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

May 2023

Agenda	
09:00	**Welcome and introduction to the day** **Dr Jugdeep Dhesi** Clinical Lead, POPS Network
	Using CPOC BGS Frailty guidance to support change **Dr Jude Partridge** POPS Consultant, GSTT
	How to identify 'at risk' patients early in the pathway **Dr James Prentis** Consultant, Newcastle
	Our Frailty Journey So Far **Dr Michael Magee**, Consultant Geriatrician, Craigavon Area Hospital
	Coffee and Networking session **All**
	Summary and Next Steps **Dr Jugdeep Dhesi** POPS Consultant, GSTT and POPS Network Clinical Lead
11:00	**CLOSE**

Housekeeping

Silence is golden, unless you want us to hear you

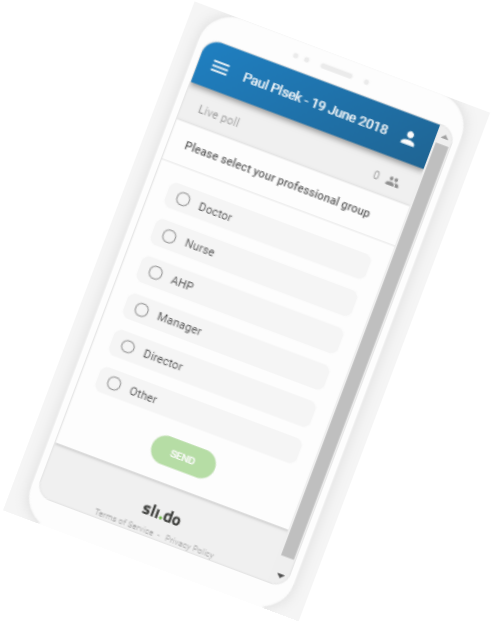
Please turn off your camera during presentations

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

No mic, feeling shy? Send us some chat

Give us a wave if you need to get our attention

sli.do

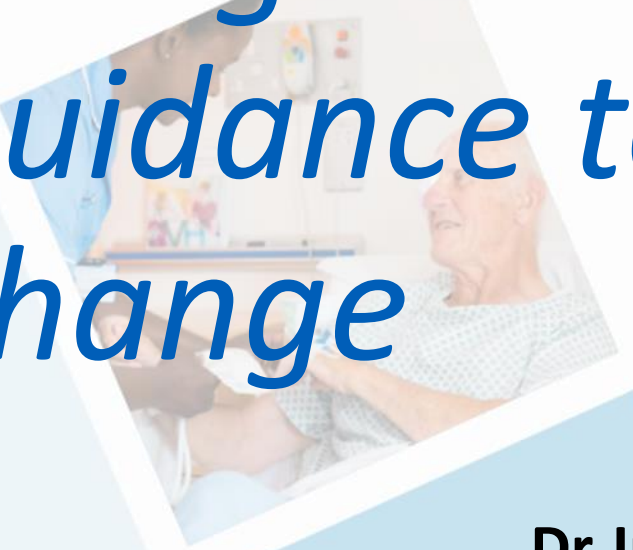


Scan the QR code below or open a browser on any laptop, tablet or smartphone and go to **www.sli.do**

And enter the event code **POPS3MAY**

Use the polls to give us feedback about the day

Using CPOC BGS Frailty guidance to support change



Dr Jude Partridge, POPS Consultant, GSTT

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

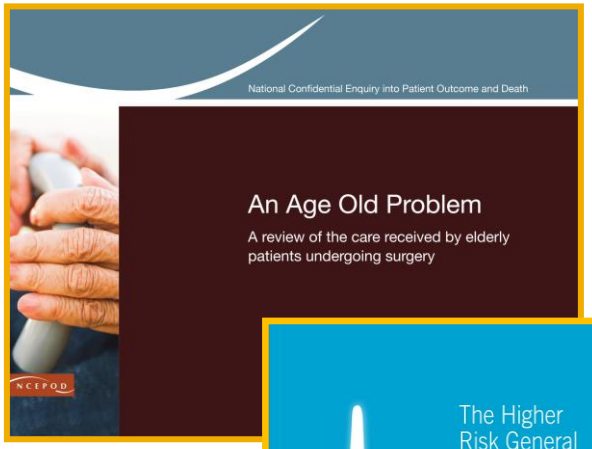
Jude Partridge
Geriatrician
Guy's and St Thomas' NHS Foundation Trust
Hon Senior Lecturer
King's College London

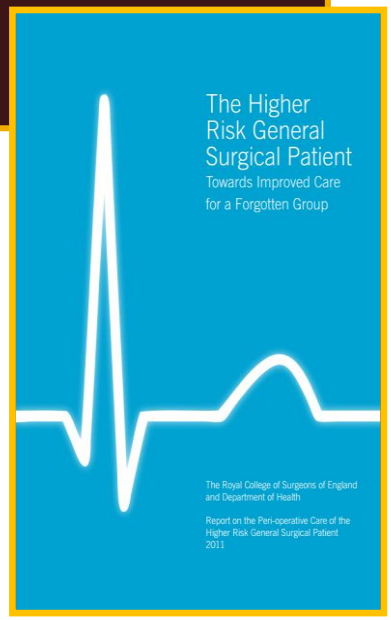
NHS
Guy's and St Thomas'
NHS Foundation Trust

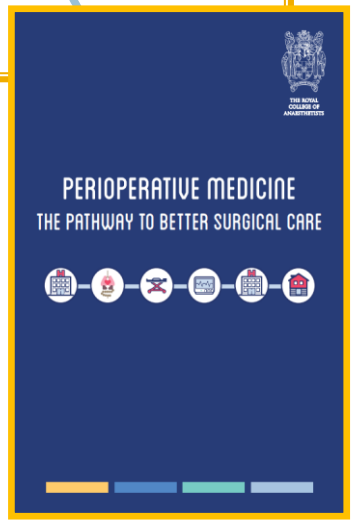
KING'S College LONDON

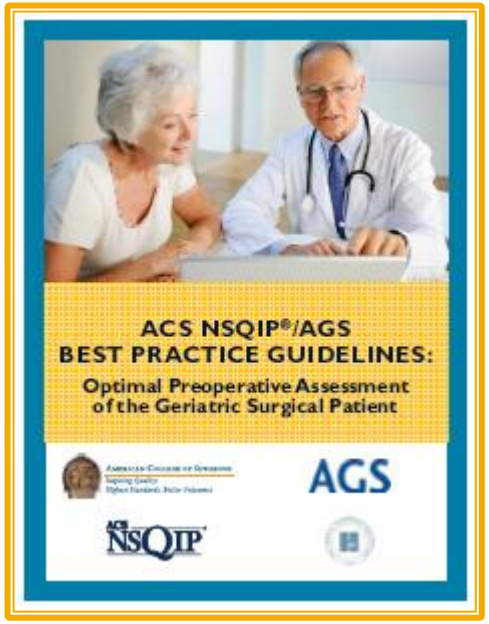
KING'S HEALTH PARTNERS

Reports and guidelines



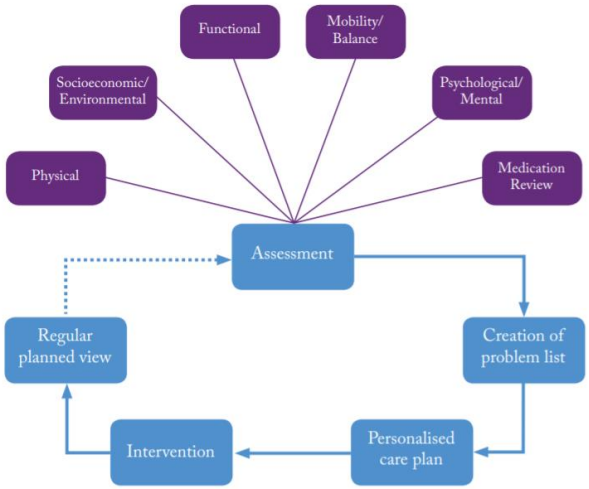






Advocating the use of Comprehensive Geriatric Assessment (CGA)

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



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

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

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

…in hip fracture…

Cochrane Library

Cochrane Database of Systematic Reviews

CGA in hip fracture results in;

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

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

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

8 RCTs comparing CGA with usual care

- 7 in hip fracture patients
- 1 in elective surgical oncology

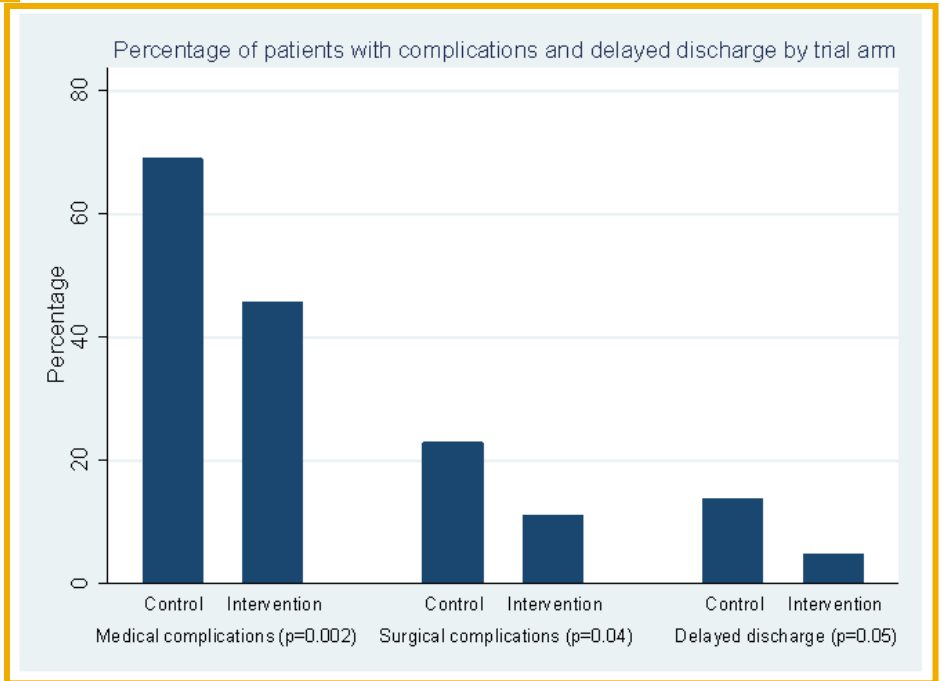
…in elective arterial surgery…

BJS

Randomized clinical trial

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

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



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

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

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

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

Affiliations + expand

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

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

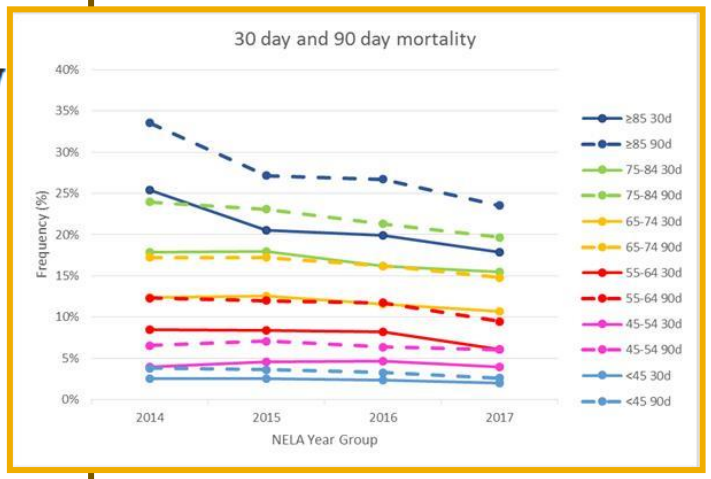
…also supported by big data studies…

EDITOR'S CHOICE

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

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

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



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

Postoperative geriatric medicine review was associated with substantially lower mortality in older patients

OR 0.35; 95% CI:0.29-0.42

…with cost effectiveness…

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

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

RESEARCH PAPER

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

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

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

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 after hip fracture showed reduced total cost

…acknowledging results are mixed

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

ORIGINAL PAPER

WILEY THE INTERNATIONAL JOURNAL OF CLINICAL PRACTICE

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

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

Original article doi:10.1111/codi.13785

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

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

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

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

Abstract

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

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

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

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

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

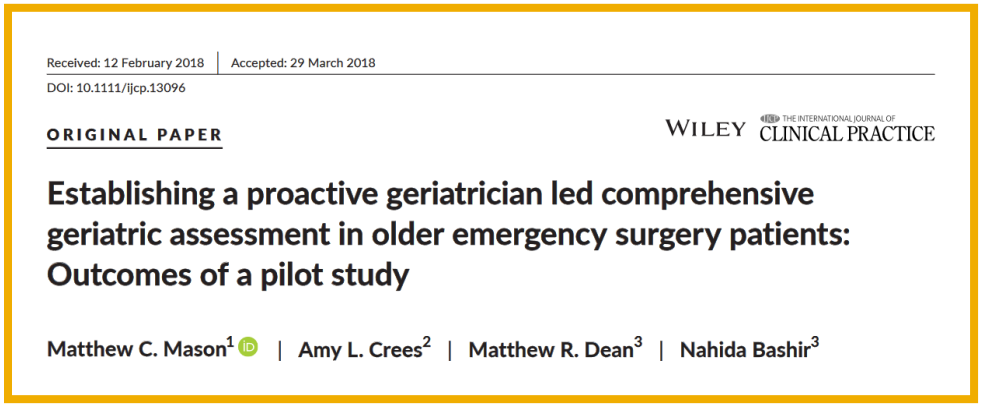
BMC Anesthesiology

RESEARCH ARTICLE Open Access

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

Aparna Saripella[1], Sara Wasef[1], Mahesh Nagappa[2], Sheila Riazi[1], Marina Englesakis[3], Jean Wong[1,4] and Frances Chung[1*]

…acknowledging results are mixed



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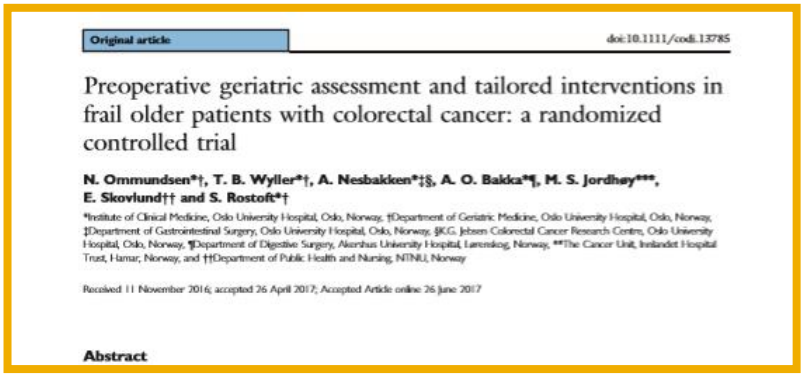

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doi:10.1111/codi.13785

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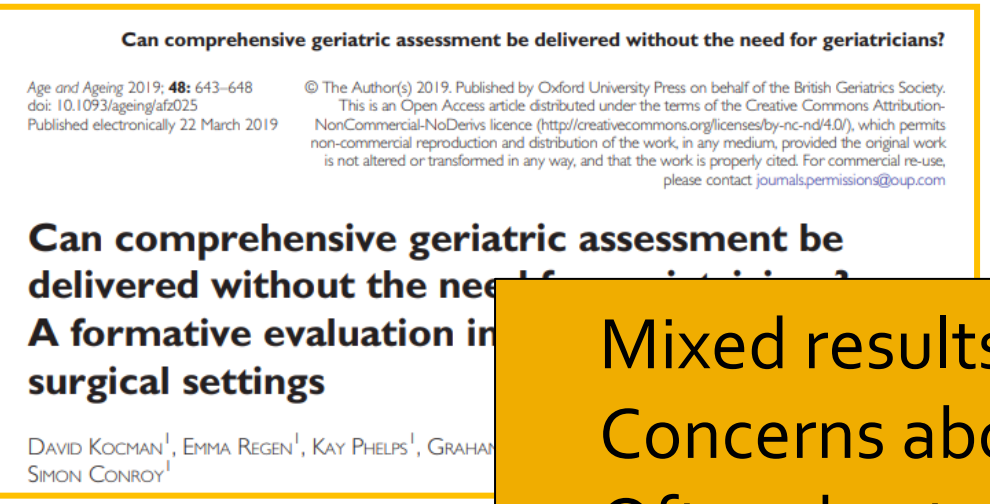

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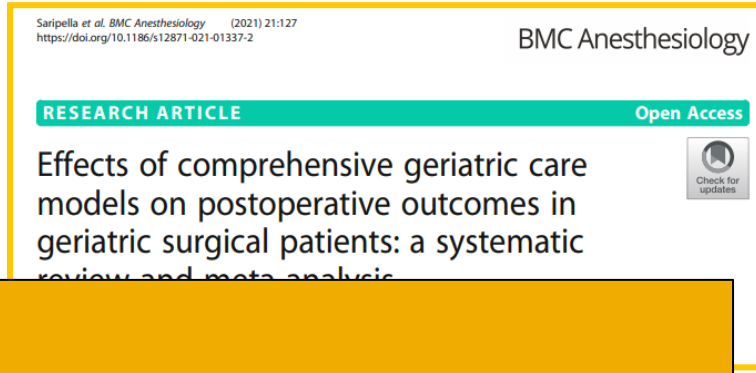


Saripella *et al. BMC Anesthesiology* (2021) 21:127
https://doi.org/10.1186/s12871-021-01337-2

BMC Anesthesiology

RESEARCH ARTICLE Open Access

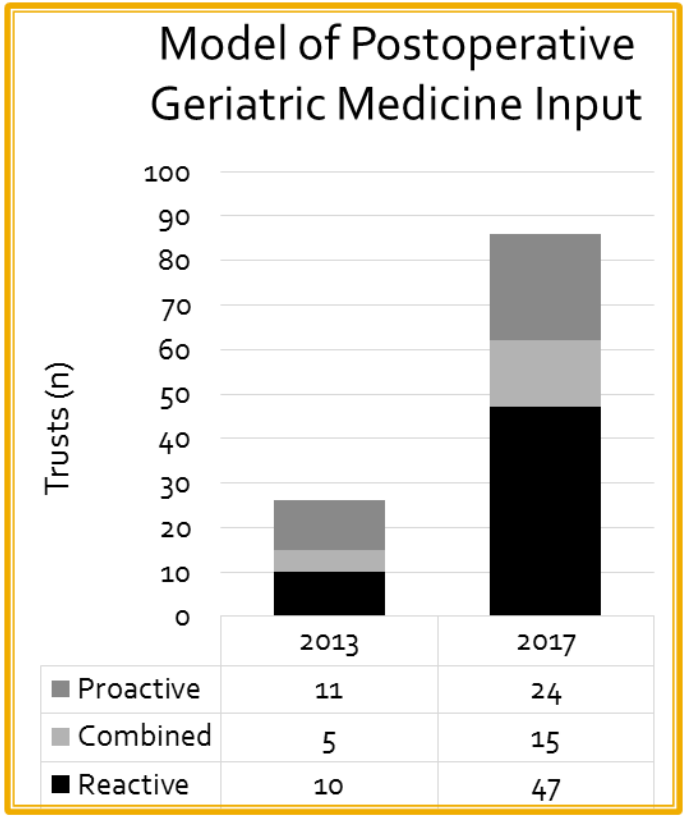
Check for updates

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

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

POPS services are being established

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



Joughin et al Age & Ageing 2019

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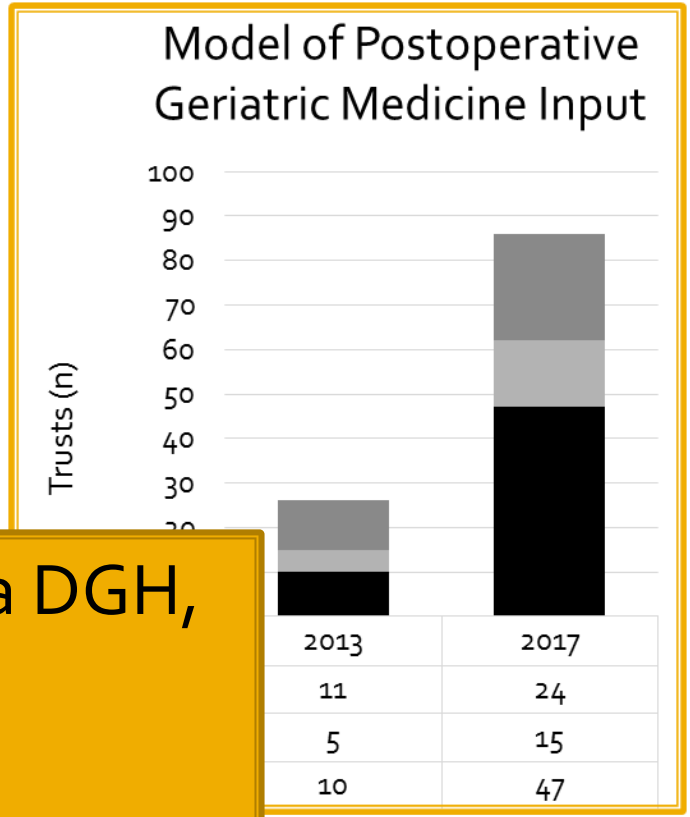


"we want to but it cant be done at a DGH, because we don't have…
- the workforce
- the money"

al Age & Ageing 2019

…at district general hospitals as well as at teaching hospitals

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

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

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

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

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

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

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

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

Affiliations + expand

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

Free PMC article

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

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

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

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

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

Affiliations + expand

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

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

Perioperative Medicine

RESEARCH Open Access

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

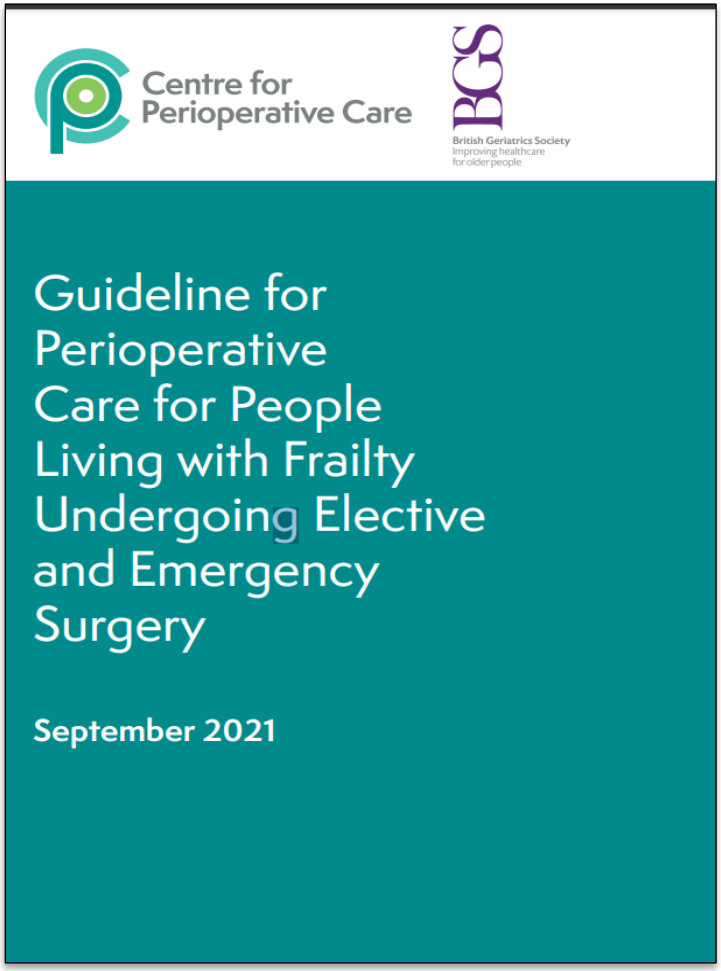
J. S. L. Partridge[1,2*], A. Rogerson[3], A. L. Joughin[4], D. Walker[5], J. Simon[6], M. Swart[7,8] and J. K. Dhesi[1,9]

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

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

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

…and now recommended by CPOC – BGS guidelines



BGS
British Geriatrics Society
Improving healthcare for older people

Centre for Perioperative Care

CPOC is a partnership between:

RCoA Royal College of Anaesthetists

Royal College of Surgeons ADVANCING SURGICAL CARE

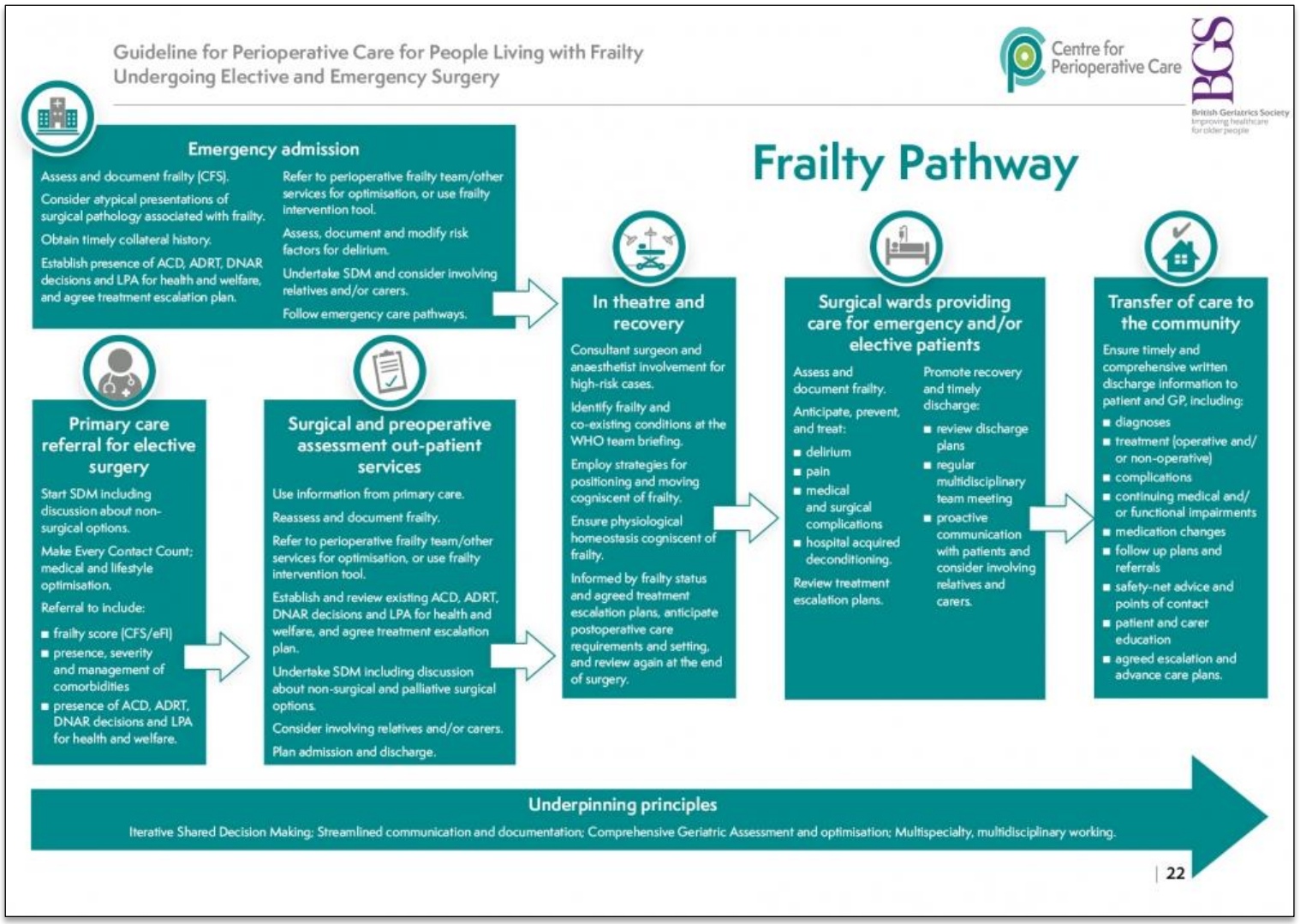
Royal College of Physicians

Royal College of Nursing

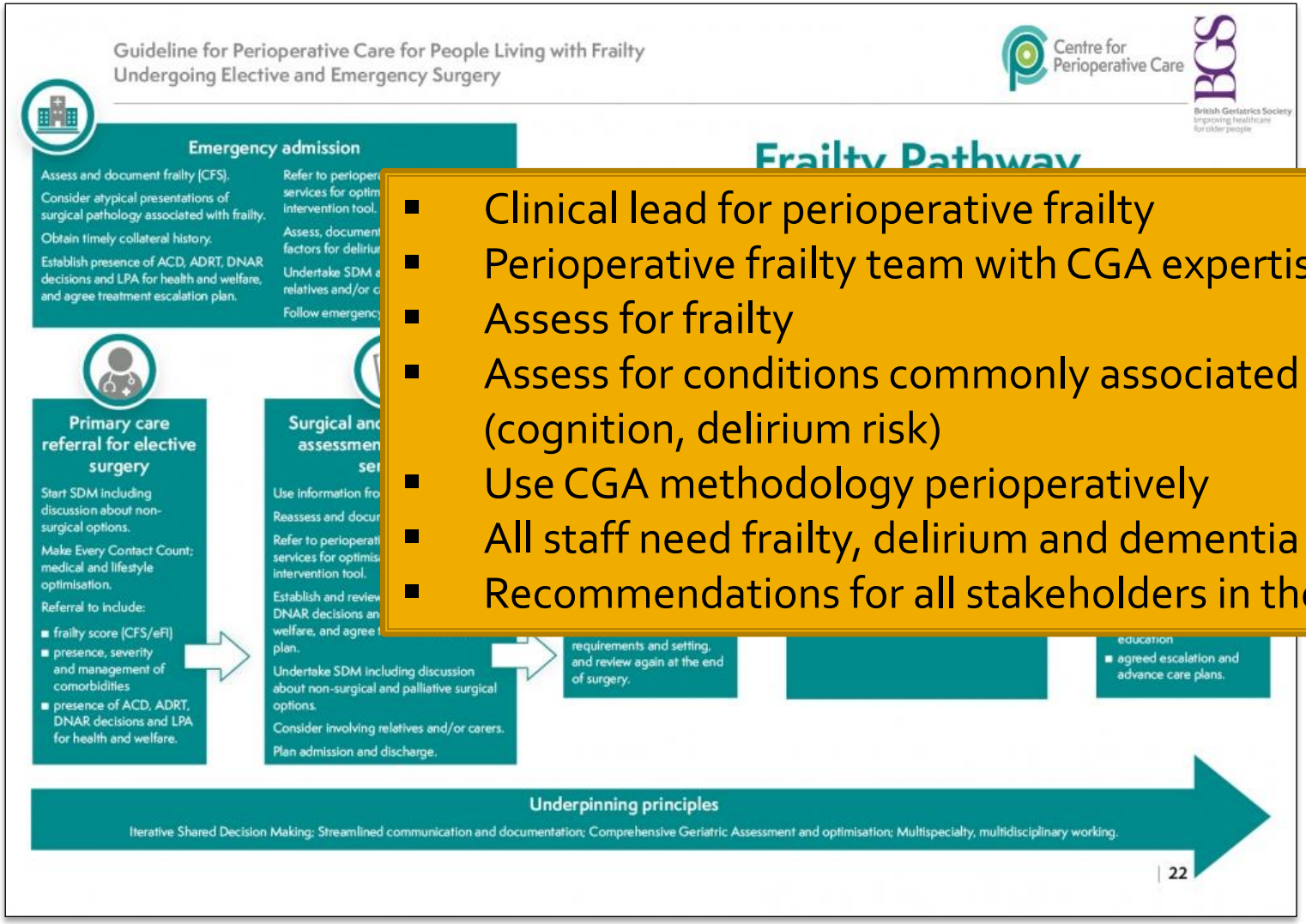
RCGP Royal College of General Practitioners

Association of Anaesthetists

CPOC – BGS perioperative frailty guideline



CPOC – BGS perioperative frailty guideline



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

Provides useful metrics

Recommendations for quality improvement and metrics

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

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

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

Metrics to support development of clinical pathway

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

Metrics to measure process

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

Provides useful metrics

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

Recommendations for quality i

The clinical lead for (perioperative) frailty should s
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Metrics to measure process

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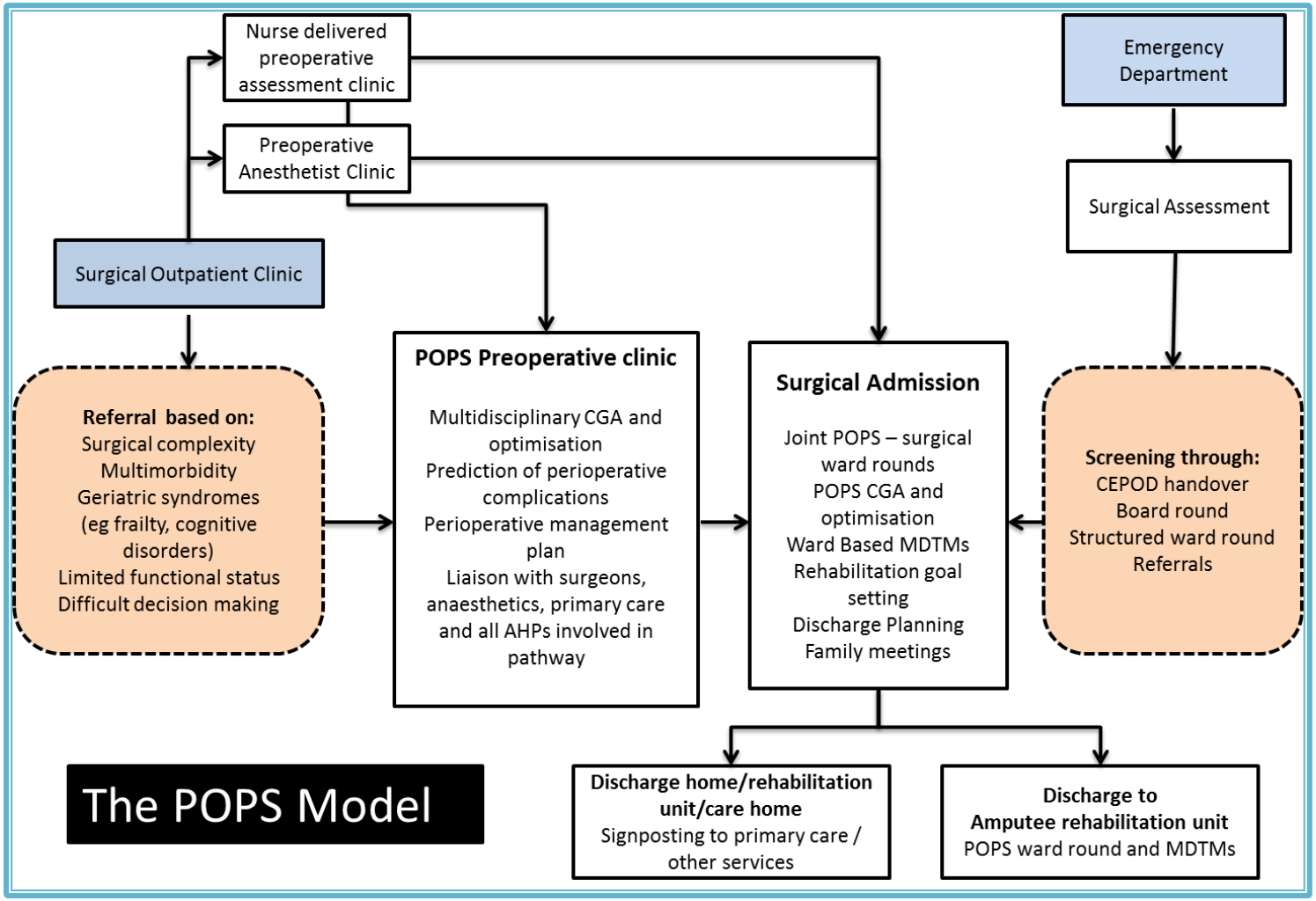
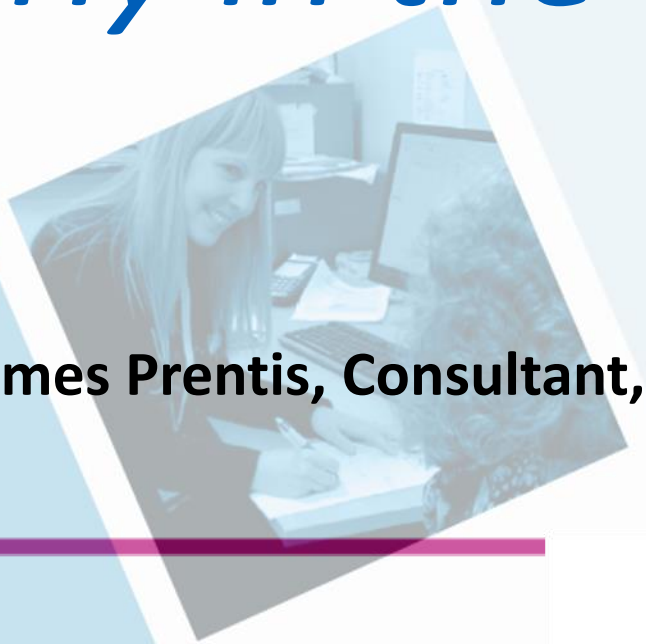
- Percentage of patients with LOS > 21 days with CFS≥5 (superstranded)
- Place of discharge from hospital

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

The POPS model



How to identify ‘at risk’ patients early in the pathway



Dr James Prentis, Consultant, Newcastle

NHS
North East and
North Cumbria

Waiting Well.

Tackling inequalities by supporting our patients to prepare for surgery and improving their wellbeing.

NHS
North East and North Cumbria

How it all began…

Long waiting times for surgery as a result of the pandemic.

77,000 priority 4
21,000 in deciles 1 and 2.

Most vulnerable communities most adversely affected.

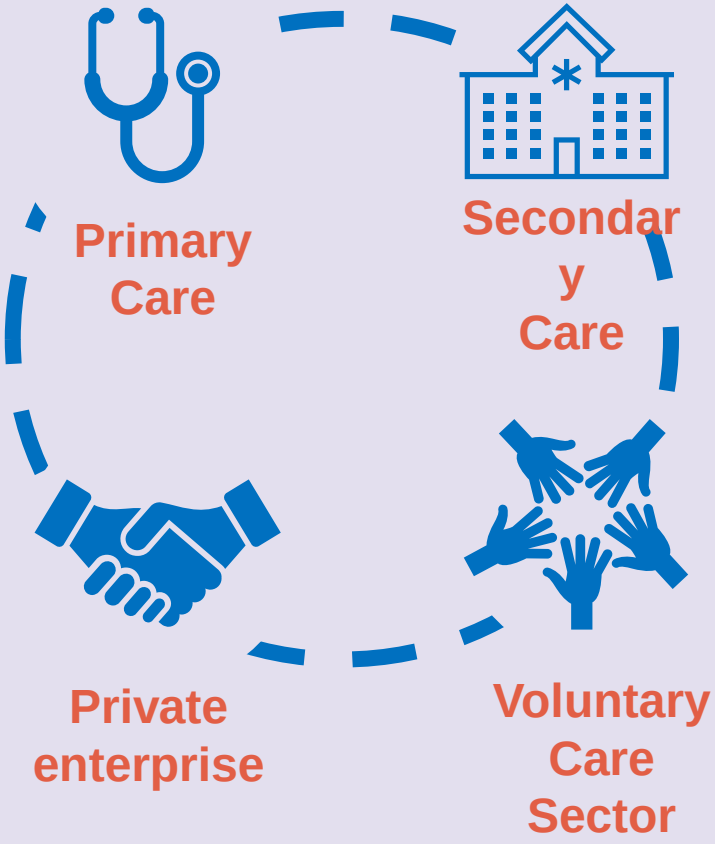
Patients need support to prepare for their surgery.

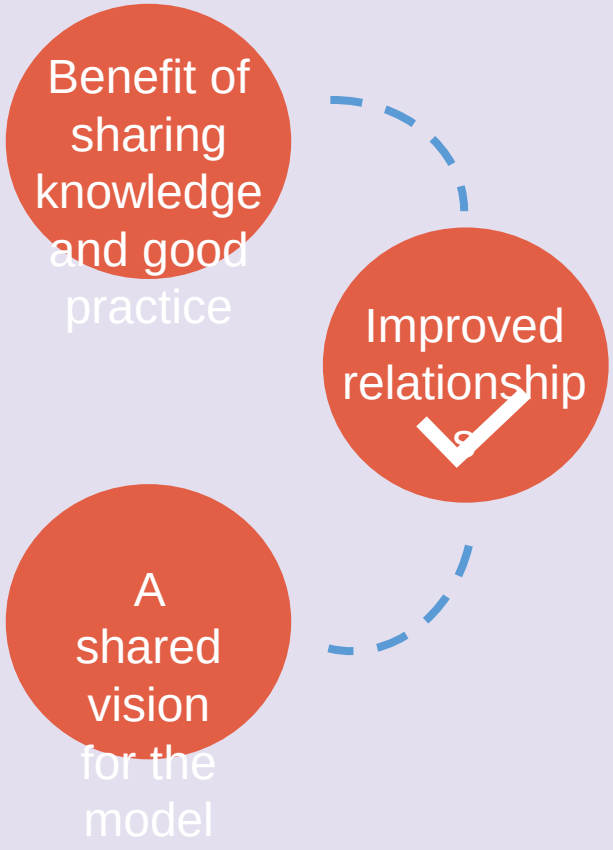
Lots of evidence.

Some work in patches across the ICB, but lack of a united approach.

NHS
North East and North Cumbria

Working together





NHS
North East and
North Cumbria

Investment

£7.4 million investment*

Over 3 years

* [£3million NECS Transformation Fund + £4.4 million from the Health Inequalities National Funding]

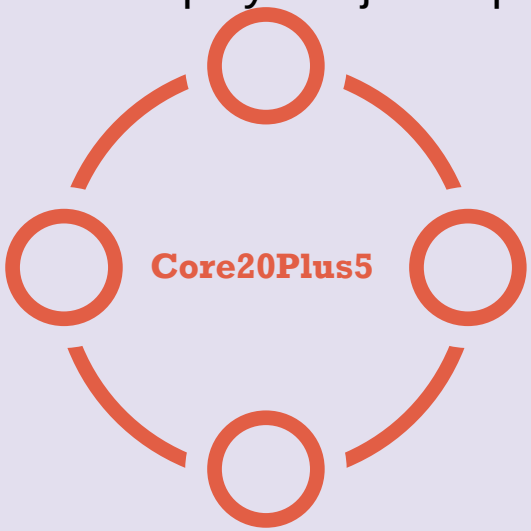
NHS
North East and
North Cumbria

The principles

Level up

To provide equity not just equality.

Integrate.
Not duplicate.



Evidence-based

Add value

NHS
North East and North Cumbria

Waiting Well NENC ICB Approach

ICB Level

Risk Stratification Dashboard

- Deciles 1 & 2
- Learning difficulties
- Ethnicity
- Diabetes
- Smokers

Central Hub assertive outreach

Place-based

Personalised Care Assessment

Including PAMS for those who need it.

Complex
Bespoke offer and intensive support for individuals.

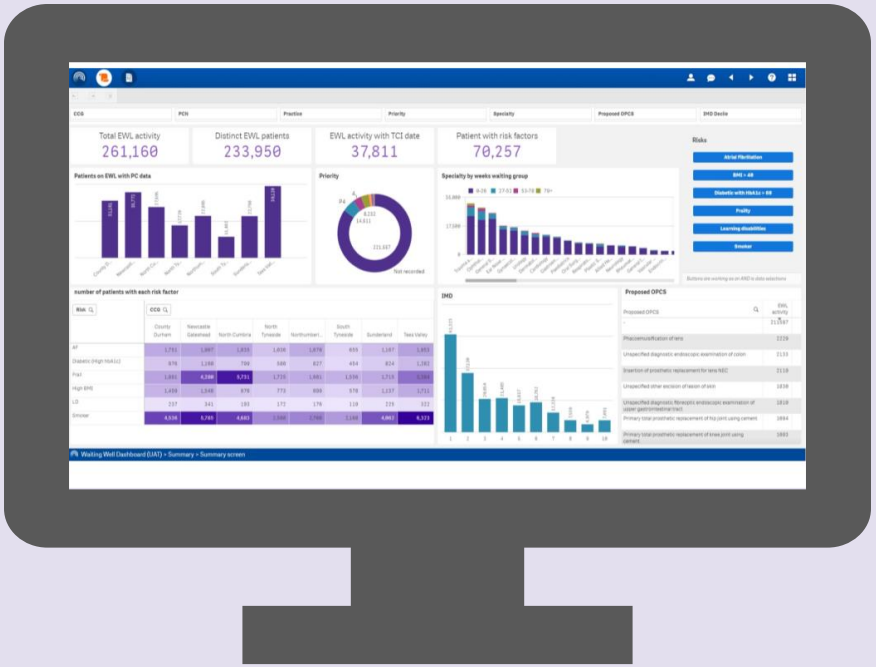
Targeted
Risk factor /procedure specific – delivered through local services and digital support.

Universal
Generic offer for digitally able and more motivated individuals.

NHS
North East and
North Cumbria

Risk stratification – and how it works

- Use of dashboard data showing waiting list data.
- Identify and target patients based on conditions.
- Innovative use of data to identify patients who will benefit the most.



NHS
North East and
North Cumbria

Importance of integration with primary care data to achieve goals

- Vast majority of issues are known but not available to the multidisciplinary team within the secondary care setting.
- Built confidence with primary care to allow data sharing to aid elective recovery process.
- Ensure we work together to solve the issues our shared patients are facing.
- Reduce reliance on primary care to solve issues at the last minute prior to surgery when the patient has been potentially waiting a year for surgery.

NHS
North East and North Cumbria

Impact of social deprivation on the elective surgical waiting list and preoperative comorbidities in the North East North Cumbria region.

Category	Patients from Most Deprived Quintile	Other Patients	Significance P<0.01
Number on Waiting list	27,237 (31.6%)	58,826 (68.4%)	-
Atrial Fibrillation	1,015 (3.7%)	2,985 (5.1%)	**Lower**
COPD	1,360 (5.0%)	1,556 (2.6%)	**Higher**
Type II Diabetes	3,160 (11.6%)	5,375 (9.1%)	**Higher**
Hypertension	5,443 (20.0%)	10,860 (18.5%)	**Higher**
Unmanaged Hypertension	281 (1.0%)	553 (0.9%)	**Same**
Learning Disability	153 (0.6%)	120 (0.2%)	**Higher**
Serious Mental Illness	645 (2.4%)	823 (1.4%)	**Higher**
BMI 30+	8,108 (29.8%)	13,831 (23.5%)	**Higher**
BMI 35+	4,294 (15.8%)	6,244 (10.6%)	**Higher**
Current Smoker	6,337 (23.3%)	6,732 (11.4%)	**Higher**
Type II Diabetes with Hba1c between 54 and 68	973 (3.6%)	1,747 (3.0%)	**Higher**
Type II Diabetes with Hba1c > 69	742 (2.7%)	1,083 (1.8%)	**Higher**
No Risk Factors	12,848 (47.2%)	35,513 (60.4%)	**Lower**
One Risk Factor	6,169 (22.6%)	9,016 (15.3%)	**Higher**
Two Risk Factors	4,683 (17.2%)	8,907 (15.1%)	**Same**
Three Risk Factors	2,473 (9.1%)	3,938 (6.7%)	**Higher**
Four Risk Factors	830 (3.0%)	1,161 (2.0%)	**Higher**
Five or More Risk Factors	234 (0.9%)	291 (0.5%)	**Same**

NHS
North East and
North Cumbria

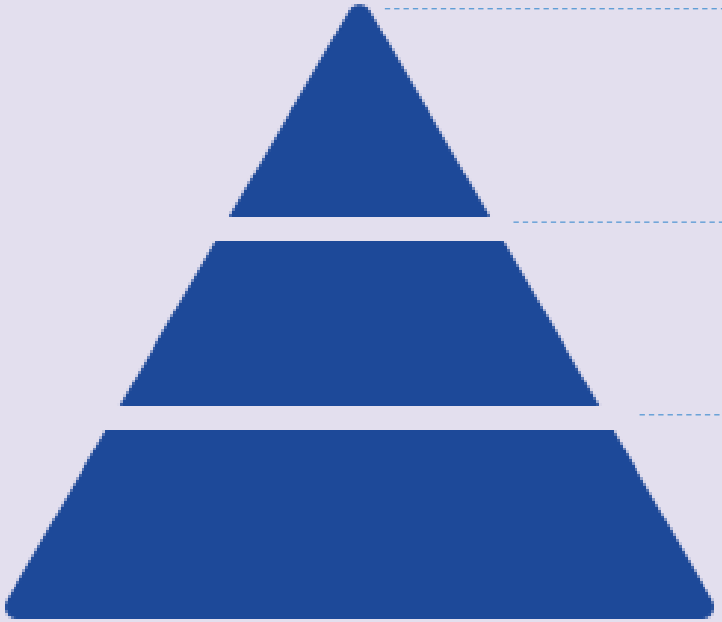
The Central Hub

- To get the right patients to the locality teams.
- An assertive outreach approach.

- Initial letter
- Follow-up phone call
- Appointment for assessment

NHS
North East and
North Cumbria

A tiered offer



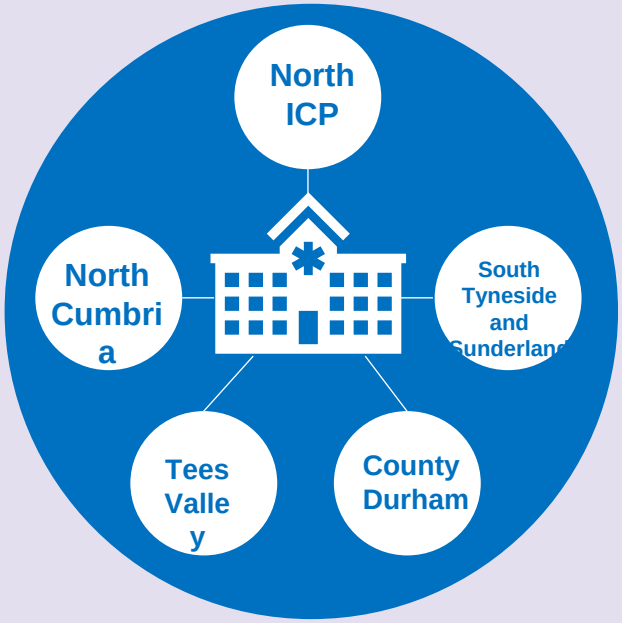
Complex
Most intensive support for patients with most complex needs.

Targeted
Link in with local services, groups, digital health coaching etc.

Universal
Generic offer for all digitally-enabled pre-operative
patients with general educational website.

NHS
North East and North Cumbria

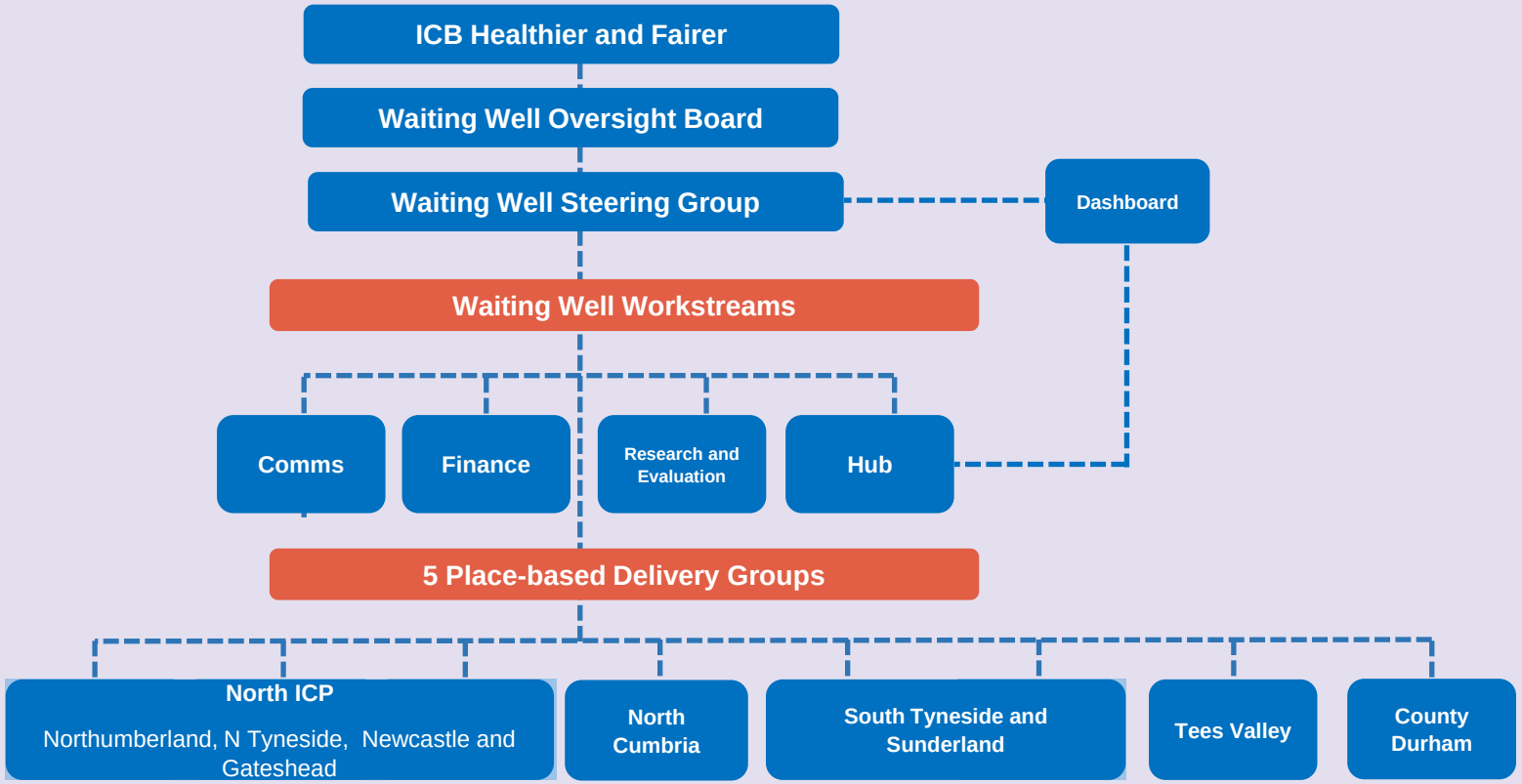
Place-based support offer



- Patient led conversation to establish what is important to them.
- Work with the patient to identify a plan of support.
- Provide a tiered offer of support that can be matched to the patients level of need.
- The programme considers mental health and wellbeing, social situation, as well as physical factors.

NHS
North East and North Cumbria

Programme governance



NHS
North East and North Cumbria

North ICP Waiting Well offer

- The North ICP Waiting Well Hub supports patients across Newcastle, Gateshead, North Tyneside and Northumberland.
- Patients undergo a holistic needs assessment with a Health Improvement Practitioner or Social Prescribing Link Worker, and a support plan is developed based upon what matters most to the patient.
- In addition to 1:1 support and signposting to local services, patients may also be offered referral into the following bespoke interventions:
    - Tailored diabetes support
    - Support for patients on high dose opioids
    - Obesity interventions (public health referrals)
    - Smoking Cessation (with an additional e-cigarette offer)

A Waiting Well case study

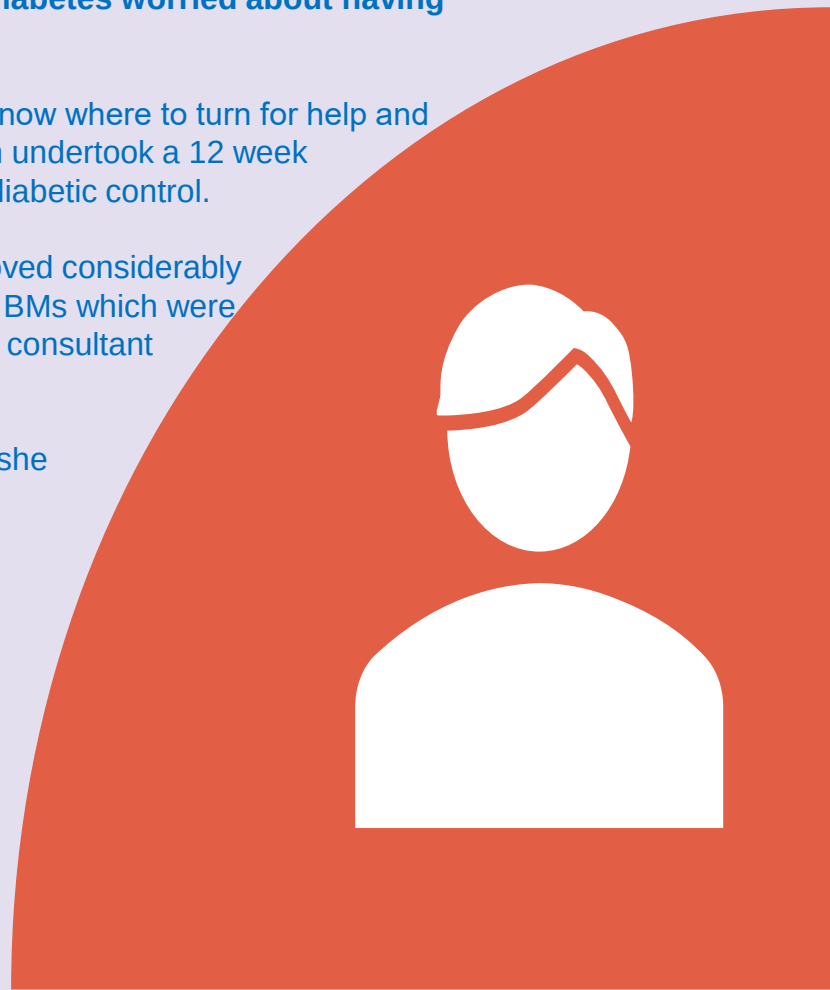
Building confidence and living a better life

Struggling with weight gain, breathing issues and uncontrolled diabetes worried about having surgery for a FESS to aid in her breathing issues.

She was having difficult walking as felt breathless all the time. Didn't know where to turn for help and knew she was about be to started on insulin. The waiting well program undertook a 12 week educational and support intervention for weight loss and improve her diabetic control.

She was able to lose 7 kg in weight and her diabetic control had improved considerably with her HbA1c reducing from 133 to 87. She was monitoring her own BMs which were running over 20 and now it was unusual to be over 10. Her respiratory consultant also found her lung function tests had improved.

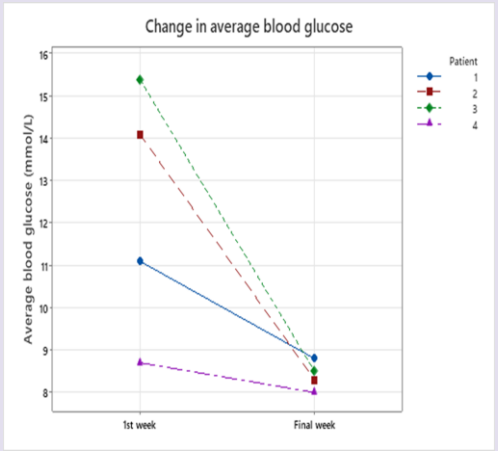
She felt so good with her breathing and walking that she decided that she now did not want to undergo surgery as she felt there was no need to undergo the operation.



A Waiting Well case study

Early diabetes interventions results

Patient	Length of intervention (days)	Time in Range BM 3.9-10mmol/l (%)		Time very high BM 10-13.9 (%)		Time high BM >13.9mmol/l (%)		Average blood glucose (mmol/L)		HbA1c (mmol/mol)	
		1st week	Final week	1st week	Final week	1st week	Final week	1st week	Final week	Closest to start of intervention	Estimated from final 2 weeks
1	69	41	71	19	4	40	25	11.1	8.8	102	54
2	77	31	74	43	4	26	22	14.1	8.3	101	57
3	54	0	83	71	0	29	17	15.4	8.5	106	54
4	17	89	91	1	0	16	9	8.7	8	70	51
Mean	54.25	40.25	79.75	33.5	2	27.75	18.25	12.325	8.4	94.75	54



Craigavon Area Hospital – ‘Our Measurement Journey’

DR MICHAEL MAGEE

Background

- 2 geriatricians appointed to CAH in Sept 2021

- Total of 4 PAs incorporated into job plan to develop a POPS service

- early discussions with surgical colleagues agreed to use the ESU as a PILOT ward

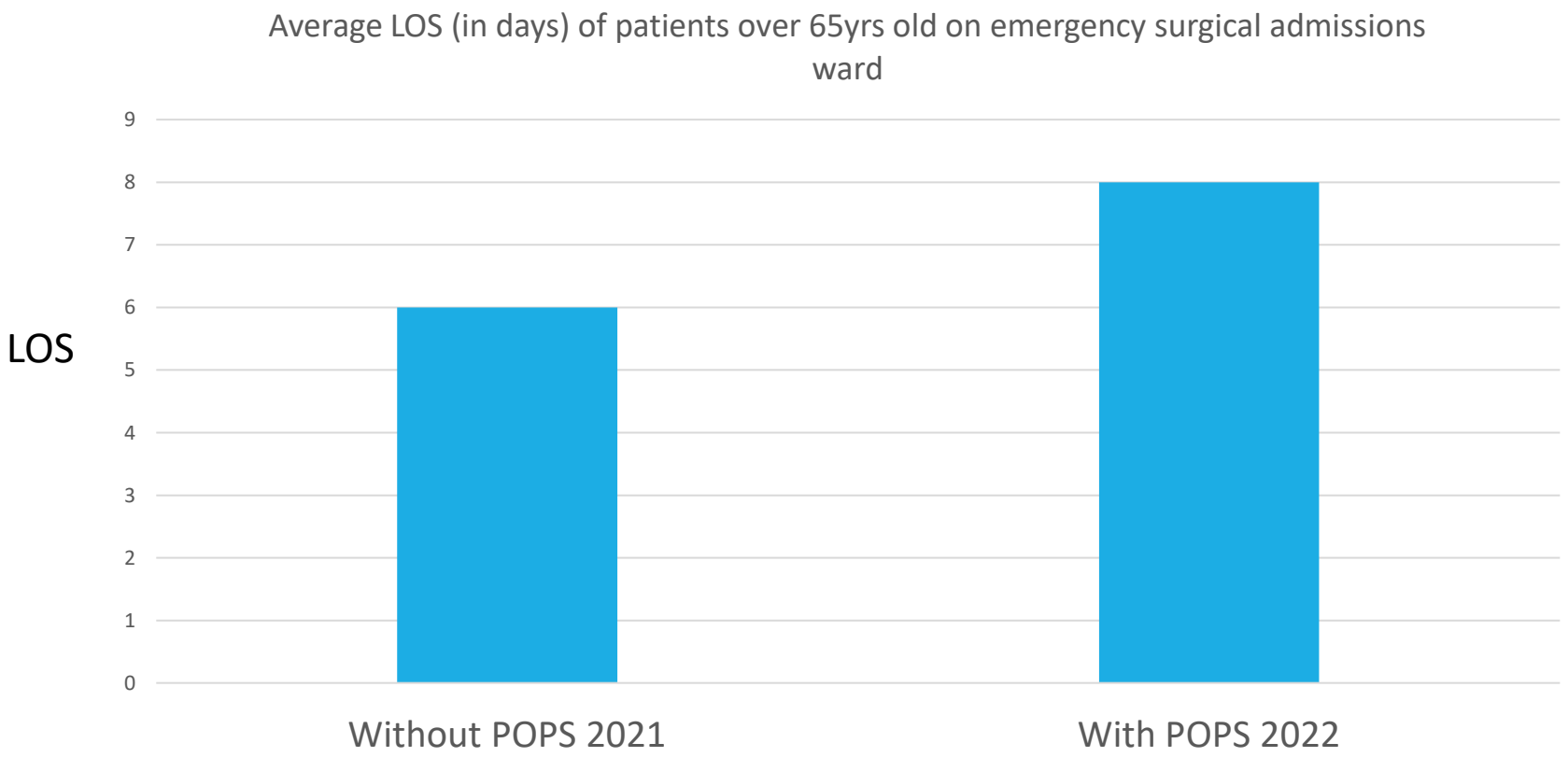
- target all over 65 to be screened for frailty and referred for CGA if CFS >5

NB

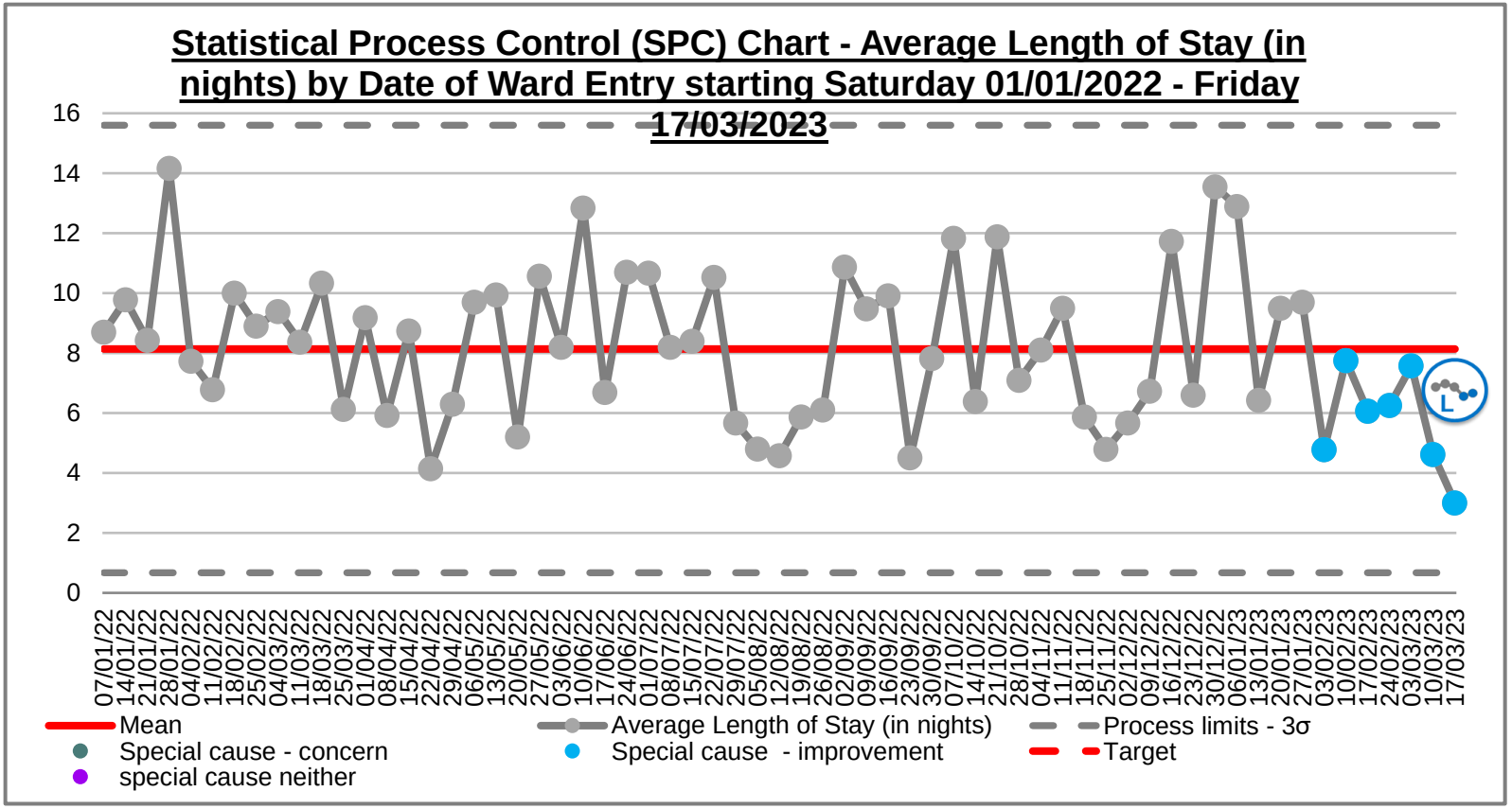
- No electronic notes or recording of frailty score

- Northern Ireland not part of NELA

How do we go from this…



To this…


Statistical Process Control (SPC) Chart - Average Length of Stay (in nights) by Date of Ward Entry starting Saturday 01/01/2022 - Friday 17/03/2023
16
14
12
10
8
6
4
2
0
07/01/22
14/01/22
21/01/22
28/01/22
04/02/22
11/02/22
18/02/22
25/02/22
04/03/22
11/03/22
18/03/22
25/03/22
01/04/22
08/04/22
15/04/22
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28/10/22
04/11/22
11/11/22
18/11/22
25/11/22
02/12/22
09/12/22
16/12/22
23/12/22
30/12/22
06/01/23
13/01/23
20/01/23
27/01/23
03/02/23
10/02/23
17/02/23
24/02/23
03/03/23
10/03/23
17/03/23
Mean
Average Length of Stay (in nights)
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target
special cause neither

Baseline practice – 4North

Approx. 65patients per month admitted to 4N under a surgical team aged over 65

(although we have recently shown this continues to increase)

Work we have done would suggest between 40 and 50% of these patients are living with frailty

BUT…

When audited

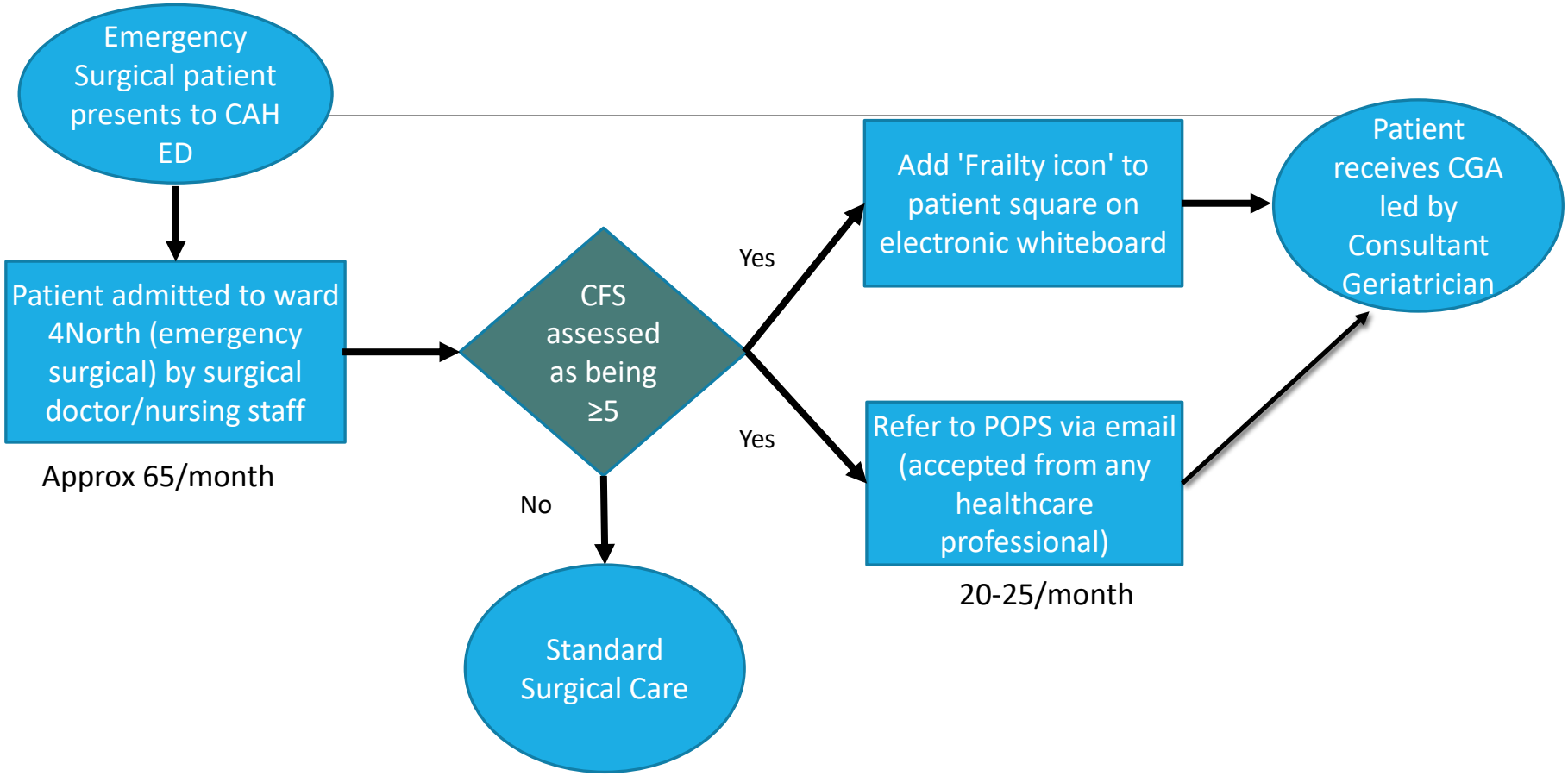
0/15 had Clinical Frailty Score

1/15 had been screened for delirium

1/15 had been seen by a geriatrician

1/15 had Delirium Bundle commenced

Our Pathway Map



NB. CFS(Clinical Frailty Score), CGA (Comprehensive Geriatric Assessment

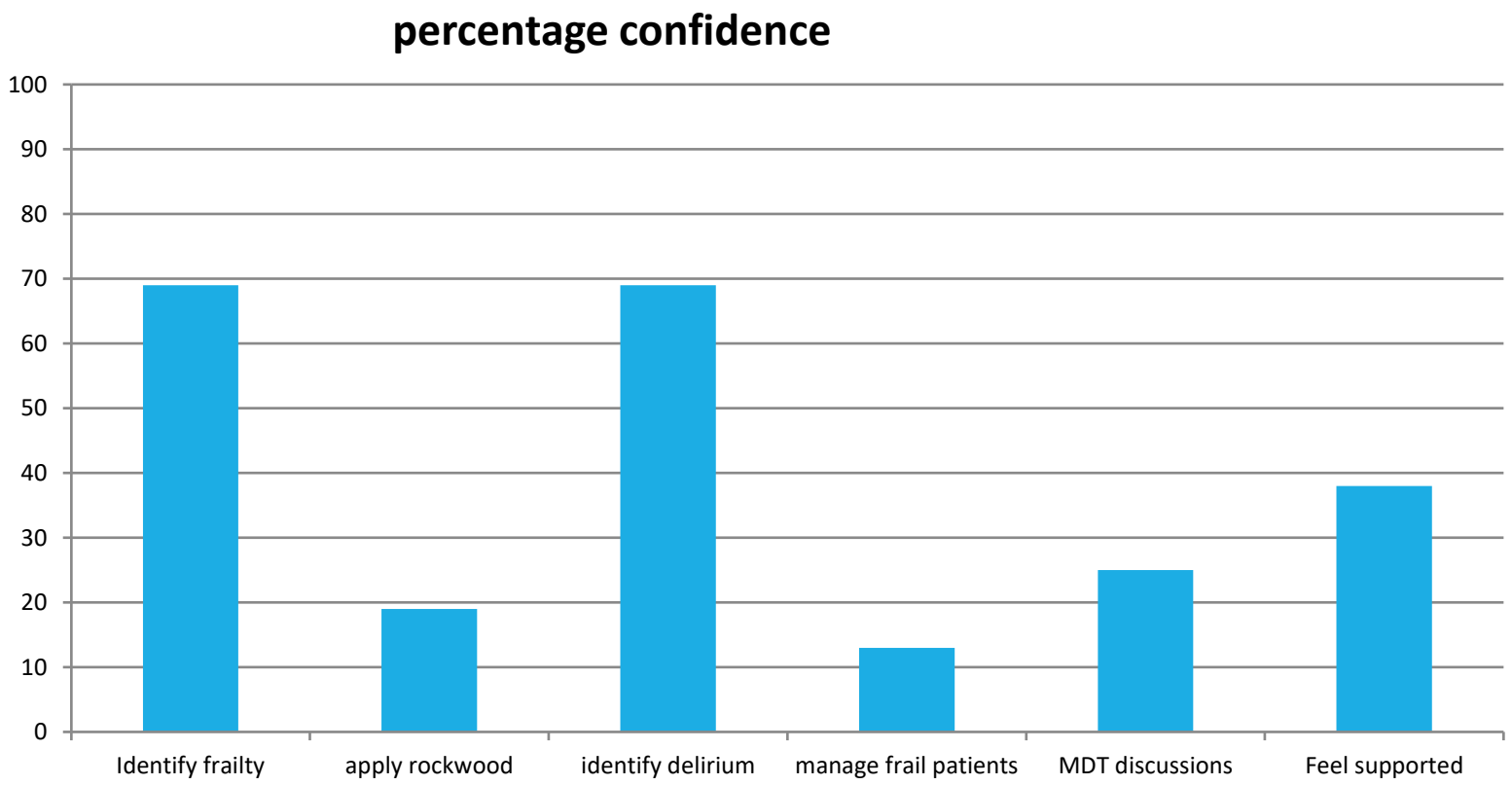
Driver Diagram

Aim

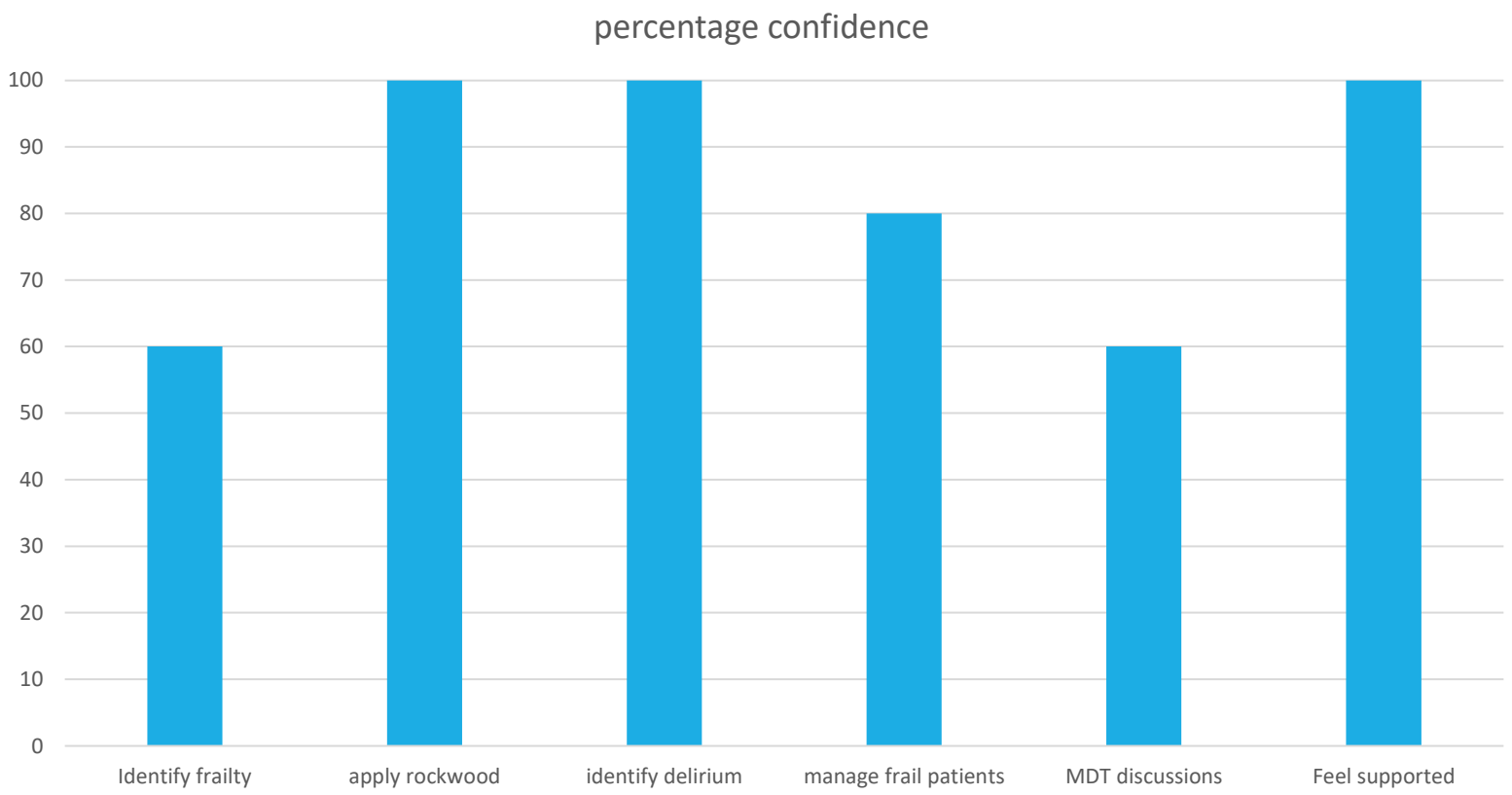
To ensure that all patients over 65 admitted to 4 North and living with frailty receive high quality comprehensive geriatric assessment

Primary Drivers	Secondary Drivers	Change Ideas
Feedback from POPS team is communicated clearly to MDT and referring medical team	POPS proforma designed	
	Consultant attendance at MDT	
Patients over 65 are screened for frailty using the Rockwood Clinical Frailty Score	Confidence in applying Rockwood CFS	Education sessions on Rockwood CFS
	Admitting doctor record frailty score on admission document	
	Nurses record CFS on nursing admission	
	Foundation doctors screen patients for frailty	Foundation POPS Champion
POPS team are available to see patient within a timely manner	4 Afternoons a week only/other consultant commitments	
	No weekend cover	
	No junior doctor medical staff	
	Annual Leave Cover	
Availability of Multidisciplinary Team	Hospital pressures and covering other patients	
	Consistent ward cover for PT and OT	
	SW availability for MDT considering cross ward cover	
Patients are referred to POPS team within a timely manner	Define criteria for referral – over 65 and frailty score greater than or equal to 5	Doctors refer via single point of contact email
		Nurses refer by adding frailty icon to whiteboard

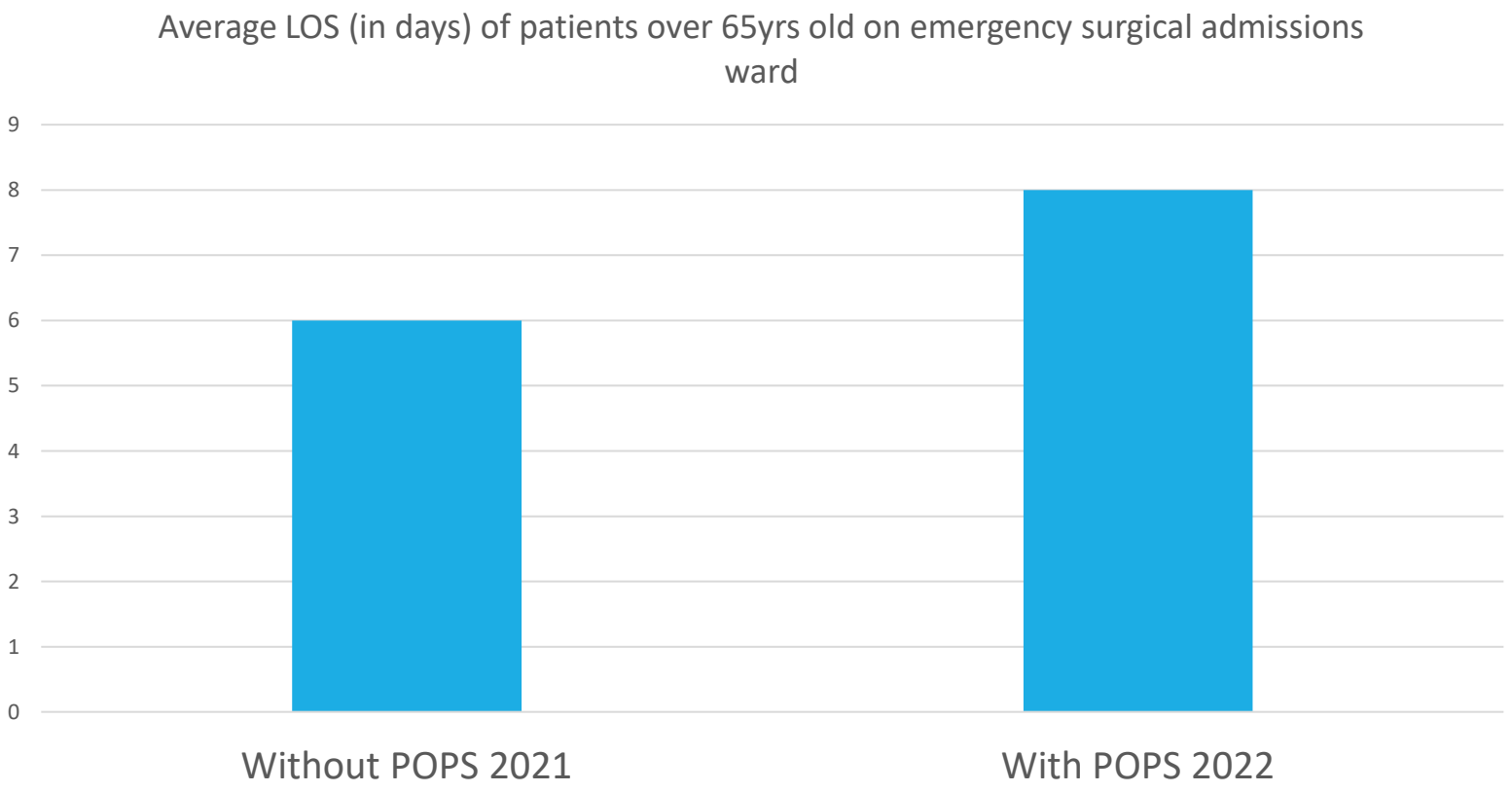
Foundation doctor survey 5.11.21 (Pre-POPS)



Foundation team survey 30/03/22 (Post-POPS)



Average LOS pre and post POPS



My Baseline Data Conundrum

If nobody has ever screened for frailty, and we are only targeting people living with frailty how will we ever analyse ‘like for like’?

My options :-

1. Massive retrospective data collection, with notes review and estimate likely frailty status
2. Use a second surgical ward without POPS input as a control group – manual data collection with regular auditing
3. Speak with Alice before doing anything rash

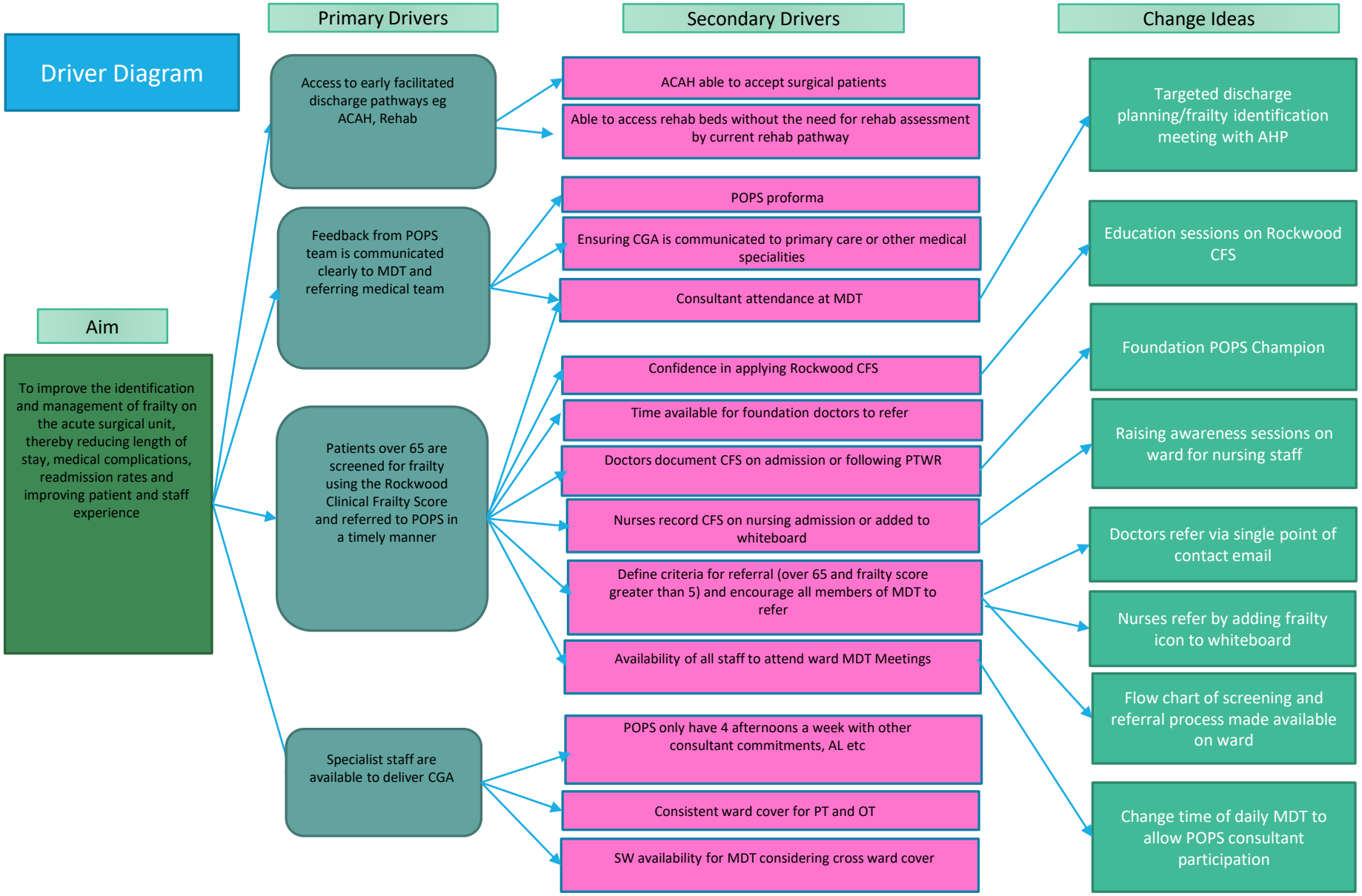
Alice’s Advice

- Stop

- Why do you need it?

- Review driver diagram

- Get a data analyst


Driver Diagram
Primary Drivers
Secondary Drivers
Change Ideas
Aim
To improve the identification and management of frailty on the acute surgical unit, thereby reducing length of stay, medical complications, readmission rates and improving patient and staff experience
Access to early facilitated discharge pathways eg ACAH, Rehab
Feedback from POPS team is communicated clearly to MDT and referring medical team
Patients over 65 are screened for frailty using the Rockwood Clinical Frailty Score and referred to POPS in a timely manner
Specialist staff are available to deliver CGA
ACAH able to accept surgical patients
Able to access rehab beds without the need for rehab assessment by current rehab pathway
POPS proforma
Ensuring CGA is communicated to primary care or other medical specialities
Consultant attendance at MDT
Confidence in applying Rockwood CFS
Time available for foundation doctors to refer
Doctors document CFS on admission or following PTWR
Nurses record CFS on nursing admission or added to whiteboard
Define criteria for referral (over 65 and frailty score greater than 5) and encourage all members of MDT to refer
Availability of all staff to attend ward MDT Meetings
POPS only have 4 afternoons a week with other consultant commitments, AL etc
Consistent ward cover for PT and OT
SW availability for MDT considering cross ward cover
Targeted discharge planning/frailty identification meeting with AHP
Education sessions on Rockwood CFS
Foundation POPS Champion
Raising awareness sessions on ward for nursing staff
Doctors refer via single point of contact email
Nurses refer by adding frailty icon to whiteboard
Flow chart of screening and referral process made available on ward
Change time of daily MDT to allow POPS consultant participation

New measures

Outcome

- Length of stay
- Readmission rates
- Medical complications
- Patient and staff experience

Process

- Number of patients receiving CGA
- Number of patients with frailty icon

Balance

- Number of additional investigations or referrals

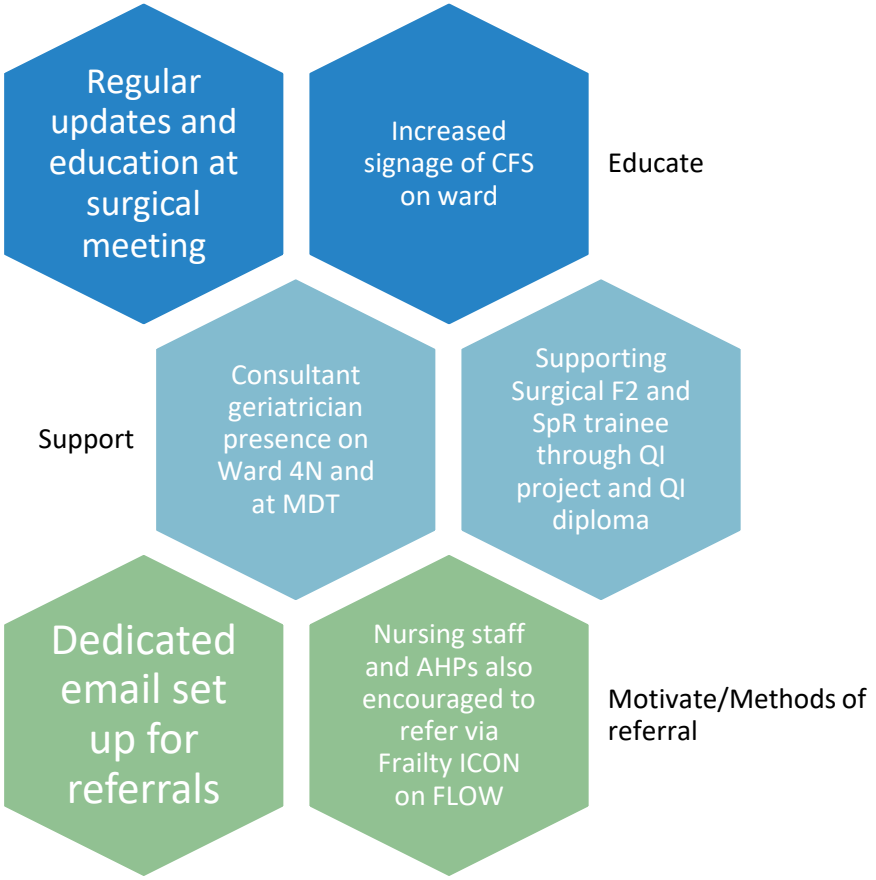
Primary and Secondary Frailty ICD Codes

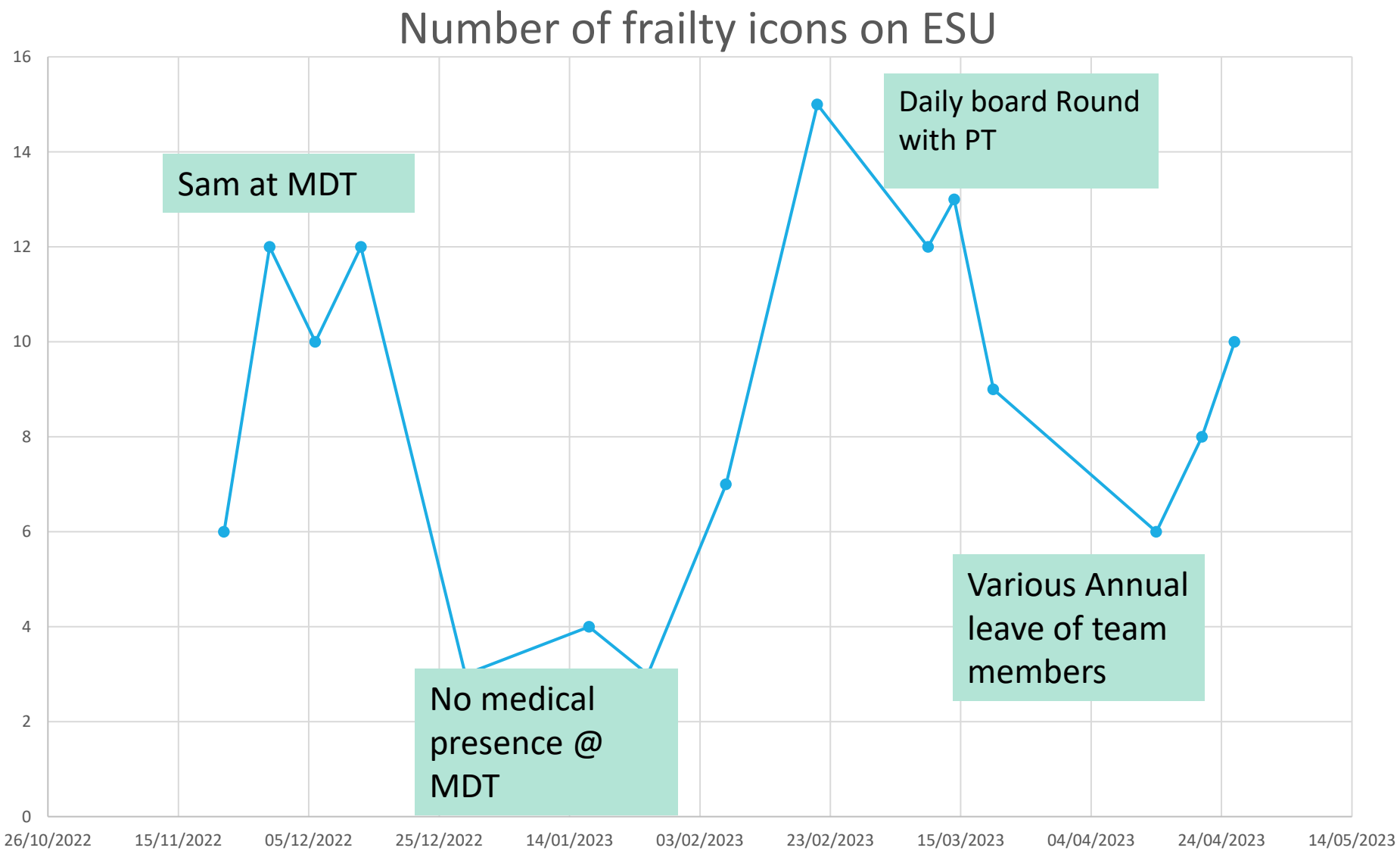
Using the Primary and Secondary Frailty Codes from the Hospital Frailty Risk Score our Information Analyst conducted a retrospective analysis of frailty identification on Ward 4N (ESU) before and after our pilot commenced.

For period 01/05/2021 – 31/07/2021 - out of the 213 inpatient admissions, 31 **(14.6%)** had one of the Frailty ICD Code(s).

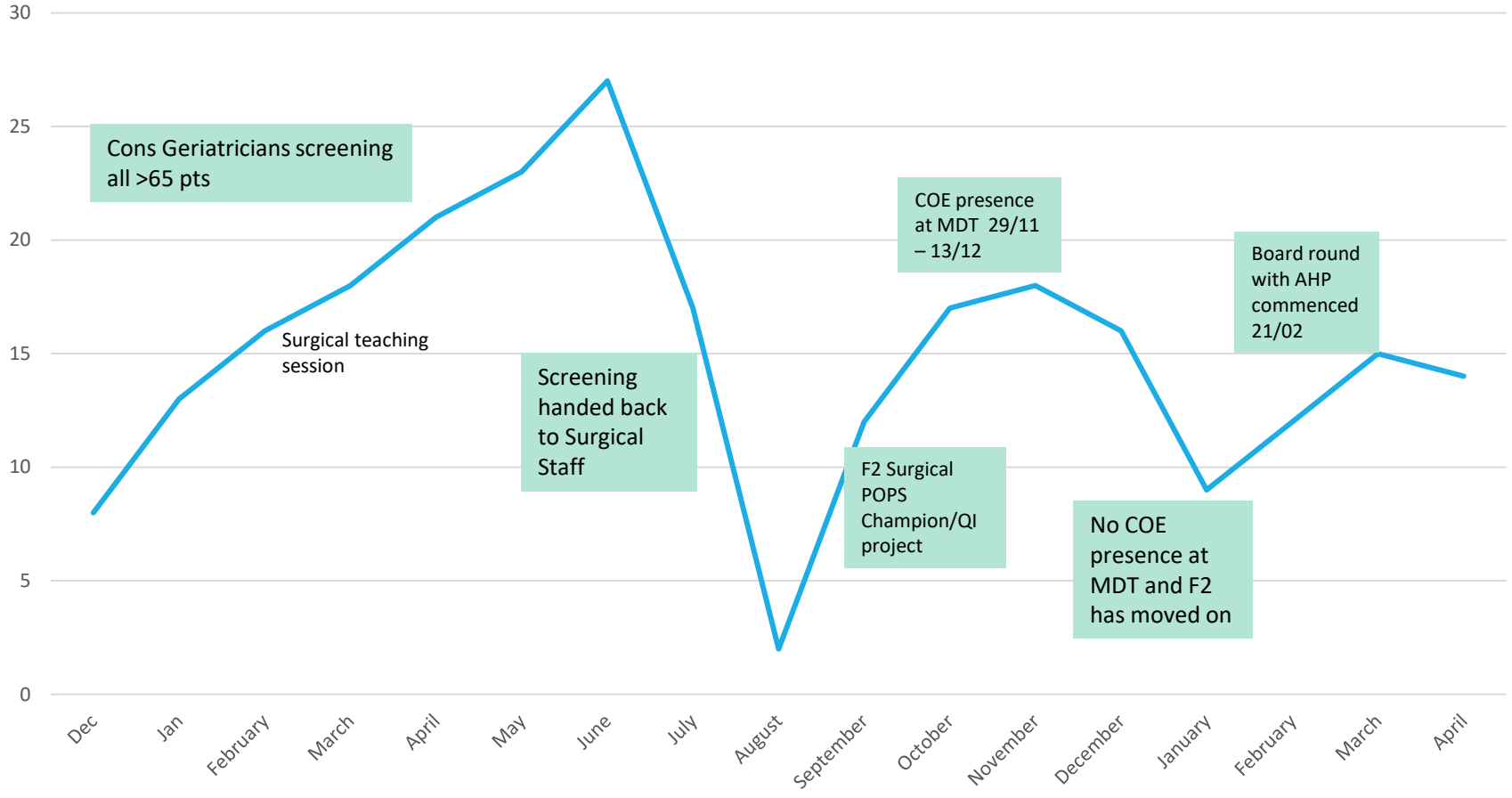
For period 01/09/2022 – 30/11/2022 - out of the 189 inpatient admissions, 38 **(20.1%)** had one of the Frailty ICD Code(s).

Interventions

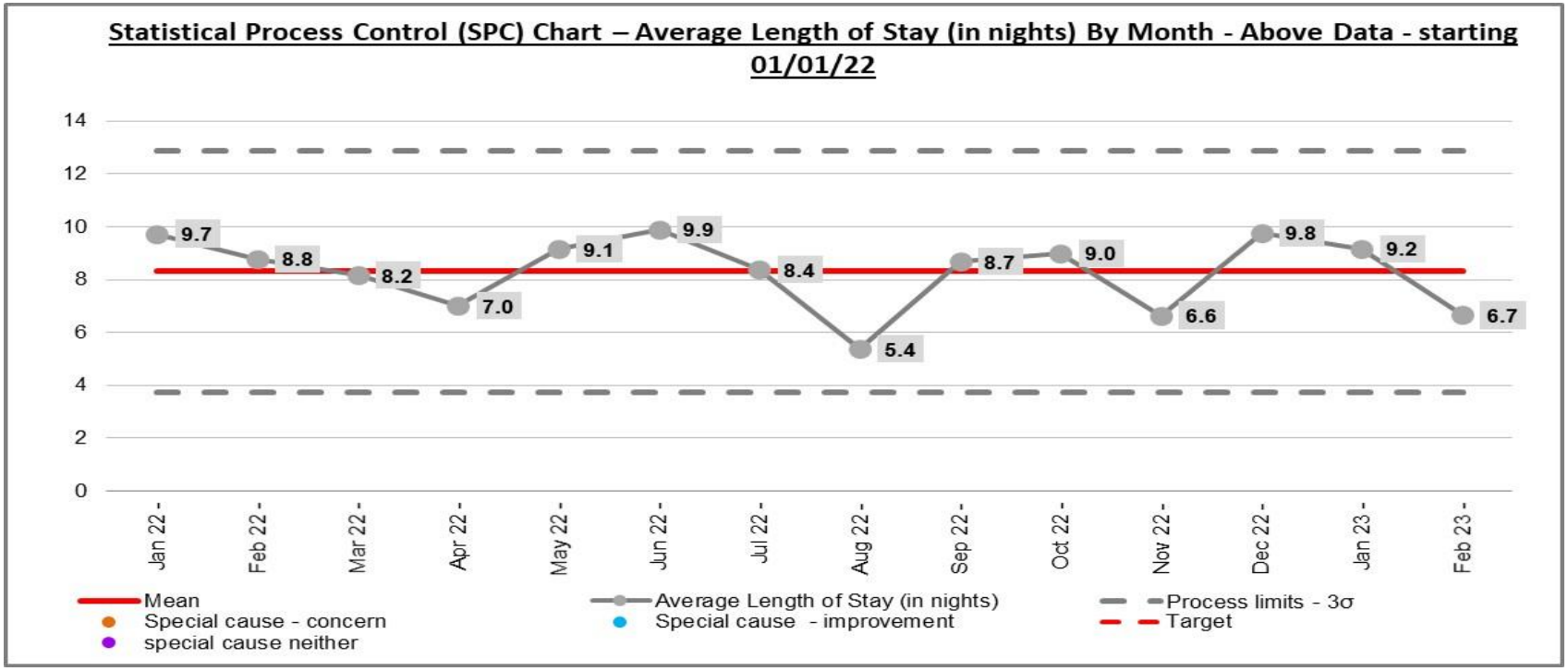


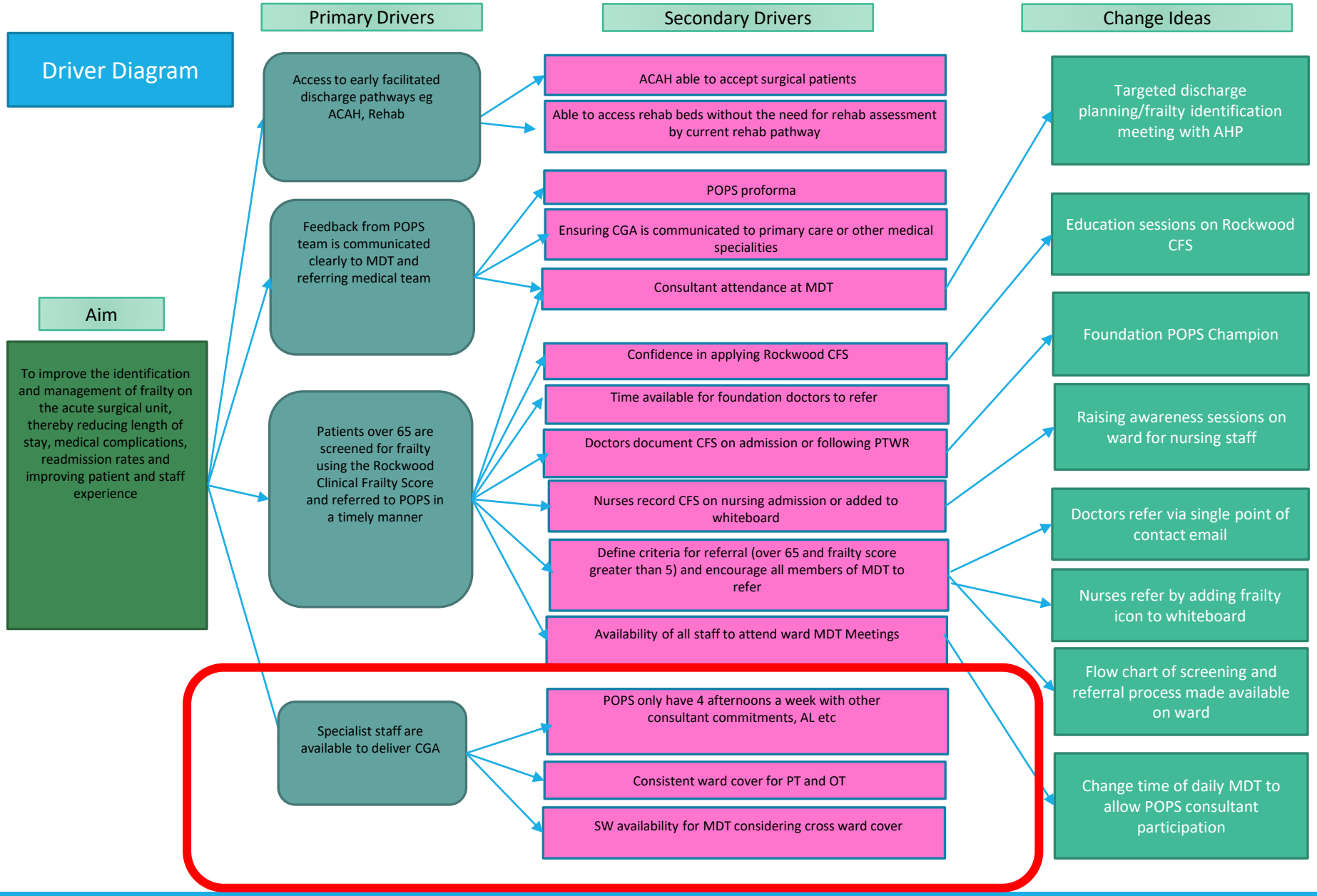

Number of frailty icons on ESU
16
14
12
10
8
6
4
2
0
26/10/2022
15/11/2022
05/12/2022
25/12/2022
14/01/2023
03/02/2023
23/02/2023
15/03/2023
04/04/2023
24/04/2023
14/05/2023
Sam at MDT
No medical presence @ MDT
Daily board Round with PT
Various Annual leave of team members

Number of Patients receiving CGA



Outcome measure - LOS

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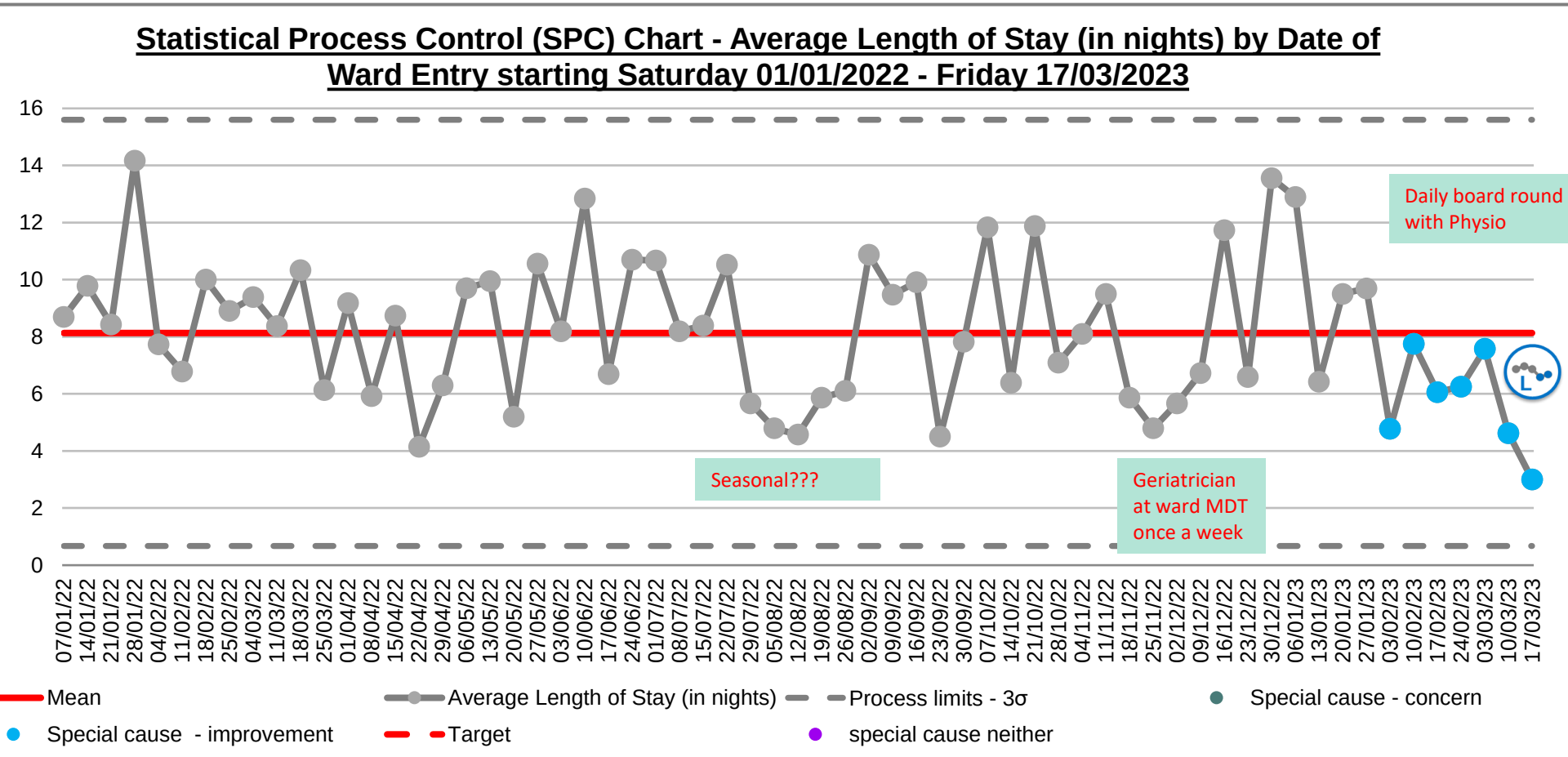
Outcome measure – LOS by week



Things going well

Frailty identification has improved dramatically

- flash audits would suggest from 0% to as high as 100% (considerable variability)
- Clinical coding has shown an increase of frailty associated diagnoses

Foundation doctors are more confident at managing patients living with frailty and feel more supported

We are beginning to show an improvement in length of stay in over 65s on our PILOT ward

- specifically when we have a greater presence on the ward

Limitations

Only on PILOT ward 4 North

Variable how much of our plan is acted upon – highlights need for middle grade/ANP/PA

Currently unable to attend MDT meetings given timings

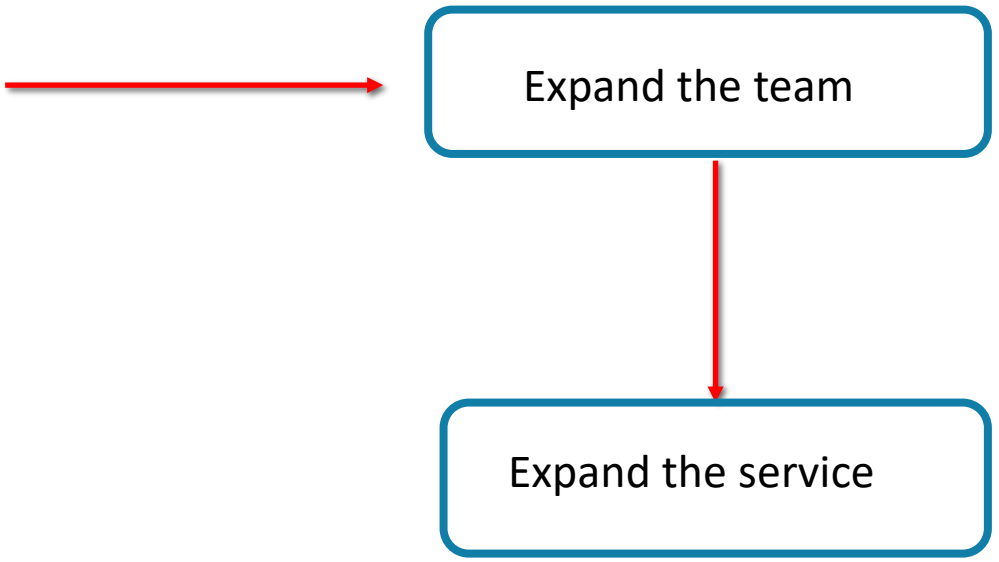
Northern Ireland not involved in NELA – limited audit against national standards – results in limited interest from surgical stakeholders

Next steps

Readmission and mortality data is being analysed

EBD work - patients and staff

Higher level engagement with data



Questions?

Coffee and Networking

Potential topics for conversation:

Whats missing from the guidelines that would support your work (clinicians, managers, data perspective)?

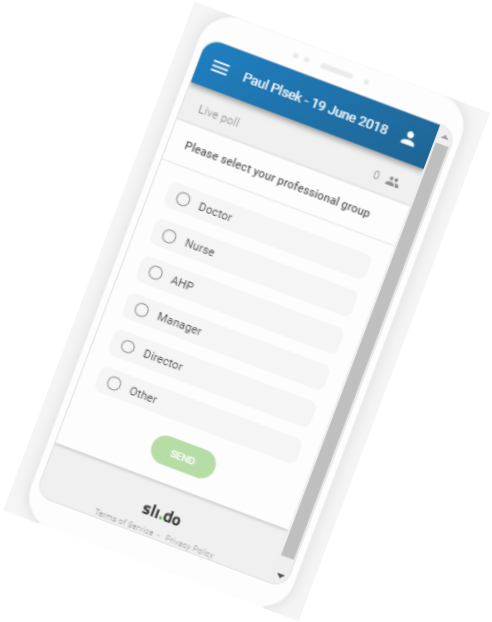
Reflecting on James presentation: What do you think is translatable, what you think are the barriers, what can we do to help?

What have you learned from Craigavon presentation, what do you need help with?

Summary and closing remarks

Dr Jugdeep Dhesi

sli.do



Scan the QR code below or open a browser on any laptop, tablet or smartphone and go to **www.sli.do**

And enter the event code **POPS3MAY**

Use the polls to give us feedback about the day

Next steps

As a team think about the following:

- Access the POPS website www.popsolderpeople.org and let us know what content would be useful. The password for the pages in the Members Area is **POPSNetwork2021**
- Focus on identification, training, process and application.
- Agree measures to understand the impact of your improvements.
- As a team, review your progress with the POPS Toolkit at the website.
- Register for the next event on 15 June at 09:00-11:30.

As always, let us know how we can help

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

networksinfo@nhselect.org.uk