Oxford University Hospitals
NHS Foundation Trust

Establishing Geriatric Perioperative Care Services
The Oxford Experience

Jo Hardwick & Shvaita Ralhan

On behalf of the Perioperative Medicine Team from Oxford University Hospitals

Autumn BGS 2019

Outline

Description of our clinical perioperative services

Our team – how we cover the work and who pays

Details about our recent expansion into Major Trauma, Vascular surgery, TAVI and appointment of perioperative care fellows

Collaboration with other networks and specialties to achieve our goals

Challenges faced and how we addressed these

Future direction of our service

Churchill Hospital

Nuffield Orthopaedic Centre

John Radcliffe Hospital

JR West Wlng

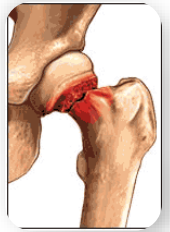
Services

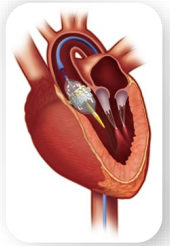
Predominant focus on emergency admissions

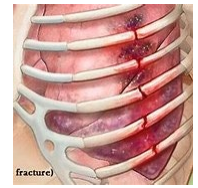
Proactive and responsive

Consultant led

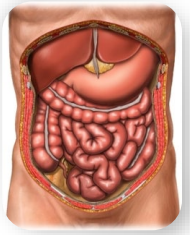
Supported by SHOs and clinical fellows







2011 2013 2014 2019 2020



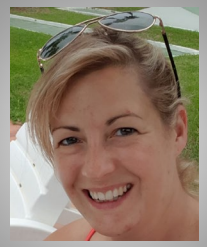
SHVAITA

JO

DAVID

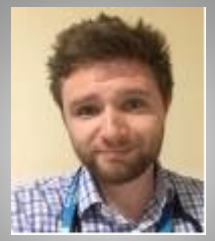
JOSEPHINE

CLAIRE

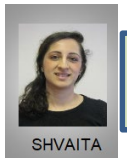

CHRISTINA

KATIE

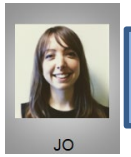
LAUREN


NATHAN

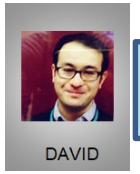
FIONA


SHVAITA

Trauma, orthogeriatrics | Vascular | TAVI | Acute medicine


JO

General surgery | Vascular | TAVI | Acute medicine


DAVID

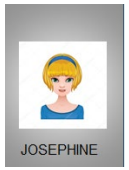
Vascular | Acute medicine

CLAIRE

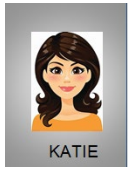
Trauma, orthogeriatrics | Dir. Med Ed | Acute medicine

CHRISTINA

Trauma, orthogeriatrics | General surgery | Acute medicine


JOSEPHINE

General surgery | Acute medicine


KATIE

General surgery | Community Geriatrics | Acute medicine

£££

(from surgical budget)

Hip fracture = 0.8
(+1 FY2)
Major Trauma = 0.3
(+ 1 fellow)
Vascular = 0.5
Gen surg = 0.6
TAVI = 0.1

Acute General Surgery

One of the busiest general surgical units in the UK

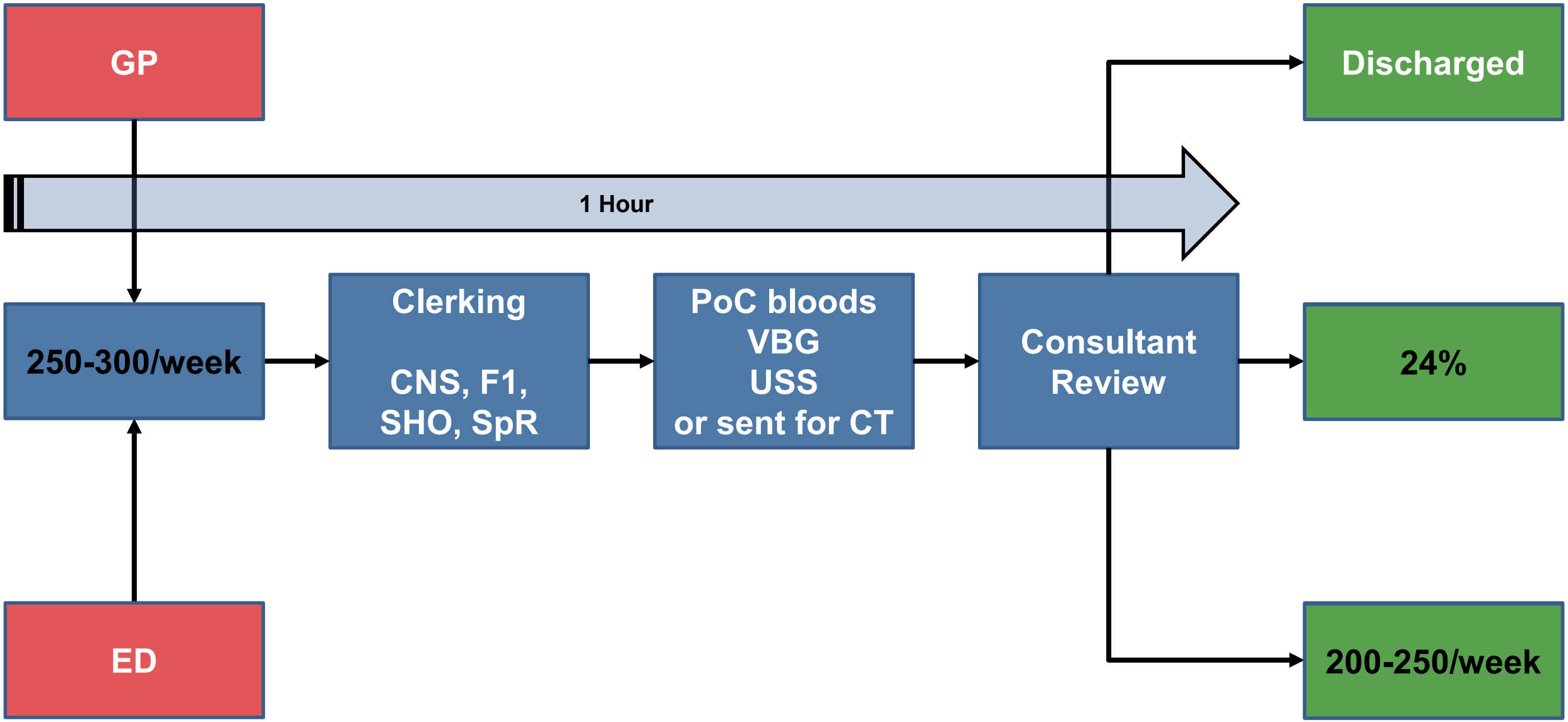
Regional centre for **complex pancreatitis** and bile duct injury

54 inpatient beds + **18** triage beds + outliers

Around **70-100 inpatients**

‘Open access’ triage policy - no barriers to review

Limited access to ITU so lots of sick patients


GP
ED
1 Hour
250-300/week
Clerking
CNS, F1,
SHO, SpR
PoC bloods
VBG
USS
or sent for CT
Consultant
Review
Discharged
24%
200-250/week

What we do

Review all acute pancreatitis, all ITU step-downs, most >75s, most laparotomies >60, any other referrals based on need

See all ages (16 - 100+)

Review 20-30 patients/day (busiest ward round on record = 54 patients seen)

How do we manage the workload? With difficulty, however

- Experienced consultants
- Daily board round (⅔ patients) - ‘quick wins and flow’
- Looking for trouble/looking for TOPADS
  - **T**hrombosis **O**xygen **P**ain **A**ntibiotics **D**elirium/DNAR **S**ugar
- The unit must keep moving! = ‘Tailored CGA’

Measure	2015	2019
No of beds	75	54
Adm from triage	69%	25%
Med LOS	3.2	2.04
Cardiac arrests	-	90% reduction
Having op	27%	42%
Laparotomy	-	Doubled
Hot GB	100	450
Revenues	-£250,000	+£700,000
VTE risk Ax	20%	>99%
Dsumm/24hrs	10%	92%
Complaints/quart	12	3

Acute structural cardiology liaison service

Regional referral centre for TAVI and MitraClip

Weekly TAVI MDT, fortnightly Mitral MDT

Edmonton Frail Scale done by TAVI CNS

Pre-procedure clinic based CGA

Ward review if LOS > 48 hours or if vascular injury

Specialised Clinical Frailty Network

NHS
Specialised Clinical Frailty Network

Major trauma

Major Trauma Centre (MTC) for the Thames Valley Trauma Network

We successfully business cased and launched a new service for older major trauma patients

Developed on the basis of financial gain, as well as quality arguments at a ‘time of external scrutiny’, estates problems and therefore opportunity…

The Changing Face of Trauma

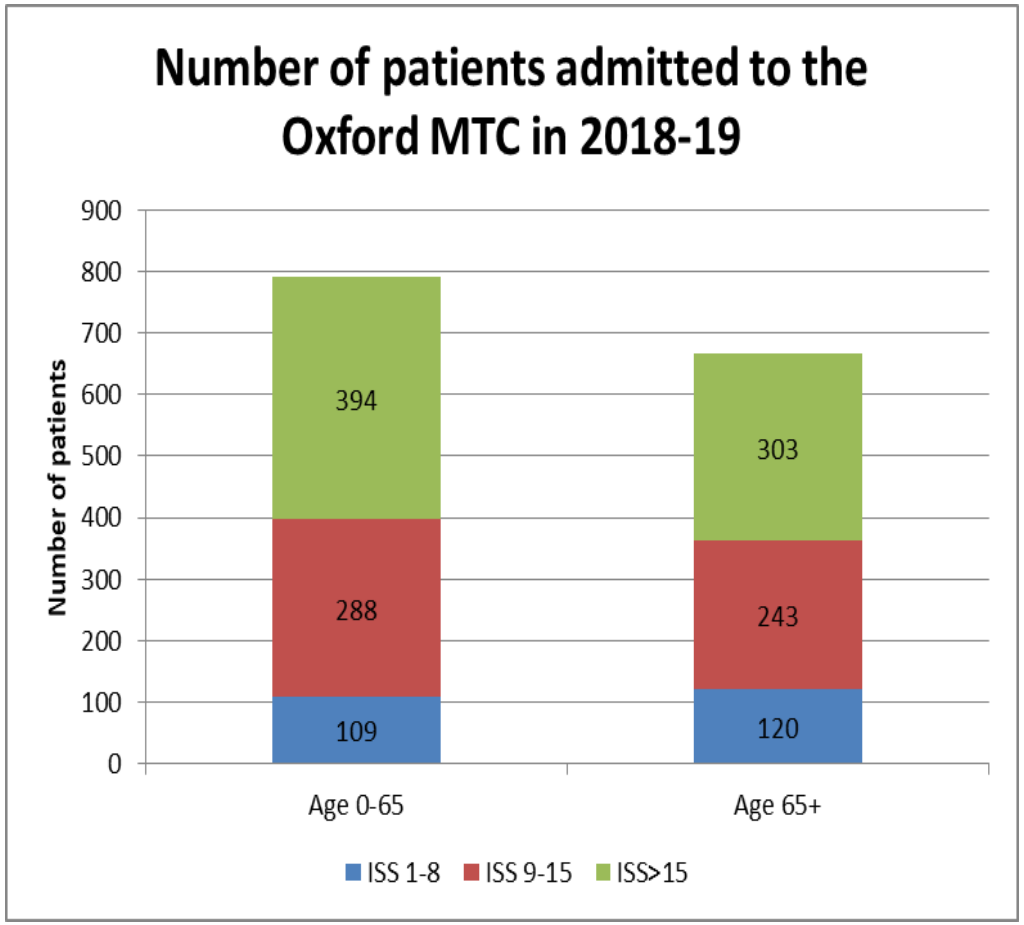
Traditionally viewed as a disease of young men

Elderly trauma patients will soon represent the largest group of patients suffering Major Trauma

The predominant mechanism of injury is falls from <2m

Associated with higher rates of mortality and morbidity

Supporting National Documents: Hip fracture care and Frailty BOAST - Comprehensive Geriatric Assessment (CGA) carried out within 72 hours of injury (published in May 2019)



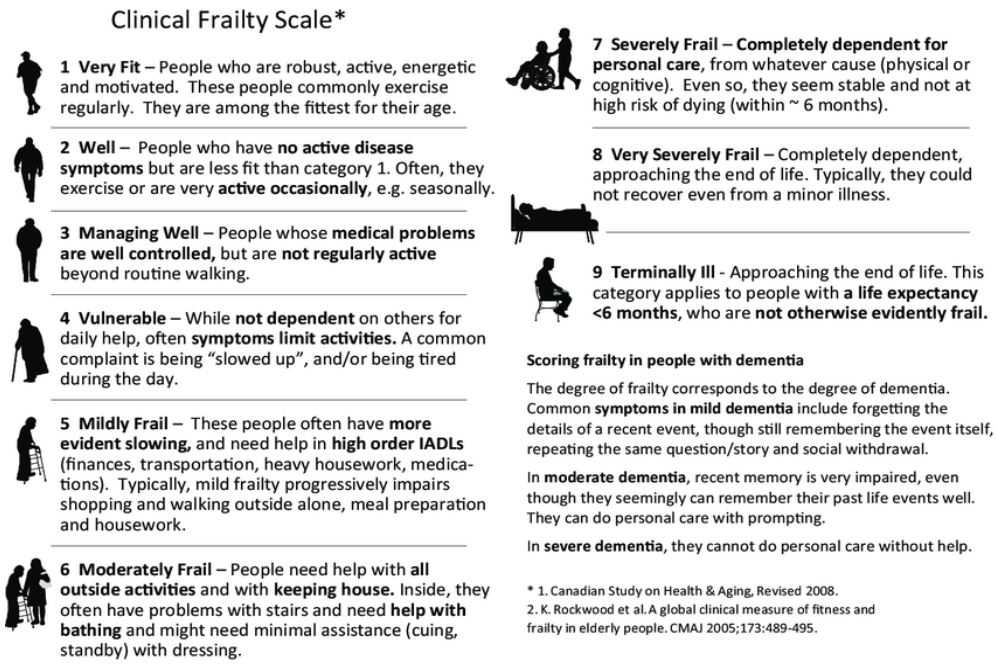
New criteria added to the existing Major Trauma Best Practice Tariff (BPT) April 2019

Most severely injured patients (ISS>15) aged 65 years or older have a Clinical Frailty Scale completed within 72 hours of admission by a geriatrician (defined as consultant, non-consultant career grade (NCCG) or specialist trainee ST3 or above

BPT uplift: £1,401 per patient

Money Matters:

£250,000 income loss for the trust if a service was not started



Clinical Frailty Scale*

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

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

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

4 Vulnerable – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

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

6 Moderately Frail – People need help with **all outside activities** and with **keeping house.** Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 Severely Frail – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9 Terminally Ill - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

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

Our New MTC Geriatrics Service

Fellow led (full time), consultant supervised service (4 PAs)

Consultant time created through recruitment of a nurse specialist for hip fracture

Part of the MDT for major trauma patients – liaison service

Currently completing CFS on all above ISS 9

Further CGA performed on selected patients focussing on those with ISS above 15

Aware some patients remain without perioperative physician input (less severely injured ISS<15 and other fragility fractures)…

Springboard: Phase 2 business case … BPT to change for hip fracture and peri-prosthetic hip fractures and rib fracture pathway

Vascular Service Pilot

24 bed specialist vascular ward

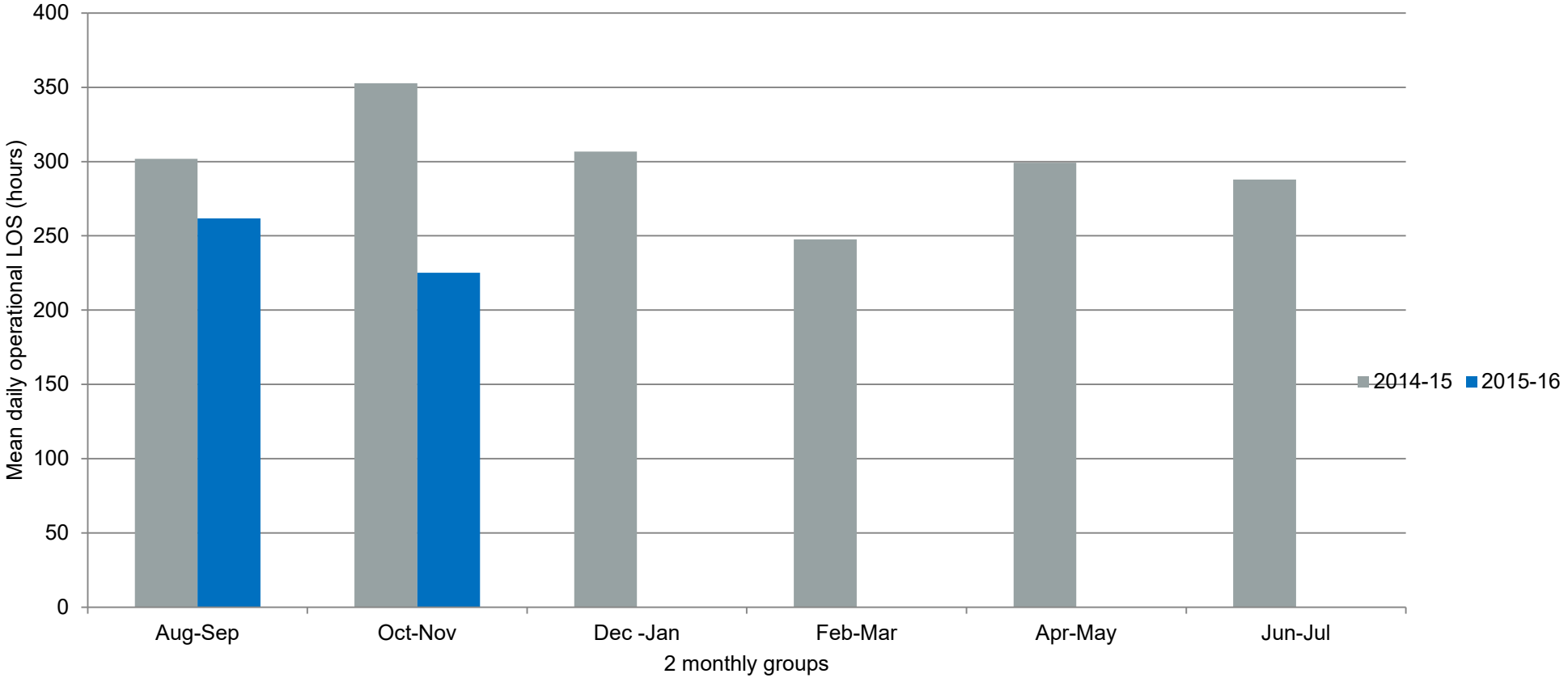
Tertiary referral centre

Identifying the problems: vascular consultants divided opinion about benefits, junior doctors unsupported, length of stay, discharge planning, late cancellations, advance care planning, unexpected medical emergency calls

4 month time limited pilot based on good will

Clear outcome measures pre and post intervention (qualitative and quantitative)

Vascular Service Pilot Results



STATEMENT SET 1	WEIGHTED AVERAGE
This service has improved the quality of care on the vascular ward.	1.89
This service has made the ward a safer place for patients.	1.86
This service has improved communication between staff groups.	1.71
This service has improved communication between staff and patients/visitors.	1.36
This service has reduced medication errors on the ward.	1.25
This service has improved antibiotic prescribing on the ward.	1.38
This service has improved the rehabilitation of patients post-surgery.	1.46
This service has improved discharge planning.	1.70
This service has helped me to work more effectively.	1.74

Vascular Service

Joint ward rounds and board rounds

Frailty assessment is embedded in the junior doctor clerking

Identifying and developing champions e.g. advance care planning and delirium

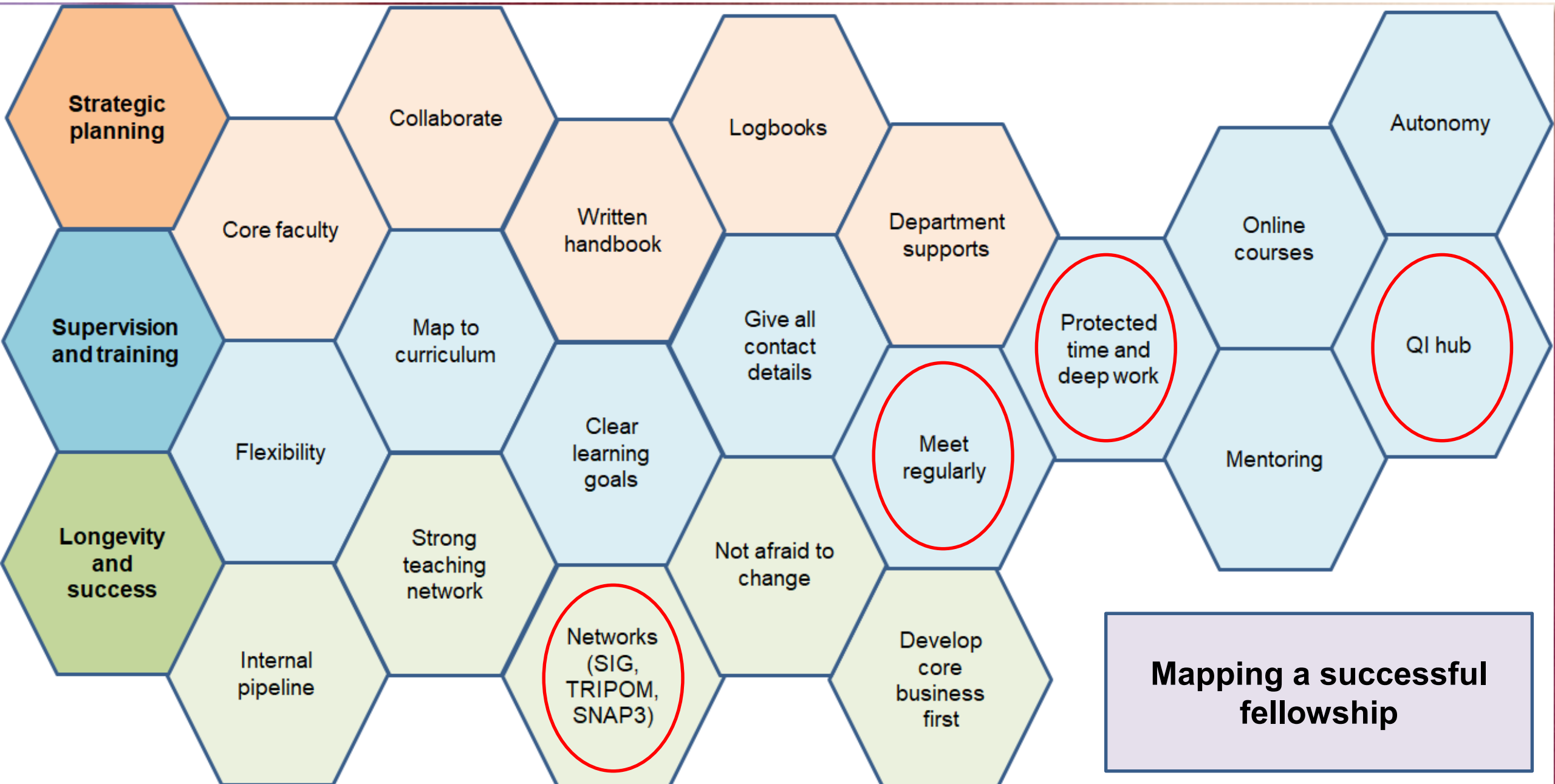
Effective use of vascular junior doctors

Input into clinical governance

Future: increasing our input into the ward and expanding into elective vascular assessment

Seminar Room 2B

GROW
YOUR
OWN


Strategic planning
Collaborate
Logbooks
Autonomy
Core faculty
Written handbook
Department supports
Online courses
Supervision and training
Map to curriculum
Give all contact details
Protected time and deep work
QI hub
Flexibility
Clear learning goals
Meet regularly
Mentoring
Longevity and success
Strong teaching network
Not afraid to change
Internal pipeline
Networks (SIG, TRIPOM, SNAP3)
Develop core business first
Mapping a successful fellowship

Moving forward

Elective surgery
- Trial in colorectal completed, trial in UGI pending
- Pre-assessment

Cardiology
- Proactive case-finding in non-structural patients

Trauma
- Rib fracture pathway
- Peri-prosthetic fractures

Specialist surgery
- Plastics, ENT, neurosurgery

Challenges	Top tips
Manpower	Pursue clinical fellow posts using unspent consultant budget Recruit from medicine, not just geriatrics Offer to shore up medical reg rotas with fellows Grow your own team Advanced clinical practitioners
Funding and proving your worth	Look at successes of 'whole unit' Less focus on LOS per se – think about discharges before lunch, numbers of acute operations, cardiac arrests, ITU transfers, complaints, supporting ambulatory pathways
Professional relationships with surgeons	Be patient Understand whole pathway, including theatres Meet regularly and ask for feedback (no matter how painful) Understand what they want from you – demonstrate what you can do for them
Workload	View additional work as an opportunity Consolidate current service before expanding Look for overlapping themes – TAVI/cardiology/cardiothoracics/rib #
Promoting geriatric care	Look for allies within MDT Explain why (for example) delirium affects outcomes (again, and again, again) Focus on 'acute' end of geriatric care for emergency surgery patients – what is important for this patient, for this admission Keep plans simple – a long plan is unlikely to be followed!

Oxford University Hospitals
NHS Foundation Trust

Thank you

To enquire about our perioperative fellowships, consultant posts or for site visits, please contact jo.hardwick@ouh.nhs.uk or shvaita.ralhan@ouh.nhs.uk

@drjohardwick

@shvaitaralhan