Guest Editorial

Perioperative medicine: from vision to implementation

In January the College launched its vision for perioperative medicine with a request to join the conversation on how we embed perioperative practice in our day-to-day delivery of care. Your responses to date have been overwhelmingly positive and encouraging, but we do recognise that some of you have concerns that our proposals could mark a threat to the specialty, leading to a significant change in job plans, less time in the operating theatre and units and more time on the wards. The article in this edition, authored by Dr Alan McGlennan et al, looks at some of the challenges facing perioperative medicine, including definitional dilemmas and barriers to the effective implementation of the programme. In this special edition of the Bulletin, we hope to address these challenges and dispel myths, highlight how we might formalise perioperative services that offer increased benefit for our patients, and look at how the future training of anaesthetists and the wider medical workforce can support the delivery of perioperative medicine.

National context and drivers for change

The work of anaesthetists is integral to the success and safety of surgery, but there is an increasing need to optimise patients’ health before, during and after surgery. To fail to embrace the need for improved perioperative care and joined up ways of working is to swim against the tide. We have an increasing elderly population with multiple medical co-morbidities who are undergoing more complex surgical procedures. We know that there is evidence to support the fact that pre- and postoperative interventions can improve outcomes and reduce complications. At the same time we need to use postoperative care facilities as efficiently as possible.

The national stage is set for change. NHS England’s (NHSE) increasing focus on vertical integration of primary and secondary care services in the delivery of population-based health supports our vision of the perioperative team in providing a single point of contact for patients, surgeons and GPs, co-ordinating the care of patients with complex needs before during and after surgery.

NHSE’s Five Year Forward View, with a focus on new models of care, is already 11 months’ old, and some hospitals are already working in partnership with GPs, social care and mental health services as ‘vanguard sites’ to pilot new and more efficient and effective ways of working.

Building perioperative models of care

Many of the components of the perioperative medicine pathway already exist within the NHS but, as far as we are aware, no single NHS hospital provides a complete service to patients.

The development of a new referral pathway, where high-risk patients are given a full pre-assessment prior to decision for surgery and prior to seeing the surgeon, is a good way forward. Such a pathway could incorporate triple integrated care, truly informed consent, fitness for surgery, lifestyle modifications and ‘knowing the

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risk’. A new referral pathway should optimise and care for patients at a higher risk, but should also screen for lower-risk patients who need less or no intervention early on in their journey. This thinking is in line with both the ‘Choosing Wisely’ agenda and NHSE’s work on efficient and effective elective care, where a more systematic approach to personalised risk assessment and effective shared decision making before a patient is formally referred for surgery could support patients in feeling more in control, and also potentially reduce the strain on the 18-week standard for referral to treatment for elective care. Professor Gerry Danjoux and Dr Elke Kothmann’s article looks at ways to enhance the primary-secondary care working relationships through knowledge sharing and communication.

The Proactive care of Older People undergoing Surgery (POPS) programme at Guy’s and St Thomas’ NHS Foundation Trust is perhaps the nearest we have by way of a fully joined up programme of care, and this approach, as you will read in Dr Jugdeep Dhesi’s article, has demonstrated reductions in postoperative medical and multidisciplinary complications and length-of-stay for patients undergoing orthopaedic surgery.

We are also aware of many other examples of successful components of the perioperative care pathway which support people to manage their own health, such as smoking cessation programmes and the use of cardiopulmonary exercise testing to provide an objective assessment of the risks and benefits of surgery.

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The balance between quality and the economic case for change is also important. The McGlennan et al. article highlights that practicing anaesthetists do not lack ambition or the skills to coordinate change, but perhaps the necessary financial resources needed to carry out significant change. We hope that any proposed changes to the infrastructure for the delivery of perioperative medicine will be modest, and can be developed from existing resources. In order for change to be adopted, solutions will need to be clinically effective but also cost effective, leading, for example, to reduced length of stay or fewer cancellations.

A recent survey of clinical directors, representing 97 hospitals, showed that much more is happening than we originally thought:

- Use of CPET is at 50% and 65% of the hospitals surveyed use risk scoring systems.
- There is increasing pre-operative treatment for diabetes, obesity and smoke cessation.
- After surgery, 85% of hospitals surveyed use critical care outreach, and 92% have an acute pain round.
- 12% have a specialist perioperative medicine review at the outpatient clinic.
- 73% have specific care pathways for colorectal patients, 70% for major joint replacements and 74% for hip fracture.
Developing the future workforce

Anaesthetists are trained and experienced to lead and coordinate the care of patients throughout the perioperative period. However, the solution to good perioperative care does not rest solely in anaesthetists’ hands, but in a multidisciplinary team based approach. As Dr Ben Shippey highlights in his article, an innovative way to train medical students in perioperative medicine would be to link surgery, anaesthesia and primary care through the stages of referral, preoperative assessment, admission, postoperative care and follow up. In doing so, we would certainly encourage a more team-based, patient-centred and collaborative approach to care. The College embraces this multidisciplinary approach, and is keen to assuage fears that perioperative medicine might serve to build barriers within, or beyond, the specialty of anaesthesia. Anaesthetists’ experience throughout the patient pathway, certainly does put the anaesthetist in an ideal position to develop new teams and engage with colleagues in different specialties. The progress in Intensive Care Medicine and Pain Medicine, through the respective Faculties, is a part of our response to the developing nature of anaesthesia and the wider acute sphere of the hospital.

Not all consultants will be expected to have a significant role in the delivery of perioperative medicine, and for many consultants their role in their departments will stay the same. However, the principles of perioperative medicine must be present throughout in order to ensure we can continue to deliver effective care that meets the needs of patients in an environment where resources are increasingly constrained.

The RCoA’s curriculum sets the standard for the training of all CCT holders in the UK and, as you will read from Dr Chris Carey’s article, the College has recently reviewed and updated the CCT curriculum content of perioperative medicine for the Introduction to Anaesthesia, Basic, Intermediate and Higher modules. It is anticipated that the changes will be introduced into the curriculum from August 2016, and this will help ensure there is a universal standard of training to support the future delivery of perioperative medicine.

It is clear that the scope and scale of perioperative medicine services is set to increase significantly over the coming years, and given the complexity of this care, it will need to be consultant-led. This will require additional numbers in the consultant workforce and changes to the training programme to support the development of this workforce.

The College will continue to work with Health Education England and the Centre for Workforce Intelligence to address concerns in anaesthesia workforce planning now and for the future.

How to get involved

None of the work we propose will be possible without the support of our Fellows and Members. Over the next couple of months we will be asking clinical directors to nominate a Perioperative Medicine Lead in their hospital to help us drive change, provide regional intelligence and support local initiatives. We will keep our leads informed of all aspects of our work as we progress. We are also planning a programme of events at national and regional level, which will showcase local examples of good practice in pre- and postoperative care via case studies. Over time we hope to assimilate this good practice into an implementation guide with practical business cases detailing how to set up components of a perioperative service.

I hope you enjoy this themed edition of the Bulletin, and that on reading it you will feel compelled to share your local experiences of good perioperative care and how to achieve it, help us to address some of the challenges, consider becoming a Perioperative Medicine Lead, or simply join the conversation at our microsite – www.rcoa.ac.uk/perioperativemedicine.