



Enhanced Recovery Partnership Programme

Report - March 2011

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Enhanced Recovery Partnership Programme

Report - March 2011

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Foreword

Over the last two years, the Enhanced Recovery Partnership Programme has raised the profile of enhanced recovery, building the evidence base, engaging clinical champions and key stakeholders, and creating drivers for change.

Clinical champions have actively worked as part of the partnership to engage the professional bodies and support the Strategic Health Authorities, to engage clinical teams. Across the NHS, teams have tested and implemented enhanced recovery pathways for colorectal, musculo-skeletal, gynaecological and urological major elective surgical procedures. These 'early adopters' have demonstrated the improvements in patient care and experience that can be delivered through enhanced recovery.

However, more still needs to be done to support further adoption and spread and embed enhanced recovery as the norm. We need to work to further reduce the variation in clinical practice, further improve patient experience and realise the associated productivity and efficiency gains enhanced recovery can deliver.

To do this still requires effort and energy. The engagement and the momentum achieved through the Enhanced Recovery Partnership Programme needs to be maintained. There is commitment from clinical champions to continue to network and form a community of practice under the 'Enhanced Recovery Partnership' banner. This will secure further engagement with the professional bodies and associations, and provide a vehicle for the ongoing dissemination of the evidence base built over the past two years.

Over the next 12 months maintaining clinical leadership together with the ongoing support of the NHS Improvement, National Cancer Action Team and the NHS Institute for Innovation and Improvement, in partnership with each of the Strategic Health Authorities, will move us closer to the goal of whole scale adoption of enhanced recovery across the NHS. This will ensure that across the NHS we deliver best practice in the care of patients requiring major elective surgical care.



Mike Richards
National Cancer Director
Chair – Enhanced recovery Partnership Programme



Executive summary

The Enhanced Recovery Partnership Programme was established to support the NHS to implement and realise the benefits of enhanced recovery in colorectal, musculoskeletal, gynaecology and urology major elective surgical pathways.

The implementation of an enhanced recovery pathway requires changes to clinical interventions and supporting clinical systems. The process of change is multifaceted and iterative and starts with awareness raising and winning hearts and minds.

Teams need time to test, evaluate, refine and embed change based on evidence of their own practice. Realising the potential productivity and efficiency gains is proving to take longer and is best achieved by adopting enhanced recovery as the standard model of care. This requires standardisation and consistent delivery by an integrated and stable multidisciplinary team, which includes primary care.

Patient focused benefits however, can be realised throughout the process of implementation and teams have reported high levels of patient satisfaction through involvement, empowerment and partnership that is central to the enhanced recovery philosophy. There is also significant opportunity for patients to become key drivers for change and truly embrace the concept heralded in the recent white paper of 'no decision about me without me.'

Enhanced recovery is contributing to the underlying trends of shorter lengths of stay and increased surgery on day of admission. The differences for fully implemented providers are not yet as great as might be realised, but they show improvements in the right direction. This appears to be achieved without affecting readmission rates or outcomes (PROMs) and with a positive surveyed patient experience.

The best estimation we have currently is that about 86% of provider organisations have enhanced recovery pathways in at least one specialty. This is significant progress from the position in April 2009 when the best estimate was 40 - 50 providers.

The rate of spread across providers is variable and is dependent on factors such as the organisational culture, strength of clinical leadership, relationships between clinicians and managers, the way clinical teams work and capability and capacity in change management.

Much has been achieved to raise the profile and initiate the spread of enhanced recovery. The professional bodies and organisations have acknowledged the ongoing role they need to play to support widespread adoption. All SHAs plan to continue some level of support but work to engage with the NHS Commissioning Board and GP Consortia will be crucial as the NHS reforms progress next year.

There is growing support for enhanced recovery principles to have universal application across surgical care. Realising this ambition has potential for greater impact in improving patient outcomes and experience and the associated productivity and efficiency gains.

Introduction

Enhanced recovery is an approach to the care of patients undergoing major elective surgery, based on the following principles:

- the patient is in the best possible condition for surgery
- the patient has the best possible management during and after his/her operation
- the patient experiences the best post-operative rehabilitation

Originally pioneered in Denmark in colorectal surgery, enhanced recovery has now been shown to also benefit patients undergoing musculoskeletal (MSK), urological and gynaecological surgery. It is now starting to be tested in other major surgical pathways.

Implementing an enhanced recovery pathway may require changes to surgical technique with a focus on minimally invasive surgery, anaesthetic technique, pain management, nutrition and fluid management and mobilisation. Central to the enhanced recovery concept is involvement of the patient as a partner in their care.

Minimising the stress a patient goes through both mentally and physically means that the patient recovers more quickly following surgery, have a reduced length of hospital stay and get back to normal activities sooner. There is additional evidence of long term improvements in health outcomes through minimising the surgical stress response. Patients report improved experience of their care and treatment.

By 2009 the adoption of enhanced recovery had remained fragmented across the NHS, limited to pioneers and enthusiasts and supported through programmes such as ERAS (Enhanced Recovery after Surgery), the Cancer Reform Strategy's; Transforming Inpatient Care Programme and Rapid Recovery (in musculoskeletal surgery). The best assessment at this time was that around 40 – 50 providers had clinical teams that practised enhanced recovery in one or more specialty, but there was no comprehensive assessment available of the rigour with which these teams had implemented the clinical elements of the pathway. Many other teams had implemented some of the elements as part of their ongoing development of clinical practice. Reviewing the national Hospital Episode Statistics data (HES) there was considerable variation in length of stay (largely unrelated to volume) which led to the assumption that there was wide variation in clinical practice and clinical systems design and delivery and significant opportunity for improvement.

A review of clinical evidence identifying the potential improvements in quality of care and resultant efficiency and productivity gains was completed and a programme of national support was established to accelerate implementation and support the NHS to realise the benefits.

This report documents the work of the Enhanced Recovery Partnership Programme, April 2009 – March 2011. It reflects the emergent evidence and changing context for the programme delivery. It also reviews the evidence of spread of enhanced recovery to date, including benefits realisation and outlines the progress still to be made.

The Enhanced Recovery Partnership Programme would like to acknowledge the role of the Advisory Board (see appendix 1 for membership) and clinical teams who have pioneered enhanced recovery, who have generously shared their knowledge, expertise and experience to develop the programme and support others with implementation.

The Enhanced Recovery Partnership Programme

The Department of Health in partnership with NHS Improvement, the National Cancer Action Team (NCAT) and the NHS Institute for Innovation and Improvement have led a two-year programme, April 2009 – March 2011, to accelerate and provide support for the spread and adoption of enhanced recovery in colo-rectal, musculoskeletal, gynaecology and urology major elective surgical pathways. Focus was given to these four specialties as the evidence of improved outcomes was most compelling

Programme aim:

'To improve the quality of patients care, through improving their clinical outcomes and experience, and reduce the length of elective care inpatient pathways across the NHS by utilising the good practice principles of the enhanced recovery model of care.'

Year one, April 2009 – March 2010

During the first year of the programme work focussed on:

- understanding the extent of enhanced recovery practice in the NHS and identifying best practice,
- learning from these pioneers using a variety of methods including workshops, meetings and commissioning a delphi study to determine the key principles of enhanced recovery, essential clinical elements of the patient pathway, key metrics and critical success factors,
- development of case studies and compendiums of clinical evidence
- setting up a website to share information and resources (including locally developed protocols, pathways and patient information shared by clinical teams) to support implementation,
- producing a full financial and equality impact assessment,
- publishing an implementation guide,
- development of an online reporting tool to support implementation,
- establishing a clinically led Advisory Board,
- setting up a programme of support for 15 innovation sites, to better understand the critical success factors for adoption, spread and sustainability,
- establishing a named lead for enhanced recovery in each SHA and running a series of information events (three events attracting 510 delegates) to prepare for a full programme of spread and adoption across the NHS during 2010/11.

Year two, April 2010 – March 2011

The principle work stream during the second year has been to support Strategic Health Authorities lead programmes of spread and adoption to support delivery and commissioning of enhanced recovery for the four specialties by providing:

- funding (£70,000 per SHA) for local networking, events and clinical leadership,
- named executive, clinical and service improvement leads from the national programme team to provide hands on support and advice,

- networking opportunities for SHA Leads to share best practice, and challenges to learn from each other and support innovation and problem solving,
- web-based service improvement resources,
- three national events to raise further awareness of enhanced recovery and improved engagement of the multidisciplinary team and attracting 515 delegates,
- a series of 10 specialty and topic based web casts, to avoid the impact of time away from the clinical service to attend national events,
- provide ongoing support and networking opportunities for 14 innovation sites, to continue to learn from their implementation experience and ensure they can contribute to their SHA programme to support spread and adoption,
- review of the clinical pathway for each specialty, linked to the development of the national Map of Medicine content for enhanced recovery,
- creating ongoing opportunities to learn about the critical success factors that support spread, adoption and sustainability,
- benchmarked data from HES on activity, LOS and readmissions,
- National reports based on progress reported by sites via the ER reporting tool.

The programme of work has undergone continued review and refinement over the year in response to:

- the emerging evidence from the innovation sites,
- national data and reports including the delphi study and enhanced recovery reporting tool,
- local SHA programmes and learning from organisations and clinical teams progress with implementation and sustainability,
- changes in the NHS delivery context resulting from the change in Government and the publication of the white paper 'Equity and excellence; liberating the NHS' in July 2010.

The spread and adoption work stream has been underpinned by the communications and engagement plan to:

- develop promotional materials (core scripts, Q&As, posters and slide sets),
- redevelopment of the DH website,
- supported the successful submission of 20 journal articles and conference abstracts,
- updating case studies and compendiums of clinical evidence,
- develop patient information, including the enhanced recovery content on the NHS Choices website and supporting the updating of national patient information,
- preparation of material to support commissioning enhanced recovery for future release,
- manage the final migration of the DH Enhanced Recovery website content to the NHS Improvement website.

Position at the end of the programme

The programme has used a variety of information sources to gather hard data and soft intelligence about the progress of enhanced recovery implementation across the NHS.

This section presents information about the progress made by the innovation sites, together with the national picture comparing key outcome measures of length of hospital stay, readmission rates and patient experience. It also presents data from the reporting tool on process measures of compliance with the clinical elements of the enhanced recovery pathway.

The soft intelligence about the critical success factors that are necessary for spread, adoption and sustainability of enhanced recovery are detailed in section 6.

Innovation sites

In April 2009 in partnership with the SHAS 15¹ organisations were selected to become innovation sites for enhanced recovery.

Innovation sites agreed to share their experience of adoption, spread and sustainability and in return were given support from a member of the Enhanced Recovery Partnership Programme Team, peer support and shared learning through a series of learning workshops and other networking opportunities.

The organisations selected had varying experience of implementing enhanced recovery and varied in their approach to testing and implementation. Some sites chose to start with an individual clinician led team, whilst others have taken a speciality wide approach.

Most innovation sites have reported their progress of compliance with the clinical elements of the enhanced recovery pathway through the Enhanced Recovery Reporting Tool. Data extracted from the tool has been analysed together with HES data to evidence progress of both process and outcome measures.

In addition, three other assessments of progress have been undertaken; the evaluation report of year one in May of 2010, followed by two surveys of spread and adoption in November 2010 and February 2011.

Findings:

In May 2010 there were approximately 43 specialty based projects. All sites had implemented enhanced recovery projects in colorectal surgery, but at this time we did not have a clear picture of the stage or scale of implementation planned or achieved.

The spread and adoption surveys aimed to address this and involved teams self-assessing their stage of planning and implementation across specialties. 13 sites participated in both surveys.

¹ One organisation withdrew during year one. Any innovation site data in this report relates to only 14 innovation sites.

Figures 1 and 2 show the percentage of teams at the four stages of implementation reported in the two spread and adoptions surveys.

Figure 1

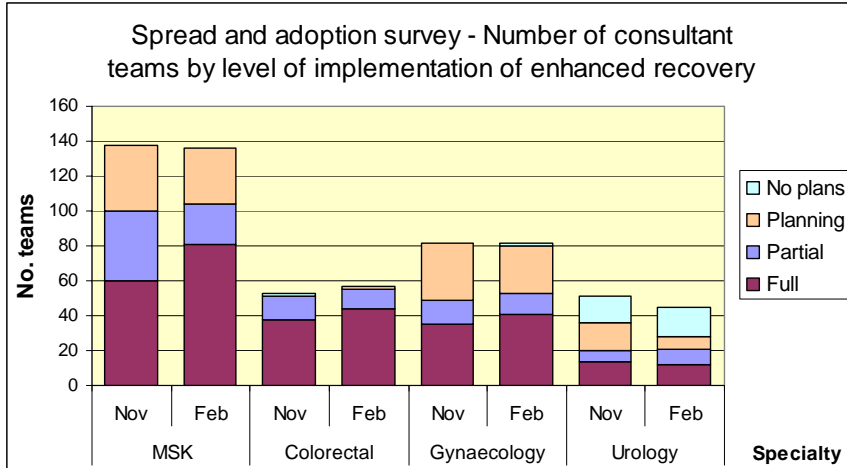
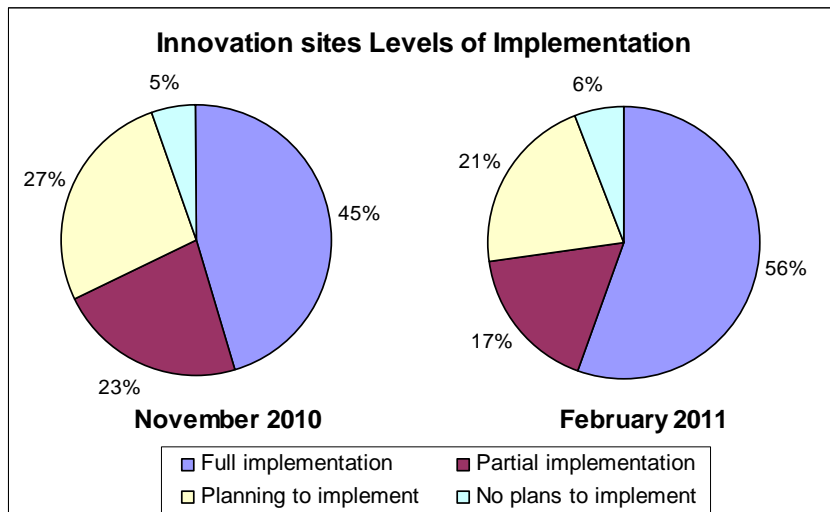


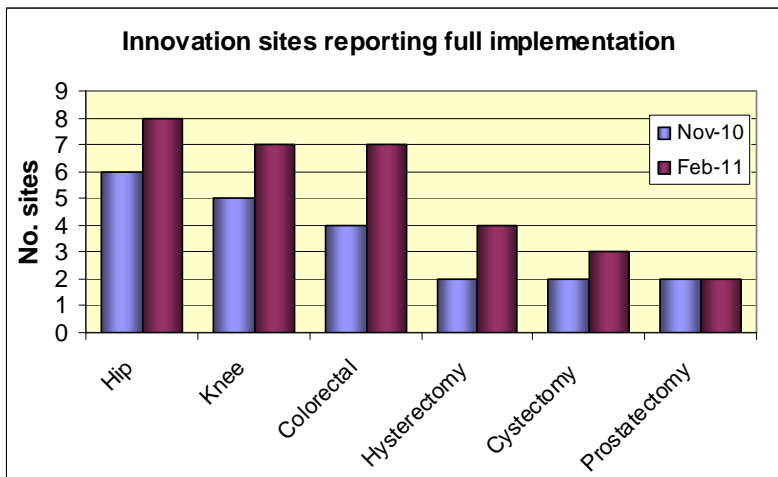
Figure 2



The number of teams reporting full implementation has increased from 147 consultant teams to 178 (representing 56% of teams reviewed) giving clear evidence of progress. Additional teams reported progression from planning to testing /partial implementation. There remain however, 6% of teams that have no plans to implement enhanced recovery and some anecdotal evidence of their lack of belief in the benefits of enhanced recovery.

In February 2011 10 Innovation Sites, compared with 6 in November 2010, have achieved full implementation in at least one specialty and three of these organisations have now fully realised their implementation plans across specialties. See figure 3.

Figure 3



Innovation sites who have not yet fully realised their implementation plans will continue to work towards full implementation during the forthcoming year.

Analysis of progress against key outcomes measures is given in the following section.

The Innovation sites have made significant progress during the two-year period of the programme. It cannot be underestimated the time, energy and effort it takes teams from winning hearts and minds through to planning, testing, implementation and embedding practice change for sustainability.

The Enhanced Recovery Partnership programme would like to acknowledge the work of the Innovations Sites who have taken the time to openly share their experience, to help other teams and contribute to the emerging evidence base for enhanced recovery implementation.

National picture

From the work undertaken by each SHA to review the extent of enhanced recovery practice across their health economy, it is now estimated that approximately 86% of acute provider organisations now have implemented enhanced recovery in at least one specialty.

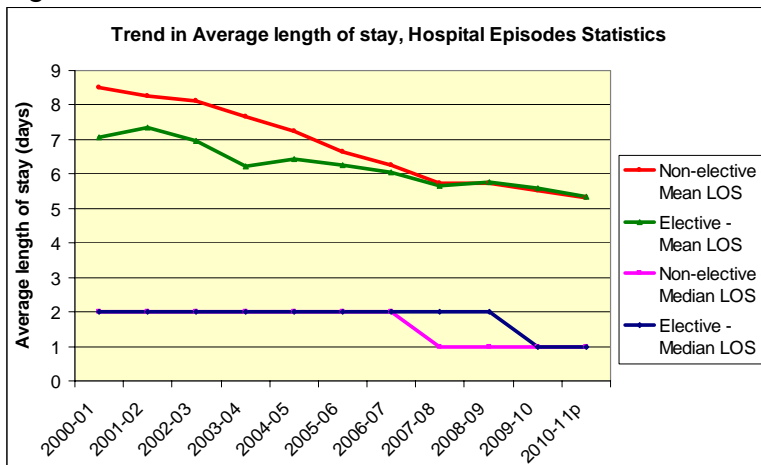
Length of stay

A key benefit of enhanced recovery is that patients spend less time in hospital. Nationally, there is a downward trend in the average length of time admitted patients stay² in hospital (Fig 4³), alongside an increase in day cases for elective patients.

² Length of stay is the period between admission and discharge, calculated by subtracting admission date from discharge date. Day cases are excluded.

³ Hospital Episodes Statistics (HES) for 2010-11 is provisional data to October 2010.

Figure 4

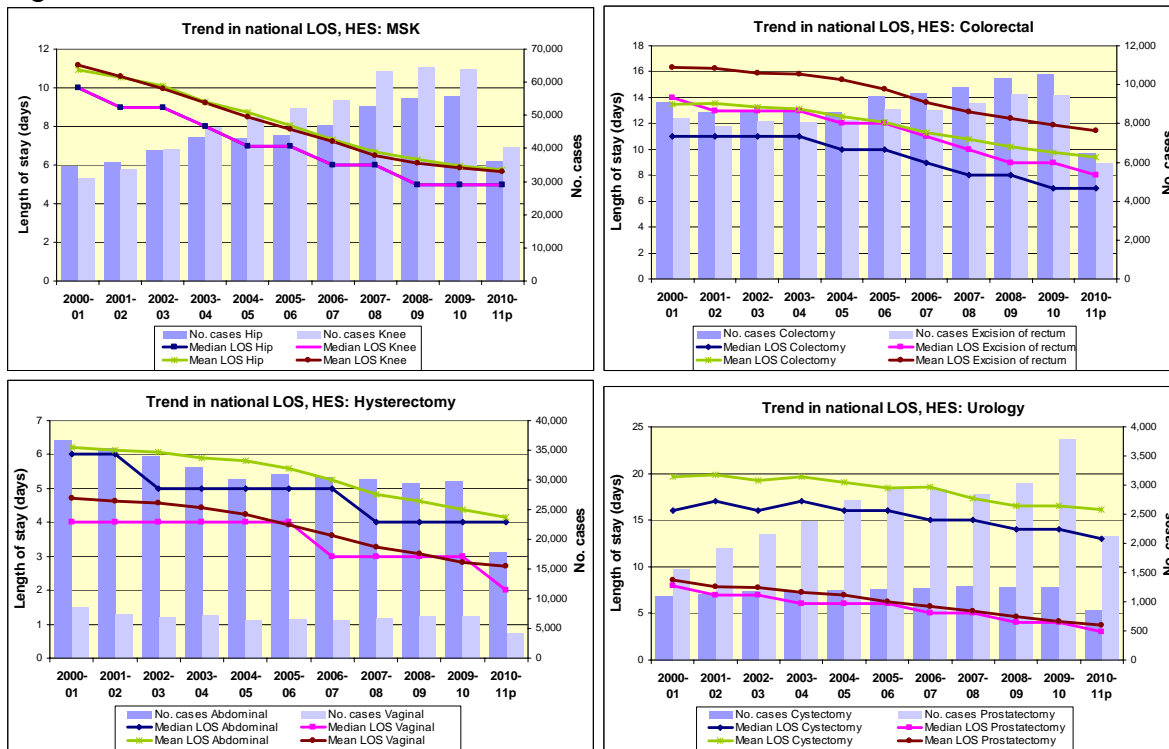


This reduction is reflected in the trend for many individual operations, including those within the scope of the enhanced recovery programme (Fig 5). Lengths of stay have fallen over the last ten years for each of these operations⁴, whilst volumes for all except hysterectomy have risen. For colorectal surgery, lengths of stay reduced by 20% - 22% over the last five years with just under half the reduction directly attributable to the growth in laparoscopic surgery (for which stays are typically 3 - 4 days shorter than other approaches).

⁴ The enhanced Recovery Programme covers elective admissions for the following operations:

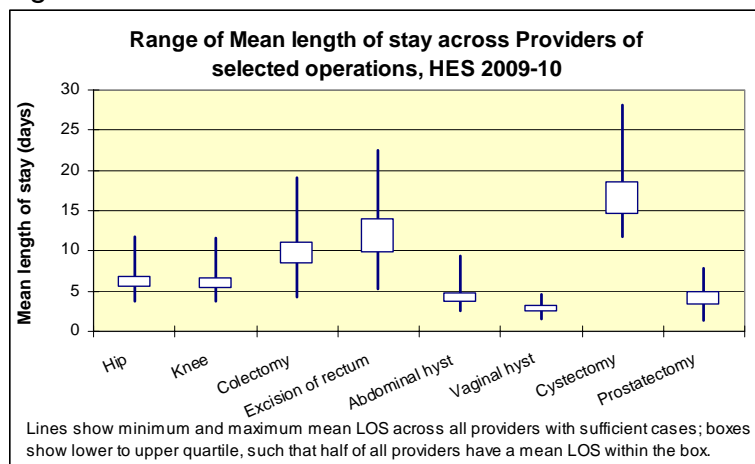
- Primary hip replacement - the primary part of each OPCS 4.3 code W37 to W39, W46 to W48 and W93 to W95 (ie W37.1, W38.1, etc.) plus W46.0, W47.0 and W48.0.
- Primary knee replacement - OPCS 4.3 code W40.1, W41.1 and W42.1.
- Colectomy - OPCS 4.3 codes H05 to H10.
- Excision of rectum - code H33 (except H33.7 Perineal resection of rectum HFQ).
- Abdominal Hysterectomy OPCS 4.3 code Q07.
- Vaginal Hysterectomy OPCS 4.3 code Q08.
- Bladder resection OPCS 4.3 code M34.
- Prostatectomy OPCS 4.3 code M61.

Figure 5



There is considerable variation in mean lengths of stay between providers (Fig 6). There is most variation between providers for Colectomy, Excision of rectum and Cystectomy⁵, which reflects greater variability in lengths of stay for individual patients receiving these operations. However, most operations have at least a three-fold difference between providers. Enhanced recovery techniques should reduce lengths of stay for patients and, in time, lessen the variation across organisations.

Figure 6



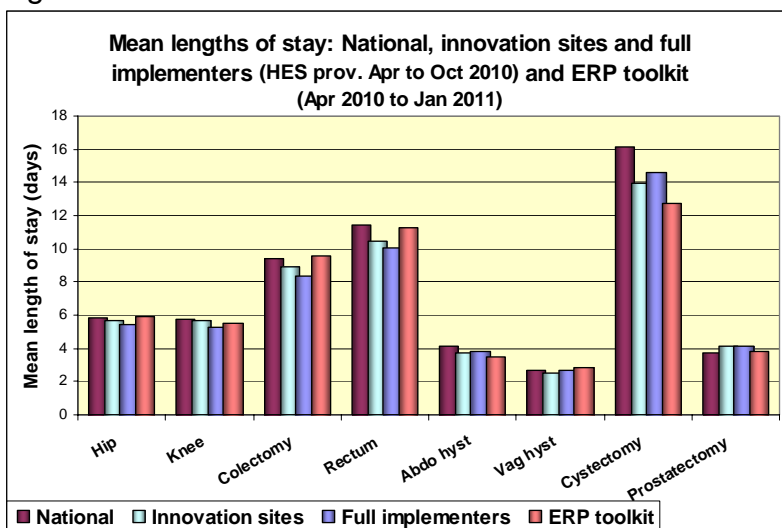
Lengths of stay may be compared for a number of groups:

⁵ Length of stay for all these operations is based on single-episode spells, to avoid including time spent in hospital for other conditions or specialties as part of the same spell. However, this excludes some patients whose care is managed between consultants, which is most common for cystectomy where care may be shared between Urology and Critical care / Anaesthetics. Lengths of stay for these patients may be longer.

- All providers, using Hospital Episode Statistics (HES);
- Innovation sites, using HES;
- Providers reporting full implementation in the Spread and adoption survey, using HES;
- Patients on an enhanced recovery pathway, reported in the ERP toolkit.

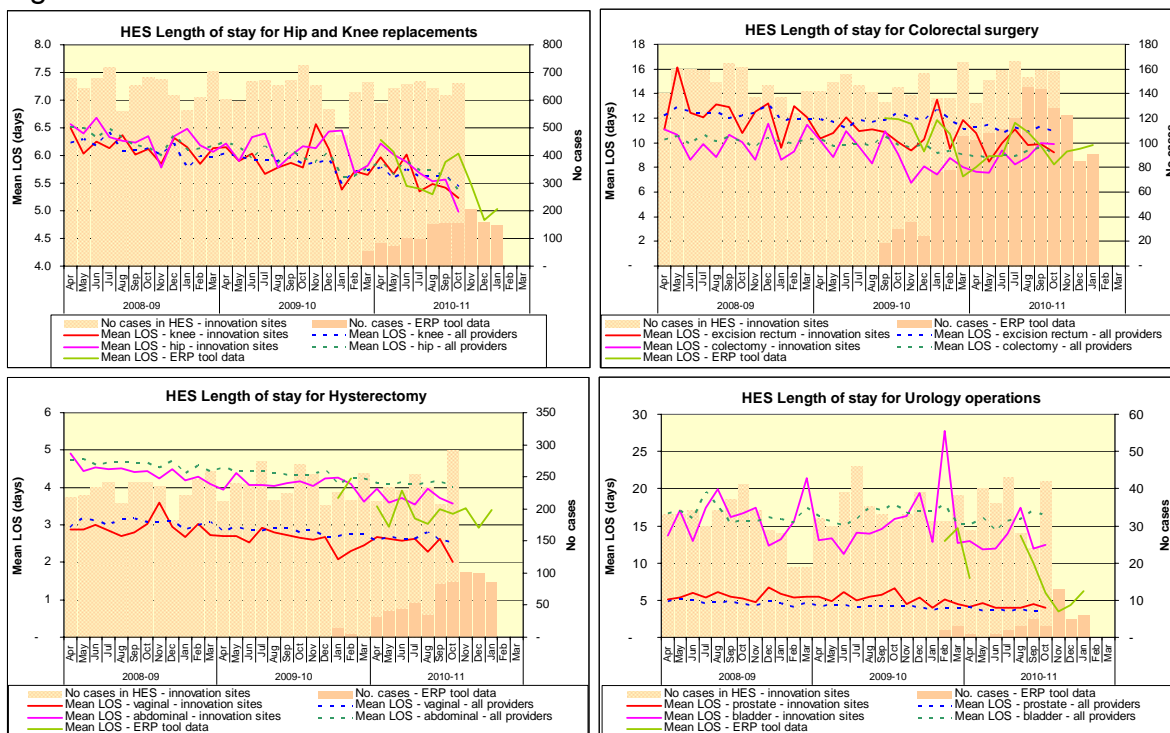
For most operations, the innovation sites have lower lengths of stay than the national average, based on the latest provisional HES data for 2010-11 (Fig 7). However, not all innovation sites have fully rolled out enhanced recovery, so the subset of providers who are fully implemented for the specialty provide a better comparison. Their lengths of stay are significantly lower for hips, knees, excision of rectum and abdominal hysterectomy. The cases reported in the ERP toolkit have higher lengths of stay than the full implementers do in HES for most operations, but this may reflect inconsistencies in the definitions or case-mix of the operations included.

Figure 7



Lengths of stay for innovation sites have fallen over the course of the programme (Figure 8), although not necessarily faster than the national averages.

Figure 8

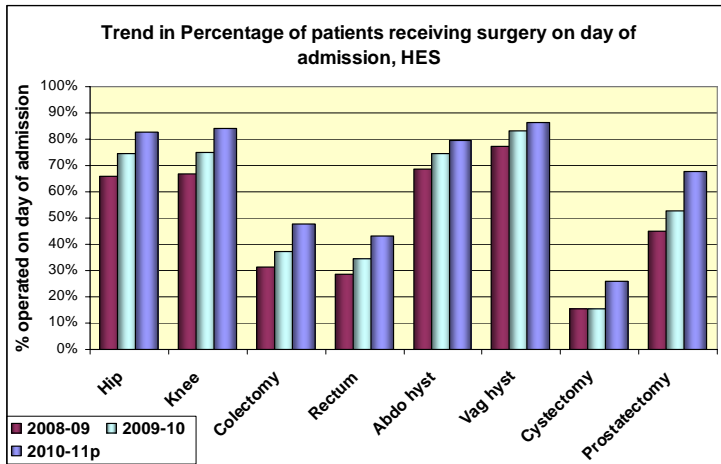


All this evidence suggests that lengths of stay are falling for the operations in the programme and are generally lower where enhanced recovery is being applied. However, the improvements in lengths of stay to date do not yet match those anticipated from early case study evidence.

Day of surgery admission

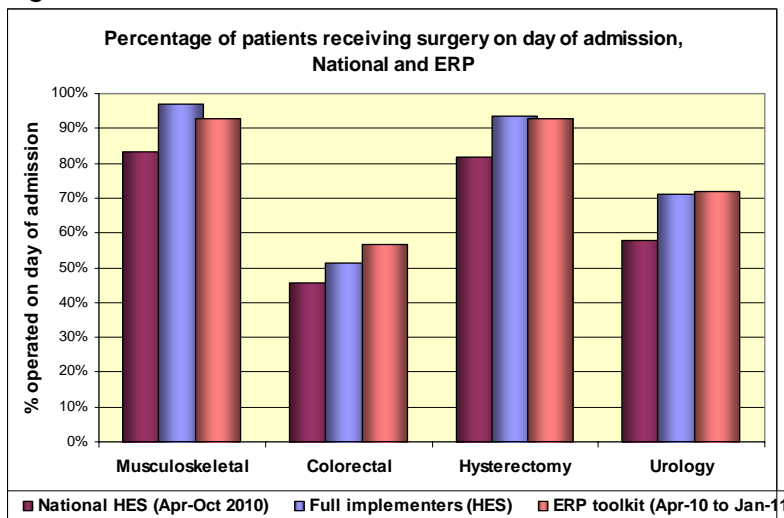
The proportion of patients who are admitted on the day of their surgery has increased over recent years, which is one component of the enhanced recovery pathway. By 2010-11 (provisional to October), HES shows around 80% patients receive surgery on the day they are admitted for hip and knee replacements and hysterectomy, whilst fewer than 50% receive surgery then for colorectal operations and bladder resection/cystectomy (Fig 9).

Figure 9



For most of these operations, the percentage of patients receiving surgery on the day of admission is higher where the enhanced recovery model is applied. Figure 10 compares the HES percentages for all patients with those from trusts reporting fully implemented enhanced recovery for the specialty and with the data reported on the ERP toolkit.

Figure 10

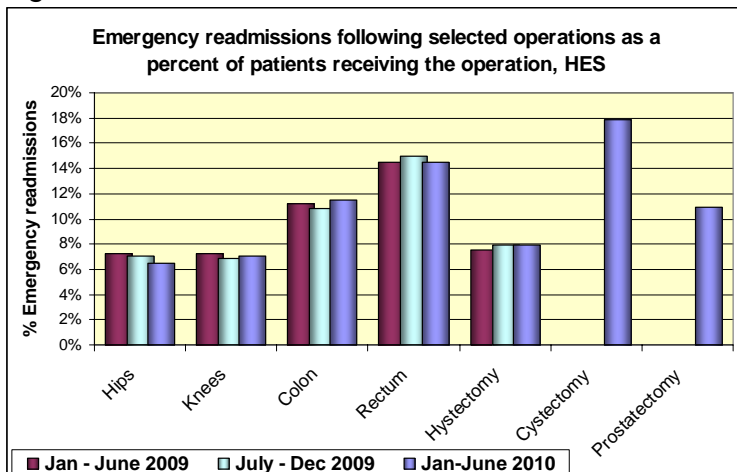


Readmission rates

Emergency readmission⁶ within 28 days of discharge following surgery, or 42 days for hip and knee surgery, varies according to the type of surgery performed (Fig. 11). For the operations included in the programme, the lowest rates are for primary hip replacement (6.4% readmitted within 42 days, Jan to June 2010) and knee replacement (7.1%), whilst the highest are for cystectomy (18% readmitted within 28 days) and excision of rectum (14.5%). These rates have not changed significantly over recent years.

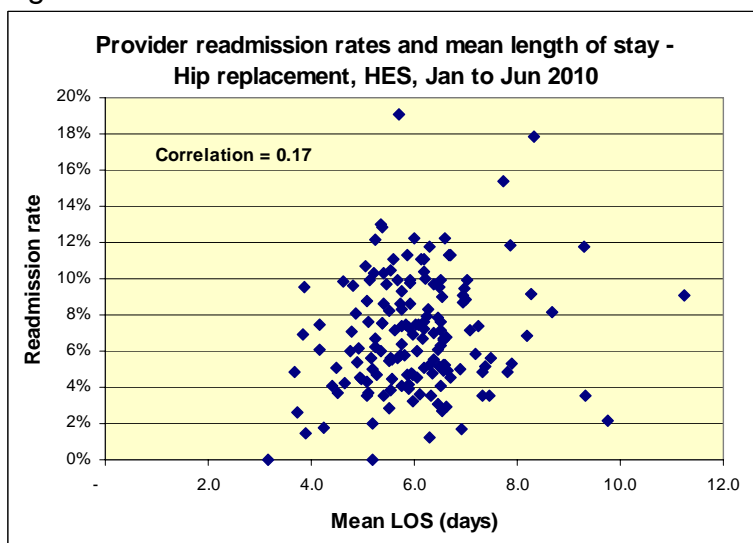
⁶ Patients may be admitted as an emergency for any reason to any provider within the period; this may be unrelated to the surgery or the condition treated by it.

Figure 11



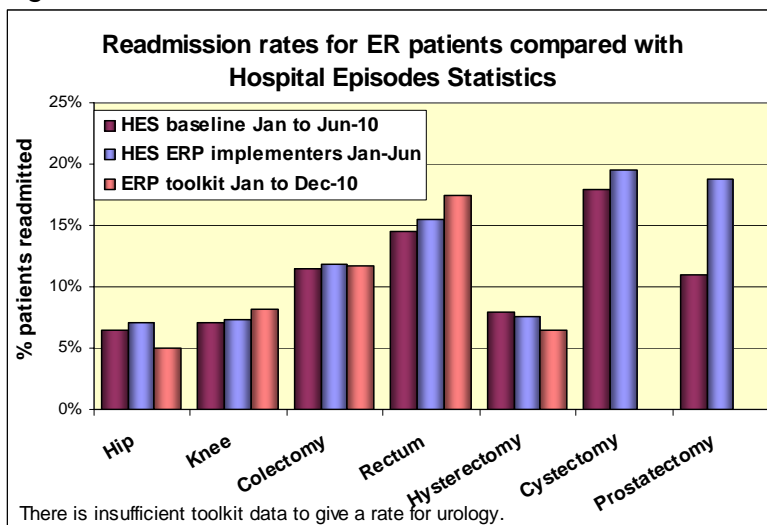
Readmission rates vary by provider as much as lengths of stay do, but for providers there is no correlation between longer lengths of stay and lower readmission rates (or the opposite). Figure 12 shows the comparison between mean length of stay and readmission rate by provider in Jan to June 2010 for hip replacements, which is typical of all the ERP operations.

Figure 12



The readmission rates for providers that have fully implemented enhanced recovery for that operation differ from the overall rates (Fig 13), but none of these differences is statistically significant. Similarly, the ERP toolkit data shows different rates of emergency readmission from HES, as do anecdotal rates obtained as part of the survey of spread and adoption. However, definitions vary between these sources and some are based on low numbers, so the differences are not significant.

Figure 13



Although inconclusive, this evidence suggests that readmission rates vary for reasons unrelated to the length of stay and are not significantly worsened nor improved by applying enhanced recovery.

Patient Reported Outcome Measures (PROMs)

Patient Reported Outcome Measures have been collected for hip and knee replacement operations since April 2009. Patients complete a pre-operative questionnaire indicating their self-reported health status, symptoms and function relating to their hips or knees. Six months later, they are asked to complete a post-operative questionnaire and the scores are compared. These can indicate the level of improvement felt by the patient following surgery using a variety of scoring systems⁷.

Over 60,000 hip or knee patients who completed pre-op and post-op PROMs questionnaires in 2010-11 (April to September) matched HES records indicating that they had elective primary joint replacements (as defined for the programme). For these, the improvement in all PROMs measures derived from hip replacement operations is consistently higher than that derived from knee replacements (Fig. 14), indicating greater observed health gains. However, none of the health gains for providers reporting to have fully implemented ERP for these operations are significantly different from the all provider average.

⁷ Three scoring systems are considered here. EQ-5D is a standardised measure of health status that provides a generic measure of health applicable to a wide range of health conditions and treatments. It has two distinct sections:

- the EQ-5D descriptive system indicates the patient's level of problem (if any) with mobility, self-care, usual activities (eg work), pain or discomfort and anxiety or depression. This is turned into an index.
- the EQ-5D visual analogue scale (VAS) asks patients to rate their health state from 0 to 100. This is more subjective.

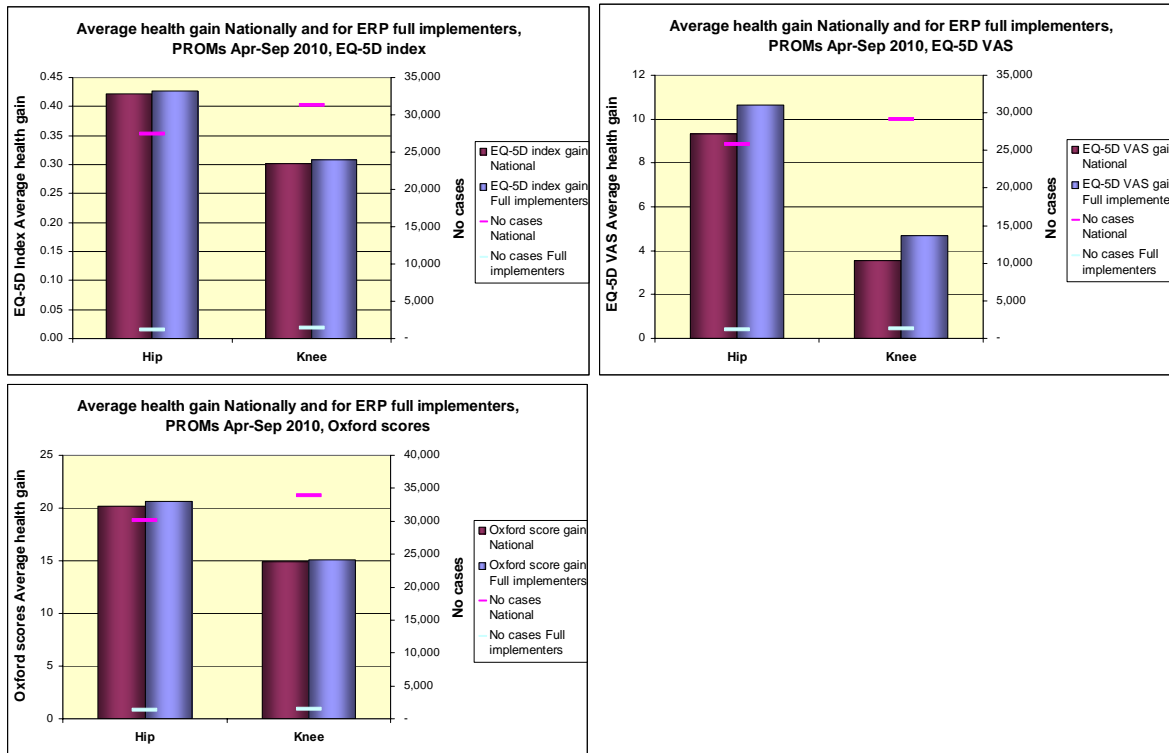
For hip and knee patients (defined more broadly than the operations in the enhanced recovery programme, but here filtered for comparison), there is also:

- Oxford hip and knee scores comprising twelve questions relating to pain, ease of joint movement, ease of walking and climbing stairs, etc.

In addition, PROMs contains some general post-operative questions about the surgery and its results.

Improvement following surgery may be assessed by looking at the paired differences between pre-operative and post-operative scores to produce an average health gain.

Figure 14



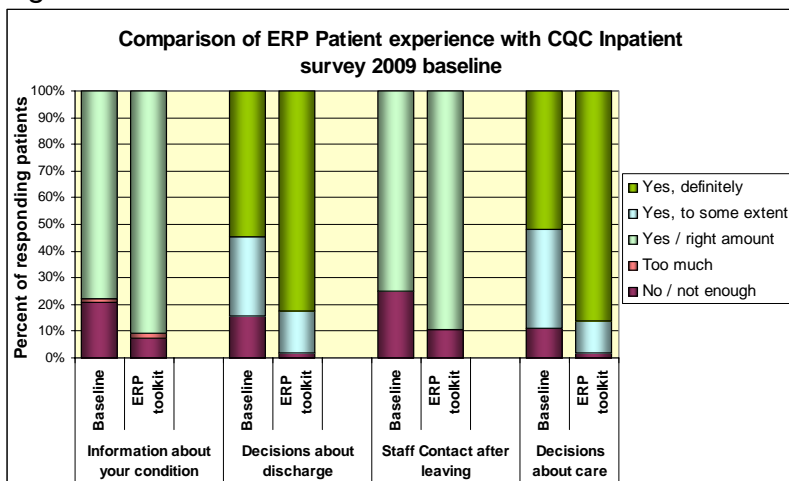
Patient experience

Providers completing the toolkit were encouraged to report their patients' responses to questions used in the Care Quality Commission Inpatient Survey. These concerned whether the patient felt they were given sufficient information about their condition, whether they felt involved in decisions about their care and their discharge and whether they were given adequate contact details to use after discharge if required.

The responses for all cases reported in the toolkit so far indicate a much higher level of satisfaction than the CQC average⁸ (Fig 15). These differences are statistically significant, although the reported toolkit responses may be biased and only reflect a few types of patient compared to the full CQC survey. Nevertheless expressed as a satisfaction score, an average 17% more patients were happy with these factors in the toolkit than in the CQC survey.

⁸ Latest CQC results are for all reported inpatients in 2009, including emergency admissions and all specialties.

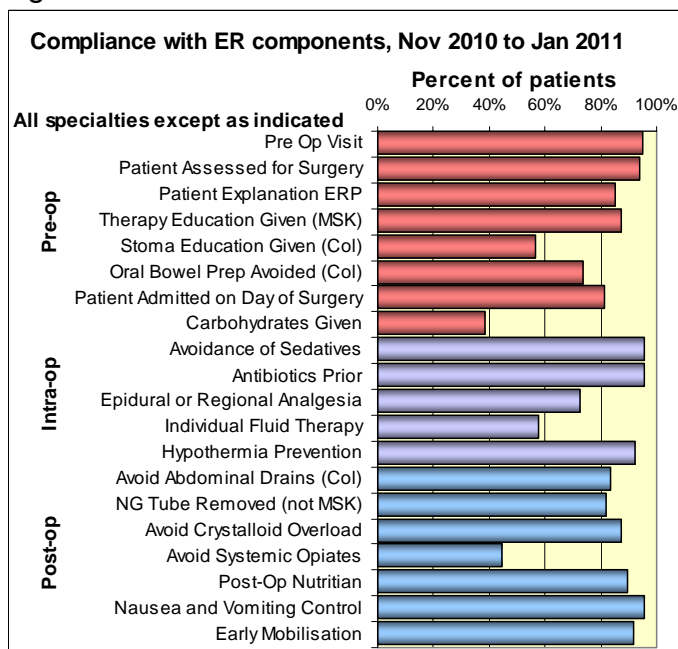
Figure 15



Compliance measures

In addition to the measures above indicating outcomes for patients on an enhanced recovery pathway, the toolkit shows which components of the pathway were applied in each case. Whilst not all components are relevant or appropriate to all specialties, Figure 16 shows the extent to which they are applied. Although full implementation of enhanced recovery is locally determined, guidance suggested that patients should receive around 80% of the relevant elements.

Figure 16



Summary

Enhanced recovery is contributing to the underlying trends of shorter lengths of stay and increased surgery on day of admission. The differences for fully implemented providers are not yet as great as might be realised, but they show improvements in the right direction. This

appears to be achieved without affecting readmission rates or outcomes (PROMs) and with a positive surveyed patient experience.

Critical success factors for spread, adoption and sustainability

The implementation of an enhanced recovery pathway requires changes to clinical interventions and supporting clinical systems. The process of change is multifaceted and iterative.

Sustainability means moving beyond an implementation project to embed enhanced recovery as the standard model of care. This requires standardisation and consistent delivery by an integrated and stable multidisciplinary team, which includes primary care.

Throughout the two-year programme work has been ongoing to understand the critical success factors for spread, adoption and sustainability of enhanced recovery. There has been remarkable consistency across all experts, practitioners and stakeholders involved in the factors identified. Many consistent with findings from other health care change programmes.

The critical success factors are summarised as follows:

Quality and safety are the key drivers for change

- The primary driver for clinical teams to adopt enhanced recovery is to improve clinical quality, patient safety and patient experience.
- Incentives such as CQUINS and PbR best practice tariff can be useful and there needs to be careful consideration about the plans in place to ensure sustainability post incentive.
- There are positive benefits for the clinical team that whilst not a primary driver is helpful to start to get people on board.

Measurement

- It is essential to have high quality data to support practice change. This should include both process (compliance with the clinical pathway) and outcome measures, including patient experience.
- Teams need time to test, evaluate, refine and embed change based on evidence of their own practice. Benefits realisation can take longer.

Change needs to be clinically led and have senior management support

- Clinical leadership is crucial for successful implementation.
- Leaders need to be respected role models who can influence both peers and other members of the multidisciplinary team.
- There needs to be involvement and engagement of the whole team in the change process, which starts by winning hearts and minds.
- Effective project management, change management and facilitation are vital.
- Securing senior management and key stakeholder support and engagement is vital as an ongoing process, not just at the outset of the implementation process.

Ethos of the clinical team

- Teams that are successful in sustaining enhanced recovery demonstrate effective teamwork. They show a high degree of pride in their work and achievements. They

show mutual respect and value the different and complimentary roles of the multidisciplinary team members.

- They have also truly embraced the concept of patients as partners in their care. They can demonstrate how patients are involved in decisions and driving their own care pathway and in the design and ongoing improvements in the care pathway.

Organisational culture

- Organisations that have successfully spread enhanced recovery across clinical teams and specialties have a 'can do' culture that empowers and enables clinical teams to test new ways of working, without fear of risk and blame.
- Safety and quality are high on the executive agenda and there are strong relationships between managers and clinicians.

The speed at which clinical teams can implement enhanced recovery is also dependent on whether they already have some of the clinical elements of the pathway in place. In particular, timely implementation is aided by having a well established pre-operative preparation service.

There has been debate about the need for initial investment to initiate the implementation process. Many organisations have managed to realign resources to support implementation, whilst others have made some short-term investment until benefits can be realised.

Enhanced recovery has the potential to transform elective and cancer care pathways across the NHS and generate capacity releasing productivity gains through reduced length of stay (LOS), fewer post-operative complications, minimising readmissions and reduced mortality rates.

Enhanced recovery is contributing to the underlying trends of shorter lengths of stay and increased surgery on day of admission. The differences for fully implemented providers are not yet as great as might be realised, but they show improvements in the right direction. This appears to be achieved without affecting readmission rates or outcomes (PROMs) and with a positive surveyed patient experience. – good for all patient ensures get care needed afterwards.

Creating drivers to maintain momentum for ongoing improvement

A work stream to manage the sustainability strategy for the Enhanced Recovery Partnership Programme has involved creating influential policy levers and exploring the role of the professional bodies and organisations. There are also opportunities to enable patients and the public to become drivers for change.

In addition, the Strategic Health Authorities will continue to play a role, as will the partner organisations, through transitional arrangements for support during 2011/12.

The work reflects the changes resulting from the white paper 'Equity and excellence; liberating the NHS' in July 2010, recognising the need to move from central co-ordination to localisation, against the changing landscape in the organisation of health care commissioning, management and service delivery.

Influential policy levers

The programme has worked jointly with other policy areas on shared objectives and explored a number of policy levers to encourage the spread and adoption of the enhanced recovery model of care. Some of the key policy levers established in 2010/11 are:

- Payment by Results – enhanced recovery is cited as a source of evidence in the Hip & Knee PbR best practice tariff guidance. A nomination for best practice tariff to be developed in urology, colorectal and gynaecology has also been put forward for 2012-13 tariff development work.
- CQUIN – enhanced recovery has been included as one of the national exemplars.
- QIPP – enhanced recovery is an independent workstream under 'Right Care' and recommended as a high impact change.
- Cancer Improving Outcomes Strategy, 2011.

Role of the professional bodies and organisations

Throughout the programme there has been ongoing engagement with the professional bodies and organisations as influential drivers for spread and adoption. Independently of the programme many of the key organisations have organised events and published materials on enhanced recovery for their members.

A successful engagement event was held in January 2011, to explore further the key role of these organisations in influencing the uptake of enhanced recovery practice.

Representatives acknowledged that the four initial specialties implementing enhanced recovery are at different stages of evolution and facing some differing opportunities and challenges. However, there was a clear need to maintain the momentum for further spread and adoption. Every patient has the right to expect to be offered an enhanced recovery pathway in these four specialties and this should not be prevented through clinical and organisational inertia. In giving

their full support and providing leadership these organisations will help to ensure that enhanced recovery is now seen, and provided as 'standard' practice.

Once enhanced recovery is recognised as a standard model of care, work will need to be progressed to embed enhanced recovery in both basic and post-basic clinical training.

Patients as drivers

The white paper 'Equity and excellence; liberating the NHS' outlined a vision for patients that there would be 'no decision about me without me'. This concept is central to enhanced recovery as patients are partners in their own care through shared decision making.

There are further opportunities to raise patient and public expectations about the benefits of enhanced recovery, so that they become drivers for change. This will require the provision of high quality, patient-focused information and service user organisations, such as Macmillan and Arthritis Care, to play an important role in this. Third sector organisations can often provide packages of supported self-management, which complement the support patients already receive from health and social care services. This can be a critical factor in promoting a positive outlook for the patient pre- and post- surgery, boosting confidence, promoting independence and leading to better long term patient outcomes

Role of Strategic Health Authorities

Looking forward to 2011/12 all ten Strategic Health Authorities have enhanced recovery work streams aligned with their Planned Care QIPP programme and are aligned with support from their Cancer Networks.

Support varies with some keeping their nominated lead, steering group and dedicated websites. Others continue networking, and providing education, training resources and support.

It will be important to engage with both the NHS Commissioning board and GP consortia as they emerge to ensure continued strategic support for enhanced recovery.

Transitional arrangements 2011/12

NHS Improvement, NCAT and the NHS Institute for Innovation and Improvement will continue to provide support to enable the sharing and dissemination of learning that has resulted from the Enhanced Recovery Partnership Programme during the last two years.

This will be through continuing partnership working with the SHAs and their local programmes, leading clinicians and the professional bodies.

The goal is to ensure the continued momentum of adoption and spread of enhanced recovery.

Equality Perspective

Enhanced recovery as a model of care, can be applied to all patient groups irrespective of age, disability, ethnicity, religious belief, gender or sexual orientation. It is about assessing each patient for surgery at the point of referral and managing their care during and after surgery. Older people for example, have particularly benefitted from this model of care due to optimising their health pre operatively and minimising the physical trauma of surgery and anaesthesia.

Enhanced recovery is a partnership between the clinician and patient based on informed and shared decision making about the potential benefits, risks and recovery paths of treatment options. It is on this basis, having had the time and support to consider, that the patient can make an informed decision to proceed with surgery.

The Enhanced Recovery Partnership Programme promoted the inclusion of all patient groups in a number of ways as detailed below.

To support informed decision making innovation sites produced patient information leaflets to increase understanding of the enhanced recovery care pathway. Leaflets have been made available in different formats e.g. large print. Having information leaflets in large print, different languages and other accessible formats ensures all patients are helped to understand and make informed choices about their care.

The Enhanced Recovery Partnership Programme identified four questions around patient experience, which were included in the toolkit available for the NHS to use to collect information and recommended to organisations for inclusion as part of their measurement of patient experience. In addition, organisations adopting enhanced recovery should consider including questions in their local patient experience questionnaires that focus on individual patient groups and their take up and experience of enhanced recovery.

To gain a deeper understanding of individual patient experience methods such as questionnaires, patient diaries, telephone follow up and focus groups have been used by innovation sites. The capturing of this information at the start of implementation is particularly valuable as patients and carers often have very practical and helpful suggestions for improvement. This learning will inform further spread of enhanced recovery and ensure its benefits are shared by all patient groups.

The programme started to work with service user organisations, such as Macmillan and Arthritis Care, to provide patient-focused information. It will be key for the NHS to engage with third sector organisations to ensure patients from all groups are informed and supported when undergoing their care pathway, complimenting the support from health and social care services.

Patients will need different levels of support after surgery, therefore discharge planning is a key element of the enhanced recovery pathway and should be tailored to the patient's needs e.g. occupational therapist involvement dependent on any reductions in mobility, loss of independence with activities of daily living, or complex social situation.

The programme also recommended experienced based design; an approach of bringing patients and staff together to share the role of improving care and re-designing services around all patient groups.

Advisory Board Membership

Professor Sir Mike Richards	Chair and Senior Responsible Officer
Peter Featherstone	DH Elective Care Access Lead
Jane Allberry	DH Cancer Policy Team
Janine Roberts	DH National Programme Lead (04/09- 07/11)
Nicki McNaney	DH National Transformation Lead
Paulette Clarke	DH Policy Delivery Lead – Elective Care
Tim Wouters	DH Policy & Project Manager for ER
Mark Collins	DH Communications Lead
Sheila Dixon	DH Statistician
Ann Driver	NHS Improvement Cancer Director
Janet Williamson	NHS Improvement National Director
Andy McMeeking	National Cancer Action Team Associate Director
Lynn Callard	NHS Institute for Innovation and Improvement
Monty Mythen	National Clinical Lead
Alan Horgan	National Clinical Lead
Alan Nye	Primary Care Lead
Kerri Jones	Clinical Adviser – Elective Care & Day Surgery
Ian Bayley/Peter Kay	Clinical Adviser - MSK
Robin Kennedy	Clinical Adviser – Audit & Measurement
Robin Crawford	Clinical Adviser - Gynaecology
Nigel Acheson	Clinical Adviser - Gynaecology
John McGrath	Clinical Adviser - Urology
Martin Kuper	Clinical Adviser – NHS Improvement
Mike Swart	Clinical Adviser – NHS Improvement
Teresa Fenech	Nurse Adviser
Sarah Bazin	AHP Adviser
Jan Yeates	SHA Adviser
Neil Betteridge	Elective Care Patient & Public Adviser
Kevin Wilcox	Commissioning Adviser
James Kingsland	Commissioning (PBC) Adviser
Helen Forbes	Clinical Information Manager
Standing Invitation	
Mark Coleman	Lead Clinician National Training Programme in Laparoscopic Colorectal Surgery