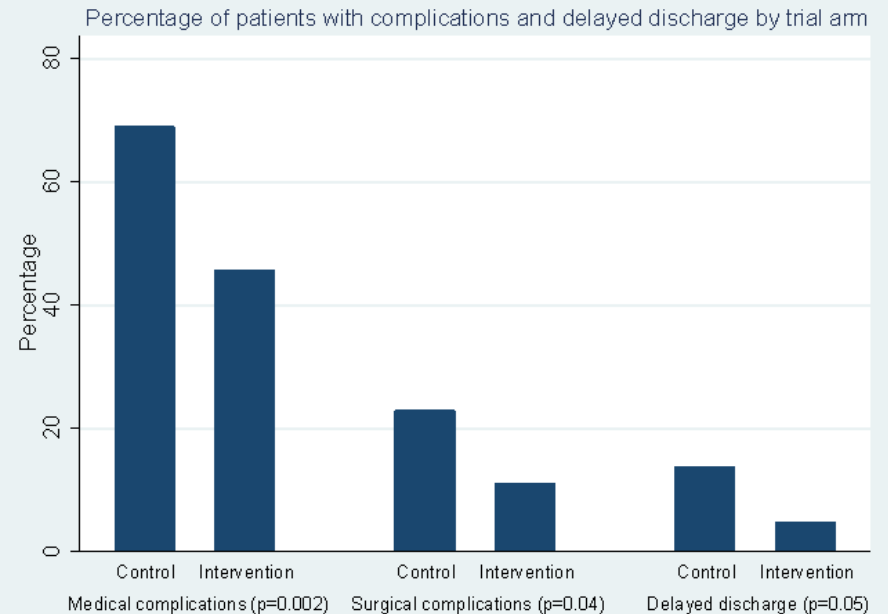
# Evidence for CGA in elective arterial surgery

BJS

Randomized clinical trial

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

J. S. L. Partridge<sup>1,3</sup>, D. Harari<sup>1,3</sup>, F. C. Martin<sup>1,3</sup>, J. L. Peacock<sup>3</sup>, R. Bell<sup>2</sup>, A. Mohammed<sup>1</sup> and J. K. Dhesi<sup>1,3</sup>



# Evidence for CGA in emergency surgery



**Cochrane  
Library**

Cochrane Database of Systematic Reviews

CGA in hip fracture results in;

- Reduced mortality rates
- Fewer discharges to higher level of care

**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


# Results are mixed

Received: 12 February 2018 | Accepted: 29 March 2018  
DOI: 10.1111/jcp.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<sup>1</sup>  | Amy L. Crees<sup>2</sup> | Matthew R. Dean<sup>3</sup> | Nahida Bashir<sup>3</sup>

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<sup>†</sup>, T. B. Wyller<sup>†</sup>\*, A. Nesbakken<sup>†</sup>§, A. O. Bakka<sup>¶</sup>¶, M. S. Jordhøy<sup>\*\*\*</sup>, E. Skovlund<sup>††</sup> and S. Rostaft<sup>††</sup>

<sup>†</sup>Institute of Clinical Medicine, Oslo University Hospital, Oslo, Norway, <sup>††</sup>Department of Geriatric Medicine, Oslo University Hospital, Oslo, Norway, <sup>‡</sup>Department of Gastrointestinal Surgery, Oslo University Hospital, Oslo, Norway, <sup>§</sup>IC. Jensen Colorectal Cancer Research Centre, Oslo University Hospital, Oslo, Norway, <sup>¶</sup>Department of Digestive Surgery, Akershus University Hospital, Lørenskog, Norway, <sup>\*\*\*</sup>The Cancer Unit, Inland Hospital Trust, Hamar, Norway, and <sup>††</sup>Department of Public Health and Nursing, NTNU, Norway

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Abstract

## Can comprehensive geriatric assessment be delivered without the need for geriatricians?

*Age and Ageing* 2019; **48**: 643–648  
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## Can comprehensive geriatric assessment be delivered without the need for geriatricians? A formative evaluation in two perioperative surgical settings

DAVID KOZMAN<sup>1</sup>, EMMA REGEN<sup>1</sup>, KAY PHELPS<sup>1</sup>, GRAHAM MARTIN<sup>2</sup>, STUART PARKER<sup>3</sup>, THOMAS GILBERT<sup>4</sup>, SIMON CONROY<sup>1</sup>

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

Aparna Saripella<sup>1</sup>, Sara Wasef<sup>1</sup>, Mahesh Nagappa<sup>2</sup>, Sheila Riaz<sup>1</sup>, Marina Englesakis<sup>3</sup>, Jean Wong<sup>1,4</sup> and Frances Chung<sup>1\*</sup> 



# Results are mixed

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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<sup>1</sup> | Amy L. Crees<sup>2</sup> | Matthew R. Dean<sup>3</sup> | Nahida Bashir<sup>3</sup>

Original article

doi:10.1111/codi.13785

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

DAVID KOZMAN<sup>1</sup>, EMMA REGEN<sup>1</sup>, KAY PHELPS<sup>1</sup>, GRAHAM SIMON CONROY<sup>1</sup>

Saripella et al. *BMC Anesthesiology* (2021) 21:127  
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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



Mixed results  
Concerns about power, methodology  
Often due to a lack of fidelity to CGA

# What are the CGA prompted interventions in the elective setting?

Component of care	Proportion of patients (n=500)
Assessment	2/3 new diagnosis
Optimisation	<b>1/2 lifestyle advice</b> 3/4 meds changed <b>1/4 therapy interventions (diet/exercise)</b>
Communication	1/5 multispecialty discussion
SDM	Documented in 98%
Referral	1/7 preoperative investigations 1/10 anaesthetic input 1/20 organ specialty advice
Anticipatory care planning	1/10 anticipatory care planning
Long term condition mx	1/3 LTC management referral

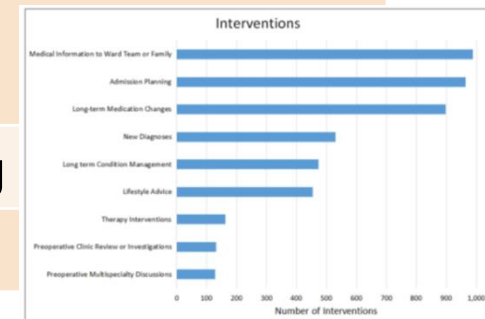


Figure 3: Comprehensive Geriatric Assessment prompted interventions

# Perioperative CGA is cost effective

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

JUDITH S. L. PARTRIDGE<sup>1,2,†</sup>, ANDREW HEALEY<sup>3,†</sup>, BIJAN MODARAI<sup>4,5</sup>, DANIELLE HARARI<sup>1,2</sup>, FINBARR C. MARTIN<sup>2</sup>, JUGDEEP K. DHESI<sup>1,2,6</sup>



**Cochrane  
Library**

Cochrane Database of Systematic Reviews

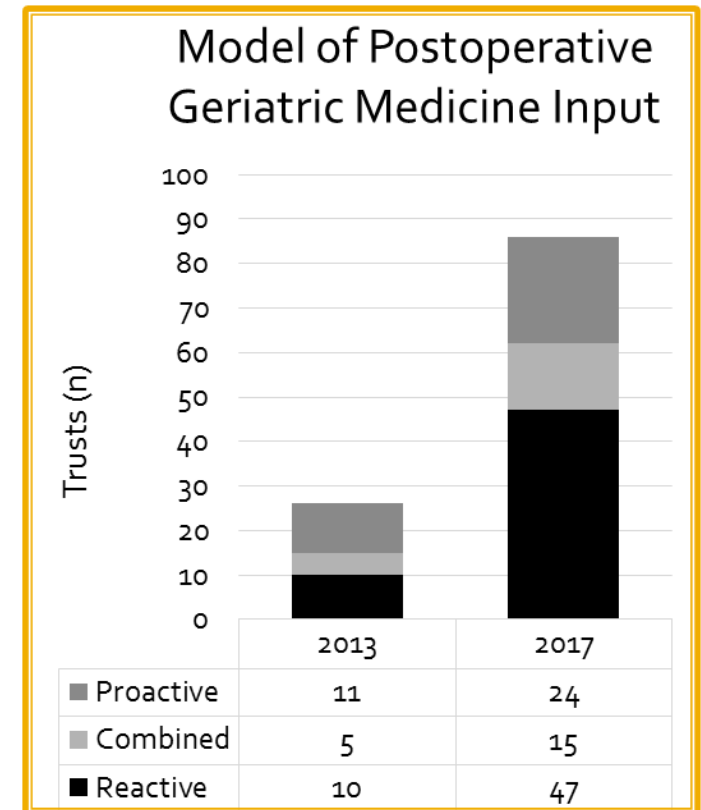
## Comprehensive geriatric assessment for older people admitted to a surgical service (Review)

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 were estimated to be £1,165 lower for CGA patients largely accounted for by reduced postoperative bed day utilisation.
- CGA group after hip fracture showed reduced total cost

# CGA based perioperative services nationally – a new standard of care?

- CGA services have increased over last 8 years
- Increase noted in
  - joint audit meetings
  - joint guidelines
  - surgical directorate funding for geriatric medicine sessions



# POPS logic model

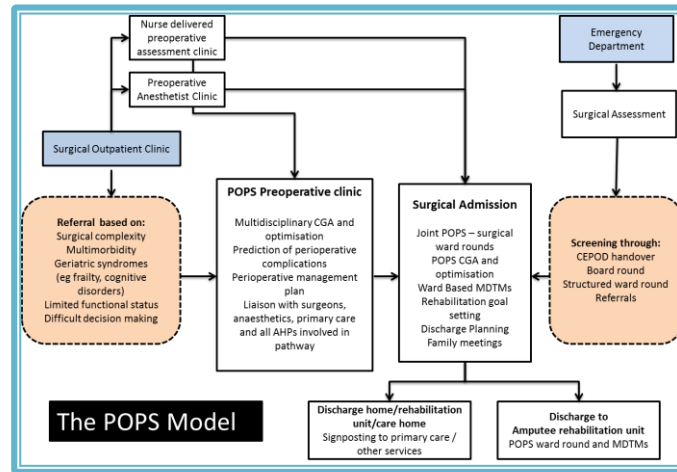
Scaling up perioperative medicine for older people undergoing surgery (POPS) services; use of a logic model approach

Authors: Emily V Jasper,<sup>A</sup> Jugdeep K Dhesi,<sup>B</sup> Judith SL Partridge<sup>C</sup> and Nick Sevdalis<sup>D</sup>

Clinical Medicine 2019 Vol 19, No 6: 478–84

- Describes core-components of CGA based perioperative service
- Can be used to facilitate establishment of new services

# We can't do it in a DGH...



de Las Casas R, Meilak C, Whittle A et al. Establishing a perioperative medicine for older people undergoing surgery (POPS) service for general surgical patients at a district general hospital. Clin Med 2021;21

# Questions and Comments



# *Summary and closing remarks*

**Lisa Godfrey**



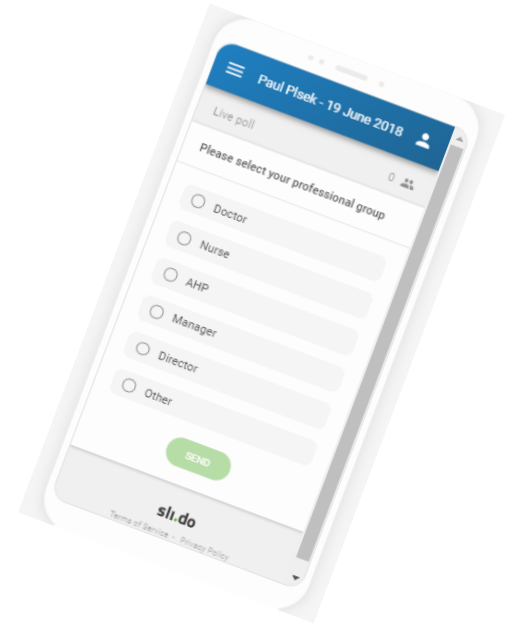
# Next steps

- Future webinar topics:
  - What if the funding and workforce aren't neatly packaged?
  - Our Vascular Journey: Implementing vascular POPS
  - Using Big Data to effect local change
  - Implementing SDM in POPS-teaching the next generation
  - Developing the workforce-supporting anaesthetists to deliver CGA
  - Building the evidence base for CGA based perioperative services
  - Developing the pharmacy workforce to deliver perioperative care
  - The interface between primary and secondary care
  - Our EGS journey: Implementing EGS POPS services
  - SDM in practice
- Please consider what materials your site has that could be shared as resources on the Members Area of the POPS website.
- Please share your driver diagram with us at [networksinfo@nhselect.org.uk](mailto:networksinfo@nhselect.org.uk).
- Register for the next Core Event on **Thursday 9<sup>th</sup> December** from 9am to 11am.

# sli.do

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- Go to [www.sli.do](http://www.sli.do) or scan the QR code below
- Enter the event code **#POPScore6**
- Use the polls to give us feedback about the day



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want/need and let the  
programme team know at*

[networksinfo@nhselect.org.uk](mailto:networksinfo@nhselect.org.uk)