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

Recommendations for Medical 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		
1.1	**Provider Executive Boards and Medical Directors:** review NELA annual and quarterly reports and changes in performance as a regular standing agenda item at Executive level (at least quarterly)	Commence from next Executive meeting (by January 2019 at the latest)
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

3 Delivering care within agreed timeframes for all patients		
Sepsis and peritonitis		
3.1	**Provider Executive Boards, Medical Directors:** ensure a Health Board/Trust-wide approach to identify patients with sepsis, that ensures antibiotics are given within 60 minutes of recognition of sepsis	January 2019
3.2	**Medical Directors, Clinical Directors, local NELA leads:** Use local NELA data to inform the hospital's Surviving Sepsis campaign	January 2019
Theatre capacity		
3.7	**Commissioners, Provider Executive Boards and Medical Directors:** review adequacy of theatre capacity based on estimation of emergency surgical caseload, and work to address any shortfall. Capacity needs to be sufficient to allow patients to receive surgery within defined timeframes. The area that needs particular attention is those requiring surgery within two hours. Improvement teams should use QI methodology such as process mapping to understand where change is required	January 2019
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
The deteriorating patient		
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		
4.1	**Commissioners, Provider Executive Boards and Medical Directors:** Review adequacy of consultant staffing based on estimation of emergency surgical caseload and work to address any shortfall. Capacity must to be sufficient to allow high risk patients to receive care directly delivered and supervised by consultant surgeons and consultant anaesthetists	January 2019

5 Effective Multidisciplinary Working		
Radiology		
5.1	**Commissioners, Provider Executive Boards and Medical Directors:** scope requirements to deliver a radiology service that provides a reported CT within a timeframe that does not delay surgery, has low discrepancy rates, and provides opportunity for meaningful senior discussion between the surgery and radiology. The NELA data suggests that an in-house consultant service provides the lowest discrepancy rate. Consideration should be given to developing local networked solutions for 24/7 consultant radiologist reporting to overcome high vacancy rates in the specialty as reported by the Royal College of Radiologists	April 2019
Critical Care		
5.6	**Commissioners, Provider Executive Boards and Medical Directors:** review adequacy of critical care bed capacity, based on estimation of high risk patients and emergency surgical caseload, and work to address any shortfall. Capacity needs to be sufficient to admit all high risk patients (predicted mortality ≥5%) and minimise premature discharge from critical care	January 2019
Elderly Care		
5.11	**Commissioners, Provider Executive Boards and Medical Directors:** scope requirements for Elderly Care input into patients undergoing emergency laparotomy, based on estimation of emergency surgical caseload, and work to address any shortfall	April 2019
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