Perioperative Care stakeholder scoping workshop facilitator notes Date: Thursday 19 October 2017 Group: 1		
Scope details	**Questions for discussion**	**Stakeholder responses**
Title: Perioperative Care	What is the definition of perioperative care (including timeframe)?	• The group were not aware of one definition used; noting it was hard to define concisely, but agreed it essentially covers everything from pre to post-operation. • The time for post-operation is hard to define and depends on the person and the procedure. However, it should include long term outcomes. • The management of patients in an integrated MDT, from contemplating surgery to care and recovery after.
2 Who the guideline is for **This guideline is for:** • people using services, their families and carers, and the public • healthcare professionals in secondary care • healthcare professionals in tertiary care • non NHS organisations commissioned to provide services for the NHS or local authorities.	Would any of this guideline apply to primary care?	• The group agreed primary care should be included. This would include GPs and the decisions around who is suitable for surgery. • The group suggested considerations should be given to consent and the legal issues around choosing not to operate.
3.1 Who is the focus: **Groups that will be covered:** • Adults (18 and older) undergoing surgery as an in-patient. Specific consideration will be given to - older people. **Groups that will not be covered** • Pregnant women	Is this the correct population? Does it cover all types of surgery relevant to the guideline? Does it inappropriately exclude any types of surgery (e.g. day surgery)? The IV fluids guideline included young people aged 16 years and over. Should they be included in this guideline?	• The group suggested that the 16-18 age group may need to be considered as a subgroup. • The group suggest that people who are obese may need to be considered as a subgroup. • The group noted that the issues surrounding older people are about frailty rather than age. They noted that extrapolating frailty scores from geriatricians for use in perioperative care is hard. The group were not aware of a validated score for the perioperative field. • The group noted that there are differences between elective, urgent and emergency surgery and preparing for surgery. • People having emergency surgery benefit most from optimisation

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• Children (17 years and younger)	Are there any specific groups or subgroups not listed that need to be considered?	but there is less opportunity to optimise than people being prepared for elective surgery. • The group agreed that the guideline needs to consider people requiring urgent surgery. • The group noted that 10-15% of people requiring elective surgery are high risk. This group may need separate recommendations. • The group noted that intra and post-operative recommendations will be similar to elective, urgent and emergency surgery recommendations. However, pre- operative recommendations could differ depending on populations and types of surgery. • The group noted that day case surgery will still require pre-operative work. • The group agreed that day cases should not be excluded as there is a variation in the procedures that are categorised as a day case nationally. • The group agreed that obstetric surgery should be excluded but pregnant women needing surgery should be included.
3.2 Settings **Settings that will be covered** • secondary and tertiary healthcare **Settings that will not be covered** • minor surgery clinics • out-patient settings		• The group agreed primary care should be included – see above.
3.3 Key areas that will be covered • Information and support needs for adults undergoing surgery • Pre- operative optimisation (1) - proactive care of older people undergoing surgery - perfusion and hydration	Are all the key areas appropriate and have they all been covered? Are the excluded areas appropriate?	<u>Information and support needs</u> • Include carers as well. • Shared decision making influences treatment decisions and the right operation or treatment to have. There is literature published and it would be useful for the guideline to signpost to other guidance.

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• Intraoperative management (2) - strict glucose control - intravenous fluid during surgery - cardiac monitoring devices • Post-operative management - pain management (3) - ICU utilisation (4) • System wide initiatives - enhanced recovery programmes (5) **Areas that will not be covered** • Preoperative tests • Blood products and blood transfusion • People with burns • People with traumatic brain injury or needing neurosurgery • Any other specific types of surgery		<u>Pre-operative optimisation</u> • The group agreed that POPS clinics work well. There is a study from Leicester looking at clinics and frailty scores. This is a relatively new area and important to include. • Hydration should be included as it is important that people drink up to a specified time. Other suggestions for this area: • Pre-operative anaemia clinics are cost effective. However, the economics relate to transfusion. • Pre-habilitation; exercise/psychology pre-surgery/smoking/drinking. • Medication management. <u>Intraoperative management</u> • Reversing anaesthetic drug. The group agreed that there is good evidence that if this isn't done well, there will be increased risk of complications. <u>Post-operative management</u> • Pain management team is more about the process rather than the type of analgesia to use. • ICU utilisation is more about the people receiving the appropriate levels of care rather than the location. • Nutrition is important. <u>Enhanced recovery programmes</u> • This includes everything in the pathway from start to finish. There

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		are variations in current practice. • The key is to identify the barriers during the whole surgical pathway. • The group agreed that traumatic brain injury will come under emergency now so can be taken out.
3.4 Economic aspects We will take economic aspects into account when making recommendations. We will develop an economic plan that states for each review question (or key area in the scope) whether economic considerations are relevant, and if so whether this is an area that should be prioritised for economic modelling and analysis. We will review the economic evidence and carry out economic analyses, using a NHS and personal social services (PSS) perspective, as appropriate.	Which practices will have the biggest cost implications for the NHS? Are there any new practices that might save the NHS money compared to existing practice? Which areas of the scope have the most variation in practice? Which area of the scope is likely to have the most marked or biggest health implications for patients?	• There is US data on savings from enhanced recovery programmes.
3.5 Key issues and questions **1 Information and support needs for adults undergoing elective surgery** 1.1 What information, education and support is useful for adults who will be undergoing elective surgery?	Is this the correct question? Are there any questions missing relating to this issue?	This was not discussed.
2 Pre- operative optimisation 2.1 What is the clinical and cost effectiveness of pre -	Is this the correct question? Are there any questions missing	This was not discussed.

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operative optimisations clinics (for example, Proactive care of older people undergoing surgery (PoPs clinics)?	relating to this issue?	
3 Intraoperative management 3.1 What is the clinical effectiveness and cost effectiveness of perioperative perfusion and hydration? 3.2 What is the clinical effectiveness and cost effectiveness of strict blood glucose control? 3.3 What is the most clinically effective and cost effectiveness intravenous fluid for patients undergoing surgery? 3.4 Goal directed therapy question? 3.5 Cardiac monitoring devices question	Are these the correct questions? Are there any questions missing relating to this issue?	This was not discussed.
4 Post-operative management 4.1 Pain management 4.2 Location of post-operative care	Are these the correct questions? Are there any questions missing relating to this issue?	This was not discussed.
5 System wide initiatives / Enhanced recovery programmes 5.1 Are enhanced recovery programmes clinically and cost effective?	Is this the correct question? Are there any questions missing relating to this issue?	This was not discussed.
3.6 Main outcomes	Are all outcomes appropriate?	This was not discussed.

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• Health related quality of life • Survival (mortality) • Adverse events /complications - surgical site infection • Symptom scores and functional measures • Length of stay in ICU/hospital • Hospital readmission • Psychological distress and mental wellbeing • Patient, family and carer experience of care	Are there any adverse events/complications missing? Are any key outcomes missing?	
<u>GC composition</u> • Anaesthetist • Intensivist with expertise in anaesthesia • Surgeon • Physician specialising in proactive surgery preparation • Theatre nurse • Operating department practitioner • Pharmacist • Critical care outreach team member • Perioperative nurse • Emergency physician with intensivist experience • Lay member x2 <u>Expert advisers</u> • Physiotherapist • Pain management physician/nurse	Do you have any comments on the proposed membership of the committee?	The group suggested the following: • 2 anaesthetists. • Theatre nurse and operating department practitioner can be the same person. • Ward nurses are important, as most care takes place on the ward. • Critical outreach member could be a co-optee. • Perioperative nurse could be someone from a POAC clinic (pre-op assessment clinic). • GP • Geriatrician • Member of acute pain management team should be a full member.