5th ERAS UK Conference 2015

Chairs: Tom Wainwright, Andrew Kinninmonth, Susan Nimmo

Presenter: Melanie Tan

Susan Nimmo: Okay while they're thinking about it I was going to ask you about CQUINS, but thank you sorted that out for us, as we are not blessed with CQUINS in Scotland. What particular staffing issues do you think you would look at if you had the option?

Melanie Tan: Given that half the hospitals said they didn't have an enhanced recovery nurse I think that's one thing to be looking at. When you do actually have an enhanced recovery nurse you need to look at how we are actually engaging with them, so some people feel like there flying by themselves and that they're not really feeling like part of the team, so it is about how you can actually be as clinician and engaging with the nurses and asking what problems are you coming up against? What can I help you with? If you're coming up against pain? Can I look at the pain protocol for you?

Also enabling them to actually engage with the surgeons, because sometimes surgeons aren't as engaged in my experience, but when you actually approach them with a specific problem and I need you to look at this, I've got this problem that I'm coming up against, What do you think, how do we overcome this? I think then nurses feel more engaged in the whole process, so it is very much about engaging them as a team.

Razdy Igasan: I'm from Leeds for liver enhance recovery. We are looking at implementing post op goal directive fluid therapy, but it is such a huge task to involve everyone, have you had any experiences in post op fluid therapy and how does it tie up with the CQUINS targets, if you're doing them?

Melanie Tan: At the Royal Free, they were using Doppler goal directive fluid therapy and obviously the patient has to be asleep for that, and over the 2 years they put a business plan through because we canvased the anaesthetists and said why are you not doing goal directive fluid therapy? A lot of the opinion was that they were finding it very difficult to get the Doppler signal.

So over the 2 years they actually moved to a from a Doppler type goal directive fluid therapy to a pulse contour goal directive fluid therapy and we actually saw the results go from 30% to 80% and that was by canvasing opinion on what barriers people were coming up against and why they weren't doing it.

So in answer to the question I think if you're using a pulse contour and they're going to a HDU or ITU environment those are the sort of aspects that you should be looking at. But really take on board why people are not doing goal directive fluid therapy, if people are finding difficulties like they don't know how to use it or its difficult in the environment that the patient is going to or they just don't like it for whatever reason. You really have to take that on board as a contribution and then look at how you can make the system work for the people and you will see results.

Delegate: Can I just ask a question, this is a general comment for today? Why do people think that surgeons aren't engaged, as a couple of people have mentioned that, and obviously I would have thought as a surgical trainee that the ERAS programme if you can get a people out the door sooner and safer then surely given all surgeons are going to now have their data looked at for this kind of thing that they would be so engaged in this, so what is it that we aren't doing or that they are

worried about? Do you have any views on that as a consultant anaesthetist as from the other side of the bed as it were? What are the problems you are coming across? Are we worried about sending people home early, obviously particular in colorectal surgery I guess with leaks? It seems really odd that we as a group would be unengaged, I don't really understand that?

Melanie Tan: Within the management training there was quite a lot of self-development and coaching around how you are as a person. One of the things I have realised is that some surgeons are very much about their interest is about the surgical procedure. They are not so engaged about with the patients beforehand or afterwards. I think if you ask a lot of people about their patient experience, patients feel like their valued when their surgeons are talking to them in the clinics' before and after, and also when they are being listened to.

But not just being listened as words coming out of their mouth but really been understood in the clinics and their concerns are been understood. So I don't know why surgeons tend to not be so be engaged, given this is an anaesthetic opinion so it may be if we done a surgical survey we might come up with more anaesthetic barriers, so I don't really know? Certainly I think the anaesthetic drive is towards enhanced recovery and there's a lot of pioneering people who do a lot of research and they are very inspirational within the anaesthetic world.

Andrew Kinninmonth: I think I have to defend the surgeon here, I'm an orthopod, and we've been engaged for quite a long time! But I've travelled around Scotland with David MacDonald and we have gone to various units and what always happens is that you sit in a room like this with 30 or 40 or 50 people and the surgeons will blame the anaesthetists and the anaesthetists will blame the surgeons, but if you can get that group of people in a room and knock a few heads together and let them speak to each other, between them they can change their practice.

Surgeons in general are well known for having no insight so it's actually quite important to tell them what they are doing wrong and then they might be able to change things because surgeons don't believe, and I'm saying as a surgeon, they do anything wrong, but once you have changed that attitude you can change people and it is really important. I agree.

Ken Fearon: I was interested in the question of DIY ERAS as one of the points you raised here was not many had allocated nonclinical time to lead the ERAS programme and I'm interested in your thoughts about the importance of that and how you engage management to take ERAS seriously enough that the clinician has identified time to lead to the programme, be that a surgeon, an anaesthetist or whoever.

Melanie Tan: So I think in partaking in a management learning, one of the things I did take on is that we have to speak to management in a different way. We have to have data to back up what we are doing, and we have to be able to prove, it's no good throwing them a load of papers saying enhanced recovery is good, we can do this, we can do that. We actually need to be auditing our process and saying this what we are doing this is where we've come, we need more resources in order to achieve the next step.

I think when you actually have the data and you're backing it up then management do listen. We are quite lucky that the senior management, I was working with the chief operation manager for the Trust, was very much engaged in helping getting the CQUIN targets achieved. The difficulty we found was actually within the top tier they understood what strategically they were trying to achieve. The middle tier got a bit lost, so one of the issues we had was we ran out of Doppler probes very early on and middle managers said we don't have the budget can't have any more that's it! I think when you understand where you can actually release the budgets and how to get that done and understanding

management better I think you able to get things done more efficiently with less struggle. So it's something we should actually embrace rather than say Oh! management are the other people.

Susan Nimmo: Okay Melanie, thank you very much.

Mike Grocott: Great presentation, thank you. Mike Grocott from Southampton Professor of anaesthesia, just wanted to completely agree with my orthopaedic colleague and there are anaesthetist with that insight as well, the key thing to remember is that it is a team game.

Ken Fearon: Now I'm really worried!

Susan Nimmo: Thank you for an excellent presentation.