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

October 2022

Celebration Event

Housekeeping

Silence is golden, unless you want us to hear you

We are recording so please turn off your camera during presentations

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

No mic, feeling shy? Send us some chat

Give us a wave if you need to get our attention

Agenda

09:00	**OPEN**
	Welcome and introduction to the day **Prof. Jugdeep Dhesi**, Consultant, GSTT & POPS Network Clinical Lead
	Sharing our improvement stories: Whipps Cross, RD&E, Lewisham **Simon Griffiths,** Director, NHS Elect & **Lisa Godfrey**, Director, NHS Elect
BREAK (10 mins)	
	Sharing our improvement stories: King's, UCH, Swansea Morriston **Lisa Godfrey,** Director, NHS Elect
	Reflecting on your measurement journey **Matt Tite,** Director, NHS Elect
	What's next for your POPS journey? **Prof. Jugdeep Dhesi**
	Summary and evaluation **Prof. Jugdeep Dhesi & Deborah Thompson**
11:30	**CLOSE**

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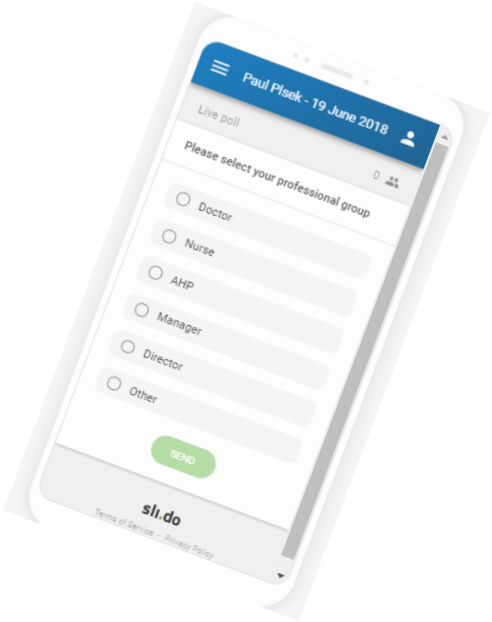


Open a browser on any laptop, tablet or smartphone

- Go to **www.sli.do** or scan the QR code
- Enter the event code **#POPS61022**
- Use the polls to give us feedback about the day

Welcome and introduction

Prof. Jugdeep Dhesi

Welcome and introduction

News

- Update from Cohort One sites
- Building a KPI ‘dashboard’ between all the sites in the network
- Recent publications
  - Shane O’Hanlon editorial
  - PRSB
  - GSTT articles on perioperative care published in Age and Ageing and JAMDA
- What’s new at CPOC
    - Diabetes
    - Education
    - CSDH
- THIS foundation and their evaluation work
- The grant application…

Reflections

- Cohort Two

Sharing our improvement stories

Simon Griffiths & Lisa Godfrey

#periop

NHS
Royal Devon
University Healthcare
NHS Foundation Trust

Celebrating success
Acknowledging difficulties
Looking to the future

Sheena Hubble, Debbie Cheeseman, Kat Haynes, Nur Khaleeda Abidin,
Rachel Tucker, Jo Wreford, Bexs Snell

NHS
POPS Network
Perioperative Care for Older People Undergoing Surgery

NHS
Elect

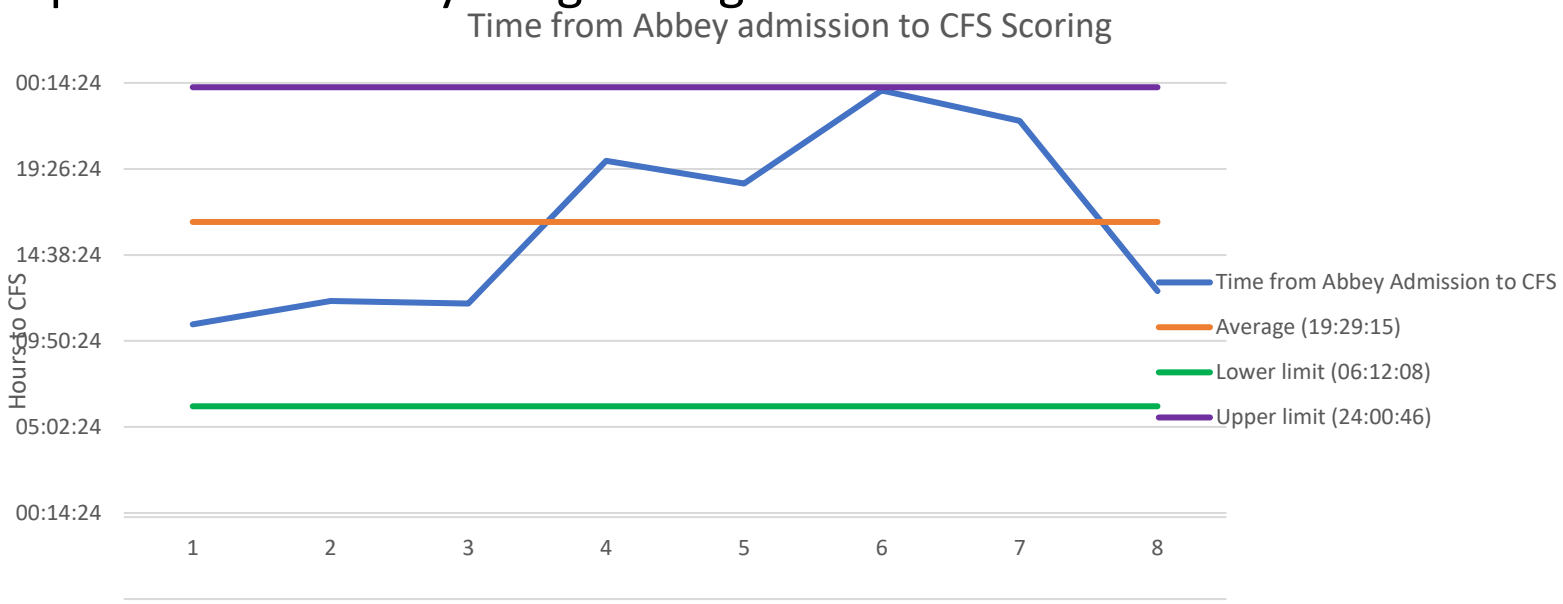
Our main objective

To improve front-door frail surgical patient recognition, assessment and management

Our story

Successes!

- Clinical frailty score has started to be embedded in surgery
- Frailty week 26-30 Sept – quizzes, awards, teaching
- CFS now being recorded, discussed and used in conversations with patient and family ‘surgical regret’



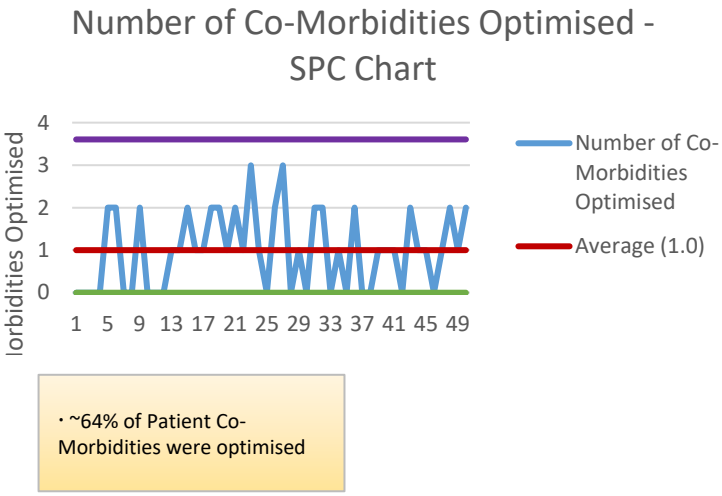
Resuscitation of NELA!

- To improve case capture and submission to the national database
- To improve our perioperative review of NELA patients from 68% to over 95% with the overarching goal to decrease mortality and /or LOS
- Audit of AKI and ward hypotension which has developed good links with the AKI service.

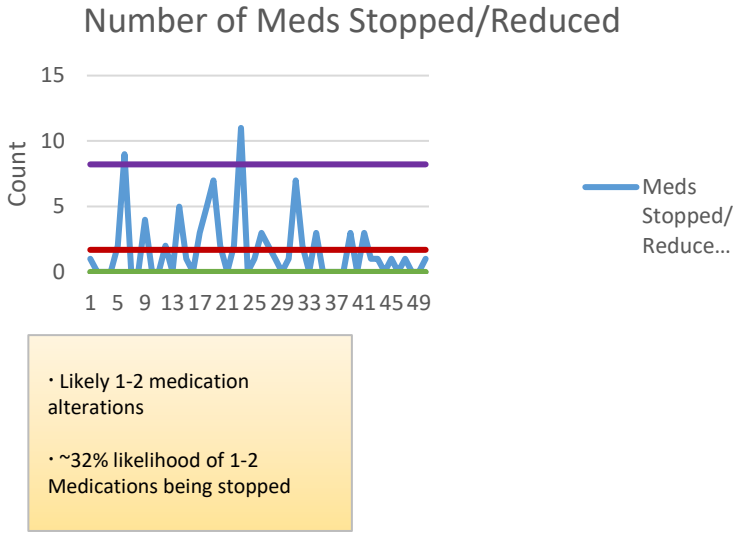
Comprehensive Geriatric Assessment

- Concept embedded in Healthcare for Older People (HFOP), but not understood elsewhere
- EPIC has made this challenging!
- Even HFOP wards don’t have CGA documentation
- We have worked on a collaborative approach with HFOP & Periop to come up with an EPIC document

Effectiveness of the periop team

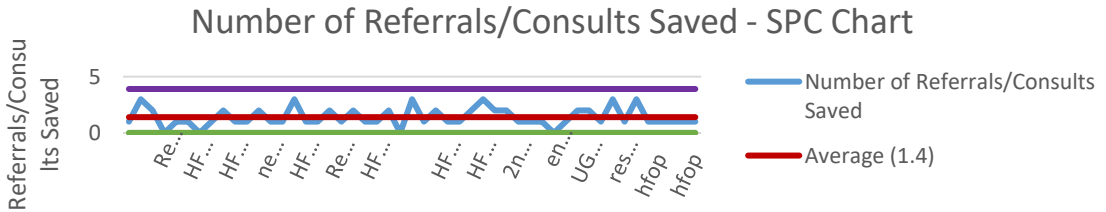


· ~64% of Patient Co-Morbidities were optimised



· Likely 1-2 medication alterations

· ~32% likelihood of 1-2 Medications being stopped



· ~80% likelihood of 1-2 referrals/consults saved

What have we learnt?

- It's been hard to lose Sheena for a year but has forced us to work differently
- Sustainability of the team is more important than trying to achieve everything
- MDT Team working is key, we need each other
- Importance of communication - project aims, needs of team members and aspirational outcomes need to be discussed at the start
- Needs of older patients are often at odds with the needs of surgical workload

Future plans

- We don’t want to let Sheena down, so we will keep going!
- Continue to build up the periop team – but we need to work differently
- Discuss the data and needs of older adults in surgery with senior management teams
- Give the patient a voice
- Continue to work with the BI team to obtain SPC data that is meaningful to executive team to effect change
- Extend collaborative POPS working
- Try to recruit a geriatrician to Periop team

POPS@LGT
NHS Elect celebration event
October 2022

NHS
Lewisham and Greenwich
NHS Trust

POPS Perioperative medicine for Older People undergoing Surgery

Guy's and St Thomas' NHS
NHS Foundation Trust

POPS@LGT Project

- Start December 2021 / 1 year secondment

Focus of project

- Emergency General Surgery at QE (primary)
  - Establishing network building business case
  - Scoping timetable for team implementation
- Review of long waiters
- Trial of UHL POPS clinic

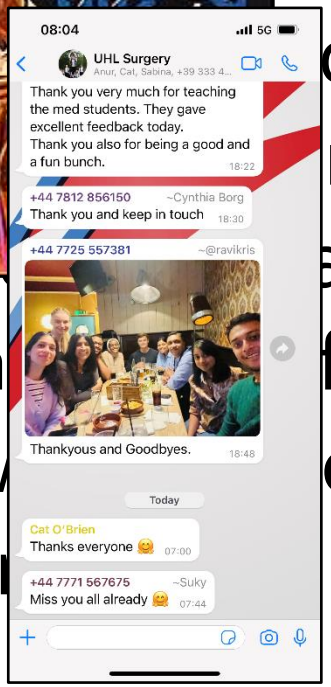


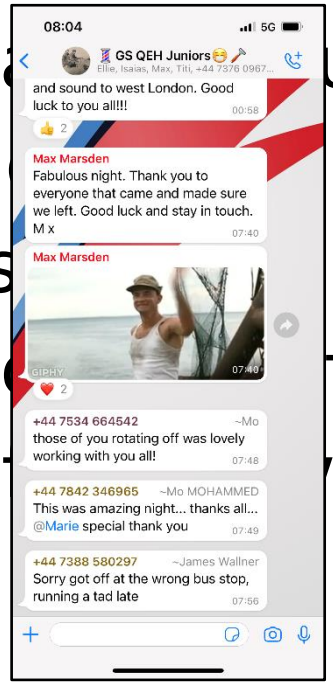



Ward in-reach – How?

Be visible, be u… …urgical

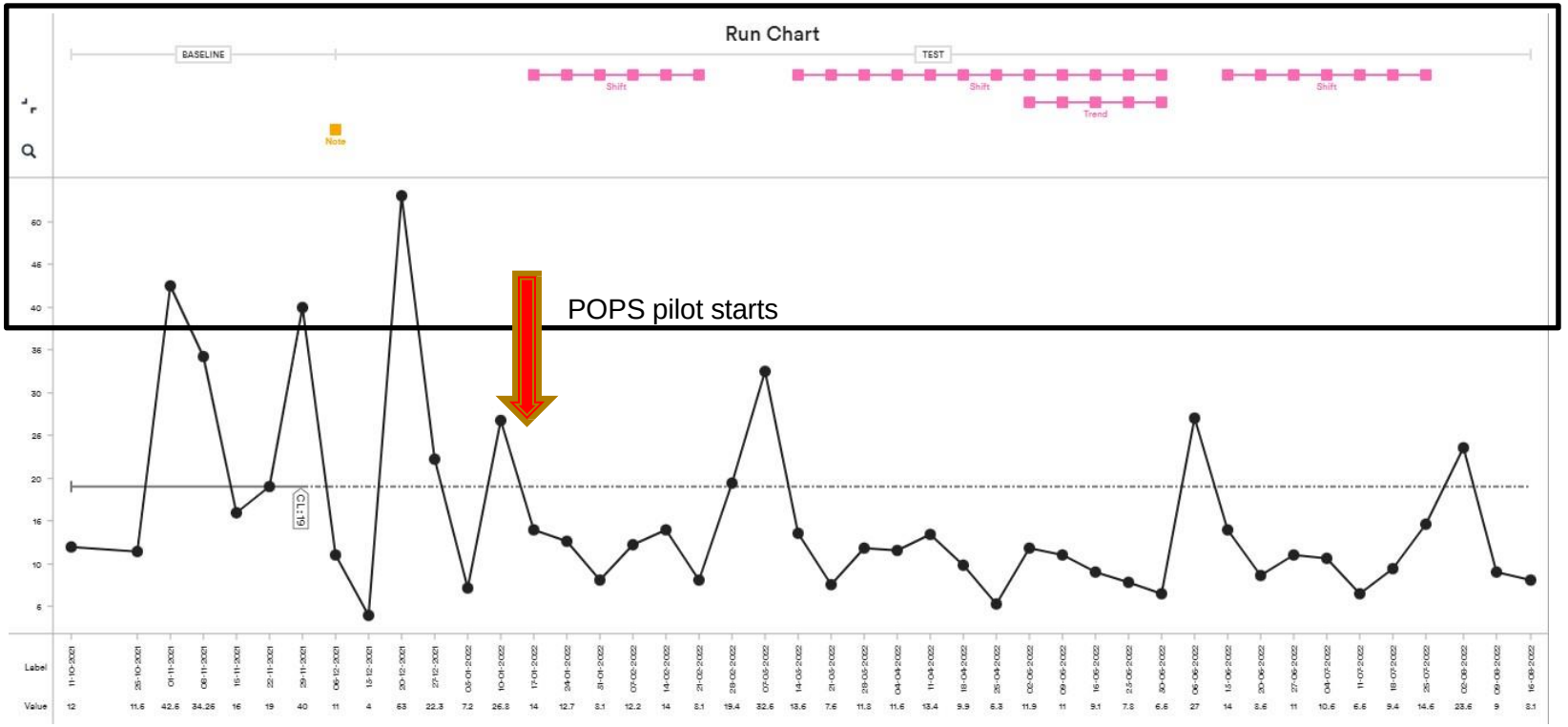
- Ea… fi… fr…
- Ov… o… vit… th…





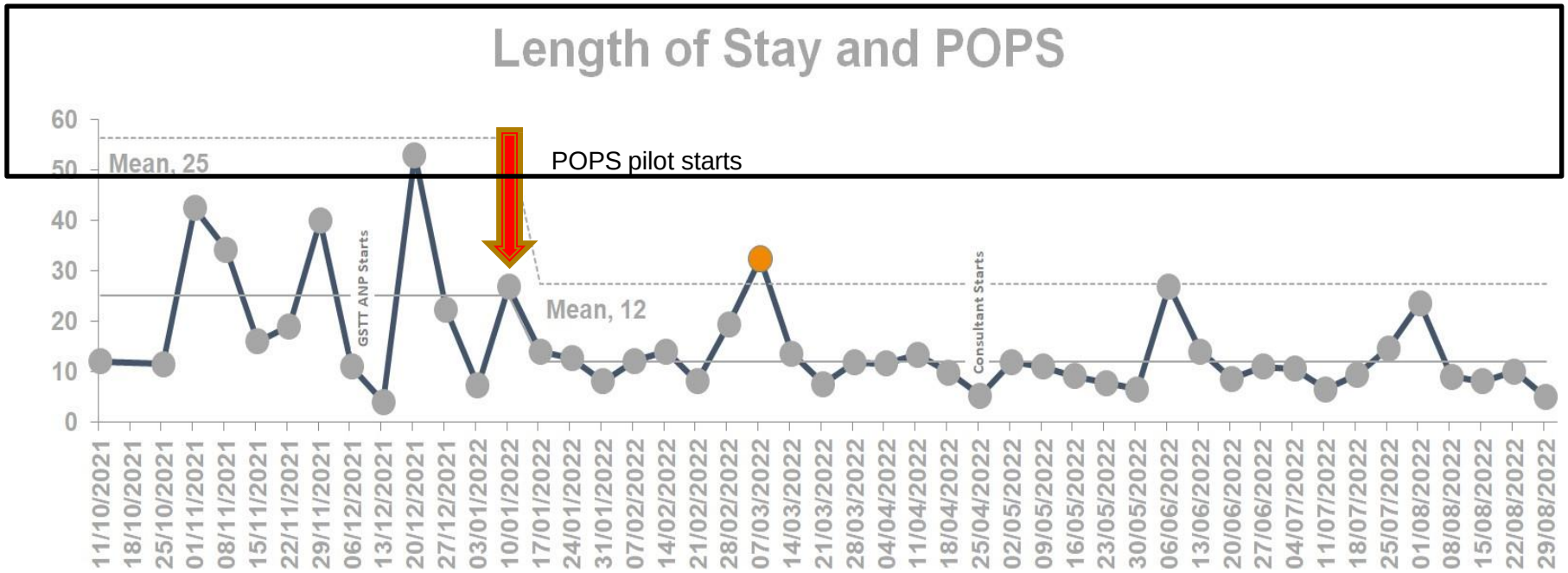
Length of stay – initial impact start of service

- *Life QI used to track weekly average LOS*
- *Prior to project - length of stay for a patient who was <u>>65 years of age</u>, <u>highlighted as frail</u>, the mean was LOS was 17 days (range 1 to 56 days).*

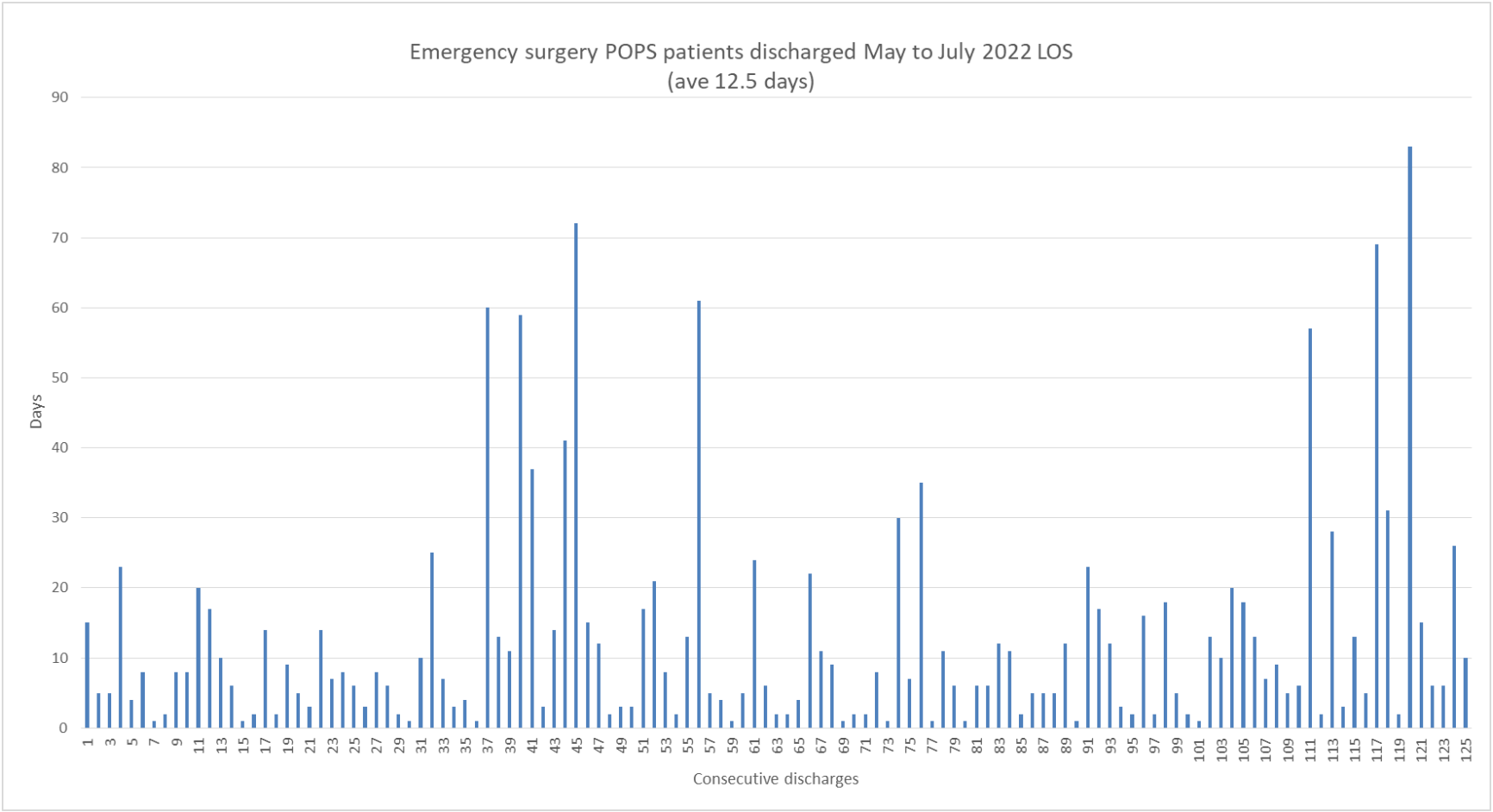


Length of stay – initial impact start of service

- *Prior to project - length of stay for a patient who was >65 years of age, highlighted as frail, the mean was LOS was 17 days (range 1 to 56 days).*
- *Reduction in the mean length of stay to 13 days*
- *Variation in LOS has also reduced the upper control limit of >50 days to 25 days.*



Length of stay – 3 month analysis



- *LOS reduction has been maintained and improved slightly*

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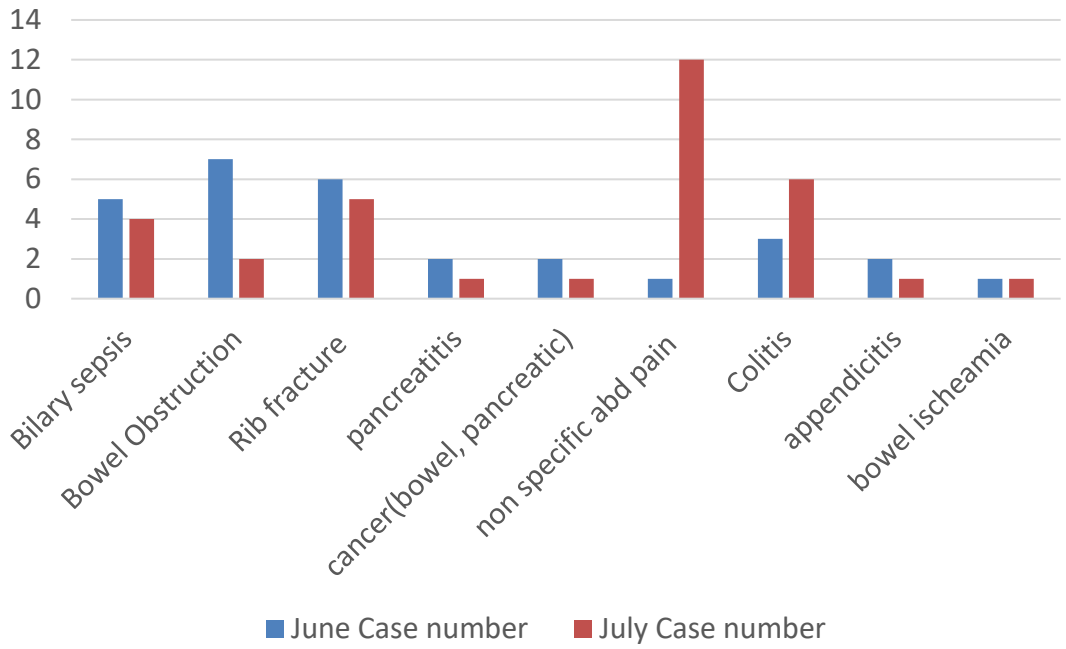
In detail monthly analysis

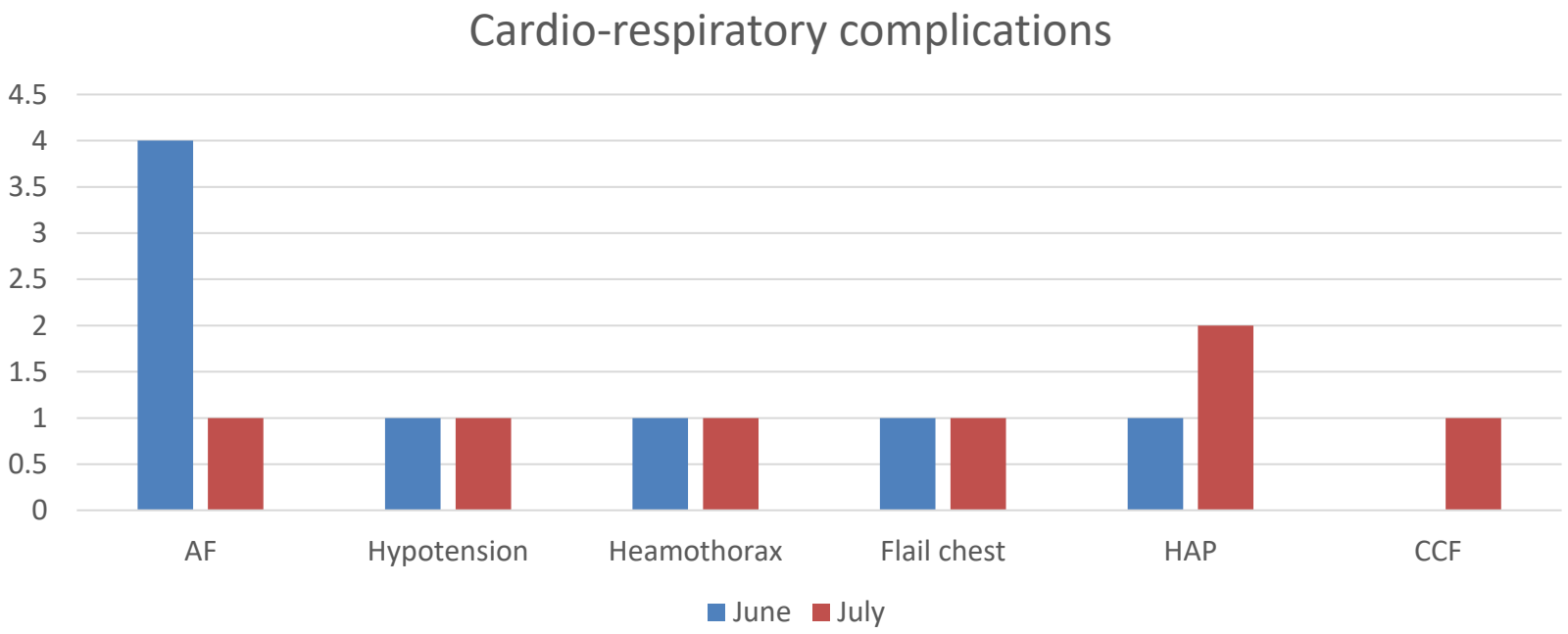
Overview of Primary Diagnosis & Profile



Total number admitted:
June - 35
July - 35
Average LOS
June - 10 days
July - 8.5 days
Required surgery:
June - 9
July - 3
Mortality:
June - 4
July – 3
Delirium
June - 3
July – 4
Average CFS – 5
Average medications - 5
Average medical condition - 5

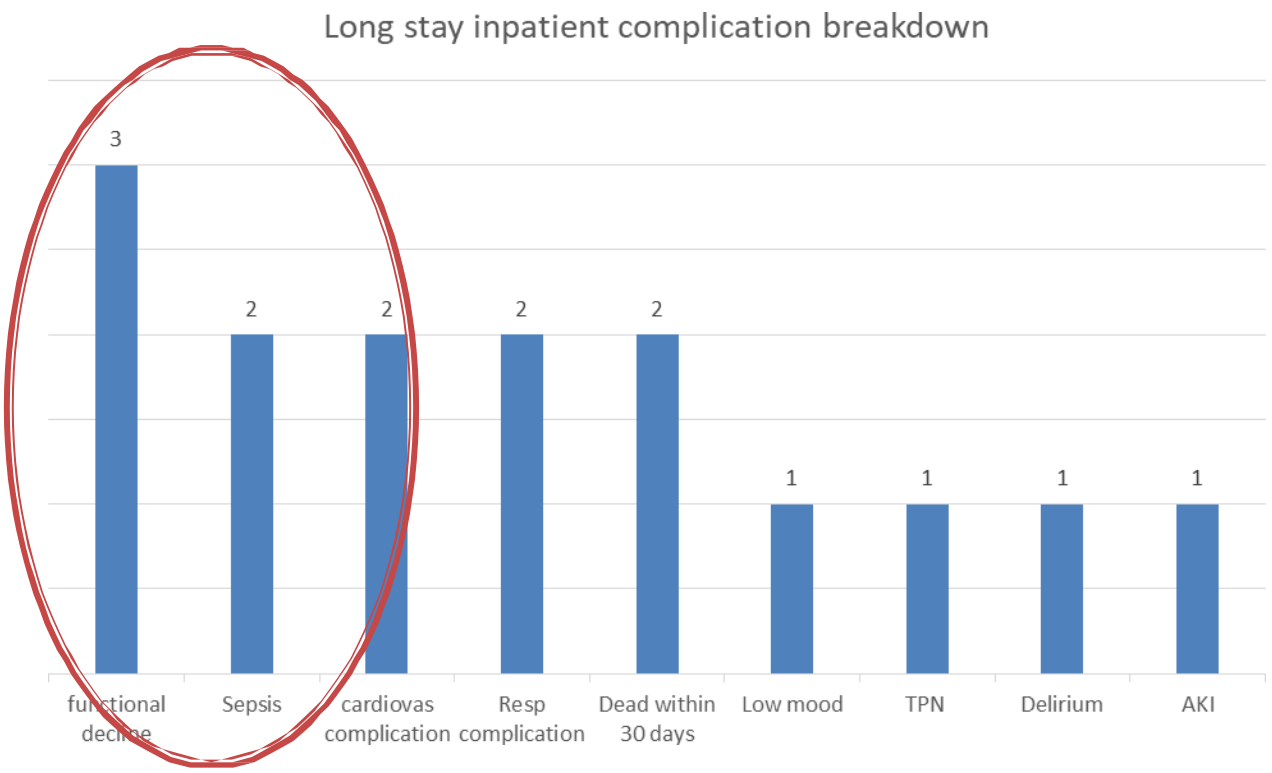
Readmissions – 6% (total over course of project)

Cardiovascular inpatient's complications



Those who stayed longest reasons

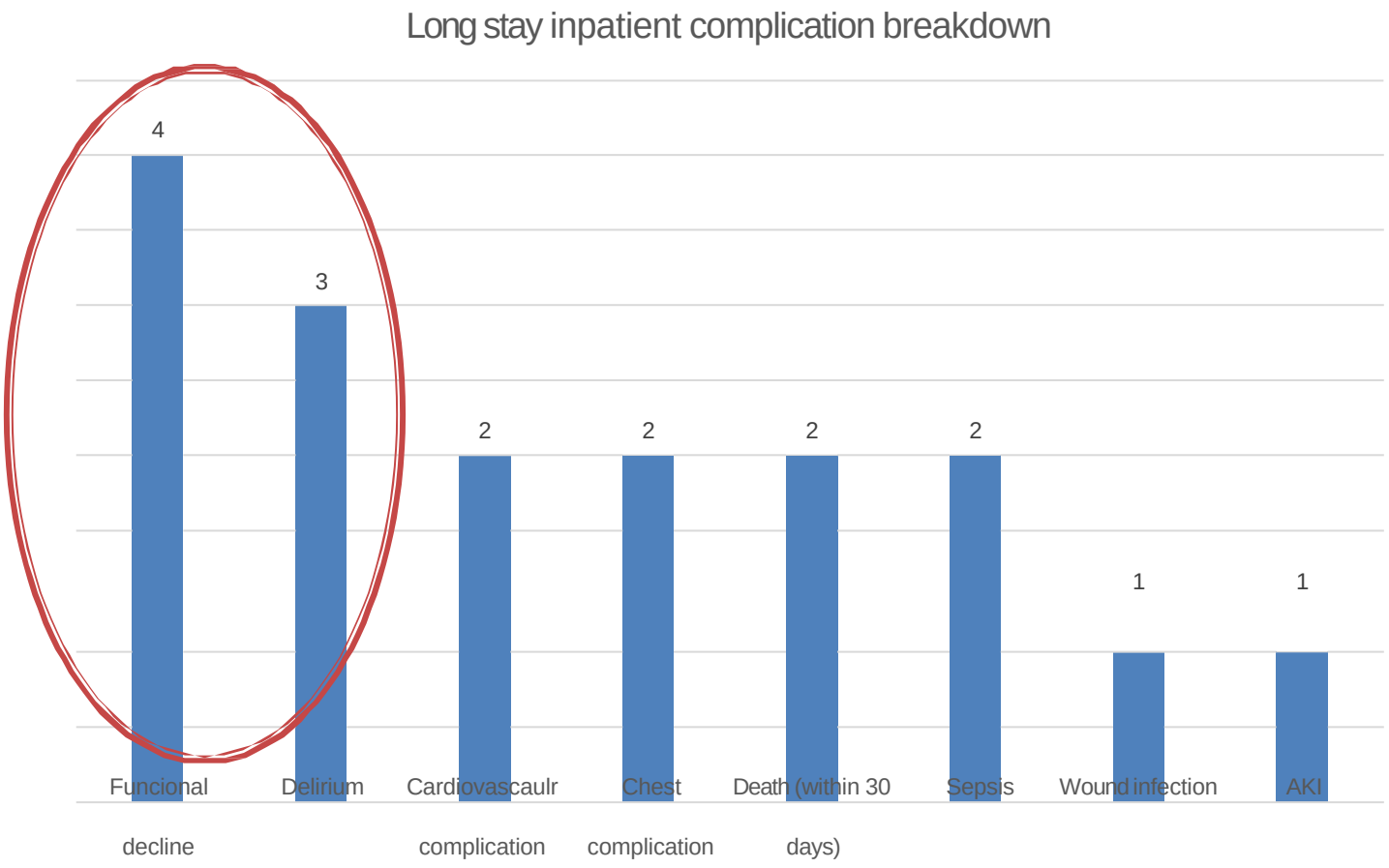
(Patients with LOS >12 days)



- n=7
- Average age 80 (range 75-89)
- LOS average 28 days (range 16-69 days)
- Frailty / CFS average 6
- Seen by POPS average of x3 times
- Underwent surgery = 3
- 2 dead both had surgery, in hospital longest (24 & 69d) and not reviewed by POPS until 4 weeks into stay (long ITU admission)

Those who stayed longest reasons

(Patients with LOS >12 days)



- n=9
- Average age 85 (range 69-93)
- LOS average 16 days (range 13-26 days)
- Frailty / CFS average 6
- Seen by POPS average of x3 times
- Underwent surgery = 1

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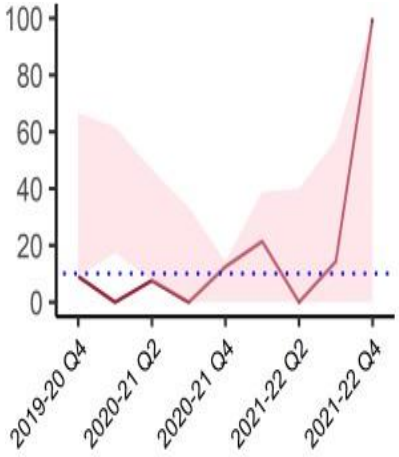
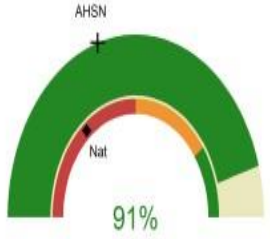
Other impact / work

NELA impact



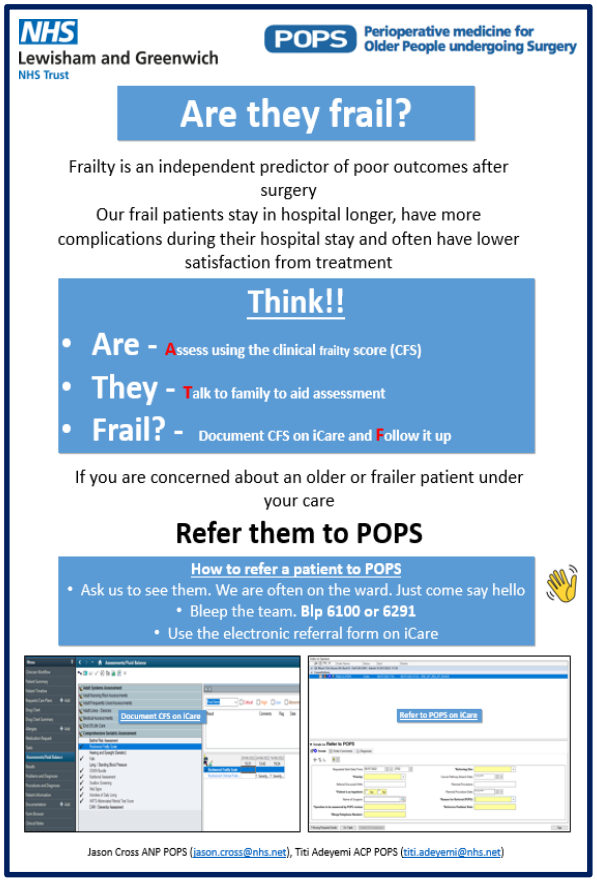


Perioperative assessment by a care of the older person specialist
01 January 2022 - 31 March 2022

Perioperative Assessment by a member of the geriatrician-led multidisciplinary team for patient aged 65 or over and frail (CFS ≥ 5) or 80+

National mean 28%
AHSN mean 40%
Number of patients included 11
Data completeness 100%

Sharing success / QI initiatives


NHS Lewisham and Greenwich NHS Trust

POPS Perioperative medicine for Older People undergoing Surgery

Are they frail?

Frailty is an independent predictor of poor outcomes after surgery

Our frail patients stay in hospital longer, have more complications during their hospital stay and often have lower satisfaction from treatment

Think!!

- **Are** - Assess using the clinical frailty score (CFS)
- **They** - Talk to family to aid assessment
- **Frail?** - Document CFS on iCare and Follow it up

If you are concerned about an older or frailer patient under your care

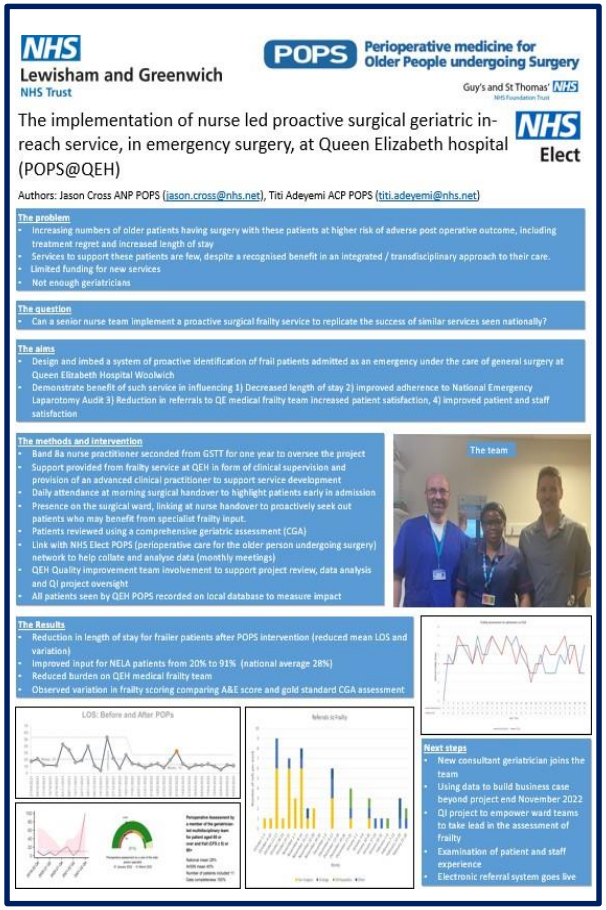
Refer them to POPS

How to refer a patient to POPS

- Ask us to see them. We are often on the ward. Just come say hello
- Bleep the team. **Blp 6100 or 6291**
- Use the electronic referral form on iCare

Jason Cross ANP POPS (jason.cross@nhs.net), Titi Adeyemi ACP POPS (titi.adeyemi@nhs.net)

- Presentation at exec and directorate meetings
- Local (ward QI) and education regarding frailty assessment
- QI showcase presentation and poster


NHS Lewisham and Greenwich NHS Trust

POPS Perioperative medicine for Older People undergoing Surgery

Guy's and St Thomas' NHS

The implementation of nurse led proactive surgical geriatric in-reach service, in emergency surgery, at Queen Elizabeth hospital (POPS@QEH)

NHS Elect

Authors: Jason Cross ANP POPS (jason.cross@nhs.net), Titi Adeyemi ACP POPS (titi.adeyemi@nhs.net)

The problem

- Increasing numbers of older patients having surgery with these patients at higher risk of adverse post operative outcome, including treatment regret and increased length of stay
- Services to support these patients are few, despite a recognised benefit in an integrated / transdisciplinary approach to their care.
- Limited funding for new services
- Not enough geriatricians

The question

- Can a senior nurse team implement a proactive surgical frailty service to replicate the success of similar services seen nationally?

The aims

- Design and imbed a system of proactive identification of frail patients admitted as an emergency under the care of general surgery at Queen Elizabeth Hospital Woolwich
- Demonstrate benefit of such service in influencing 1) Decreased length of stay 2) improved adherence to National Emergency Laparotomy Audit 3) Reduction in referrals to QE medical frailty team increased patient satisfaction, 4) improved patient and staff satisfaction

The methods and intervention

- Band 8a nurse practitioner seconded from GSTT for one year to oversee the project
- Support provided from frailty service at QEH in form of clinical supervision and provision of an advanced clinical practitioner to support service development
- Daily attendance at morning surgical handover to highlight patients early in admission
- Presence on the surgical ward, linking at nurse handover to proactively seek out patients who may benefit from specialist frailty input.
- Patients reviewed using a comprehensive geriatric assessment (CGA)
- Link with NHS Elect POPS (perioperative care for the older person undergoing surgery) network to help collate and analyse data (monthly meetings)
- QEH Quality improvement team involvement to support project review, data analysis and QI project oversight
- All patients seen by QEH POPS recorded on local database to measure impact

The team

The Results

- Reduction in length of stay for frailer patients after POPS intervention (reduced mean LOS and variation)
- Improved input for NELA patients from 20% to 91% (national average 28%)
- Reduced burden on QEH medical frailty team
- Observed variation in frailty scoring comparing A&E score and gold standard CGA assessment

Next steps

- New consultant geriatrician joins the team
- Using data to build business case beyond project end November 2022
- QI project to empower ward teams to take lead in the assessment of frailty
- Examination of patient and staff experience
- Electronic referral system goes live

Team and vision for future

Current	Future
ANP (GSTT secondment)	**ANP / AHP**
ACP	
Staf 202	
QEH	
- EGS frailty in-reach - 1 x POPS clinic.	EGS frailty in-reach - 2 POPS clinics

- In-reach for emergency surgery at UHL started
- Scoping and commencement of LGT POPS clinic
  - Interface with existing services
  - Cross site working
- Point of contact
- Business case completion

Next steps

- Ensure sustainability of service
- In-depth analysis of August and September
  - More detailed review of long LOS
- Business case finalisation
  - Version 4 currently
  - presenting to board in November
- Readmission review
  - 408 patients d/c during pilot / 26 readmissions (6%)

POPS@LGT
NHS Elect celebration event

Questions

NHS Lewisham and Greenwich NHS Trust

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Guy's and St Thomas' NHS NHS Foundation Trust

Questions and Comments

Comfort Break

Sharing our improvement stories

Lisa Godfrey

King's College Hospital NHS Foundation Trust

NHS Elect

NHS Elect- King's

Building a pre-operative clinic

Dr Nicola Lochrie & Dr Felicity Woodward

With thanks to the NHS Elect team

Established post-op surgical liaison service but limited pre-op

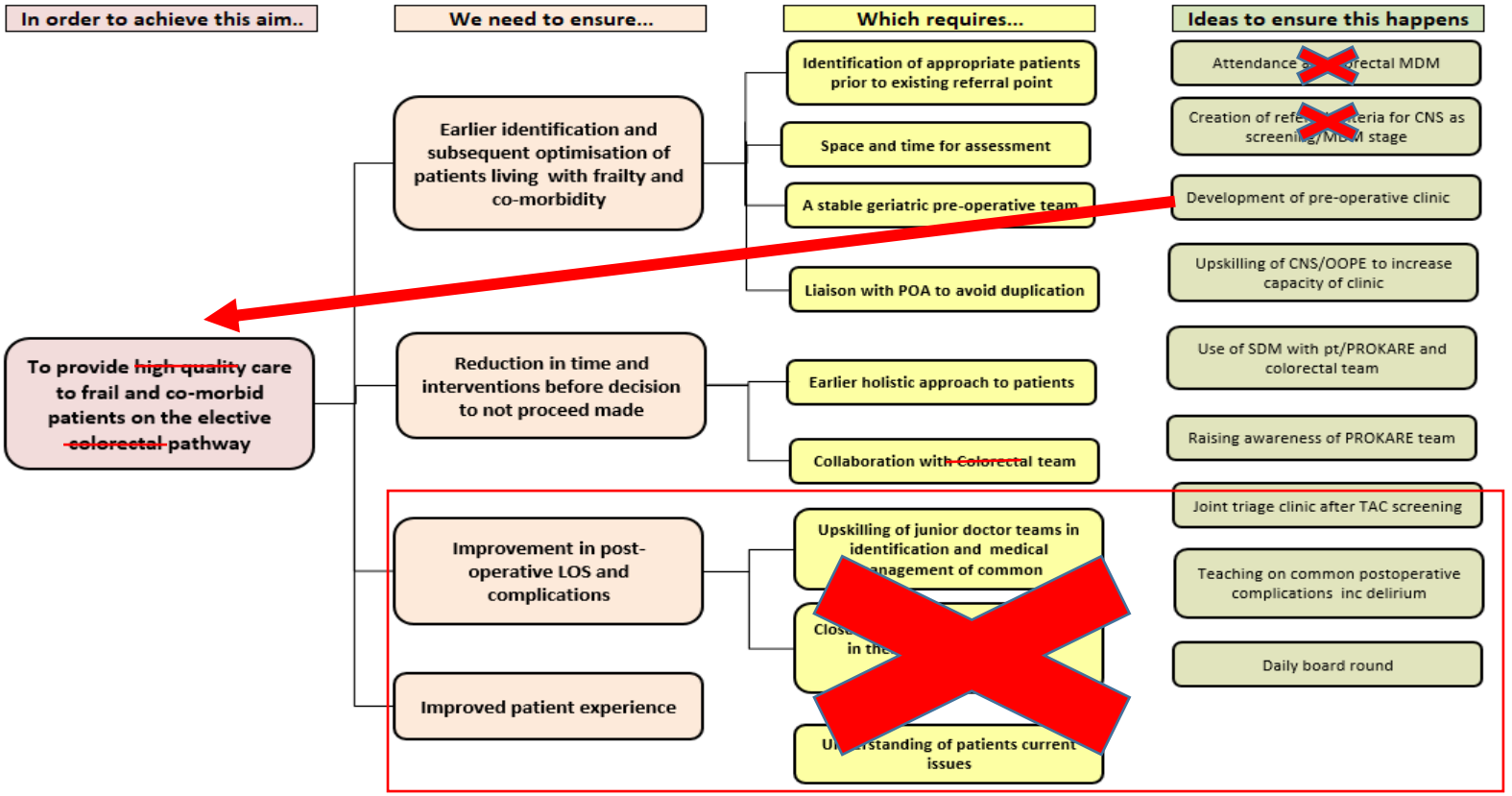
Good timing- national interest and NHS Elect

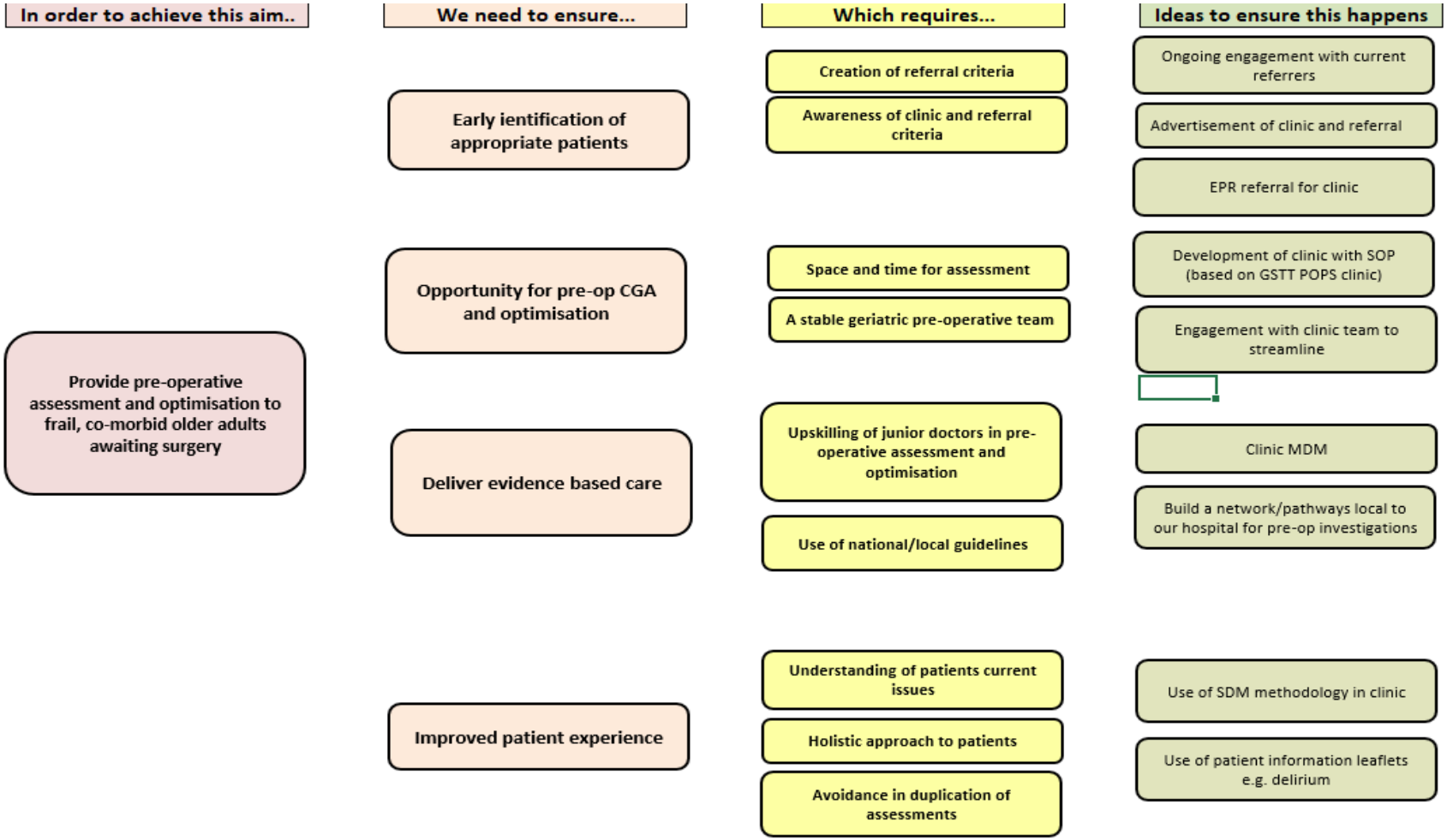
Enthusiastic new consultants seek new project

Experience of the POPS model

Enthusiasm from a surgical team, anaesthetics and exec

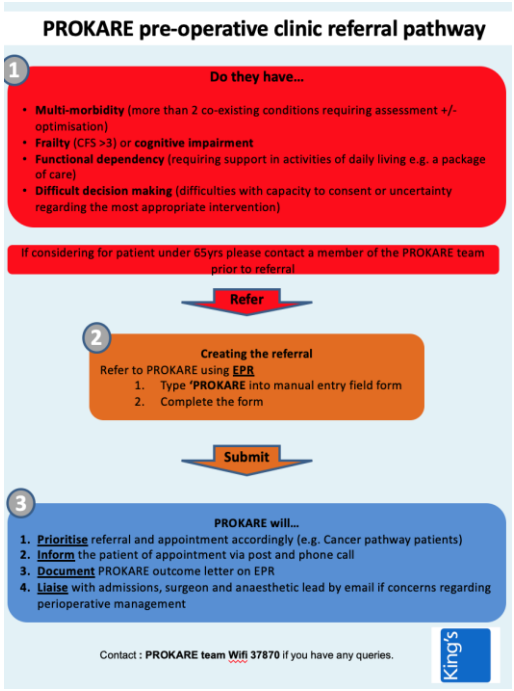
What we wanted to do and initial thoughts



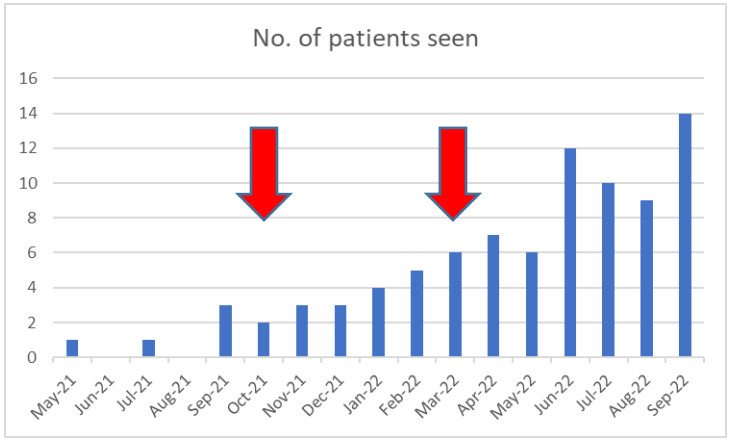

In order to achieve this aim..
We need to ensure...
Which requires...
Ideas to ensure this happens
Provide pre-operative assessment and optimisation to frail, co-morbid older adults awaiting surgery
Early ientification of appropriate patients
Creation of referral criteria
Awareness of clinic and referral criteria
Ongoing engagement with current referrers
Advertisement of clinic and referral
EPR referral for clinic
Opportunity for pre-op CGA and optimisation
Space and time for assessment
A stable geriatric pre-operative team
Development of clinic with SOP (based on GSTT POPS clinic)
Engagement with clinic team to streamline
Deliver evidence based care
Upskilling of junior doctors in pre-operative assessment and optimisation
Use of national/local guidelines
Clinic MDM
Build a network/pathways local to our hospital for pre-op investigations
Improved patient experience
Understanding of patients current issues
Holistic approach to patients
Avoidance in duplication of assessments
Use of SDM methodology in clinic
Use of patient information leaflets e.g. delirium

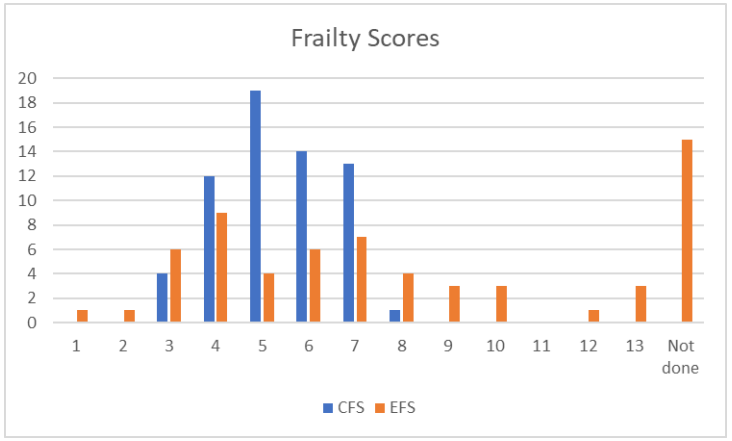
Set up and Promotion

- Existing clinic
- Got our faces out there
  - MDM/forums/emails invites/consultant meetings
- Spread the message
- Got started

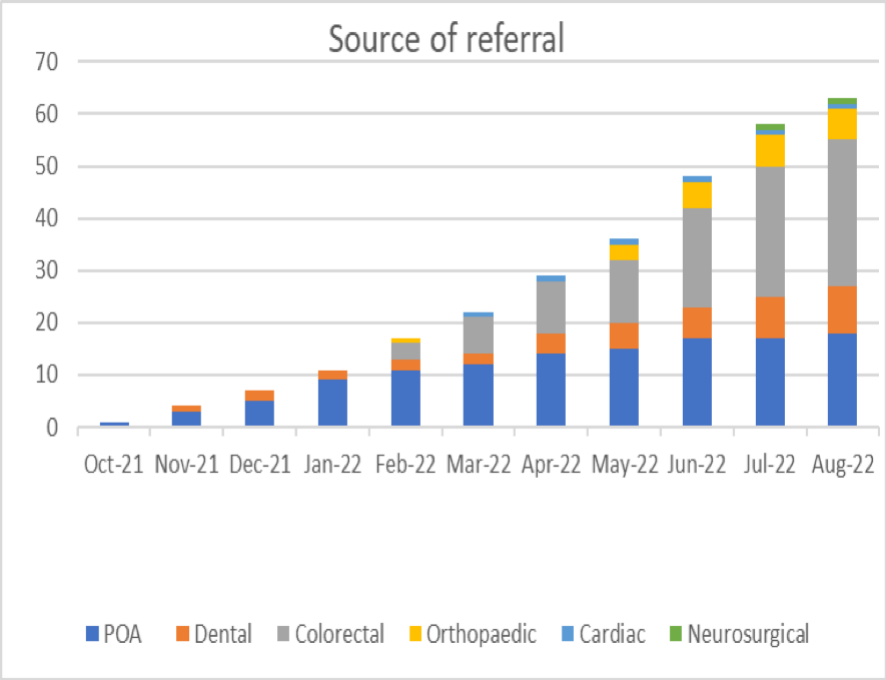


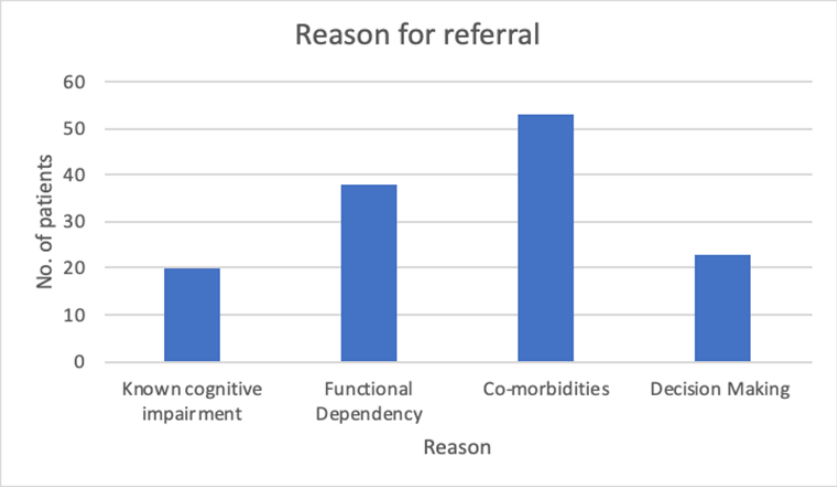
Clinic so far….

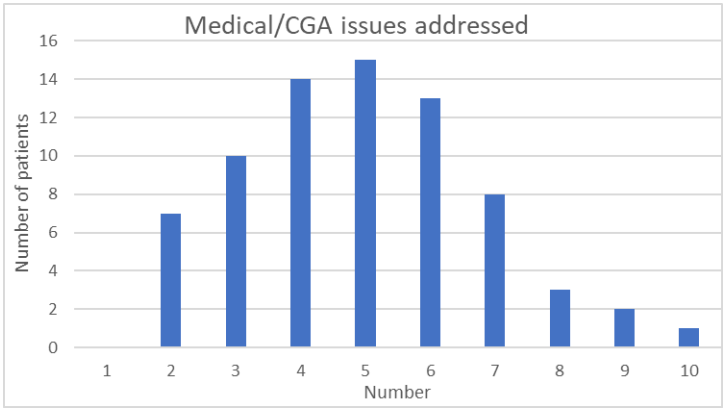


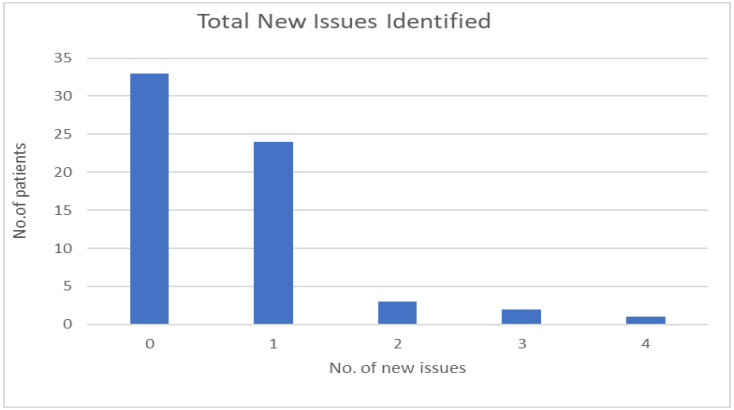


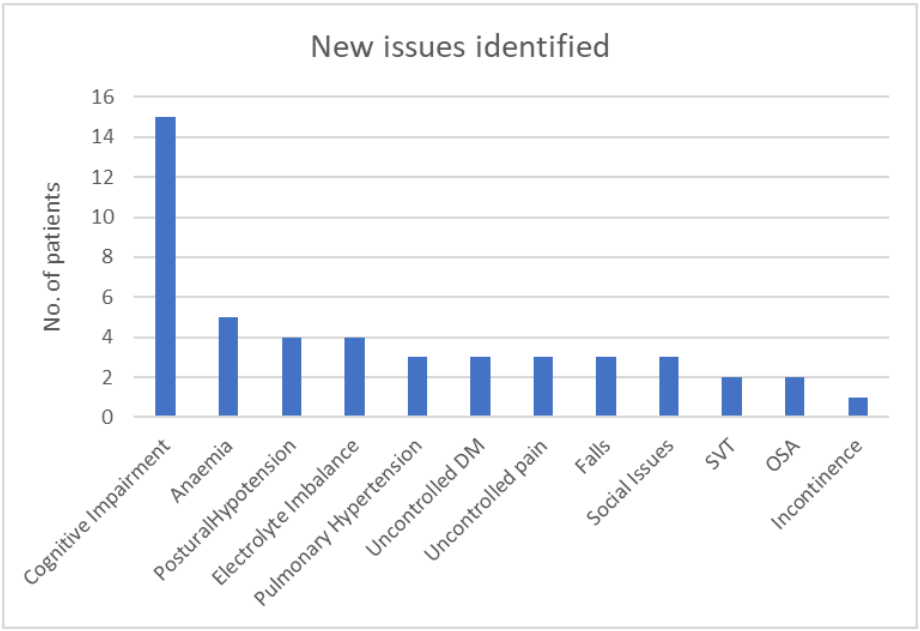
Referrals

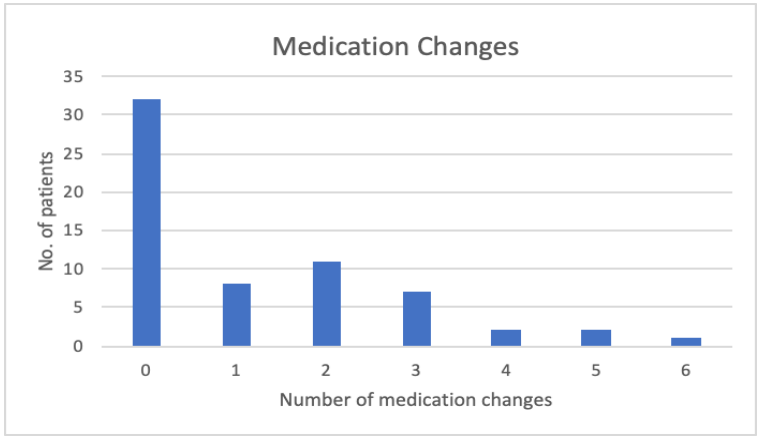

Source of referral
70
60
50
40
30
20
10
0
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
Jul-22
Aug-22
POA
Dental
Colorectal
Orthopaedic
Cardiac
Neurosurgical

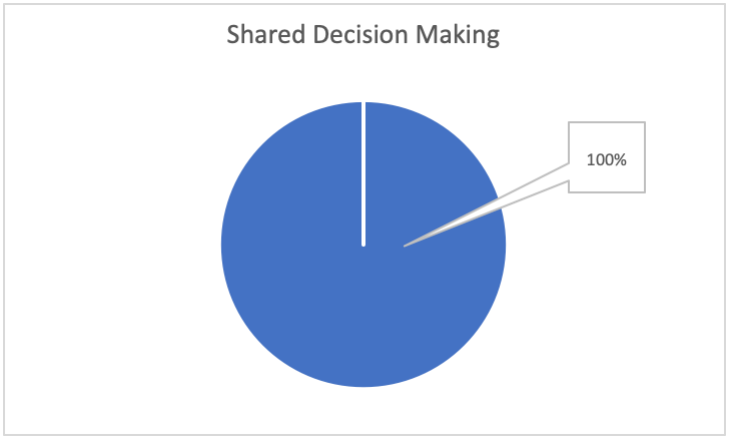

Reason for referral
No. of patients
60
50
40
30
20
10
0
Known cognitive impairment
Functional Dependency
Co-morbidities
Decision Making
Reason

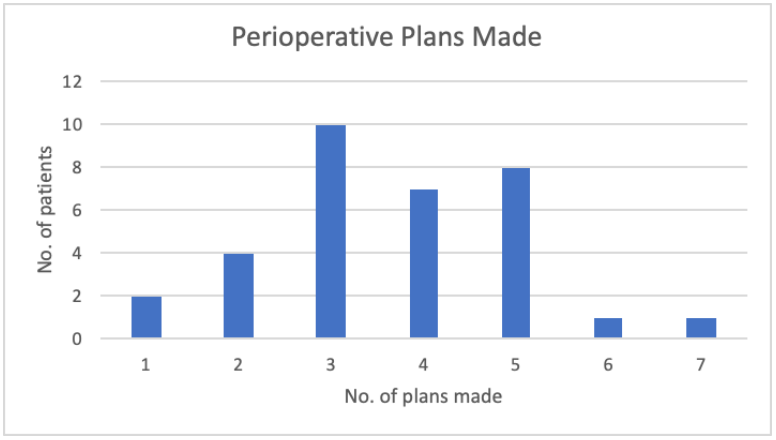

Medical/CGA issues addressed
Number of patients
16
14
12
10
8
6
4
2
0
1
2
3
4
5
6
7
8
9
10
Number

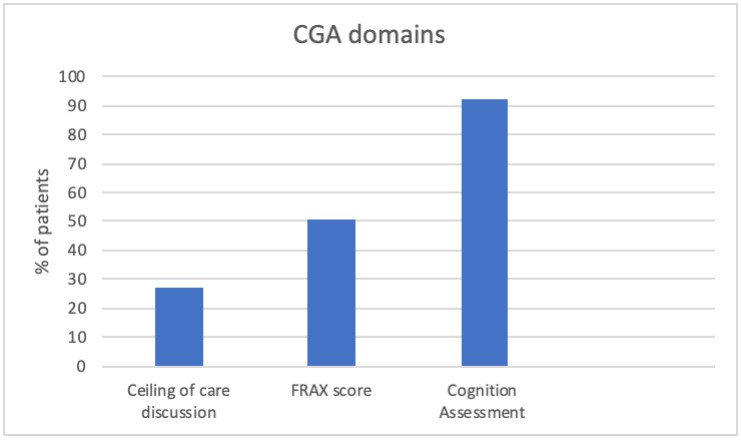

Total New Issues Identified
No.of patients
35
30
25
20
15
10
5
0
0
1
2
3
4
No. of new issues


New issues identified
No. of patients
16
14
12
10
8
6
4
2
0
Cognitive Impairment
Anaemia
PosturalHypotension
Electrolyte Imbalance
Pulmonary Hypertension
Uncontrolled DM
Uncontrolled pain
Falls
Social Issues
SVT
OSA
Incontinence

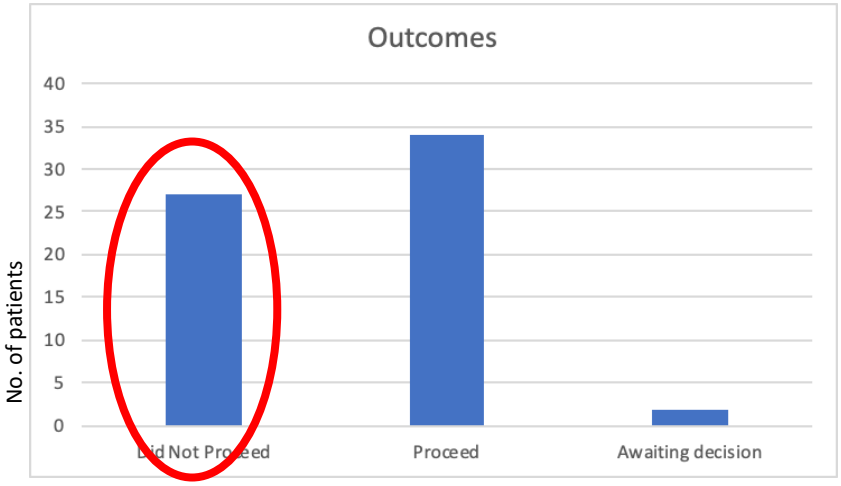

Medication Changes
No. of patients
35
30
25
20
15
10
5
0
0
1
2
3
4
5
6
Number of medication changes

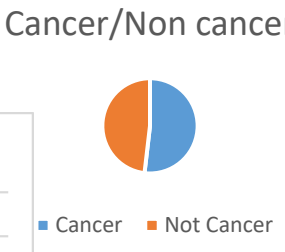

Shared Decision Making
100%

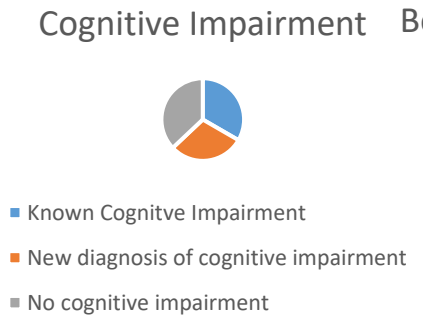

Perioperative Plans Made
No. of patients
12
10
8
6
4
2
0
1
2
3
4
5
6
7
No. of plans made

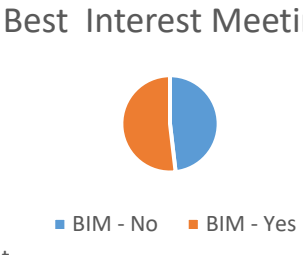

CGA domains
% of patients
100
90
80
70
60
50
40
30
20
10
0
Ceiling of care discussion
FRAX score
Cognition Assessment

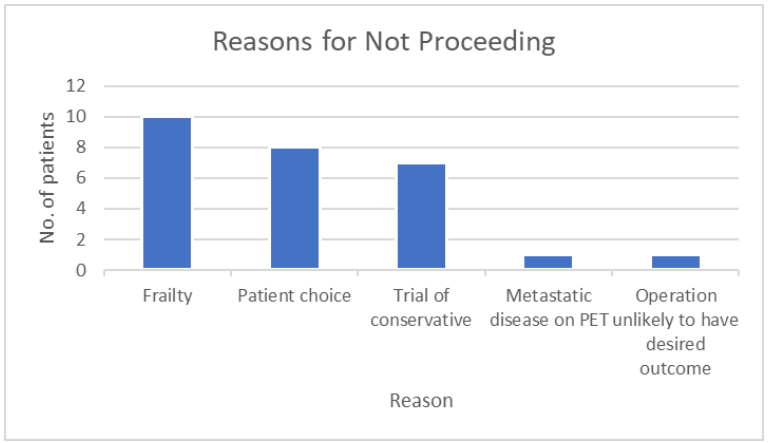
Outcomes





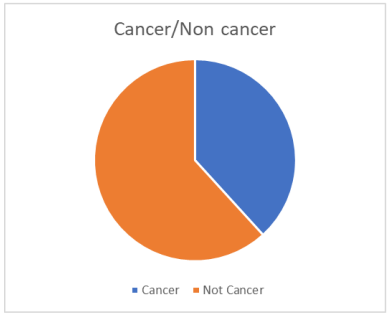


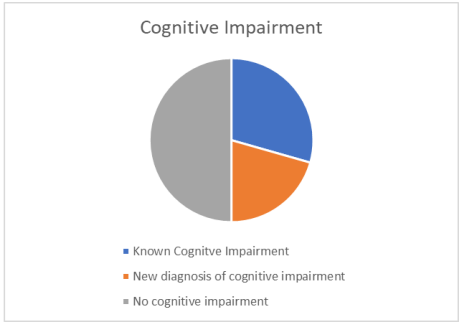




SDMQ9: All patients/families where the patient didn't proceed scored the consultation as strongly agree or completely agree for all 9 domains


Outcomes
40
35
30
25
20
15
10
5
0
Did Not Proceed
Awaiting decision


Cancer/Non cancer
Cancer
Not Cancer


Cognitive Impairment
Known Cognitve Impairment
New diagnosis of cognitive impairment
No cognitive impairment

Potential Cost Savings

Proposed Operation	Minimum	Maximum
Anal Cancer Resection	6747	22471
AP + IGAP flap	6747	22471
Appendiceal Resection	5232	13342
Cholecystectomy	5418	11802
Closure of peritoneal defect	9701	9701
Colonoscopy	1613	1613
Colonoscopy	1613	1613
Cystopscopy and SPC insertion	4204	4204
Dental Extraction	3958	3958
Inguinal hernia repair	4656	6719
Left hemicolectomy	10543	30051
Liver biopsy	1338	1338
Rectal Prolapse repair	3795	5651
Re-do Delormes	3795	5651
Right hemicolectomy	11351	30051
Right hemicolectomy	11351	30051
Right hemicolectomy	11351	30051
Right hemicolectomy	11351	30051
Sigmoid Resection	10543	30051
Sigmoid resection	10543	30051
TAVI	7365	12594
Total Hip Replacement	10166	29925
Total Knee Replacement	7526	17503
Total Knee Replacement	7526	17503
Total knee replacement	7526	17503
Whipple's	13417	24904
Total Cost	189376	440823

Challenges

- Process planning glitches
- What type of patients do we want to see?
- Is our role around decision making or optimisation?
- Decision making?
- Contacts and credibility

Things that worked for us

- Show your face
  - Attendance at pre-operative clinic monthly meeting
  - Introduction to colorectal team via F2F, MDM and email
  - Responsive, helpful and enthusiastic
- Development and **constant** advertisement of the clinic via flyer and email
- Education and enthusing team members
  - Streamlining of booking process - involvement and engagement with clinic team
  - Improved turnaround of clinic letters and feedback to surgeons
- Future
  - Working with POA team to strengthen pathway
  - Trial of virtual appointments for dental patients
  - Presenting work to wider hospital team to try and secure funding for additional clinic slots
  - Plan for expansion of clinic and team

THANK YOU!

NHS
University College London Hospitals
NHS Foundation Trust

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Celebration Event- POPS-2 Network

Dr Imran Mannan
Consultant Geriatrician

Dr Wint Mon, Dr Oliver Boney
Consultant Anaesthetists

Vision & Outcomes

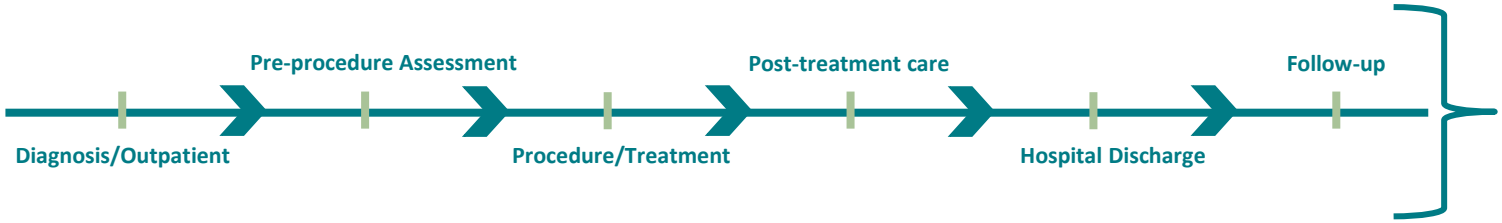
"Every older person living with frailty and/or with multiple medical comorbidities, who comes to UCLH for elective surgery, (across all hospital sites), will have access to high-quality Comprehensive Geriatric Assessment and geriatrician-led MDT input throughout their treatment journey – from diagnosis to discharge"

This strategy aims to achieve the following outcomes for older patients:

- Reduce medical and surgical complications of treatment
- Improve mortality rates
- Improve length of stay on surgical wards
- Reduce hospital readmission rates
- Improve access to treatment
- Improve screening & assessment of frailty within surgery and cancer services
- Improve patient experience

Modules of care

Geriatricians offer expertise in the assessment and treatment of older people living with frailty and/or multiple medical co-morbidities and can support older patients undergoing surgery or cancer treatments in a number of different ways **throughout their entire treatment journey**. The MFE team will work with individual departments to piece together these different modules to create a **bespoke service** that meets the needs of their patients. These modules focus on elective care but are also applicable to supporting teams with emergency admissions.



1 Service Design & Co-production

2 Shared Decision Making

3 Supporting MDT Discussion

4 Pre-treatment optimisation

5 Inpatient ward support

6 Rehabilitation

7 Virtual Ward & Community

8 Supporting Academic Research

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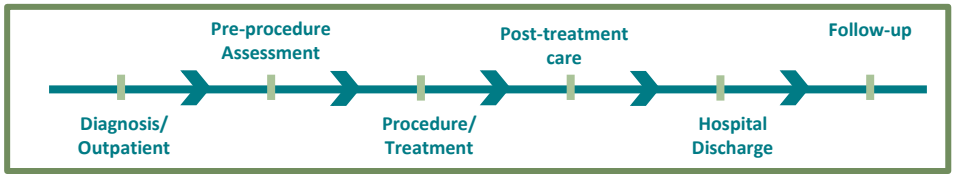
Service Design & Co-production

Each department within UCLH that offers surgery treatments will have unique patient demographics, treatment options and service design.



Stakeholder Engagement
- Engage relevant MDT members to understand service needs
- Agree outcomes new service aims to achieve and use data to determine frailty burden

Shadowing
- Recommend a period of shadowing where geriatricians observe existing processes
- This helps the team best understand the outlines of a new service

Service Design
- Use data and experience to develop a draft new service model
- Share this with stakeholders to gauge opinion

Agreement in principle
- Share provisional service design with wider team for feedback and agreement

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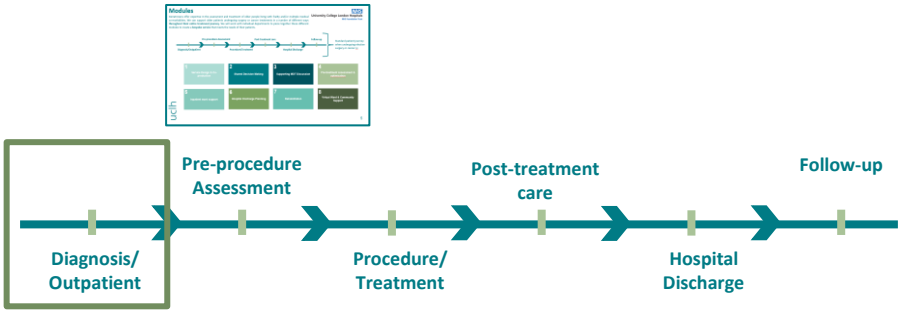
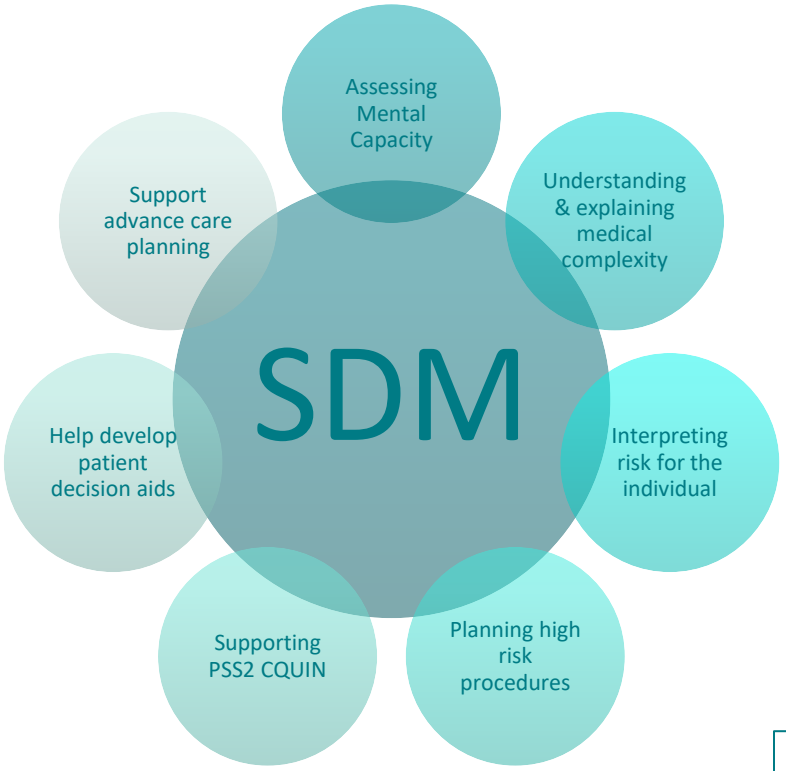
Shared Decision Making

SDM is a joint process in which healthcare professionals work together with a patient to help reach a decision about their care.





Models of care that could support shared decision-making include:

- Joint clinics with specialists (surgeons/oncologists)
- Joint clinics with anaesthetists
- Ad Hoc telephone (or face-to-face) appointments

Predicted Consultant DCC Time to support SDM:	2 hours/week

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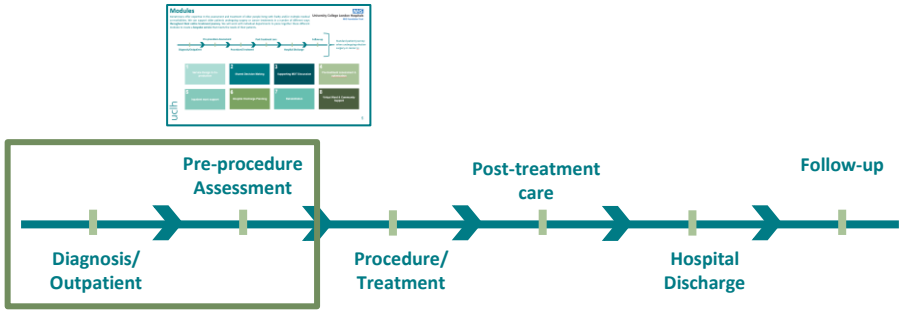
Supporting MDT Discussion

Geriatricians are experts in understanding patients' general function, in medical complexity and in polypharmacy. The tools that geriatricians use to understand function are more sensitive and discriminatory than WHO Performance Status. We can provide valuable input into MDT Discussions to help expert teams determine appropriate treatment options.

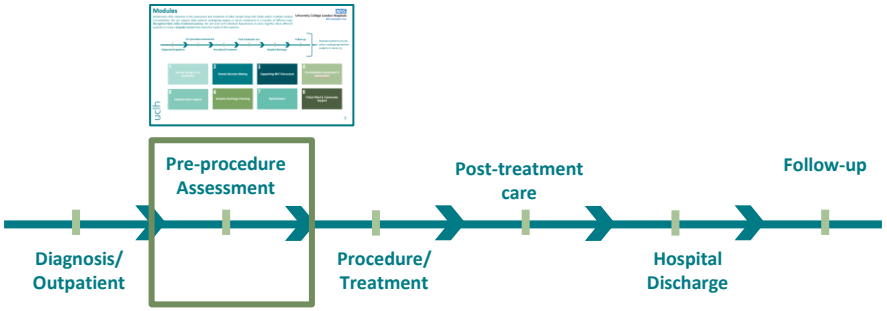


- Putting medical conditions and function in context of the individual for the wider MDT
- Granular understanding of outcomes based on frailty scoring
- Start pre-treatment assessment earlier, giving more time to affect change

Predicted Consultant DCC Time to support MDTs:	1-2 hours/week

Pre-treatment optimisation

Medical and physical optimisation before treatment can lead to both improved clinical outcomes and, in some cases, allow patients to access more intensive treatments.



Optimising a full complement of medical conditions in a “one stop shop” to improve patient experience and outcomes.

Access to the entire MDT to improve frailty, physical conditioning and performance status prior to treatment.

Providing and amending treatment for co-morbidities including anaemia and osteoporosis

Aiming to improve performance status of patients to improve access to more life-saving interventions

Providing comprehensive documentation that will stay with the patient and guide decision-making

Predicted Consultant DCC Time to support PTO:	4 hours/week

COM-PAC

- >65y
- Moderately to severely frail patients
- Known cognitive impairment

- Physician, anaesthetist and therapist (on call)
- Embedded within the pre-assessment service

- UCLH + Whittington patients

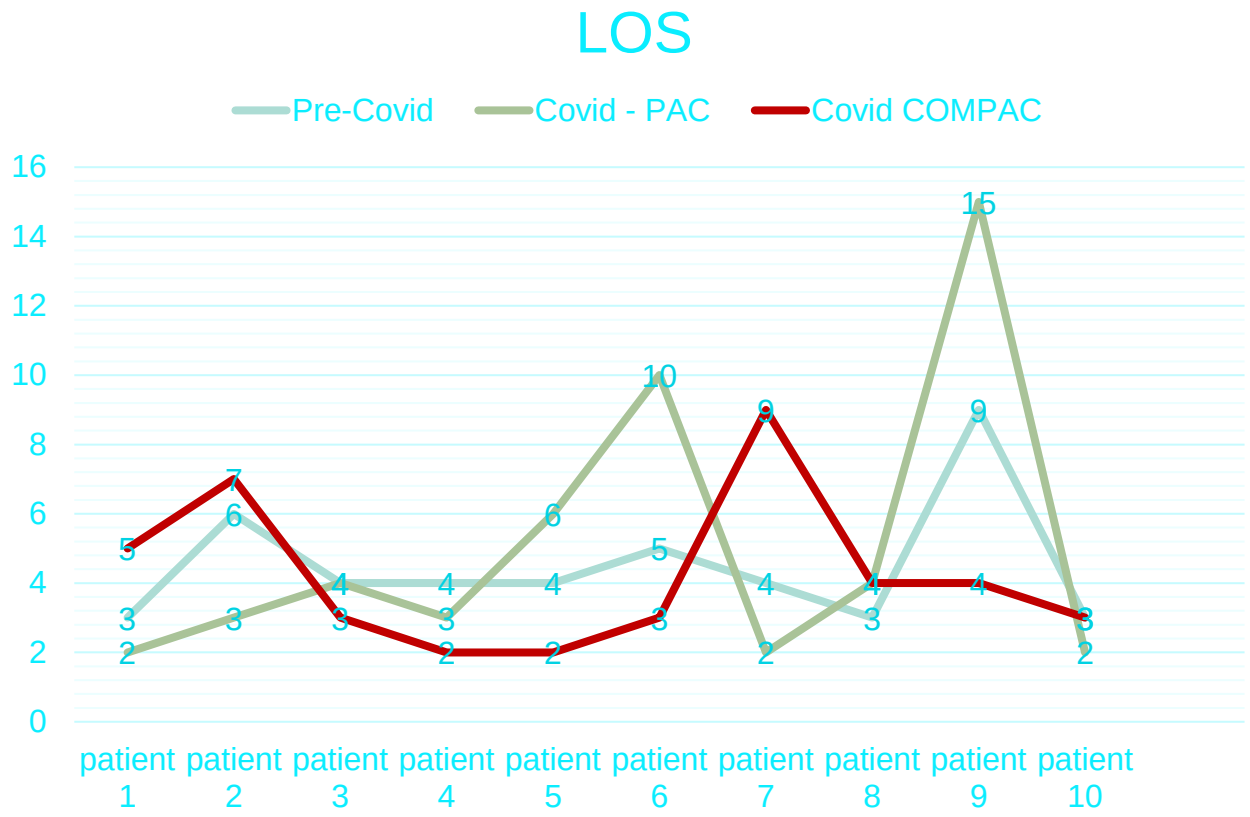
- Every Wed afternoon – 4 slots since the opening of GWB
- Referrals – surgeon, anaesthetist or PAC nurse

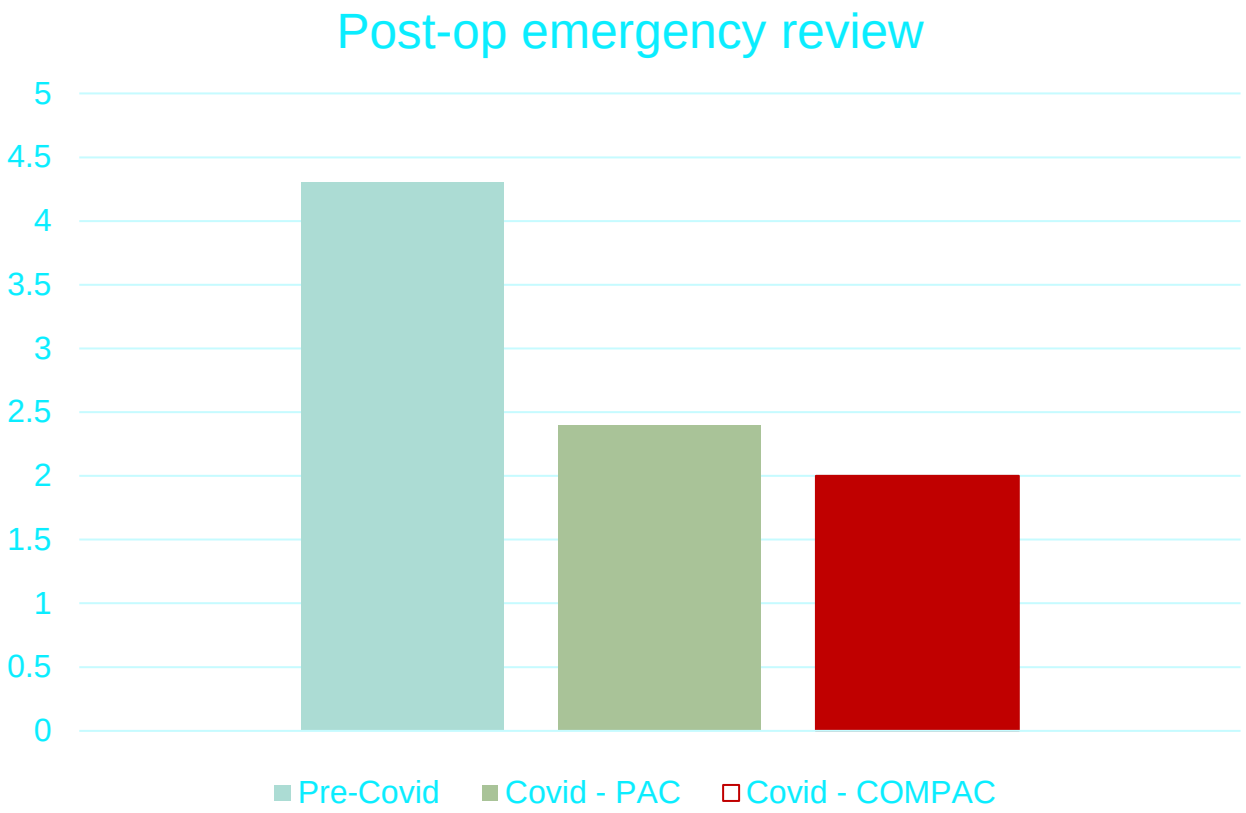
Theatre review meeting + PACU booking

Metric	Daniel Sommer	Ollie Boney	Wint Mon	Comments
Number of Complaints	Would Be Nice	Would Be Nice	Would Be Nice	I can check with the ortho team if they have done any patient satisfaction survey for GWB.
SOMOS	Unnecessary Metric	Unnecessary Metric	Unnecessary Metric	Likely too onerous
Death within 30 days	Essential Metric	Essential Metric	Essential Metric	
Any pre-operative function change before operation because of pre-op CGA assessment	Would Be Nice	Unnecessary Metric	Would Be Nice	If we have time for prehab or if andwhen prehab is expanding to orthopaedics
MOTOM moriston oronspational outcome measure (used for OT goals setting)	Unnecessary Metric	Unnecessary Metric	Unnecessary Metric	
Cognitive function pre and post operation	Essential Metric	Unnecessary Metric	Would Be Nice	we really need to start doing cognitive assessment at PAC
Number of patients returned to baseline functionality	Would Be Nice	Essential Metric	Essential Metric	
Hospital-acquired pressure ulcer?	Essential Metric	Would Be Nice	Would Be Nice	
Number of inpatient falls	Essential Metric	Would Be Nice	Would Be Nice	
Reduction in SSI	Would Be Nice	Essential Metric	Essential Metric	Reported at the monthly GWB governance meeting
Ability to rehabilitate with physiotherapy	Unnecessary Metric	Would Be Nice	Would Be Nice	
Length of stay in recovery	Unnecessary Metric	Unnecessary Metric	Unnecessary Metric	This can be affected by a number of issues such as ward staffing
Post-operative hospital length of stay	Essential Metric	Essential Metric	Essential Metric	
Length of stay in rehabilitation	Would Be Nice	Essential Metric	Essential Metric	
Care Package before admission?	Would Be Nice	Would Be Nice	Would Be Nice	
Care Package on discharge?	Would Be Nice	Would Be Nice	Would Be Nice	
Pre-operative POPS assessment?	Essential Metric	Essential Metric	Essential Metric	age cut off?
Post-operative POPS assessments?	Essential Metric	Would Be Nice	Essential Metric	POPS team review rather than assessment?
Assessed for delirium post-op? (4AT)	Essential Metric	Essential Metric	Essential Metric	
Nutrition Assessment completed pre-op?	Unnecessary Metric	Essential Metric	Essential Metric	pre-op or post op?
Cognitive assessment pre-operatively (MoCA vs CLOX)	Essential Metric	Essential Metric	Essential Metric	Mel was trying to add mini COG to PAC pre-COVID. We can check in with her again.
Time from initial surgical review to POPS/pre-op review	Essential Metric	Essential Metric	Would Be Nice	
Time from pre-op/POPS review to admission	Essential Metric	Essential Metric	Essential Metric	We have PAC to TCI data every month.
Time from admission to surgery	Would Be Nice	Would Be Nice	Would Be Nice	
Late cancellation of surgery?	Essential Metric	Essential Metric	Essential Metric	On the day and cancellation with < 7 d notice
Readmissions to ITU after operation	Essential Metric	Essential Metric	Essential Metric	Agree with Olly. We should add unplanned ITU admission
Readmission to hospital within 30 days	Essential Metric	Essential Metric	Essential Metric	
Return to theatre within 30 days	Essential Metric	Essential Metric	Essential Metric	
Patient satisfaction	Find out what is collected already	F&F Test?	Sam	
What is the correct cognitive screeening test	Telephone MoCA - Wint	Might struggle to get PAC nurses to c	Dan	Caution that GSTT have a different model
Delirium outcomes	Look into industry standard - POPS		Dan	
check if PAC nurses ask about care packages? Freetext vs data inputs			Wint	
Nutrition assessment - what is the score?			Wint	
PROM Return to baseline			Sam	

Metrics prioritisation

Patient groups			
	Pre-Covid	Covid – PAC	Covid - COMPAC
Avg Age	73	73	79
CFS (median)	4 (not done)	3 (not done)	5
LOS (average)	4.5	5.1	4.2


LOS
Pre-Covid
Covid - PAC
Covid COMPAC
16
14
12
10
8
6
4
2
0
patient 1
patient 2
patient 3
patient 4
patient 5
patient 6
patient 7
patient 8
patient 9
patient 10

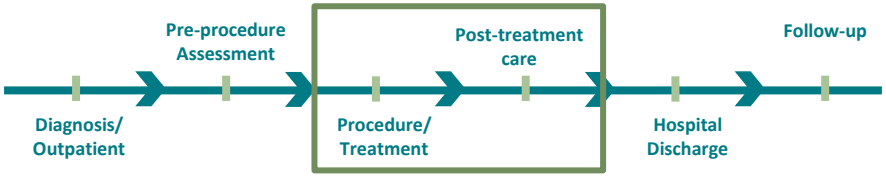

Post-op emergency review
5
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
Pre-Covid
Covid - PAC
Covid - COMPAC

Current Challenges

- Not capturing all eligible patients
- Delay in anaesthetic review + F2F due to late booking of cancer cases (at least 50% not reviewed until a week before surgery)
- More education and engagement needed for frailty scoring and cognitive assessment
- MDT discussion and continuity of care – difficulty in engagement with the stakeholders
- Data support

Inpatient ward support

Geriatricians have a large inpatient bed base and have developed regular cadences of board rounds and MDT discussions that support flow.



Board Rounds	•Daily morning MDT huddle •Drive forward plans and discharges
Ward Rounds	•Regular, proactive clinical review of patients •Either separate or joint with treating clinicians
Ward MDT	•Weekly meeting with MDT (nurses, AHPs) •Discuss complex patients and unblock issues
Discharge Planning	•Understanding function and outcomes to improve flow •Navigating complex discharge pathways and funding streams

Predicted Consultant DCC Time to support IWS:	4 hours/week

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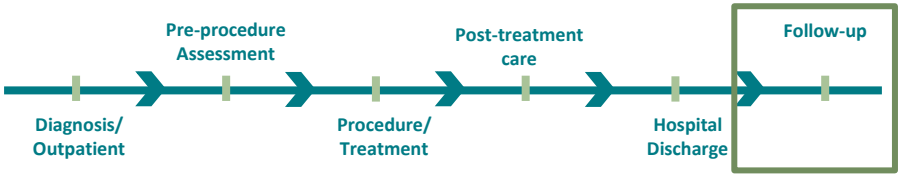
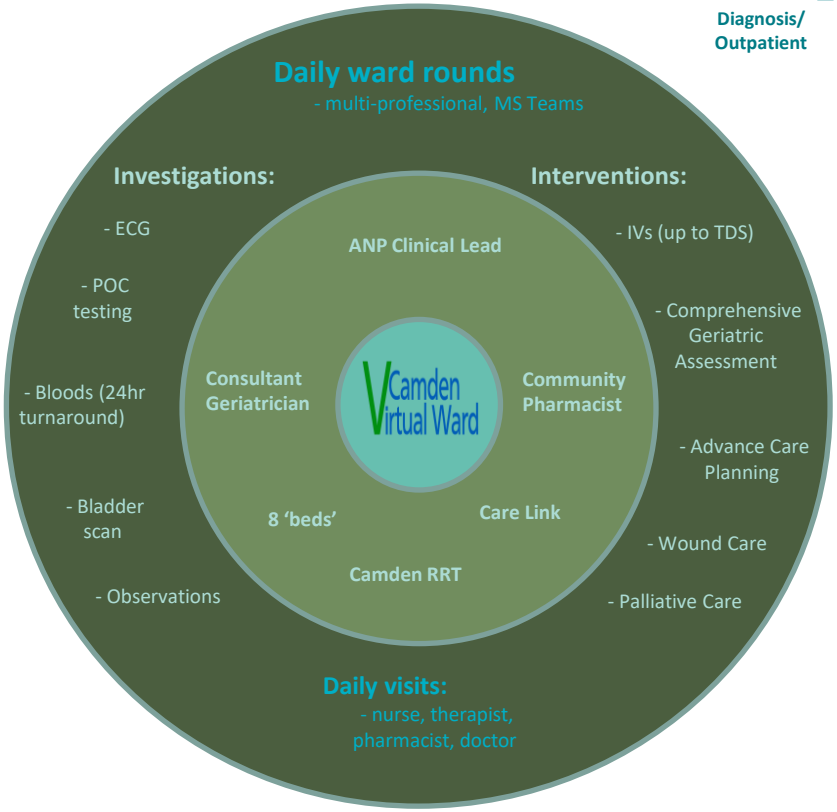
Across NCL, and especially in Camden, geriatricians are taking a leading role in running virtual wards – a new model of care that provides clinical oversight and regular patient supervision in their own homes. This model of care can provide additional support to patients after their treatments if primary teams feel they need closer monitoring or support.

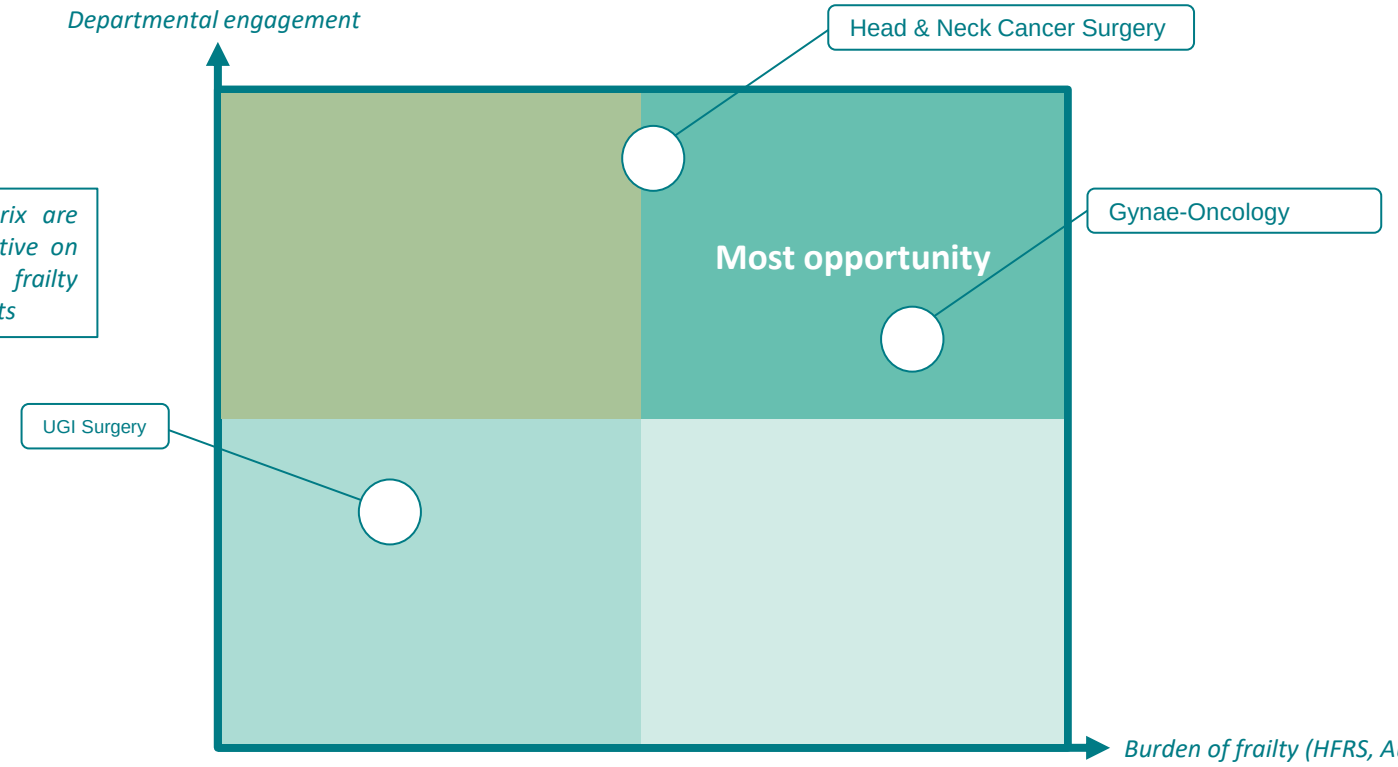




Virtual wards are available in most boroughs across London and stand ready to support patients who are ready to leave hospital with additional support or who are at risk of deterioration at home. UCLH geriatricians are involved in running the virtual ward in Camden, so can provide additional support to patients living in the borough.

Prioritisation Matrix

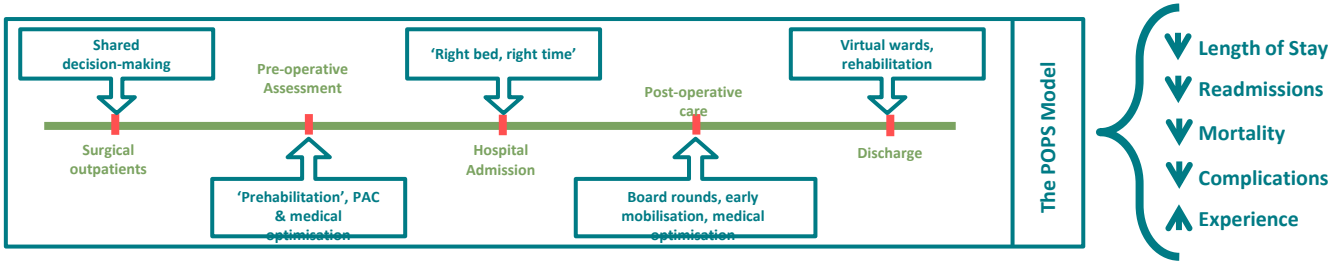
There is limited clinician resource, therefore decisions around which services to support and how best to support them will require prioritisation. Services should be prioritised based on need (which requires data) and level of engagement from individual departments.



The results in this matrix are indicative and not reflective on actual engagement or frailty burden within departments

POPS GYNAE-ONCOLOGY PROPOSAL

Geriatricians are experts in the diagnosis and treatment of older people who are living with frailty and/or multiple medical co-morbidities. We have a key role to play in improving outcomes for older people undergoing surgery. We will support the gynae-oncology team to enhanced shared decision-making, improving pre-operative optimisation and develop post-operative care models to improve operational and clinical outcomes.



Pathway	Geriatrician Involvement	Time Commitment
Shared Decision-Making	• Weekly discussion with anaesthetists every Tuesday morning to discuss relevant patients from the previous week's clinic • Develop delirium/cognitive impairment pathway to support surgeons/oncologists assess capacity/consent	0.25 PA/week
Pre-operative Assessment/ Prehabilitation	• Joint teleconference alongside anaesthetists for appropriate patients • Regular involvement in prehabilitation screening triage meeting • Ad Hoc patient reviews in clinic (virtual vs face to face) as necessitates	0.75 PA/week
Post-operative care	• Twice weekly morning board rounds alongside MDT on ward • Weekly MDT meeting on ward • Weekly geriatrician-led ward round	1 PA/week
	Total:	2 PA/week DCC

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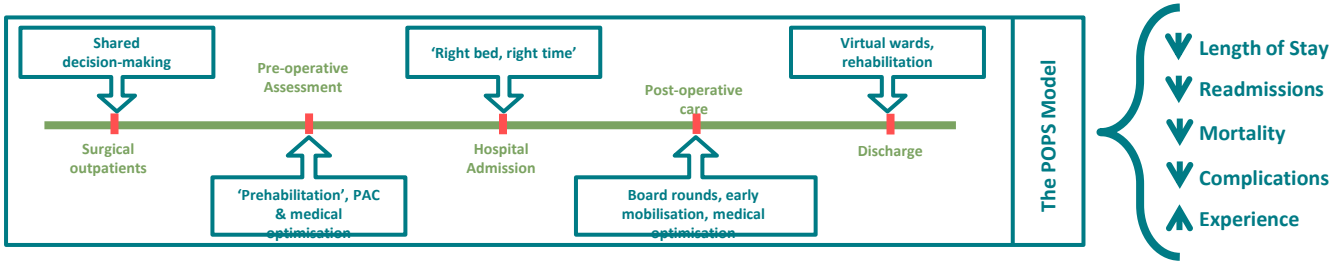
POPS HEAD & NECK CANCER SURGERY PROPOSAL

Geriatricians are experts in the diagnosis and treatment of older people who are living with frailty and/or multiple medical co-morbidities. We have a key role to play in improving outcomes for older people undergoing surgery. We will support the Head & Neck Cancer teams to enhanced shared decision-making, improving pre-operative optimisation and develop post-operative care models to improve operational and clinical outcomes. There is operational complexity due to multiple hospital referral routes necessitating an agile and flexible approach.



Pathway	Geriatrician Involvement	Time Commitment
Shared Decision-Making	• Explore geriatrician involvement at other sites (e.g. RLH, BHRUT) • Acknowledge challenge that patient's diagnosis and treatment often discussed before patient arrived as UCLH and the further away the patient lives, the later in their journey they are seen at UCLH • Scope to get involved in complex best interest decision-making on an ad hoc basis	?
MDT & Surgical Planning	• Geriatrician attendance at MDT meetings and surgical planning meetings to identify patients and key issues	0.5 PA/week
Pre-operative Assessment	• Joint meeting in PAC between anaesthetists/Geriatricians every Friday morning to discuss appropriate cases from previous week • Ad Hoc patient reviews in clinic (virtual vs face to face) as necessitates	0.75 PA/week
Post-operative care	• Twice weekly morning board rounds alongside MDT on ward • Weekly MDT meeting on ward • Weekly geriatrician-led ward round	1 PA/week
	Total:	2.25 PA/week DCC

Improving planned Care in the frail

David Burberry, Elizabeth Davies, Alex Burgess, Isabell Wissenbach, Ka Ng, Duncan Soppitt, Gregory Taylor, Jugdeep Dhesi

The project

- Project awarded funding from the Bevan commission after initial work under POPs network.
- Running from May 2021- May 2022
- Running PDSA cycles to develop an elective perioperative service

Aim of the project

- To improve the care and experience of patients on waiting lists within Swansea Bay.
- To improve patient outcomes of patients on current waiting lists within Swansea Bay.
- To reduce length of stay for elective patients.
- To reduce waiting list length.

First cycle (cholecystectomy waiting list)

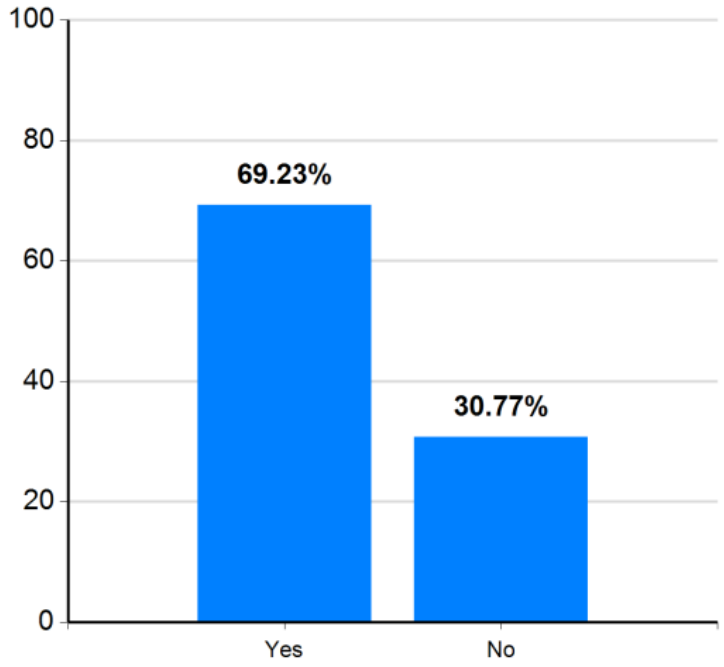
- 256 patients on Cholecystectomy waiting list over the age 65.
- 26 patients have responded to initial survey to date (responses still being received).
- In process of phoning the 256 patients.

Baseline data

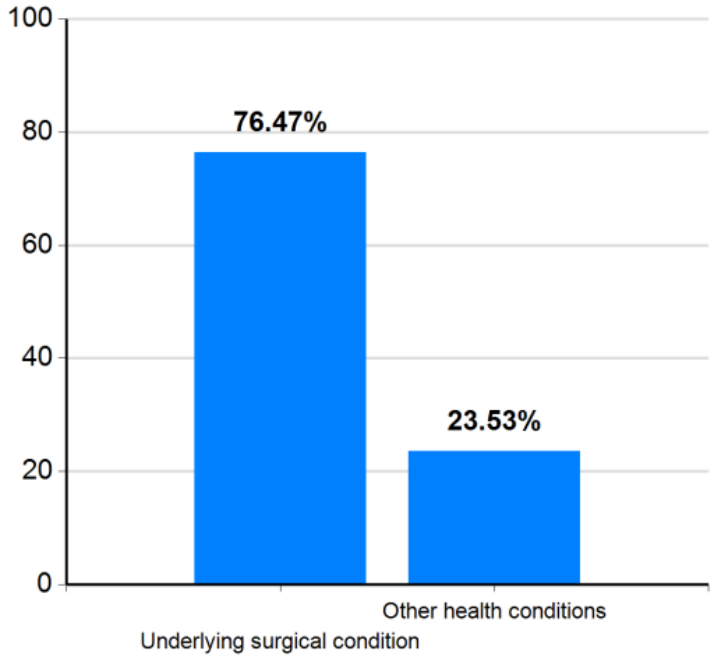
- Longest wait 5.5 years
- Oldest patient 94
- 5-10 new referrals per month

Initial patient survey responses

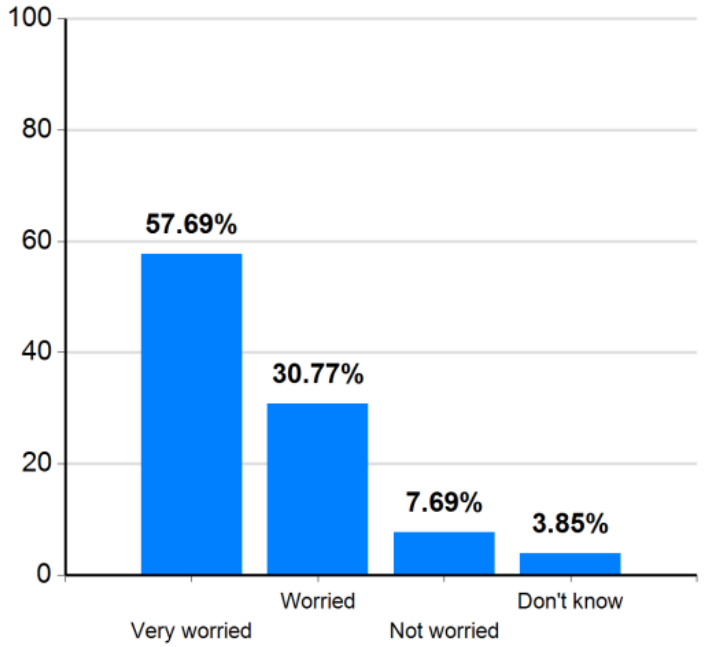
Do you think your health has deteriorated since you were referred for surgery?



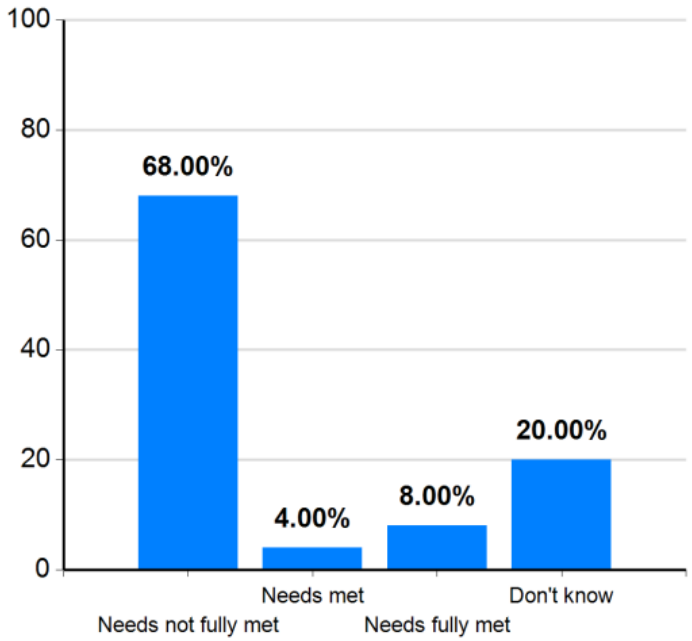
If yes do you think this is due to your



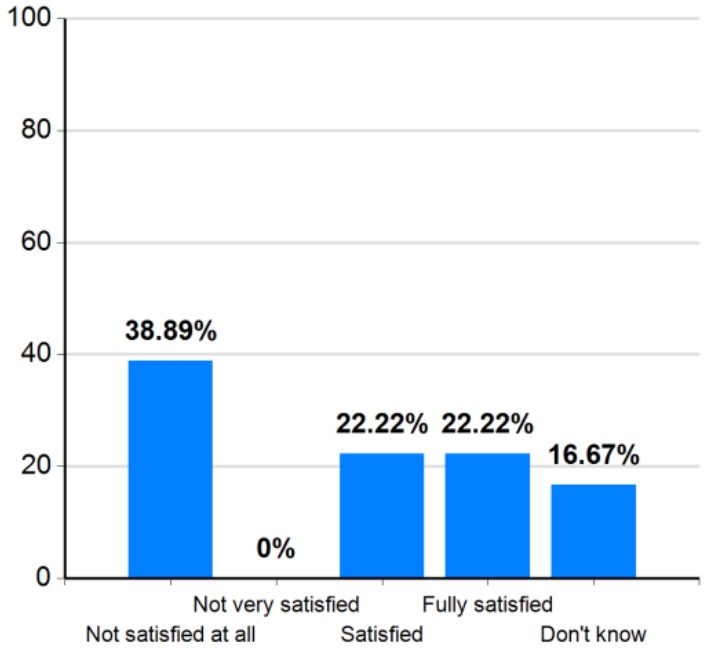
Do you worry about your wait for surgery?



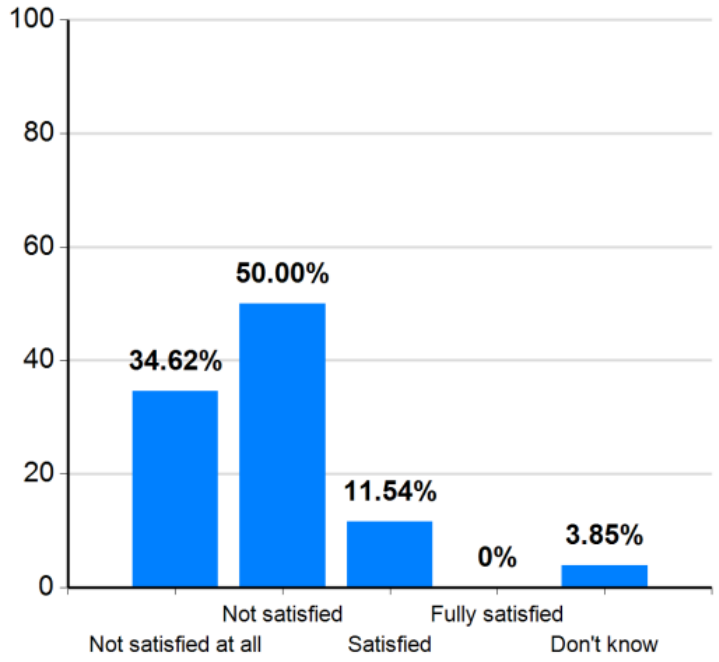
Do you think your health needs are being met?



Do you think your social needs are being met?



How satisfied have you been since you were referred for surgery?



Other outcomes to date

- 1 person asked to be removed from waiting list after receiving standard letter.

- List being formed to commence reviewing patients in Geriatrician led clinic.

Questions and Comments

What's Next for your POPS Journey?

Professor Jugdeep Dhesi

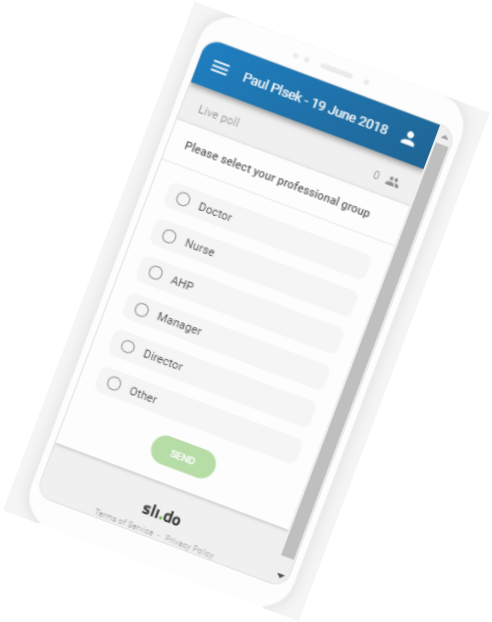
First iteration of the POPS Principles

1. Have systems in place to ensure patient experience and values are at the forefront of all care
2. Establish mechanisms to identify frail older people
3. Work as an interdisciplinary/Multidisciplinary team to proactively liaise with other teams
4. Develop pathways to appropriately capture CGA and optimisation
5. Invest in communication, stakeholder, and executive engagement
6. Provide relevant education and training to support clinical professional standards
7. Adopt a QI approach to develop perioperative services for older people
8. Adopt a measurement for improvement mindset
9. Put plans in place for service expansion & development to roll out to new cohorts of patients
10. Have systems and process in place for governance and evaluation from the outset

Next Steps

- You will receive an email with MS Forms link to complete a programme evaluation. Once submitted you'll receive a framed certificate for your participation in the programme.
  - The aim of this evaluation is to establish whether the POPS Network is meeting its objective in supporting implementation of peri-operative services for older people living with frailty.
  - We will use the learning from this evaluation to shape subsequent waves of the programme and other network/product development.
- Keep in touch with us – we're keen to hear how your POPS journeys continue and how your improvements progress. You will continue to be part of the Network and able to access the website, access our webinars and receive the newsletter.
- Please register for our virtual Frailty Conference on 20 October. An opportunity to hear about the national strategy for Frailty, as well as breakout sessions on Specialised Frailty, Same Day Emergency Care (SDEC) Frailty and POPS services. Link in the Chat now!

sli.do



Open a browser on any laptop, tablet or smartphone

- Go to **www.sli.do** or scan the QR code
- Enter the event code **#POPS61022**
- Use the polls to give us feedback about the day

Anything else?
Please let the NHS Elect team know at:

networksinfo@nhselect.org.uk