5th ERAS UK Conference 2015

Chairs: Prof K Fearon & Prof O Ljungqvist

Speakers: David McDonald, Rachael Barlow, Tom Wainwright, Angie Balfour, Imogen Fecher-Jones, Irene Fitt

Chair: Could you just say who you are because is a multi-disciplinary audience and it's good to know who is asking the questions?

Delegate: My name is Simon I'm a general surgical trainee in Bristol, one of the things about compliance, although my motivation is high, is that nothing at any hospital that I have been at has this been mentioned in the doctor's induction. We hear about it on the ward, if it is becoming so important that is one thing maybe we can change across the UK, to get it into the junior doctor induction when they start a new hospitals. Saying how important it is and it not just about looking at the paperwork but the whole ethos behind why we are trying to do enhanced recovery because it works and junior doctors are such an important part of that, so I think that could be something we can implement.

What I was saying was at no point in any of my inductions in the last 5 years in any hospital I've been at has enhanced recovery mentioned at the start, we hear about it on the ward, but if you want to increase compliance you've got to get everyone knowing about it and knowing why it is important and not just filling in documents actually the ethos behind it and why it works and demonstrating to the hospital managers who may be less excited at the moment about the length of stay reductions because it clearly does work. and patients like to be out of hospital sooner. But I think getting it in the induction and February is going to be a really important part of moving it forward. Because a lot of our junior doctors haven't heard about it accept vaguely when they arrive.

Chair: I completely agree with that statement, and I think the issue starts at the under graduate level through training to the post graduate level, we should be thinking about introducing enhanced recovery to our medical under graduates and we should include elements of ERAS in post graduate examinations That certainly what I've tried to do and we introduced that into the exit exams for surgeons. Obviously these themes do occur in all the specialities that contribute to ERAS I know that anaesthetist for example have elements of ERAS in their training scheme I think about fluid balance for example during surgery. I completely concur with you that as a house officer or senior house office or registrar, you turn up on the ward and you wonder what is the pathway that is being followed here?

I think we need to be much more structured in having the ERAS pathway lead out in the induction pack that the juniors receive and it should be part of the paperwork that they actually use. These elements trying to integrate into the whole system are so important.

Chair: Do we have anybody on the speakers that would like to comment on that?

Rachael Barlow: We were talking last night how the society should be moving forward for the next 12 months priority and that's exactly what we were talking about is how to actually integrate enhanced recovery teaching both at undergraduate and postgraduate level and using the royal colleges, I sit on the nutrition curriculum development group and it has been very successful, so all Deans of education for medical schools have been sent the curriculum it's up to each university to

implement the guidelines for nutrition and we were saying last night whether we should have a comparable thing for enhanced recovery which I think would be very powerful.

We were also talking about induction, how to get core in at the start, I teach within Cardiff University so locally we have it, but obviously like Tom was saying this is about equity, how do we spread this across the UK? So any thoughts would be very welcome, as I said that was one of our key points last night.

Tom Wainwright: Just to add, on my trips around the country if I was to characterise the high preforming ERAS units across the specialties who have made improvements 5 years ago and have maintained those, one of the common features is that the lead clinicians are actively involved in ongoing training of not just medical staff but of all health professionals in all the wards and departments. We have a constant changing of staff so that core group that got together where you implement enhanced recovery for the first time, some people will get promoted and move on, how do you invigorate all the people that come into it?

One example in orthopaedics, that is an exemplar example is Northumbria which I was at 2 or 3 weeks ago, they have an annual conference where they raise money for training their staff for throughout the year and sending their staff on trips to visit other exemplar sites and they are ongoing training programme is not just for the doctors and anaesthetists it's for all of the professional groups.

So I think your bang on and I think there will be many people in this room who would do that sort of training for new staff, it's how we ensure it is new staff all the time. Again it comes back to the pressure on the ERAS nurses, because it takes time to bring those things together so we have to have a supportive environment in our hospitals to allow us time to spend time on those activities.

Imogen Fecher-Jones: I just what to say in Southampton we have managed to get on to the Doctors induction, but they have given us 5-10 minutes so it's not enough time for 5 pathways but what it has enable us to do is to is a really simple idea which works very well for us, is we have developed a credit card style aid memo of our pathways and it's a 2 sided laminated we give it out to all the junior doctors and they just attach it around their waist or in their pockets, but it is that reference they can use every day. So they're not asking the question what is this pathway? They might not have had time to have read the entire document, although we would suggest they did. But they have got it to hand so there is no excuse not to know every day what that patient should be doing. I am happy to share that with you, it is a very, very easy thing to knock out and give to your junior doctors.

David McDonald: Another thing we have done in Scotland we have developed a learn pro tool kit, so your know mandatory modules you have to do your fire training etc. we've developed an enhanced recovery learn pro module which we will hopefully launch in January this year, it will be available for everyone and hopefully it will become mandatary training that you will have to complete the module and it is aimed at every speciality it's not speciality specific and it is to ensure we get some of that training out there. We have it in NHS Scotland I'm happy to share it with everyone, there is no need to invent the wheel again!

Ollie Ljungqvist: Just a comment from Sweden, we have introduced enhanced recovery as part of the training on the course for the trainees for colorectal so that is embedded in their training and I think this is also happening in other domains of surgery, the other thing is I think clearly the panel has pointed out that it not just having the process in place it is about making sure you are putting it in the hands of the people coming. We have rotation of younger staff all the time and new nurses and

so forth. So that's a very important task, but I think again the nurses are the best organisers of this but it has to be a team effort in the teaching.

Ken Fearon: Okay we will now diversify of the education theme. I know we are all believers here, but I'm interested to see if we do a quick audience survey we what you to put your hands up if you believe an ERAS nurse is essential for a successful ERAS programme?

Now I would say that looks like 80%. Now I'm coming back to Tom now, I'm starting with you I will ask the rest as I go along the table. I'm interested in your data where you were looking at outcomes. I'm very passionate about ERAS nurses I think no ERAS nurse, no programme. When I say ERAS nurse, it can be an ERAS professional who's aligned to that principle cause, it can be a multi-disciplinary role, but it is general a nurse that performs that, but you have to have someone running the programme. What was interesting for me in the data you present today Tom, was for example in orthopaedics' fantastic outcomes really for England to be sawing their way through 8000 knee replacements a year and having that length of stay. I actually think that is a fantastic achievement and I take my hat off to my musculoskeletal colleagues and say abdominal surgeons nil orthopaedic surgeons 10.

So that's one thing that really impressed me, but the other side of the coin that was missing was can you tell us in how many hospitals contributing to that data is there an active ERAS nurse? Have you got any handle on that have you any idea is it 1%, 10% or 50%?

Tom Wainwright: There is a short answer to that Ken, I don't know! If we take orthopaedics as an example because of the volumes involved, it's an interesting talking point about ERAS nurses this is a generalisation there is not the historical same ERAS nurse in orthopaedics but that is largely because we do higher volumes of those procedures compared to all the others. It has to be a much more process and system approach to get those kind of results. I think the thing we can learn about from process and system improvement from that data I've only started digging slightly behind it, there is a change where this operations are being performed.

From my visits from around the country for hip and knee replacements there is no doubt that the private providers who are doing NHS work are doing it in a very tight process manner. They don't have ERAS nurses but they have very tight protocol and paper work and also performance measures in that it is only going to be worth their while doing the procedure if the can do them efficiently, so that has bought a focus in terms of an orthopaedic perspective.

In terms of the question more widely about the other specialities, regarding ERAS nurses they seem to be a vital cog when we go to an exemplar unit. For me their role is actually a result of the inherited structure that we have in our hospitals and that is a patient moves along their journey but they move across departments and managerial structures and hierarchy.

What the ERAS nurse does is they are the person how cares about the end to end pathway. We are traditionally set up to care about our bit of it and as long as we do our bit and we keep our budget in our department that seems to be what we focus on.

The ERAS nurse role sees the value in the outcome of the end to end pathway and this is analogous with industry, especially with lean and process redesign, they call it a chief engineer position were you don't have any managerial responsibility for everyone in the pathway but you have a responsibility for the outcome of the pathway and I think that is where they definitely have their value.

Olle Ljungqvist: You pointed out, and I think all of you showed pretty much a similar trend, that over time length of stays were coming down and in fact we didn't have a national programme in Sweden for enhanced recovery like you did, but if I look at the colorectal numbers they are pretty much identical.

One of the things that has happen in Sweden, well two things actually, we have trained about 40% of the hospitals that are doing it and we know the results of them is actually lower than the national average and we know if you do laparoscopic surgery which is getting more and more common that would bring it down by another day or so.

So my question was do you have any grip as you have a huge variation at least initially and what brought down the variation and is there any way you could look at the data to see the ones that had a nurse or had more compliance or things like this for the better outcomes?

Tom Wainwright: The data interrogated was the hospital episode statistics data, that doesn't tell us if there was a nurse or not, but overlaying that data with a survey with the actual set ups and characteristics of hospitals would be a really valuable exercise, there is evidence from the NHS institute on their focus on their series back about 5 or 6 years ago they looked at the top 10 performers and the bottom 10 performers and just done a very clear look at what was the differences in their set ups and that's one way in getting to the answer quicker than doing every hospital.

Rachael Barlow: I alluded to my brief slides that I've used this data, which was hot off the press we only received this data through the data analysis last week, but certainly with in Wales already flagged up to Ministerial level, that we're potentially an outlier, it's always good to be able to compare yourself as a nation to other local nations and also in Wales and certainly if you can compare to England that's the biggest motivation to change.

So I have now been tasked with writing reports and we have actually looked at this data very briefly, but looking at things like, age, depredation also down to consultant level where we can look at variation, not at performance management strategy because that in my view would be wrong. But certainly we can look at hospital level, Health board level, so it's actually quite fascinating how detailed this information can be.

One thing I did pull off was emergency verses elective and certainly by default it looks like our emergency colorectal surgery is reduced by about 3 days presumably because of the osmotic effect of enhanced recovery.

We are not deluded in Wales at all, we know we have a huge way to climb and certainly I think the majority our improvement took place when we had an active national funded programme. Without going into too much detail but we pulled down a £1million grant from the Welsh Government to launch our enhanced recovery programme and this was on an investment to save basis, which was very fascinating being the lead on that piece of work, it was very financially driven and possibly the message for quality was lost in that. The next year is certainly going to be quite interesting for Wales.

Ken Fearon: Can I ask the nurses in the panel, is the difference between MSK and abdominal surgery the fact that generally the abdominal surgery, certainly in colorectal the majority of patients have cancer, so they are slightly sicker patients they have a systemic illness when they come into the pathway, where as MSK you are dealing with relatively healthy, not all healthy, but they are relatively healthy individuals and is that the difference between the need for the role of the enhanced recovery nurse.

I'm just interested in your views about why Tom says MSK can run a pathway, can get it all working and produce these phenomenal results on an industrial scale and we abdominal surgeons are faffing about in the breeze, is it because we have sicker patients that we are a bit more nervous about we need more nursing input. What is it?

Finally I'm going to ask my colleague Param Mariappan from Edinburgh, Why is it urology is still dawdling around there in nationally a 14 day stay for cystectomy, but we will come to that at the end. What about the nurses, why is there a difference between abdominal surgery and MSK and Tom's not allow to answer?

Irene Fitt: I'm not convinced that there is, I think the same principles are applied no matter what speciality. I think probably between us all we need to be a patient advocate and therefore we all need to have the same goals, as a team in our own hospital we are seeing amazing results with colorectal patients going home in 3 days and doing follow up and we have reduced our readmission rates as well.

Ken Fearon: I know there are stellar centres where these fantastic result can be achieved and even in Edinburgh our medium stay for colonic resection is down to 4 days now. I'm interested in national thing, what is it at national level we can't really get this moving in the abdominal surgery. What's the problem?

Tom Wainwright: On the note of complexity what we see in some of the orthopaedic series is actually the most complex patients within those cohorts gain the most from the enhanced recovery, so I think that's a key point really it's not just for fit people it's for everyone and the most benefits are for the one at most risk, so that bears out really the answer of my colleague.

Nader Francis: If I may say a couple of words about all of these comments, I think we can celebrate what we have been through in the last 5 years, I think we have moved quite far as a country, but obviously from the data we have seen there is still a lot of work to do and if I just reflect very briefly on colorectal (being a colorectal surgeon) to come as a nation as England from 8 days to 6 days that's quite a big achievement and If you look at any learning curve you have a rapid increase at the beginning and things plateau, but that's not yet, we are not there yet and things slow down.

Our task in the next few years is to keep it moving from 6 for example to 4. My personal perspective in how to do that is by examining very carefully what we do. For learning any skills you have a very initial rapid improvement then you slow down, then you sit and examine what you have been doing and you can examine by looking at your own data and examining the areas which you can improve and put resources into these areas how to take it to the next stages. So I'm hoping in a few years' time to sit down in the same conference and see our length of stay come down to 4 days. I really, really hope that will happen if we put the time and effort in.

Ken Fearon: Any further comments from the audience?

Delegate: I am Eleanor, I am one of the stoma nurses at UCLH, as of Monday I'm an Enhanced Recovery nurse at a different Trust, it sounds like I have a lot of work to do as an Enhanced Recovery nurse, we have a lot of support as stoma nurse, we have a lot of support, we have the association of stoma care nurses etc. and we have regional groups, is there anything out there for Enhanced Recovery nurses and how do I get involved?

Angie Balfour: There is a communication network amongst ourselves but that's emails at the moment there was a forum set up but perhaps isn't working quite as well as would be expected and I think that is what we are going to look at today, a better way to be able to communicate. We are a huge resource for ourselves, communication and not reinventing the wheel. I think Imogen has some ideas how we might be able to share some of the information that we've got and access it, have it there ready so we can look when we need it.

Imogen Fecher-Jones: Keep your eyes on the ERAS UK website because we will be working closely with Fiona and Nader and once we have got something established for the nurses we will be putting it out there and we want you all to chip in so we can all be sharing knowledge and not having to keep sending out the same things out every time 3 years as you get new team members in.

Angie Balfour: There is also the ERAS international nurse forum that we are working hard to improve and make it more user friendly and we are hoping to have a patient related section on that later on.

Irene Fitt: Just to say for the mean while the emailing is a half way measure and if you're not on that email list at the moment, if you want to grab one of us later we can certainly put your name to it.

Delegate: I'm Rachael, and I'm an Enhanced Recovery nurse at Salford Royal and that comment there that the young lady has just mention in the North West we meet every 4 months as a group, there's about 20 of us. We met last week and we sit and discuss data, we spent a long time discussing data, and it works quite well for us, email conversations, but meeting once every 3 or 4 months.

Angie Balfour: I think it is fair to say that it needs a little work we need to make ourselves more approachable to one another, because that's an excellent idea and I would like to tap into that up in Scotland. We have a Scottish nurse forum that meets every 3 or 4 months, but it is challenging in this particular climate to get people released from their work areas. We try and have it as centrally as possible, but we have people coming from up North and down South it's tricky but it is something that we have to work towards.

Delegate: I have one further comment on that list that you had earlier on, I would like to see discharge follow up phone calls, because people think it's just a nice thing to do, but actually from our perspective as nurses it is reducing readmissions, so that it is one thing we thought you could add to there.

Ken Fearon: So, okay there seems to be a clear need for better communication within the nursing component of this. So there is clarity of lines of communication in terms of web sites and groups and I think that is something that you are very keen to develop and I think there is a clear need for that from the audience. Last question.

Delegate: Good morning I'm Marcus Fletcher, I am a consultant anaesthetist from Kent, I think to answer some of the points you raised earlier the first thing you need to do about Enhanced Recovery is actually get it ingrained in the fabric of the NHS delivery in the United Kingdom. If you look at big role out changes that have happened in the last few years "WHO check list", really aggressive targeting of venous thermos embolisms and treatment of prophylactic and infection control. They all

came from bottom up and top down. I don't think yet Enhanced Recovery has got that department of Health presence that allows the fabric and infrastructure just to allow us to drive this process forward.

So at the local level in my experience the key person in delivering Enhanced Recovery, yes the Enhanced Recovery nurse is absolutely vital in the actual implementation, audit and hopefully the delivery of the service, but until you get the surgical teams on board and specifically the consultant surgeon I think you will struggle the reason for that is in the United Kingdom it's the surgeon owns the patient, it's the surgeons who's data is analysed, it's the surgeon who has the control about discharge and admission and the whole perioperative care pathway. So for example our Trust has appointed an Enhanced Recovery nurse now, and the surgeons just by appointing her thinks will happen, but because they are not helping her deliver the vision that they asked her to deliver we aren't doing particularly well.

Ken Fearon: I completely agree with that, without surgeon engagement in the process you are going to be working with one hand tied up behind your back. I think experience from other centres is equally well getting the anaesthetist to adopt a uniformed pattern of care in theatre is an important element of this and equally getting the nurses who are not ERAS nurses but in the process to engage with the process pathway fully is also important, so I completely agree that the surgeon is important element of this pathway but I think in different circumstances you will find there are other areas which also need to engage fully and it is when you get them all lined up that is when the programme can be successful.

Delegate: Your absolutely right, but if you look at our own institution, one of the slides earlier on actually said this in essence, the difficult bit of enhanced recovery is after the operation, the easy interventions are pre-op, nutrition and I think most anaesthetists are coming round in using shorter acting agents and not being too heavy handed with analgesia and looking at local anaesthetic techniques but your intervention there is relatively discreet and limited and then you hand over to the ward and things become a lot more difficult to implement there and there is a lot more variability in the standard of care.

Now you could argue that we should all be working in a multi-disciplinary approach I shouldn't be tied to an anaesthetic machine and I should be seeing patients post-operative with the surgeon and offering input in to pain management and nurses should be coming into theatre and understanding what it is we do about our operations that means certain patients will be easier to put through a programme then others.

The way the UK system is set up at the moment means the surgeon is going to be the key player. The surgeon and the Enhanced Recovery nurse are the two key players and because the surgeon takes the responsibility and carries the can it is really key to get the Royal College of surgeons involved and the Department of Health top down to get Enhanced Recovery ingrained in the fabric of the NHS

Ken Fearon: Very helpful points.

Olle Ljungqvist: I completely agree.