# **Enhanced Recovery**

"You're better sooner"

# Maintaining the momentum Spread & Adoption

Angie Robinson
National Improvement Lead
NHS Improvement

## Enhanced Recovery Partnership

#### The Partnership:

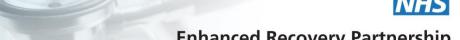
- National Clinical Leadership, NHS Improvement, National Cancer Action Team, Department of Health, SHA's, Cancer Networks
- National Advisory Board for enhanced recovery

Dedicated Enhanced Recovery Website

www.improvement.nhs.uk/enhancedrecovery

Named ERP Lead within the partnership working with each SHA to support local spread and adoption of enhanced recovery

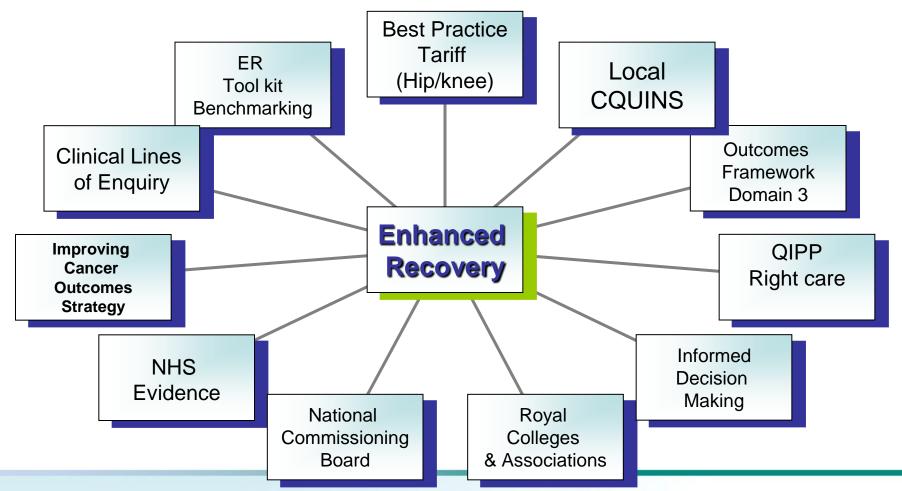
SHA Leads & Enhanced Recovery Partnership Leads North East SHA - Lynda Dearden **ERP Lead: Marie Tarplee** North West SHA - Rhona Collins **NHS Improvement Advancing Quality Alliance (Aqua) ERP Lead: Wendy Lewis** Yorkshire & Humber SHA - TBC **ERP Lead: Pamela Hayward-**Sampson **NHS Improvement Associate** West Midlands SHA - Jan Yeates East Midlands - Tika Kahn **ERP Lead: Bernie County ERPP Lead: Marie Tarplee NHS Improvement Associate NHS Improvement** East of England SHA – Heather **Ballard** South West SHA- Paul Stroner **ERP Lead: Sue Cottle ERP Lead: Angie Robinson NHS Improvement NHS Improvement** London SHA - Khadir Meer **ERP Lead: Sue Cottle NHS Improvement** South East Coast SHA - Kay South Central SHA - Rachel Wakefield **MacKay ERP Lead: Ann Driver ERP Lead: Andy McMeeking National Cancer Action Team NHS Improvement** 





The next 12 months Maintaining the momentum

### Opportunities Enablers, Levers & Alignment



# Enhanced Recovery You're better sooner...



- •SHA's reported most providers have enhanced recovery at some stage of evolution in at least one specialty (Colorectal, Gynae, MSK, Urology -cystectomy/prostectomy)
- Continue to compile clinical evidence FOR OTHER SPECIALITIES
- Enhanced recovery tool kit valuable benchmarking include other specialities
- Update Implementation guide –LOOKING FOR NEW CASE STUDIES
- Engagement with national bodies to embed enhanced recovery as the standard model of care

### Maintaining the momentum

 Incentives: CQUINS and PbR best practice tariff can be useful. Plans need to be in place to ensure sustainability post incentive.

## Regional CQUIN

- A Commissioning for Quality and Innovation (CQUIN) payment is a contractual incentive payment that enables commissioners to reward excellence. A regional CQUIN has been agreed for use by commissioners in London in 2011/12 to incentivise the implementation of enhanced recovery pathways for 8 procedures within colorectal, urological, gynaecological and orthopaedic Indicators
- Reporting on the National ER data base
- 80% Surgery performed on day of admission
- Goal directed fluid therapy for colorectal surgery
- Reduction in Length of stay



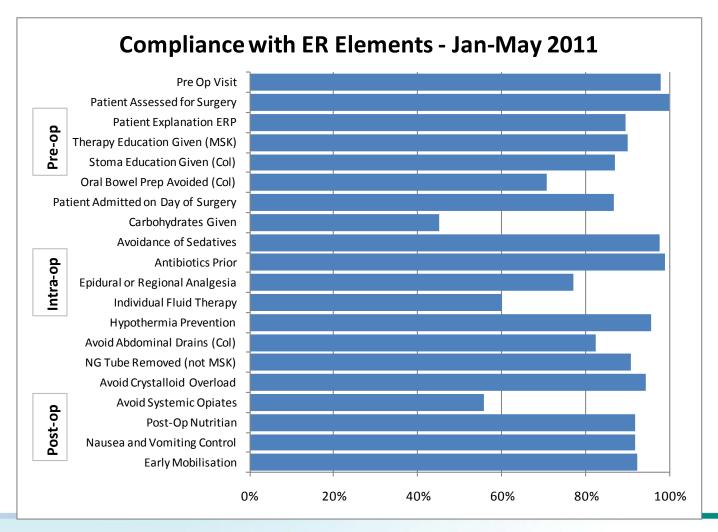
**Enhanced Recovery Partnership** 

#### **National Enhanced Recovery Tool**

- A national tool has been developed to allow any trust to audit their implementation of their local enhanced recovery pathway. It's free to use and provides immediate access to benchmarking reports.
- The dataset consists of data fields which covering the following
  - Audit number, DOB, Gender
  - Operation, diagnosis, dates of admission, operation, discharge
  - HDU or ITU bed days
  - Patient experience
  - Details of re-operations or readmissions
  - Death?
  - Compliance against ER pathway (19 measures)
- In addition there are 25 fields covering risk adjusters, post-op morbidity score, POSSUM (morbidity and mortality risk)
- The tool allows users to download their data for local analysis or to run one of the pre-defined reports.
- To access the tool and to obtain a user name and password go to

https://www.natcansatmicrosite.net/enhancedrecovery

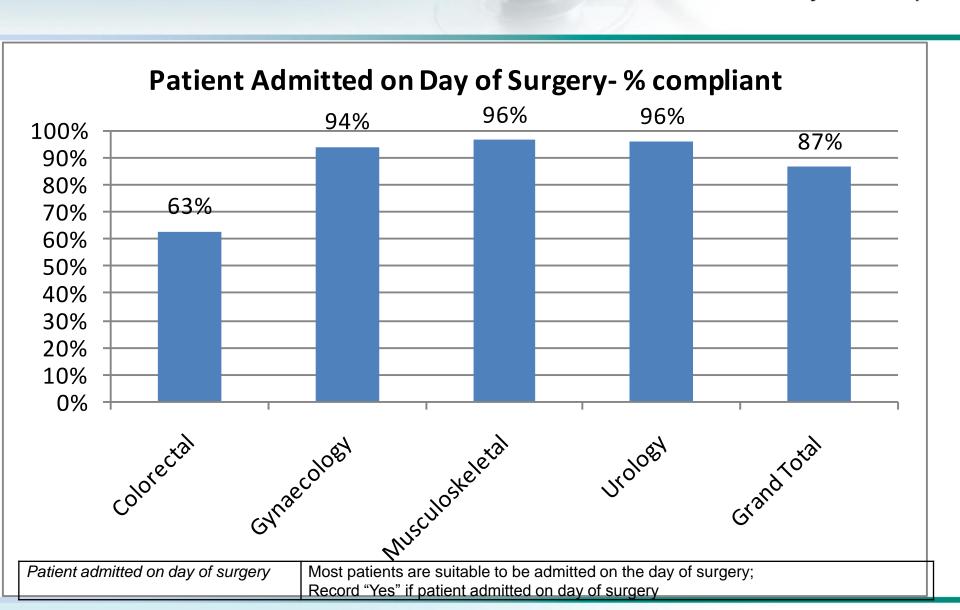
#### **Uptake of the elements of ER**



# Enhanced Recovery You're better sooner...

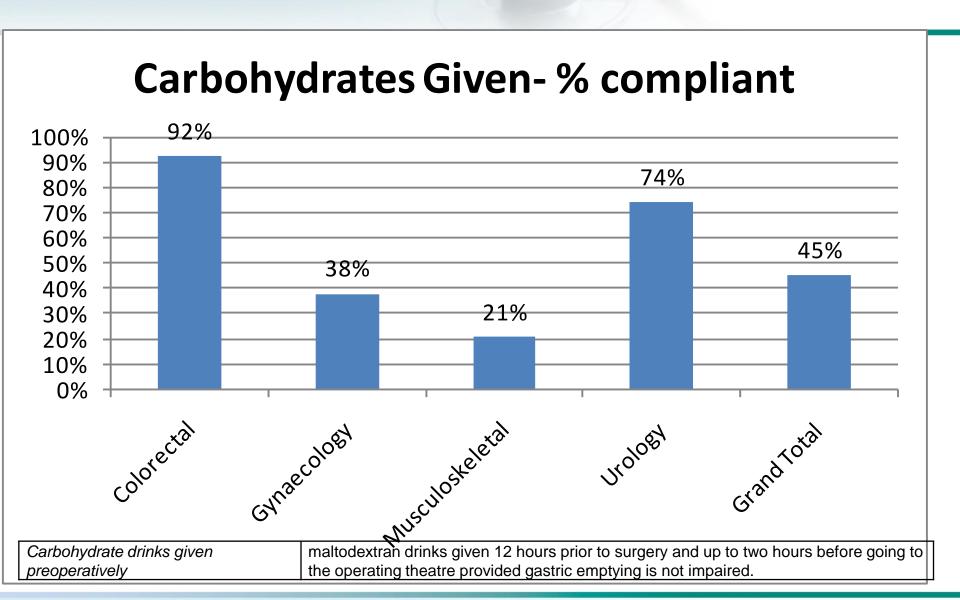


**Enhanced Recovery Partnership** 

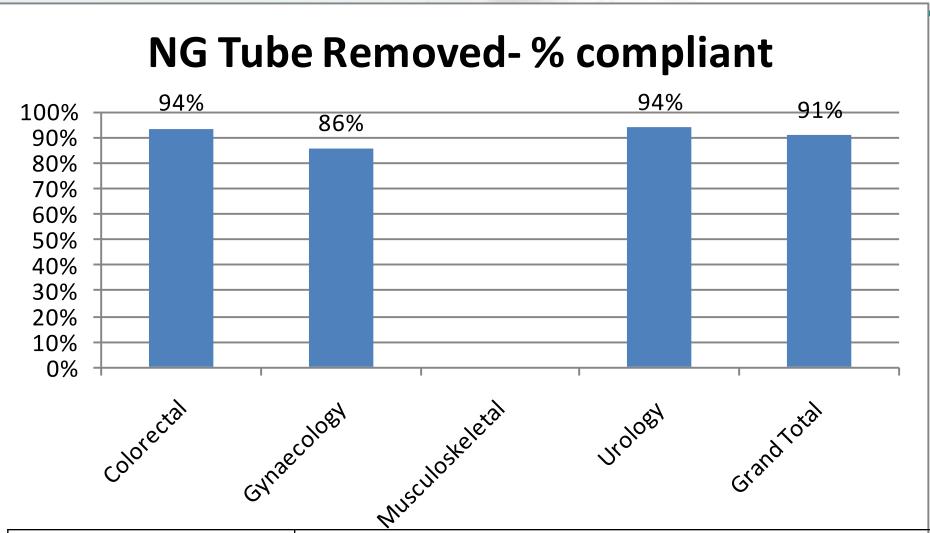












NG Tube removed before exit from theatre

Definition not required (not applicable for MSK patients)

### How do we move forward in Upper GI?

How many patients are benefiting?
How many should be?

How many elements of enhanced recovery do you have implemented?



What are you doing locally to take
Enhanced Recovery forward?

How do we share what you are doing? Building the evidence base



### What Bill has found

#### ER UPPER GI AUDIT

		Number	Median CCU Stay (days)	Median Hospital Stay
Oesophagectomy	Pre	16	7.5	20.5
	Post	9	7	17
Total Gastrectomy	Pre	7	5	18
	Post	11	5	15
Subtotal gastrectomy	Pre	13	3	13
	Post	7	2	12

#### **Enhanced Recovery**

You're better sooner...



#### What elements are relevant to Upper GI?

**Admission** 

Referral from Primary Care

- Optimising pre operative haemoglobin levels
- Managing pre existing co morbidities e.g. diabetes

<u>Pre-</u> Operative

- Admission on day
- Optimised Fluid Hydration
- CHO Loading
- Reduced starvation
- No / reduced oral bowel preparation ( bowel surgery)

Planned mobilisation

NHS

- Rapid hydration & nourishment
- Appropriate IV therapy
- · No wound drains
- No NG (bowel surgery)
- Catheters removed early
- · Regular oral analgesia
- Paracetamol and NSAIDS
- Avoidance of systemic opiate-based analgesia where possible or administered topically

 Optimised health / medical condition

- Informed decision making
- Pre operative health & risk assessment
- PT information and expectation managed
- DX planning (EDD)
- Pre-operative therapy instruction as appropriate

- Minimally invasive surgery
- Use of transverse incisions (abdominal)
- No NG tube (bowel surgery)
- Use of regional / LA with sedation
- Epidural management (inc thoracic)
- Optimised fluid management Individualised goal directed fluid therapy

Intra-Operative

> Post-Operative

- DX when criteria met
- Therapy support (stoma, physio)
- 24hr telephone follow up



Follow Up



- Please discuss and record on your worksheet
- Are there any differences for Upper GI patients. Please record them and the reason why?
- What do we need to do to help build the evidence base for Upper GI?