Fourth Patient Report of the National Emergency Laparotomy Audit (NELA)

Recommendations for Clinical Directors

It is clear from the NELA data presented in this report that there remain some crucial areas of care which must be improved if all patients undergoing emergency laparotomy are to receive the right care, by the right people, at the right time. In this 4th report there are six key themes which cover the standards against which NELA measures delivery of care for patients undergoing emergency laparotomy. For each theme there are associated actions allocated to specific owners; all are underpinned by the principles of quality improvement being specific, using measurable data from NELA, and are intended to be achievable tasks that are relevant and realistic to teams and patients within the defined time frame.

The six key NELA themes are:

1. improving outcomes and reducing complications
2. ensuring all patients receive an assessment of their risk of death
3. delivering care within agreed timeframes for all patients
4. enabling consultant input in the perioperative period for all high risk patients
5. effective multidisciplinary working
6. supporting quality improvement.

Some actions are applicable to more than one area.

	Detailed Action and Owner	Timeframe
1 Improving outcomes and reducing complications		
Maximising the value of NELA data		
1.2	**Medical Directors, Clinical Directors, local NELA leads, Multidisciplinary clinical teams:** ensure NELA outcome data (mortality, length of stay, unplanned returns to theatre and critical care and mortality) and processes of care are presented and reviewed at regular multidisciplinary governance meetings. These meetings should consider current performance and change over time, identify gaps in care and areas of good care, and develop appropriate action plans	Commence from next governance meeting (by January 2019 at the latest)
1.3	**Medical Directors, Clinical Directors, local NELA leads:** collaborate to understand how local NELA data can inform and align with other hospital improvement programmes, such as *Getting it Right First Time (GIRFT)*, Surviving Sepsis, The Deteriorating Patient, National Emergency Warning Score, and hospital flow workstreams	Develop collaboration plan by January 2019, with integration of data flows by April 2019
1.4	**Medical Directors, Trust Medical Examiners, Clinical Directors:** integrate review of patient deaths into Trust Mortality reviews and the National Mortality Case Record Review programme	Commence from next governance meeting (by January 2019 at the latest)
Clinical pathways		
1.7	**Medical Directors, Clinical Directors, local NELA leads, Multidisciplinary clinical teams:** develop and agree pathways of care that apply from admission to discharge to ensure a consistent approach to care throughout the perioperative stay. Pathways should define timelines for delivery of care, diagnosis, referral and escalation pathways, seniority of clinicians, and expectations of team members	Pathways to be in place by April 2019 in anticipation of Best Practice Tariff
2 Ensuring all patients receive an assessment of their risks associated with surgery that is documented in the medical record, communicated to members of the multidisciplinary team, and used to inform clinical decision-making		
2.1	**Medical Directors and Clinical Directors:** develop policies that define allocation of resources (consultant delivered care and admission to critical care) according to a patient's risk	January 2019
2.2	**Clinical Directors, NELA leads, Multidisciplinary clinical teams:** develop and agree multidisciplinary pathways that ensure all patients receive a documented preoperative assessment of risk based on objective risk scoring and senior clinical judgement. This risk assessment should guide allocation of resources and subsequent delivery of care (recommendation 2.1). Where patients do not have a preoperative risk assessed and documented, they should be treated as if they are high risk patients and receive the appropriate standards of care for high risk (>5%) patients. Patients should only be treated as low risk if the multidisciplinary team agrees and documents	Pathways to be in place by April 2019 in anticipation of Best Practice Tariff

	that they can be considered low risk on the basis of clear and agreed clinical evidence	
2.3	**Clinical Directors, local NELA leads, Multidisciplinary clinical teams:** ensure that risk assessment is based on a combination of both clinical and formal objective assessment (in particular using the NELA risk assessment tool which is more accurate than other methods for NHS patients undergoing emergency laparotomy). Risk assessment is done to facilitate the planning of care and communication and its limitations for an individual patient should always be considered. This risk assessment should be used as part of the consent process and to enable shared decision-making for high risk patients. A risk score can be easily calculated using the standalone NELA webtool and NELA risk app	January 2019
2.5	**Clinical Directors, College Tutors, local NELA leads:** promote the use of the NELA risk calculator (using webtool or NELA risk app) at junior doctor induction	Commence at next Junior Doctor induction
3 Delivering care within agreed timeframes for all patients		
Sepsis and peritonitis		
3.2	**Medical Directors, Clinical Directors, local NELA leads:** Use local NELA data to inform the hospital's Surviving Sepsis campaign	January 2019
3.3	**Clinical Directors, local NELA leads, Multidisciplinary clinical teams:** develop and agree multidisciplinary pathways for the management of sepsis and/or peritonitis to include patients who are admitted under non-surgical specialities. These should also ensure administration of antibiotics within 60 minutes of recognition of sepsis and appropriately rapid source control	Pathways to be in place by April 2019 in anticipation of Best Practice Tariff
3.4	**Clinical Directors, local NELA leads, Multidisciplinary clinical teams:** audit and review peritonitis cases to assess own performance and pathways, benchmarking performance against national recognised sepsis pathway	January 2019
3.5	**Clinical Directors, College Tutors, local NELA leads**: present emergency laparotomy pathways and their links with sepsis at new staff inductions (both senior and junior, surgeons, anaesthetists, ED, radiology, relevant allied healthcare professionals including nurses and operating department practitioners), and add as a standing item agenda for surgeon and anaesthetist MDT meetings	Pathways to be in place by April 2019 in anticipation of Best Practice Tariff
Theatre capacity		

3.8	**Medical Directors and Clinical Directors:** develop policies that define the timeline to surgery, prioritise emergency cases according to risk and surgical urgency, and deferral of elective work if theatre space is unavailable to meet clinical urgency	Policies to be in place by April 2019 in anticipation of Best Practice Tariff
3.9	**Clinical Directors, local NELA leads, Multidisciplinary clinical teams:** develop and agree pathways to facilitate arrival of patients in theatre within appropriate timeframes, which define the roles of all team members and when they should be involved.	Pathways to be in place by April 2019 in anticipation of Best Practice Tariff
The deteriorating patient		
3.11	**Clinical Directors, local NELA leads, Multidisciplinary clinical teams:** develop and agree pathways to promptly identify deteriorating patients and subsequent referral to senior decision makers in pre- and postoperative periods. This will also include those admitted under non-surgical specialties	Pathways to be in place by April 2019 in anticipation of Best Practice Tariff
3.12	**Medical Directors, Clinical Directors, local NELA leads:** collaborate with hospital leads for The Deteriorating Patient and National Emergency Warning Score workstreams to ensure a uniform approach	January 2019
4 Enabling consultant input in the perioperative period for all high risk patients		
4.2	**Clinical Directors from Surgery, Anaesthesia:** Review adequacy of job plans, rotas and staffing to ensure delivery of an uninterrupted consultant delivered service, 24 hours a day, seven days a week. There should be consultant presence for high risk patients regardless of urgency of surgery, time of day or day of week of surgery	December 2018
4.3	**Clinical Directors, local NELA leads, Multidisciplinary clinical teams:** develop and agree pathways of care for patients undergoing emergency laparotomy which are tailored to the hospital service and structure. Pathways must ensure consultants are informed, involved and lead in the care of patients undergoing emergency laparotomy throughout the care pathway. These should include escalation pathways for deteriorating patients and high risk patients such that they receive timely perioperative input into decision-making and clinical care by consultant surgeons, anaesthetists and intensivists. This should also cover the postoperative period to ensure the recognition, evaluation and management of complications which may result in unplanned return to theatre, or unplanned admission to critical care	Pathways to be in place by April 2019 in anticipation of Best Practice Tariff
5 Effective Multidisciplinary Working		
Radiology		
5.2	**Radiology and Surgery Clinical Directors, Chief CT Radiographer, local NELA leads, Multidisciplinary clinical teams:** develop and agree pathways to facilitate rapid access to reported CT scanning	Pathways to be in place by April 2019 in anticipation of Best Practice Tariff

5.3	**Radiology and Surgery Clinical Directors, clinicians:** ensure that all acute abdominal CT discrepancies are reviewed and discussed by surgery and radiology within their clinical governance programme. All discrepancy cases should be anonymised and referred to the Radiology Events and Learning Meetings following discussion between the relevant clinical teams. For most Trusts, this will be required for 1–2 scans per month	Commence from next governance meeting (by January 2019 at the latest)
Critical Care		
5.7	**Clinical Directors from Surgery, Anaesthesia and Intensive Care, local NELA leads, Multidisciplinary clinical teams:** develop and agree multidisciplinary care pathways that include clear guidance for the clinical team as to when patients should be admitted to critical care	Pathways to be in place by April 2019 in anticipation of Best Practice Tariff
Elderly Care		
5.12	**Clinical Directors from Elderly Care, Surgery, Anaesthesia, Intensive, local NELA leads, Multidisciplinary clinical teams:** develop and agree multidisciplinary care pathways that define when input from Elderly Care should be sought	Pathways to be in place by April 2019 in anticipation of Best Practice Tariff
6 Supporting Quality Improvement		
6.2	**Executive Boards, Medical Directors, Clinical Directors:** Ensure infrastructure and links are in place for NELA leads to access help and support from hospital improvement or transformation teams to implement change. Ensure that time (study leave) for NELA leads and multidisciplinary teams is available (guided by appraisal) to attend workshops and training in QI methodology	April 2019
6.4	**Clinical Directors, local NELA leads:** ensure job planned time and resources are available for NELA leads to carry out all expected duties, guided by the NELA local clinical lead job description	Immediate, for confirmation by NELA leads next job plan review