

Editorial

MARK SKUES



Workers, unite!

The ever repeated mantra of planning elective surgery from the first referral by a

General Practitioner to post-operative support after home discharge by the Surgical Team is never more evident than in this edition of the Journal. There are two articles written by familiar individuals under their different guises of Clinical Leads to both the NHS Institute and the NHS Elective Care and Diagnostics Group, that provide both sound evidence of benefit and practical advice for implementation. Both emphasise and demonstrate the advantages of a 'joined up' pathway that bridges the sadly 'traditional' potential divide existing between primary and secondary care. Surely it is time to break down these barriers so that patients can benefit from a seamless process that offers enhanced quality of care, that they, actually, also prefer?

Irrespective of the specific procedure of day case laparoscopic cholecystectomy cited in Smith and co-workers' paper (pages 80–86), here is a generic template emphasising the role of every member of the team, including the GP, ensuring that appropriate diagnostics results and information is provided with the first referral to surgical outpatients. Subsequent progress of a patient down the pathway is optimised by consideration of potential bottle-necks in the process, and, eliminating them. What's the outcome? A reported improvement of day surgery rates from the pilot sites that is little short of phenomenal for a significant number of the participating hospitals. Emulation

and adoption of such evidence based models is surely a priority for us all.

Similarly, Kerri Houghton (pages 92–95) has emphasised that the ongoing promulgation of the Enhanced Recovery Pathway has foundations soundly based on optimal Day Surgery care. Professor Henrik Kehlet, the 'Great Dane' who brought his vision of fast track surgery to the surgical community, cited in a paper in the *British Medical Journal* in 2001 that, "Use of these methods in day surgery units will be extended to more complex surgical procedures, thus decreasing length of time in hospital"¹. The Enhanced Recovery Pathway also emphasises 'Whole Team Involvement', hence the title of this Editorial, as well the fundamental tenet of patient 'buy in', based upon both disseminated knowledge of the proposed care pathway, and expectations of the process and outcome of their operation. Whilst the recent Health White Paper² soundbyte of "No decision about me, without me" may sound a little contrived, it encapsulates an ethos of healthcare and provision of information that we should justifiably be striving to accommodate, recognising that outcomes are improved when patients are fully informed and engaged with their proposed care. On this basis, the paper from Grace Dimbleby and Andrew Garnham (pages 96–99) is somewhat salutary reading, following their audit of consent for hernia repair, and their recognition that all was perhaps not well with their in-house provision of information to patients.

A take home message? Surely, it's 'pathway, pathway, pathway' and it is no coincidence that the theme of next year's BADS Annual Scientific Meeting as mentioned in the Presidential Letter, will be focussing on this overarching topic. Plan your pathway from beginning to end, include and engage with your patient as the most important person involved, break down the barriers impeding seamless care, recognise it's a whole team effort, and both quality and efficiency enhancement will happen. It sounds so easy, doesn't it?

But... isn't it? Workers, unite!

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References

1. Wilmore DW, Kehlet H. Management of patients in fast track surgery. *British Medical Journal* 2001;**322**:473–6.
2. Department of Health. *Equity and Excellence: Liberating the NHS*. July 2010.