Academic Health Science Network
North East and North Cumbria

North East North Cumbria AHSN EmLap Stocktake Survey

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Hospital and Specialty of Respondent

	Hospital	Response Percent	Response Total
1	NSEC	6.5%	4
2	Cumberland Infirmary	11.3%	7
3	RVI	58.1%	36
4	FRH	16.1%	10
5	QEH	1.6%	1
6	Sunderland	1.6%	1
7	South Tyneside	1.6%	1
8	Darlington	0.0%	0
9	Durham	0.0%	0
10	North Tees	1.6%	1
11	James Cook	1.6%	1
		answered	62

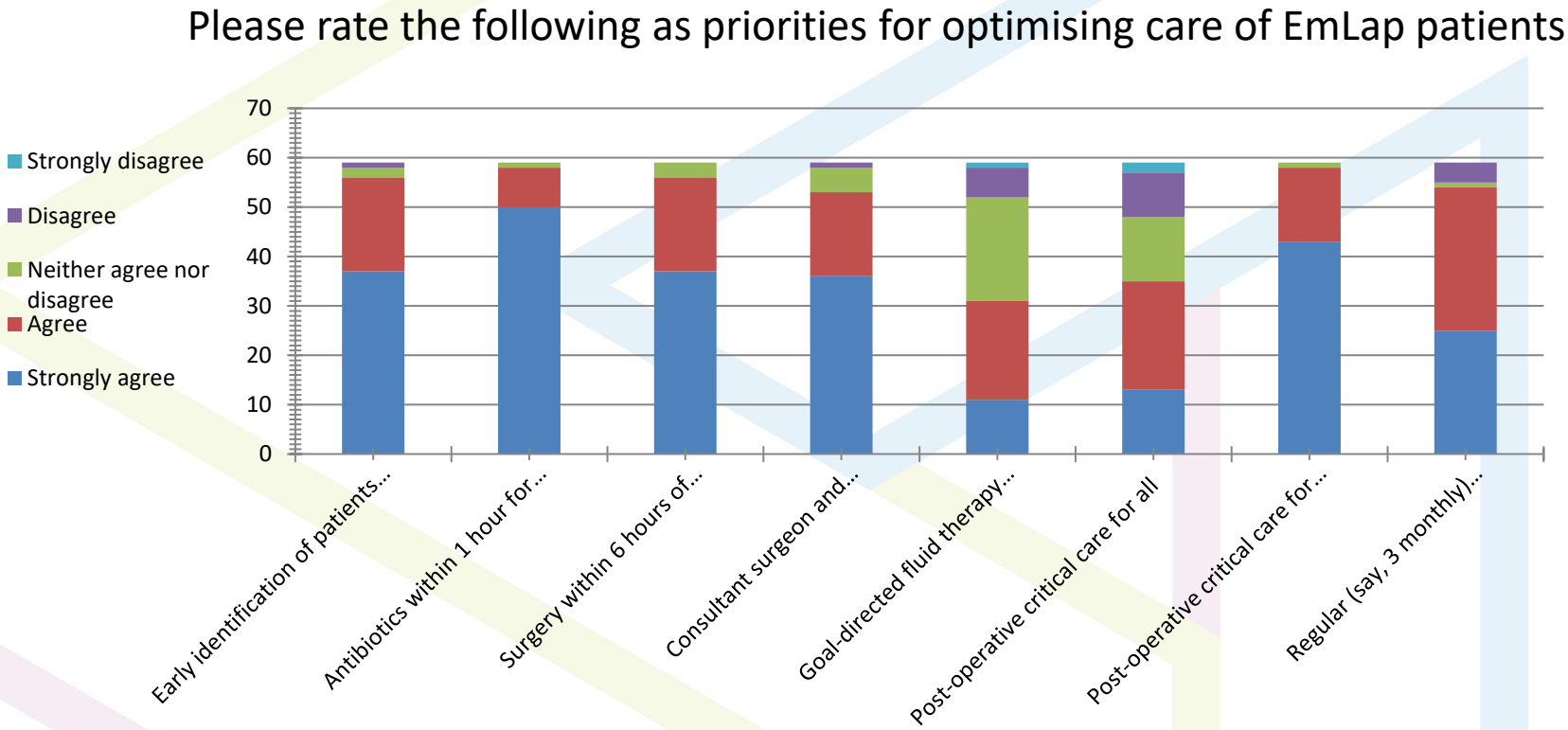
Speciality			
Answer Choice		Response Percent	Response Total
1	Anaesthesia	64.5%	40
2	Surgery	16.1%	10
3	Critical care	14.5%	9
4	Radiology	3.2%	2
5	Elderly care	0.0%	0
6	Emergency Medicine	1.6%	1
		answered	62

Opinions - clinical priorities

Clinical priorities for optimised care of EmLap patients in your hospital. Please rate the following as priorities for optimising care of EmLap patients. The aim is to understand which standards you would aspire to deliver in your own hospital.

Answer Choice		Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Response Total
1	Early identification of patients at risk of deterioration using NEWS2 scores	39	19	2	1	0	61
2	Antibiotics within 1 hour for those with suspected sepsis	52	8	1	0	0	61
3	Surgery within 6 hours of decision	39	19	3	0	0	61
4	Consultant surgeon and consultant anaesthetist present in theatre	37	18	5	1	0	61
5	Goal-directed fluid therapy during surgery and critical care	11	20	23	6	1	61
6	Post-operative critical care for all	13	23	14	9	2	61
7	Post-operative critical care for high risk patients (5%+)	45	15	1	0	0	61
8	Regular (say, 3 monthly) multidisciplinary meetings to review morbidity & mortality related to EmLap	24	29	1	4	0	58
Comments:							14

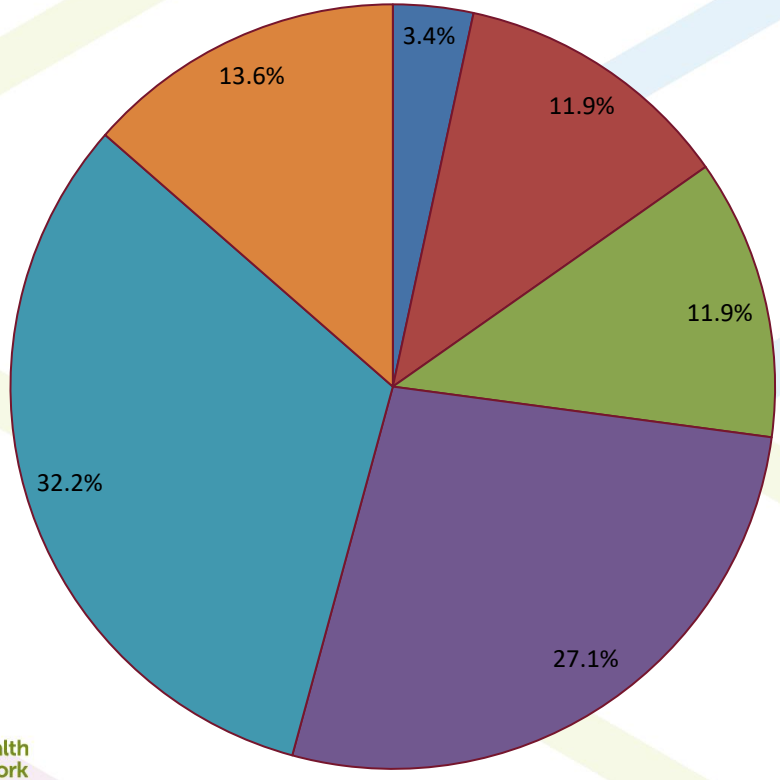
Opinions - clinical priorities



Opinions – free text comments

Comments:
correct score for news 2 selection key. over triage rate hisgh if news of 3 used. news of 5 comes from sepsis data. clinician plus news 2 score (senior decision maker) is ikely where the intersect lies
Not job planned
Feel time is always an issue and we get none for M and M. Just getting the data would be a start
The only way that we can evolve learning and accommodate all views is with frequent analysis of cases that highlight good and less good practice. Patterns emerge that guide future practice. Critical care is a limited resource, and is not beneficial for patients with a terminal diagnosis, or severe levels of frailty- unless this is combined with appropriate advanced care planning, and is thought likely to prove effective in achieving their end of life wishes, by those expert in this area (i.e. intensive care medicine). This would require prior discussion, and rarely happens in practice for EmLap.Patients arriving on ICU after inappropriate /futile surgery - who then expectedly deteriorate and die, does not represent good use of this resource. There are many factors that need considering when identifying patients at risk of deterioration. NEWS2 is one of these, but is far too sensitive, and not specific enough to function in isolation. Good medicine, involving experienced doctors and nurses can easily identify patients at risk of deterioration. No patient should be admitted to ICU due to 'risk of deterioration' if they have a surgical diagnosis amenable to surgical treatment. They should have resuscitation and ongoing care in theatres, whilst their surgery is conducted. Then appropriate critical care post-operatively.
Not sure that a consultant anaesthetist is a mandatory requirement in fit young patients with low calculated mortality and when there is a consultant in the theatre suite who can advise. I am unsure of the impact of offering goal-directed fluid therapy. This could be a failure of communication on behalf of Crit. Care.
We should recognise that a peri-operative mortality figure of <5% still represents a significant risk which could be mitigated through post-op admission to critical care. We accept critical care as being mandatory for major elective cases with peri-op mortality rates much lower than 5%.
MDT review of cases vital - to enable reflection and learning, as well to maintain team motivation.
As a radiologist, difficult for me to answer the detailed clinical questions. I am of course against any new MDTs!
Think we are already doing this
I wonder if more promotion of the concept of PACU with close working with critical care is a more realistic aspiration for lower risk emergency laparotomies. Hestation on surgery with 6 hours of decision links to known risk associated with overnight operating which likely needs to play into decision making and impacts 6 hour interval for some - recognising need for risk/beneft assessment
While this would be ideal, the logistics of m n m meetings may be challenging
Point 5 is currently under study obvs to preferences should be "parked".
Have always taken issue with the concept that consultant anaesthetists need to be in theatre for all laparotomies. For some, sure, but all other aspects of our supervision rotate around the assessment of skill mix in theatre vs patient challenges. Whilst recognising these are often sick, many times senior trainees are completely capable of delivering optimum care. As for goal directed therapy I don't understand why on earth we're still banging the drum on this one, as there's bugger all evidence for it, and none on the horizon with the way flo-ela is progressing.
Do not believe GDFT should be the standard of care. Potential for over administration of fluid, and would prefer to see it used only as indication to stop fluid administration.

At what stage is your hospital in the introduction of formal pathways of care for EmLap patients?



Which areas do you feel are priorities for improving/ developing services for EmLap patients in your hospital? please select all that are relevant			
Answer Choice		**Response Percent**	**Response Total**
1	Upstream of theatre – ED support and engagement/ resources	37.3%	22
2	Upstream of theatre – Radiology support and engagement/ resources	30.5%	18
3	Upstream of theatre – microbiology support/ guidance/ expedited sepsis management	22.0%	13
4	Access to emergency theatre capacity	44.1%	26
5	Downstream of theatre – Critical care support/ resources/ capacity	20.3%	12
6	Downstream of theatre – elderly care support/ resources/ capacity	59.3%	35
7	Other (please specify):	8.5%	5

Other (please specify):
Pre-op rational MDT discussion, so the decision to operate is not presented as a fait accompli to the patient +/or next of kin.
I think the radiology support is already there. Can't comment on other items
None I think we do pretty well - marginal gains required only
I catn comment on upstream aspects as I am not involved in this
issue is with consistent engagement and resources across all steps. Particular issues with shortage of substantive staffing in surgical teams currently

Comments:
radiology capacity to image and report in timely fashion esp when faced with multiple high priority scans eg trauma CT , stroke CT. ED identification robust(though like anything always room for improvement) but this is the key stakeholder area
Have limited insight into local engagement of radiology services to EmLap
Getting people with surgical diagnoses to theatre quicker, or avoiding theatre (in those that don't need it) is where the greatest gains can be made for those who can be expected to return to a good quality of life for a long period.
There are some resource issues with regard to laparotomy in that as the importance of this group of patients is well understood, then many other emergency cases are considered as secondary importance and this means that delivery of care
Generally good engagement throughout the process. The largest deficit is in rehabilitation for the elderly or those recovering from prolonged ITU stays.
Just because we can, doesn't always mean we should.
Some delays known due to second hospital transfer which is being worked on to improve Don't have access to geriatric support for surgical patients as routine
I think we are pretty well developed in all areas
I believe that we should have 2 theatres for emergencies which will help with delays in getting patients to theatre.

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Support for service development – what are the main priorities as you see them in your hospital?			
Answer Choice		Response Percent	Response Total
1	NELA data collection assistance	33.9%	20
2	NELA data interpretation	20.3%	12
3	Widening clinical engagement ("core" – anaesthesia, surgery, Crit Care)	28.8%	17
4	Widening clinical engagement ("wider" – radiology/ ED/ Elderly care/ gen med)	67.8%	40
5	Non-clinical – management and audit support	35.6%	21
6	None of the above	10.2%	6
Comments:			7

data management is important, but should not be the job of clinicians who are otherwise busy.
I would like more to be done with the NELA data in terms of our local outcomes and also comparisons to peer groups and even those units with exemplar status. This probably requires a little more support.
All of the above.
I'm not really sure as we don't do very many and I don't have any idea of where the issue are
I think post op input by medicine/anaesthesia/?periop physicians would be valuable for this group once they are d/c from critical care - they then get left to be looked after by very junior surgical team members
I think data collection assistance is important but my trust doesnt agree-I dont understand which of these your question means
Similar to having consultant surgeon and anaesthetist, we should be engaging with consultants in radiology to have scans reported in a timely manner to allow for enhanced decision making