Written Evidence submitted by the Centre for Perioperative Care (CPOC) (ECS0025)

1. About CPOC

The Centre for Perioperative Care (CPOC) is a partnership between the Royal College of Anaesthetists, Royal College of Surgeons of England, Royal College of Physicians, Royal College of Nursing, Royal College of General Practitioners, Association of Anaesthetists, Royal College of Paediatrics and Child Health, Faculty of Public Health and the College of Operating Department Practitioners. It includes representation from patients, trainees, and fully qualified clinicians. As a highly respected clinical collaboration, we produce evidence-based guidance and standards for the benefit of patients, clinicians, NHS leaders, patients, and the health service as a whole.

2. Scope of our submission

We shall restrict our answer to the commitment, *"**By 2021 where appropriate every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support**"* and the question *"**Is the commitment specific enough?**"*

3. Is the commitment specific enough?

While we support the commitment, we believe it is underspecified. In particular, it makes no reference to concepts such as prehabilitation and shared decision making. Incorporation of these concepts into routinue NHS practice can reduce post operative complications, reduce length of stay, and save money – however without reference to them in the commitment, it is possible they may be ignored by policy makers, commissioners, and service designers.

4. Prehabiltation

4.1 The healthier someone is before a medical intervention, such as an operation, the lower the chance of post-procedure complications. Complications are bad for the patient and dealing with them costs the NHS considerable amounts of time, money, and impacts on patient hospital flow.. Unfortunately, 10% - 15% of operations have a complication – which are often predictable and many might have been preventable[i]. Within hospitals, 45% of costs can be attributed to 3% of patients – typically those having complications[ii]. At present, there is wide variation in practice, results and complication rates across the NHS. The patient's health status may be documented, but it is seldom optimised particularly in a personalised manner.

4.2 Opportunities to improve the health of patients prior to undergoing operations and other forms of treatment are usually missed. Currently, many patients going into surgery have unhealthy lifestyles. They may smoke, be overweight, have poor diets, and do little exercise. The pandemic willhave exacerbated this, with many people staying at home, perhaps due to the need for shielding. They have low muscle mass and struggle to mobilise after surgery. Most do not know how to start exercising or that they would gain major benefits from doing so. Half the patients having an operation that requires an anaesthetic are over the age of 65[iii], an age at which 50% of people have more than two

long-term conditions (e.g., heart disease, diabetes, or dementia). People who are frail and/or are physically inactive (do no exercise) have four times the risk of complications. Tailored interventions can work to improve health – as we set out below.

4.3 Prehabilitation is a formal programme including physical exercise, and other interventions including one or more of: smoking cessation, nutrition, psychological preparation, alcohol moderation, and practical support. There are many pockets of good practice across the UK where local areas have integrated prehabilitation into their pathways. However, this is far from universal. The best results have been seen in cancer treatment, where there is a short, focused time to prepare.

4.4 Many programmes have been part-funded by Macmillan, for example in Manchester www.erasplus.co.uk and www.prehab4cancer.co.uk –which achieved a 3 day shorter length of stay and halving of lung complications[iv]. Across the UK, we have identified 32 examples of good practice. Patient satisfaction scores of 95% have been achieved, including with virtual patient contact developed during the pandemic. Other published results show:

- Reduction of length of stay[v] [vi] [vii].
- 46% - 75% reported lifestyle behaviour change[viii] [ix] [x] including 48% to 75% patients increasing physical activity, 40% stopping smoking and 40% reducing alcohol consumption[xi].
- Significant reductions in complications[xii] [xiii].

4.5 Guidance has been issued by MacMillan on how prehabilitation can be implemented for cancer services[xiv], which provides an easy template for trusts to draw on.

4.6 While prehabilitation is often referenced in regard to surgery, it does not need to be limited to this. It could also be used for other forms of cancer treatment, such as radiotherapy or chemotherapy[xv],.

5. Shared Decision Making

5.1 Shared decision making (SDM) is the process whereby patients and clinicians work together to make evidenced based decisions centred on patient values and preferences. This may be to select a test or intervention such as going ahead with surgery. SDM ensures individuals are supported to make decisions which are right for them.

5.2 Patients who are effectively involved in making decisions about their care have fewer regrets about treatment, better reported communication with their healthcare professionals, improved knowledge of their condition and treatment options, better adherence[xvi] to the selected treatment and an overall better experience with improved satisfaction[xvii].

5.3 While the GMC believes that SDM and consent are "are fundamental to good medical practice", and has issued guidance to clinicians on the subject[xviii], implementation is often poor. We do not believe that personalised care is possible without SDM, simply put care cannot be personalised without knowing what is important to the patient. We

believe the Government should take every opportunity to reinforce that message and embed the practice across the NHS.

6. Conclusion

Given the positive impacts of both prehabilitation and shared decision making, and given their frequent absence from current NHS practice, we strongly recommend promoting and embedding their use. A more specific wording of the aforementioned commitment would have helped in this regard.

7. Contact

If helpful, we would be happy to supply oral evidence. If so, please contact Peter Kunzmann pkunzmann@cpoc.org.uk

8. References

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