NELA Standards of Care – NoLap Cohort

These standards of care and associated RAG ratings will apply from April 2024. Data is collected to report on a variety of standards. The decision over whether to include certain standards is guided by consideration of its role in improving outcomes for patients, quality assurance and quality improvement, balanced against burden of data collection. Advice is also taken from NELA's Clinical Reference Group of stakeholder professionals and lay members.

Workstream	Standards benchmarked by NELA	Details of the source of standard reported	Source of standards	RAG ratings	Associated Process Measures
Risk assessment	Proportion of patients in whom a risk assessment was documented prior to non-operative decision	Patients admitted or transferred under the care (or joint care) of a general surgeon, whether for operative or non-operative management, should have their risk of morbidity and mortality assessed and recorded in the medical records by a senior surgeon (ST3 and above) within four hours of admission or transfer, using appropriate risk prediction tools, where available, and clinical judgement.	RCS HRGSP 2018, p22	Green: ≥85% Amber: 55 – 84% Red: <55	Proportion of patients with a formal risk assessment of mortality risk.
		An assessment of mortality risk should be made explicit to the patient and recorded clearly on the consent form and in the medical record.	NCEPOD Knowing the Risk 2011, p7		
Frailty assessment	Proportion of patients aged 65 or older for whom a formal	Patients aged over 65 years and other patients who appear frail for their age admitted or transferred under the care (or joint care) of a	RCS HRGSP 2018, p19	Green: ≥75% Amber: 40-74% Red: <40%	Proportion of patients aged 65 or older whom a formal

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	assessment of frailty was documented	general surgeon, whether for operative or non-operative management, should have their level of frailty assessed and recorded within four hours of admission or transfer, using a recognised assessment tool that is valid, reliable, and easy to use.			assessment of frailty was documented.
		All patients aged over 65 years, and younger patients at risk of frailty, should have frailty status documented at admission using the Clinical Frailty Scale (CFS).	CPOC Perioperative care of people living with frailty 2021, p9		
CT scanning and reporting	Proportion of patients who had a CT scan that was reported by a senior radiologist and communicated with the team in the correct time scale	Adult patients admitted or transferred under the care (or joint care) of a general surgeon, whether for operative or non-operative management, should be managed in accordance with a unit protocol, which should include availability of a radiologist's report within one hour when emergency abdominal CT is performed.	RCS HRGSP 2018, p44	Green: ≥85% Amber: 55 – 84% Red: <55	Where appropriate, the proportion of patients who had a CT scan that was reported by senior radiologist (ST3 or above) within one hour of being undertaken.
		For high-risk general surgery patients being considered for major surgery, there should be joint preoperative discussion between	RCS HRGSP 2018, p33		Where appropriate, proportion of all patients who undergo CT scan and

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		senior surgeon and senior radiologist (ST3 and above), either in person or by telephone, followed by postoperative comparison of imaging and operative findings. Best care includes preoperative discussion between a consultant surgeon and an in-house consultant radiologist.			where there is direct communication between radiologist (ST3 and above) and surgeon (ST3 or above), either via phone or in person to discuss CT findings.
Advance care plan	Proportion of patients in whom staff have proactively identified advance care plans to support the decision-making process preoperatively	To support decision making, surgical and preoperative assessment teams should: ascertain presence of pre-existing Advanced Care Directives, Advance Decisions to Refuse Treatment, 'do not attempt resuscitation' orders and treatment escalation plans. Ensure documentation is complete and available.	CPOC Perioperative care of people living with frailty 2021, p15	Green: ≥85% Amber: 55 – 84% Red: <55	Proportion of patients where the admitting team attempted to ascertain the presence of advance care plan preoperatively.
		Adult patients admitted or transferred under the care (or joint care) of a general surgeon, whether for operative or non-operative management, should be managed in accordance with a unit protocol. This protocol should include appropriate response at key points	RCS HRGSP 2018, p44		

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		within the patient pathway, and of escalation pathways in the event of patient deterioration in the non-operative period.			
End-of-life care	Proportion of patients who were recognised to be dying who have an individualised end-of-life care plan documented.	Ensure that all people who are recognised to be dying have a clearly documented and accessible individualised plan of care developed and discussed with the dying person and those important to them to ensure the person's needs and wishes are known and taken into account.	National Audit of Care at the End of Life (2022/23), p10	Green: ≥85% Amber: 55 – 84% Red: <55	For those patients who died in hospital, proportion of patients with an individualised end-of-life care plan documented.
	Proportion of patients who died in hospital, who received direct input by member of a palliative care team	The surgeon should seek to discuss the patient's case with relevant professionals to ascertain: • the appropriate treatment options at the end of life available to the patient • the patients' wishes, preferences and beliefs to inform their best interests. A formal consultation with the palliative care team is particularly useful in this context.	RCS Caring for Patients Nearing the End of Life A Guide to Good Practice, p16	Green: ≥85% Amber: 55 – 84% Red: <55	For those patients who died in hospital, proportion of patients who received direct input by member of a palliative care team.
		Seek advice from colleagues with more experience of providing end of life care when there is a high	NICE Care of dying adults in the last days of life 2015, p32		

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		level of uncertainty (for example, ambiguous or conflicting clinical signs or symptoms) about whether a person is entering the last days of life, may be stabilising or if there is potential for even temporary recovery.			
Case Ascertainment				Not RAG rated	
Mortality				Not RAG rated	
Hospital length of stay				Not RAG rated	