Enhanced Recovery Partnership Programme - Implementation Plan

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Purpose:
The purpose of this report is to inform all stakeholders on our approach to the implementation of the Enhanced Recovery Partnership Programme. It builds upon our application which was approved by the Department of Health in August 2009.

Approval:
The Programme Board are asked to approve the implementation plan.

Distribution:
- Internal
  - Service Improvement Group
  - Divisional Boards
  - Clinical governance forums
- External
  - Department of Health
  - NHS East of England
  - West Hertfordshire and East and North Hertfordshire PCT
  - Patients Forum/LINKs
  - Neighbouring acute providers
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**Appendix A** - West Hertfordshire Hospitals NHS Trust application to join the Enhanced Recovery Partnership Programme

**Appendix B** – Colorectal Project Plan

**Appendix C** - Gynaecology Project Plan

**Appendix D** - Musculoskeletal Project Plan
1. Background

What is enhanced recovery
Enhanced recovery is a new approach to elective surgery, which ensures that patients are in the optimal condition for treatment, have different care during their operation, and experience optimal post-operative rehabilitation. The approach – sometimes known as rapid or accelerated recovery – was pioneered and evaluated in Denmark, and has been successfully implemented in a few centres in England. The scope for more patients to benefit is large. It has been applied to colorectal, orthopaedic, gynaecological and urological operations, but could possibly be extended to some other forms of surgery.

Patients on enhanced recovery pathways recover more quickly following surgery, and so can leave hospital and get back to normal activities sooner. Enhanced Recovery programmes should involve the whole health community, including primary and secondary care, surgeons, anaesthetists, nurses and allied health professionals, and NHS managers in PCTs and acute hospitals.

The perceived benefits
Enhanced recovery has many benefits, broadly categorised into health (not least of which is an improved patient experience) and cost efficiency. Patients are fitter sooner, which enables faster rehabilitation and return to work. There is an improved patient experience and improved clinical outcomes, and the need for ongoing care interventions are reduced, or can happen more quickly when needed. However, a reduced length of stay, shorter pathways/reduced waits, increased capacity, the meeting of operational and quality standards, and improved cost efficiency are a sound financial argument for the adoption of enhanced recovery, and an improved staff experience adds weight.

The elements of enhanced recovery
The generic elements of enhanced recovery, and a list of its benefits, were agreed at an event on 2 June 2009 attended by representatives from sites already implementing similar models of care. Examples of the elements of enhanced recovery can be found in the enhanced recovery section of www.18weeks.nhs.uk, but include:

- Optimising the pre-operative health state, commencing in primary care
- Anaesthetic pre-admission assessment with medical optimisation, risk stratification and discharge planning
- Informed decision making and managing patient expectations
- Admission on day of surgery
- Carbohydrate loading and maximising patient hydration pre-operatively
- Individualised goal directed fluid therapy
- Using short-acting anaesthetic agents and minimal access incisions when possible
- Minimal use of drains/tubes where no supporting evidence
- Avoidance of post-operative opiates when possible
- Active early planned mobilisation
- Early post-operative oral hydration and nutrition
- Procedure-specific daily goals
- Discharge once predetermined criteria met
2. **West Hertfordshire Hospitals NHS Trust as an innovation site for the East of England**

**Our application and the national picture**
In July 2009, the Department of Health set out to increase the local expertise on enhanced recovery in each SHA. Their proposal was to support one local health economy (LHE) in each strategic health authority (SHA). A LHE was defined as an acute trust, their local PCT, with primary care and community services engagement.

In August 2009, we were confirmed as the innovation site for the East of England for the four main pilot elective care pathways –
- Colorectal
- Gynaecology
- Musculoskeletal
- Urology

A country wide map of the innovation sites is shown on the next page.

Why we wanted to join the programme was to improve the quality of patient care through improving clinical outcomes and experience, and to reduce the length of the elective care inpatient pathway in the four targeted specialties by utilising the good practice principles of enhanced recovery models of care.
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Legend
The following denotes a trust is working in this specialty:
(M) Musculoskeletal
(C) Colorectal
(U) Urology
(G) Gynaecology
Enhanced Recovery Innovation Sites are shown in red

North East
Gateshead NHS Foundation Trust (M)
Newcastle Hospitals NHS Trust (C)
City Hospitals Sunderland NHS Foundation Trust (U)

South Tyneside Hospitals NHS Foundation Trust (C, U)

Yorkshire & The Humber
Sheffield Teaching Hospitals NHS Foundation Trust (M)
York Hospitals NHS Foundation Trust (C)
Salford Healthcare NHS Trust (C)
Leeds Teaching Hospitals NHS Trust (C, U)
Cottingham and Hullcote NHS Foundation Trust (C, U)

East Midlands
Derby Hospitals NHS Foundation Trust (M)
Queen’s Medical Centre (C)
Sunderland Royal Infirmary NHS Foundation Trust (C, M) (U)
The University Hospitals of North Midlands NHS Trust (C, M, U)

East of England
Cambridge University Hospitals NHS Foundation Trust (C)
West Suffolk Hospital NHS Trust (M)
Norfolk and Norwich University Hospitals NHS Foundation Trust (C)

North West
Aintree University Hospitals NHS Foundation Trust (M)
East Lancashire Hospitals NHS Trust (C)
Royal Liverpool Hospital (M)
Wrexham University Teaching Hospitals NHS Foundation Trust (C, M) (U)
Aintree University Hospitals NHS Foundation Trust (C, M, U)

West Midlands
City Hospital NHS Trust, Birmingham (C)
Good Hope Hospitals (C)
University Hospitals Birmingham NHS Foundation Trust (C)
Birmingham Heartlands NHS Trust (C)
University Hospital of North Staffordshire NHS Trust (C, M, U)

South West
North Devon Healthcare NHS Trust (C)
South Devon Healthcare NHS Foundation Trust (C, M) (U)
Royal Devon and Exeter NHS Foundation Trust (U)
Royal Bournemouth Hospital (M)
South Bristol NHS Trust (Southmead Hospital) (C)
Trelcud某 Hospital NHS Foundation Trust (C, M)
South Devon Healthcare Foundation Trust (C)
Dorset County Hospital NHS Foundation Trust (C)
South Devon Healthcare NHS Foundation Trust (Torbay Hospital) (C, M, U)

South East Coast
Brighton and Sussex University Hospital NHS Trust (C)
Canterbury Hospital (Canter and Gravesham Hospitals Trust) (M)
Royal Surrey County Hospital NHS Trust (C)
Worthing Hospital (C)
East Kent Hospitals University NHS Foundation Trust (Queen Elizabeth, the Queen Mother Hospital) (C, M)
Midway NHS Foundation Trust (C)
Medway NHS Foundation Trust (C, M, U)
Brighton and Sussex University Hospitals (C, M, U)

London
Barnes & Chase Farm Hospitals NHS Trust (C)
Guy’s & St Thomas’ NHS Foundation Trust (C)
Hillingdon Hospital NHS Trust (M)
Imperial College Healthcare NHS Trust (C)
South West London Electrical Orthopaedic Centre (M)
St George’s Healthcare NHS Trust (C, U)
St Mark’s Hospital (North West London Hospitals NHS Trust) (C)
The Westminster NHS Trust (C, M)
UCLH NHS Foundation Trust (C)
Whipps Cross University Hospital NHS Trust (C)

The Willows NHS Trust (C, M)
North Middlesex University Hospital NHS Trust (C, M)
3. **Programme objectives**

Our application is attached as Appendix A. Our application was supported by NHS EoE and West Hertfordshire and East and North Hertfordshire PCT.

The benefits, which in affect are our programme objectives, detailed in our application are:

**Service objectives**

1. Reduced length of stay
2. Improved productivity
3. Increased capacity
4. Operational and quality standards met
5. Fitter patients sooner
6. Improved waiting times – to meet the 18 week pathway
7. Improved staff experience
8. Improved clinical outcomes
9. Improved reputation

**Patient objectives:**

1. Optimum condition for treatment
2. Empowered patients, better informed and involved in the process
3. Reduced stay in hospital
4. Reduced risk of hospital acquired infections
5. Quicker patient recovery – continue recovery within home environment

4. **Project objectives**

As we develop the four projects we will agree specific, measurable, achievable, realistic, timely (SMART) objectives for Colorectal, Gynaecology, Musculoskeletal and Urology.

This will in turn provide the framework for measuring the establishment and subsequent sustainability of the change management programme we will have undertaken.

Initial scoping has been undertaken as part of the development of the first versions of the project plans.
5. **Project leads and project groups**

For each of the four elective care pathways we have dedicated project managers, which are listed below.

- Colorectal – Helen Broadwell
- Gynaecology – Janette Buckley
- Musculoskeletal – Paula King
- Urology – Karen Bowler

As at November 2009 we have established project groups for three of the elective care pathways, which meet monthly. Membership of the groups is listed below.

- Colorectal - Mr Amin (Chair), Mr John Meyrick Thomas, Mr Hallam, Mr Arbuckle, Jill Stokes, Vivienne Robson, Aruna Navapurkar, Laura Liles, Rachel Colgan, Michelle Ashwell, Linda Loader, Rekha Shah
- Gynaecology - Mr David Griffin (Chair), Janette Buckley, Lynette Ametewee, Kirsty Green, David Redman
- Musculoskeletal - Russell Griffin (Chair), Paula King, Martina Wade, Tim Waters, Annie Wiggs, Jane Jackson.

Each of the project managers is also working towards securing GP representation on the respective project groups.

A Urology project group will be established in November 2009.

6. **Primary care and Social Services involvement**

Our application to the national programme was a joint application with the PCT. At a planning level the establishment of our programme has been well supported by the PCT, but further work is required in ensuring we achieve benefits realisation across the patient’s pathway. We have volunteered the PCT as a pilot site for enhanced recovery, but are yet to hear whether they would like to pursue this option.

Therefore, up to November our approach has focused on the establishment of the programme within the acute pathway, but our approach will continue to be to actively engage PCT and Social Services partners in the development of the Programme.
7. Governance

With a critical service development of this nature sound project governance is recognised as being of paramount importance. We will establish a programme board in order to coordinate the four projects and ensure the contributions of key staff from across the Trust, to optimally take forward the work required. The Programme Board will report to the Service Improvement Group.

The terms of reference for the Programme Board are listed below.

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<thead>
<tr>
<th>Membership</th>
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<tbody>
<tr>
<td>Name</td>
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<tr>
<td>1. Russell Harrison</td>
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<td>2. Russell Griffin</td>
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<td>3. David Griffin</td>
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<td>4. Paula King</td>
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<td>5. Helen Broadwell</td>
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<td>6. Janette Buckley</td>
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<td>7. Karen Bowler</td>
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<td>8. Maxine McVey</td>
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<td>9. Elaine Odum</td>
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<td>10. Claire Jones</td>
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<td>11. Jessica Watts</td>
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<td>12. Elilis Parker</td>
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<tr>
<td>13. Jane Jackson</td>
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<tr>
<td>14. Kirsty Green</td>
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<td>15. Jason Seez</td>
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Role and Remit
1. Will provide the overall direction and management for the programme.
2. Is accountable for setting the scope of the programme, and for overseeing its successful delivery.
3. Will approve all major plans and authorise any major deviation from agreed milestones.
4. Will meet every month, receiving Highlight Reports from the project manager and making any decisions that are required.

Agenda
The Enhanced Recovery Programme – Programme Board will typically follow the following agenda:
5. Apologies
6. Review of actions since last meeting
7. Highlight report
8. Progress against project objectives/plan, key issues/risks
9. Next steps and recap
10. AOB
11. Date of next meeting.

Action focus
1. Papers to be circulated at least three working days before the Board
2. Participants have taken steps ahead of the meeting to obtain relevant input to make time spent at the meeting more productive and focused on the agenda
3. Meetings start and finish on time
4. Do what you say you'll do - individuals are accountable for following through on agreed actions and the Board should hold each other mutually accountable
5. Silence is agreement - it is unacceptable to remain silent during a meeting and then later say you don't agree with the Board decision
6. Project manager recaps main points at end of meeting
7. ‘Operational issues’ are logged for off-line resolution by service leads.

Positive and constructive approach
1. Mobile phones switched off
2. If you can’t attend, send a suitable, informed, delegate instead
3. One conversation at a time
4. People volunteer versus are volunteered for actions
5. Respect shown for all ideas even where others disagree.
8. National programme milestones

**Key Milestones**

<table>
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- **2009**
  1. 23rd Sept Workshop – General Principles, overview & project planning
  2. Project plan & Team established including baseline measurement and preparation work
  3. 27/10 Workshop – Detailed sessions on elements of ER, informed decision making, optimising pre operative health state, Specialty specific aspects. Change management and service improvement methodologies, sustainability
  4. prep work, identify patient groups, communications to wider team, engage pt user groups, testing & measuring
  5. 17/12 Workshop – progress from sites, specialist issues workshops, sustainability, technology & innovation, one to one clinic sessions
  6. Evaluation of ERPP to central team & recommendations for future
  7. 4/2 – Workshop Requested sessions, benchmarking progress & associated learning, planning 2010/2011 local spread & sustainability strategy

- **2010**
  8. Refine implement / Measure** / Mainstream / sustain

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The DoH is organising four national events

- September 2009 – London
- October 2009 – Birmingham
- December 2009 – Birmingham
- February – London

Presentations from the national events are available on the internet at [www.18weeks.nhs.uk](http://www.18weeks.nhs.uk)

Search: Enhanced Recovery Programme
9. **Project plans**

As at November 2009 we have project plans for three of the elective care pathways, which are attached as appendices.

- Colorectal – Appendix B
- Gynaecology – Appendix C
- Musculoskeletal – Appendix D

As at November 2009 we are in the process of developing the project plan for Urology.

In assuring our project planning is robust we will be using the Institute for Innovation and Improvement’s Sustainability Model to review implementation.

10. **Data Collection**

The DoH has established a dedicated website with on line reporting for all those patients who are treated as part of the enhanced recovery partnership programme.

Our process for data collection will be:
- Paper copies of the on line form will be incorporated in the patients notes and completed as part of the administration of the patient journey
- The respective project managers for each of the pathways will be responsible for ensuring data collection and data accuracy
- When the forms have been completed they will then be forwarded to the 18 weeks project office
- The 18 weeks team will then enter the information on line (subject to appropriate resourcing of the team).

11. **Patient pathway and Map of Medicine**

Key to implementation will be ensuring that we have embedded robust patient pathways.

Our approach will be to use *Map of Medicine* to formalise, and then support the management of the four pathways.

Each of the project plans has identified the development of patient pathways as a critical action.
12. Stakeholder Engagement

**Internal**
- Surgery and Women’s and Children’s Divisional Clinical Governance meetings will be used as the main channels to engage clinical (doctors and nurses) leads

**External**
- PCT representation on the Project Board
- Social Services to be invited to join the Project Board
- GPs to be invited to join each of the Project Groups
- To review with the SHA and the PCT plans to develop how we will spread the lessons learnt as the EoE pilot site to other providers in the EoE.
- To continue to develop our relationships with other enhanced recovery sites in learning from them how they have implemented enhanced recovery.

**Communications Plan**
A communications plan will be developed to further formalise our approach to stakeholder engagement. As part of this process we will review how we will establish patient engagement in the programme and also review patient communication materials.
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<td>19&lt;sup&gt;th&lt;/sup&gt; November 2009</td>
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<td>Circulated to project leads for checking</td>
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<td>Submitted for inclusion in 25&lt;sup&gt;th&lt;/sup&gt; November West Hertfordshire Hospitals NHS Trust Enhanced Recovery Partnership Programme Board</td>
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