The panel (left to right): Mike Farrar, Dr Junaid Bajwa, Dr William Fawcett, Karen Castille, Dr Charles Alessi, Rachel Barlow (top), Wendy Lewis, Archie Kaul-Mead, Dr Matt Dickenson, Francis Nader

ENHANCED PERSPECTIVE

Enhanced recovery programmes should be an integral part of a surgery patients' care plan both before and after surgery. Alison Moore reports

ROUNDTABLE PARTICIPANTS

Mike Farrar independent consultant and former NHS Confederation chief executive (chair)
Dr Junaid Bajwa GP and member of Greenwich CCG board
Dr William Fawcett consultant anaesthetist at Royal Surrey County Hospital Foundation Trust
Karen Castille associate director at the NHS Confederation and former interim chief executive at Cambridge University Hospitals Foundation Trust
Dr Charles Alessi National Association for Primary Care chair and senior adviser to NHS England
Rachael Barlow dietitian and lead for the national programme for enhanced recovery in Wales
Wendy Lewis enhanced recovery programme lead at the Advancing Quality Alliance
Archie Kaul-Mead operational manager for physiotherapy at Colchester Hospitals Foundation Trust
Dr Matt Dickinson clinical director and consultant anaesthetist at Royal Surrey County Hospital Foundation Trust
Nader Francis colorectal surgeon at Yeovil District Hospital Foundation Trust and chair of the Enhanced Recovery After Surgery Society
Professor Olle Ljundqvist professor of surgery at Orebro University Hospital, Sweden, and chair of the international ERAS society

Ensuring patients recover quickly and without avoidable complications from any hospital treatment offers benefits to both the NHS and the patient.

Enhanced recovery programmes – a package of measures including optimal nutrition before and after surgery – have been adopted by some hospitals to try to achieve this. Reduced length of stay and fewer complications will reduce costs for hospitals, but patients also recover from treatment and get back to normal life more quickly.

An *HSJ* roundtable, supported by Nutricia, explored why enhanced recovery programmes are being adopted in some areas but not others, and how they can be encouraged and embedded in hospital processes.

Former NHS Confederation chief executive and independent consultant Mike Farrar – chairing the event – stressed the importance of context in the NHS to ensure patients receive good care. The roundtable offered a way of getting a message to senior levels of the NHS about what was important in creating that context.

However, he added that the backdrop to this was a health service facing severe financial challenges, a new

commissioning system determined to commission on clinical value, and continuing critical reports in the media, including one the previous week focusing on nutrition and hydration in the NHS.

Turning to enhanced recovery, he said there as a sense of frustration. "We have a system that is really not adopting the type of procedures we could and should be doing," he said.

The panel's experience was that there were significant benefits from introducing enhanced recovery programmes. Yeovil District Hospital Foundation Trust colorectal surgeon Nader Francis said: "The whole concept of a patient coming for an operation starving and dehydrated with a long length of stay has never been routine practice in my hospital."

However, he stressed that adopting enhanced recovery was about the whole team rather than an individual. "Enhanced recovery is not about a single person. It is about 10-20 people... when you lose a champion you need another champion but you discover it's more than that."

While enhanced recovery was commonplace in some departments in his hospital, other areas were still struggling with it, he added.

Professor Olle Ljundqvist is one of the world's foremost proponents of enhanced recovery and has researched it extensively. He highlighted some of the benefits of reduced length of stay and fewer complications.

"In colorectal surgery, if we move from less than 50 per cent compliance with an ideal protocol to 90 per cent then complications come down 60 per cent," he said.

Dietician Rachael Barlow has worked to introduce enhanced recovery programmes in Wales and has been instrumental in getting funding from the Welsh government to promote it. She said the programme has led to significant savings being made, for example, through reduced length of stay for oesophagogastric patients. Enhanced recovery was now included in Wales' annual quality framework and cancer delivery plan.

Anaesthetist William Fawcett, from the Royal Surrey County Hospital Foundation Trust, said it was important to look at enhanced recovery from a number of different perspectives. "From a hospital manager's point of view a key driving point is to reduce length of stay. As clinicians, a key driving point is to reduce complications. The key driving point for patients is that they are involved in their care in a way that they were not when I first qualified."

'Enhanced recovery is not about a single person. It is about 10 to 20 people'

However, there was now evidence that long-term survival was improved in patients undergoing enhanced recovery programmes as well. Professor Ljundqvist said the first evidence of improvements in mortality had come from orthopaedics, but there was also evidence that patients were more likely to be alive in five or 10 years if they did not have complications after surgery.

Dr Junaid Bajwa, a GP who sits on Greenwich CCG, said as a commissioner he said he would expect enhanced recovery programmes to be used as a measure of good practice. "We would ask if the hospital down the road is doing it why aren't you?" he said.

But there was a gulf between health providers on the ground and those higher up, said National Association of Primary Care chair Dr Charles Alessi. But he added that it would only be a short time before enhanced recovery would be a part of any commissioning. He said the question was what was the point of surgery if patients' lives were not improved by it?

NHS Confederation associate director Karen Castille added that there were opportunities to develop a "co-production" model that everyone signed up to and understood their role in. She cited her own father, who had recently had an operation and was very clear about both what he needed to do to aid recovery and what therapists and others would be doing to help him.

She pointed out how individual patients' valued different outcomes: her dad's view of a good outcome would be to mow the lawn again. This could link to how the success of a procedure was measured. "There is an opportunity to change the accountability framework. At the moment, it tends to be very task driven."

WILDE FRY

"At the moment, enhanced recovery is seen as a surgery problem... we may have extended it to the hospital, but it's a whole system problem," she said. "What are health and wellbeing boards doing? Is this on their agenda?"

She added that commissioners could provide some pump-priming money to overcome problems in implementing enhanced recovery – such as funding extra equipment.

Royal Surrey County Hospital Foundation Trust clinical director Matt Dickinson also raised the issue of what outcomes should be measured.

Length of stay was often measured, but should other longer term measures be examined as well? Dr Alessi added: "We are measuring what can be measured, but not what is important. What we should be measuring is what people regard as being of value to them."

But is offering incentives to hospitals to provide an enhanced recovery the answer? Wendy Lewis, the enhanced recovery lead at Advancing Quality Alliance, said that local commissioning for quality and innovation (CQUIN) payments had been used, but these only lasted a year. "There are a lot of people who dabbled their toes in enhanced recovery because there was a CQUIN... it had a negative effect," she said.

"A 12 month period is not enough to have gone through introducing it across all the clinical systems and measuring the outcomes. The idea that in a year's project you can introduce enhanced recovery did us no favours at all," she added.

She stressed there were real benefits from enhanced recovery programmes. For example, when she had been working as a ward manager she had introduced it and the number of patients needing critical care beds dropped.

However, operational manager for physiotherapy Archie Kaul-Mead highlighted other issues around implementation. Her department at Colchester Hospital pushed forward early mobilisation for orthopaedic patients. "We did it without involving any of the medics. We wanted to shave a day off our length of stay," she said.

But to do this they had to change clinicians' behaviour; in particular, the use of spinal blocks in anaesthesia was a barrier to early mobilisation. This has been done successfully, but it was not always easy to change long-established habits.

She added that some patients were already nutritionally compromised when they come into hospital, which meant their nutrition needed more attention if they were to benefit fully. "Giving them special supplements the day before surgery will not be enough. There is a need to work them up," he said.

Professor Ljundqvist, chair of the international Enhanced Recovery After Surgery Society, added: "It's extremely important to get everybody on board from the top to the bottom. We make sure that it is always the team on the floor that runs the change. We don't let any team come onto our implementation training without the written support of their management."

He highlighted the importance of data in building communication within teams. Getting consultants and anaesthetists together to review data was important. "To change doctors, we need to have data to show that the practice they have is actually inferior to what some of their colleagues are performing," he said.

Ms Barlow added that there needed to be a shift in undergraduate education so that clinicians were taught best practice, which also required those delivering the teaching to be up to date with nutrition.

But Dr Fawcett suggested the postgraduate level should be where the focus should lie, because medical students would not be operating at a high level for 15 years. Although there had been support for a consensus statement on enhanced recovery from the royal colleges some time ago, there had been little action.

Summing up the debate so far, Mr Farrar said: "We have a really clear understanding of the benefits of applying enhanced recovery. We have identified a number of drivers that are likely to change that."

'At the moment enhanced recovery is seen as a surgery problem... but it's a whole system problem'

One of these was patient expectation of what care they would receive and the knowledge of their role in it, as well as using patients and their experiences to develop appropriate outcome measures.

Another factor was clinicians. "Do they have an understanding of best practice? What's their role within teams? Visible comparative performance between clinical teams that show uptake of best practice is a huge driver," Mr Farrar said.

Finally, he said, there was commissioning. "What are the incentives that could act as a catalyst for enhanced recovery? Commissioning has to reinforce best practice."

Seven or eight years ago enhanced recovery was a buzzword. "It feels to me that we have drifted back towards local adoption. Is there enough to drive this in the policy context? Which of these angles would be most fruitful to pursue?" Mr Farrar asked.

Mr Francis questioned whether commissioners should continue to fund operations at hospitals where there is no appropriate pathway for perioperative care, while Dr Alessi pointed out that people who leave hospital not in the correct state are likely to need help from local authorities as well as healthcare: there would be downstream effects.

But Mr Farrar pointed out that the NHS was both "a large rational organisation and a small village". To change behaviour it would be necessary to operate in the irrational – emotional – space.

He pointed out that the Advancing Quality Alliance had published data on compliance with a bundle of care: no one wanted to be seen to perform badly and this could be used as a driver for other changes. Patient questioning could also support change.

Ms Lewis said an elective patient at an engagement event in the North West had said if you can't get it right for us when you know we are coming how can you get it right for emergencies?'

She added: "Organisations completely refuse to pick up the evidence base because no one will fund them a nurse."

She warned against making it one person's job – what happened if they went on leave? – rather than embedding it so it was seen as a job for the whole team. "It does need leadership, but that should not sit in one place. It should be across the whole team," she said.

Professor Ljundqvist stressed the importance of sustainability. When he was involved in implementation, it took eight to 10 months and involved looking at data and acting on it. "The database is just a facilitator," he said. "The key is that we have people sitting in the room. I would like to extend an invitation to anyone in England to join us to see if we can put this in place for England as well."

Mr Farrar said that the nutritional aspect of people's care – an integral part of enhanced recovery – seemed to be in some respects quite straightforward to understand. It can come up in everything from Mid Staffordshire to a recent report on the rise in acute kidney injury and the role of hydration in that.

"There is no way that you would undertake a marathon dehydrated and fasting," Mr Fawcett pointed out. "We are now realising that carb loading and nutrition is key."

Ms Barlow said that the Welsh health service specified that everyone coming into major institutions should be nutritionally screened, but compliance with this was variable. "Nutrition fitted in with the dignity agenda," she added.

"The number of dietitians in our health service is barebone and the number working in perioperative care is miniscule," she said, warning that some areas had expanded the number of surgeons, but had made cuts in the services around them.

Cardiff had invested in dietitians in primary care who could see patients before they reached hospital. But while some hospitals used carb loading peroperatively, others 20 miles away did not.

Many panellists also welcomed the idea of personalisation and addressing the particular needs of each patient. "We are moving to a place where we are starting to talk about more personalised metrics," said Dr Alessi. But he warned some people would have their eyes firmly on the financial imperatives. There was a need for incentives to be aligned before things would change.

But how will things change? Mr Farrar said people seemed clear about why enhanced recovery programmes should be used and what should be done: what single step would make the most progress?

Dr Bajwa suggested making nutritional assessment easy would be helpful – along with an approach that every contact should count with everyone having a responsibility for making enhanced recovery work.

For Dr Fawcett it was the availability of good data that was key to enable everyone to see where everyone else is. Ms Castille described a tripartite approach with a fact-filled clinical leader with time dedicated to the task, good project management and support from the top. "In my experience, this approach is always successful whatever we apply it to," she said.

And Dr Alessi called for a change in "currencies" that determine payment in the NHS. Changing the basis on what organisations were paid for could be a driver, he said.

Ms Kaul-Mead said it was important that staff felt they were getting something out of change. "We were able to sell it to the nurses because it reduced stress because the patients were doing it for themselves [rather than ringing buzzers]. It was calmer and much less hassle for them," she said. "We all say that we think about patients, but deep down we also think about ourselves. Making that connection would be a key way to sell that message."

Professor Ljundqvist said: "I would like to encompass all of these." But added: "If we could join forces and work together to try to use the model we have seen in other countries to make another step in England."

Mr Farrar closed by saying: "There is a message here to the top of the office that says: instead of having the horror stories around nutrition, there are places that are doing better on this and they follow this programme." ●

WILDE FRY