| Provider line of sight table on report recommendations for submission to the funders | |
|---|---|
| **Please can the provider complete the following details to allow for ease of access and rapid review** | |
| **Project and Title of report, including HQIP Ref.**<br>***e.g., Ref. XXX, Project and report title*** | **Ref 413, National Emergency Laparotomy Audit, Ninth Patient Report of the National Emergency Laparotomy Audit; December 2021 to March 2023** |
| 1. What is the report looking at/what is the project measuring? | **Clinical Audit of adult patients having emergency bowel surgery.** |
| 2. What countries are covered? | **England, Wales** |
| 3. The number of previous projects (e.g., whether it is the 4th project or if it is a continuous project) | **Continuous project** |
| 4. The date the data is related to (please include the start and end points – e.g., from 1 January 2016 to 1 October 2016) | **1 Dec 2021 – 31 Mar 2023** |
| 5. Any links to NHS England objectives or professional work-plans (only if you are aware of any) | |

| **Please can the provider complete the below for each recommendation in the report** | | | | | | | |
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| **No.** | **Recommendation** | **Intended audience for recommendation** | **Evidence in the report which underpins the recommendation** *(including page number)* | **Current national audit benchmarking standard if there is one** | **Associated NHS payment levers or incentives'** | **Guidance available (for example, NICE guideline)** | **% project result if the question previously asked by the project (date asked and result). If not asked before please denote N/A. This is so that there is an indication of whether the result** |

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| | | | | | | | **has increased or decreased and over what period of time** |
| Rec 1 | Royal Colleges should work together to publish consensus pathways for patients presenting to hospital who might require emergency laparotomy. These pathways should include:<br>• diagnostic, radiological, and initial management phases of a patient's presentation prior to a decision to operate.<br>• targets for timeliness of each pathway step. | **Royal Colleges of Emergency Medicine, Radiologists, Surgeons, and Anaesthetists** | amongst those with suspected sepsis:<br>• Only 20% received antibiotics within 1 hour<br>• 25% waited at least 6.5 hours after arrival in hospital before receiving antibiotics<br>• 50% waited for more than 15 hours before arrival in theatre.<br>• Performance varied significantly between hospitals<br><br>Page 8. | • Surgical source control of sepsis should be undertaken within 3-6 hours of diagnosis<br>• In patients with a NEWS2 of ≥5, and who are likely to require surgery or radiological intervention to control a source of sepsis, appropriate antimicrobials should be given within one hour | • None | • *The high-risk general surgical patient: raising the standard*. RCS Eng, 2018. Available at: https://www.nela.org.uk/downloads/RCS%20Report%20The%20HighRisk%20General%20Surgical%20Patient%20%20Raising%20the%20Standard%20%20December%202018.pdf<br>• *Statement on the initial antimicrobial treatment of sepsis*. Academy of Medical Royal Colleges, 2022. Available at: https://www.aomrc.org.uk/wp-content/uploads/2022/10/Statement_on_the_initial_antimicrobial_treatm | • For patients with sepsis suspected at arrival, 22% received antibiotics within an hour (NELA Year 8)<br>• For patients presenting with suspected sepsis, 25% waiting at least 6.8 hours after arrival before receiving |

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| | | | | | | ent_of_sepsis_V2_1022.pdf<br>• | antibiotics (NELA Year 8)<br>• For patients presenting with suspected sepsis, the median interval between arrival at hospital and arrival in theatre was 15.6 hours (NELA Year 8)<br>• Median time to administration of antibiotics in those with suspected sepsis on arrival was 3.0 hours |

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| | | | | | | | (NELA Year 8) |
| Rec 2a | Commissioners should ensure that Trusts/hospitals provide adequate specialist care for older patients and those with frailty following emergency laparotomy, per guidance published by the Royal College of Surgeons of England, British Geriatrics Society, and the Centre for Perioperative Care. | **Regional and local commissioners (Integrated Care Boards and Health Boards) in England and Wales** | • 33.2% of patients aged 80+, or 65+ and frail, had input from a member of a geriatrician-led team during any part of the perioperative pathway<br><br>Page 9. | • 80% for assessment by a member of a geriatrician-led team by NELA standards at time of data collection; current standard is 85% | • Best Practice Tariff in England for geriatrician input which came into effect 1 Apr 2023 | • *Guideline for Perioperative Care for People Living with Frailty Undergoing Elective and Emergency Surgery*. Centre for Perioperative Care, 2021. Available at: https://www.cpoc.org.uk/sites/cpoc/files/documents/2021-09/CPOC-BGS-Frailty-Guideline-2021.pdf<br>• | • Geriatrician input: 31.8% in Year 8, 27.1% in Year 7, 28.4% in Year 6 |
| Rec 2b | To expand the pool of clinical staff with the requisite specialist skills, Royal Colleges of Physicians, Surgeons and Anaesthetists should consider working together to develop common competency-based training curriculae around optimising perioperative care for older patients and those living with | **Royal Colleges of Physicians, Anaesthetists and Surgeons** | • 33.2% of patients aged 80+, or 65+ and frail, had input from a member of a geriatrician-led team during any part of the perioperative pathway<br><br>Page 9. | • 80% for assessment by a member of a geriatrician-led team by NELA standards at time of data collection; current standard is 85% | • Best Practice Tariff in England for geriatrician input which came into effect 1 Apr 2023 | • *Guideline for Perioperative Care for People Living with Frailty Undergoing Elective and Emergency Surgery*. Centre for Perioperative Care, 2021. Available at: https://www.cpoc.org.uk/sites/cpoc/files/documents/2021-09/CPOC-BGS- | • Geriatrician input: 31.8% in Year 8, 27.1% in Year 7, 28.4% in Year 6 |

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| | frailty who undergo emergency surgery. | | | | | Frailty-Guideline-2021.pdf<br>• | |
| Rec 3 | Healthcare services provided to those from more deprived backgrounds need to be matched to their greater need. This requires strategic planning. | **NHS England; Regional and local commissioners (Integrated Care Boards and Health Boards) in England and Wales** | • There is a pattern of lower in-hospital mortality amongst patients within the less deprived quintiles; in-hospital mortality is 10.7% in England vs 11.3% in Wales in the most deprived quintile and 7.8% in England vs 9.6% in Wales in the least deprived quintile<br><br>Page 12. | • none | • none | • none | • similar pattern in NELA Year 8; in-hospital mortality was 9.5% in England vs 10.7% in Wales in the most deprived quintile and 8.7% in England vs 10.4% in Wales in the least deprived quintile |