

Welcome to the **NELA NoLap Introductory Webinar**

Tuesday, 27 February 2024 | 12:00 – 13:00

Speakers:

Angeline Price

Ee-Neng Loh

Lyndsay Pearce

Before we start...

- Submit questions and comments through the Q&A tab
- Exit and restart Zoom if you are having audio or visual problems
- A recording of the webinar will be available in due course
- Please complete the post-webinar survey

Thank you for joining us today

Background

- 24,000 EmLap cases per year across England & Wales
- Consistent improvement over past decade
- Overall in-hospital mortality has fallen and plateaued - 9 % *(extreme risk cases falling)

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 - Longer LOS
 - Readmissions
 - Higher 30, 90 day and 1 year mortality
 - Functional deterioration



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 - Functional deterioration
- *Who doesn't have surgery? The NoLap group*



NoLap – the definition

‘Patients with acute abdominal pathology treatable by emergency laparotomy, but who do not undergo surgery (NoLap)’

McIlveen et al, 2020

NoLap... what we know so far

- 3 published studies, 1 pending

SURGICAL OUTCOME



The Perth Emergency Laparotomy Audit

Katherine J. Broughton^{*,*} Oscar Aldridge,[†] Sharin Pradhan[‡] and R. James Aitken^{*,*}

^{*}Department of General Surgery, Sir Charles Gairdner Hospital, Perth, Western Australia, Australia

[†]Department of General Surgery, Fiona Stanley Hospital, Perth, Western Australia, Australia and



[‡]Department of General Surgery, Royal Perth Hospital, Perth, Western Australia, Australia

Multi-centre, prospective study – 12 weeks data collection
198 EmLaps, 13 NoLaps (6.6%) via WAASM
10 were aged 80 yrs or above, 4 had ischemia
69.2% of NoLaps died within 5 days

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10 were aged 80 yrs or above, 4 had ischemia

69.2% of NoLaps died within 5 days

non-operative cases have almost doubled since WAASM introduced...these patients should be included in future prospective studies

Anaesthesia

Peri-operative medicine, critical care and pain



Association
of Anaesthetists

Original Article | Free Access

A prospective cohort study characterising patients declined emergency laparotomy: survival in the 'NoLap' population[†]

E. C. McIlveen , E. Wright, M. Shaw, J. Edwards, M. Vella, T. Quasim, S. J. Moug

First published: 18 September 2019 | <https://doi.org/10.1111/anae.14839> | Citations: 31



Single centre, prospective study

314 patients: 214 EmLap and 100 NoLaps (32%)

'Poor fitness' main reason, lower consultant involvement

26% of NoLaps alive at 12 months



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26% of NoLaps alive at 12 months

Care leading up to decision is substandard compared to EmLaps

NoLaps significant in number

What is poor fitness?





Triage and outcomes for a whole cohort of patients presenting for major emergency abdominal surgery including the No-LAP population: a prospective single-center observational study

Mohamed Ebrahim¹ · Morten Laksáfoss Lauritsen^{1,2} · Mirjana Cihoric³ · Karen Lisa Hilsted¹ · Nicolai Bang Foss^{2,3}

Received: 7 March 2022 / Accepted: 30 June 2022 / Published online: 15 July 2022
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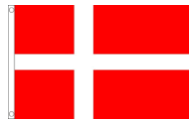
Single centre, prospective study
252 consecutive patients requiring emergency surgery
21 NoLaps (8.3%), older, co-morbid, higher ASA score
'Poor functional performance' and futility as main reasons
30-day mortality 95%, all died within 90 days



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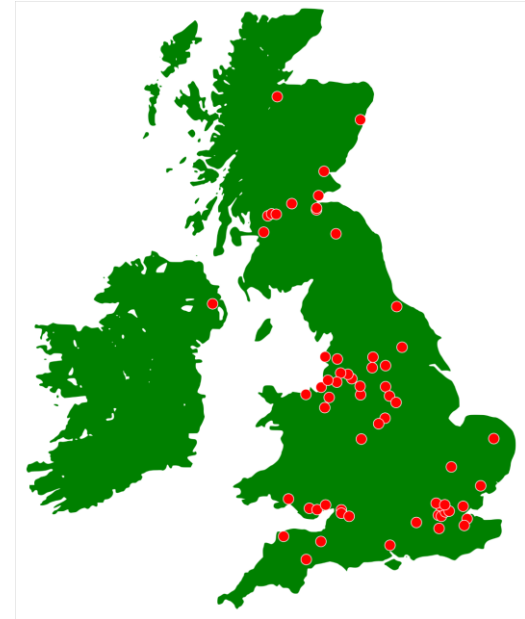


Single centre, prospective study
252 consecutive patients requiring emergency surgery
21 NoLaps (8.3%), older, co-morbid, higher ASA score
'Poor functional performance' and fertility as main reasons
30-day mortality 95%, all died within 90 days

Potential cultural differences, larger multi-centred studies needed

ELF2 – results imminent

- Multicentre, prospective study
- 6-month recruitment period
- 62 sites
- **825 NoLap patients**



ELF2

- Older, co-morbid, frail (70%), advanced malignancy
- Only half had a recorded risk assessment score
- Diverse reasons behind NoLap decision
- MDT and patient involvement lower than expected
- **30-day mortality 69%, 90-day mortality 79%**

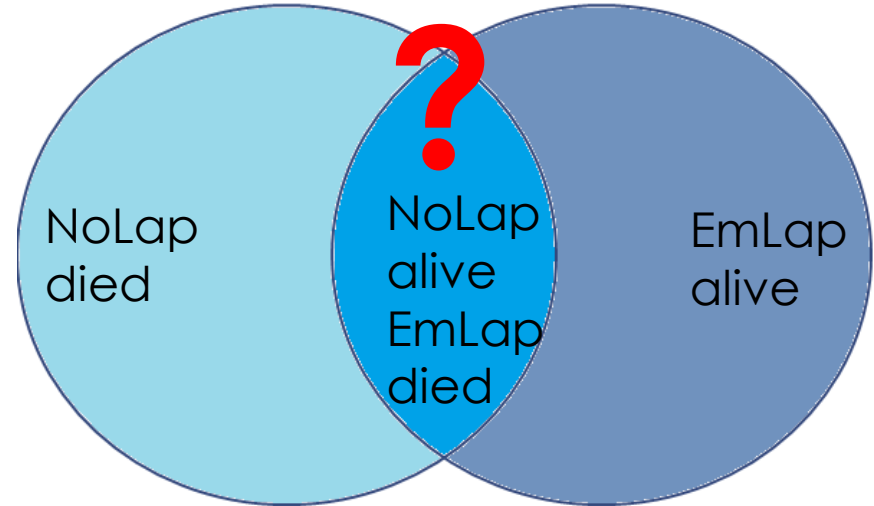
Summary

- NoLap patients appear to be older, multimorbid, high incidence of advanced malignancy (and frailty) – *opportunity for pre-emptive planning*
- Approach to the NoLap decision not standardised
- Conflicting results **BUT** some patients remain alive at 90 days/1 year
- What is the best approach to management?

What we don't know

How... Who... Why... What next?

Is NoLap a viable alternative for some?



Please input any questions
into the Q&A

Introduction to NoLap

Dr Ee-Neng Loh

NELA Anaesthetic Fellow

Project overview

- To look at non-operative group of surgical patients
- Roll out in April 2024 (NoLap Year 1)
- Start off with:
 - Bowel ischaemia
 - Bowel perforation
- Later: to include all other diagnosis

Preparatory work

- **Virtual nominal group technique consensus meeting**
 - MDT (clinicians + lay representative)
 - Aim of the meeting:
 - To establish the definition of NoLap
 - Identify essential care processes for NoLap group of patients
- **NoLap working group**
 - Develop key standards, question proforma, case ascertainment pathway

Definition of NoLap

- A NoLap patient is a patient who presents with acute abdominal pathology needing surgical intervention which would meet NELA inclusion criteria, where a decision is made that they will not undergo emergency surgery



NoLap documents

Inclusion criteria for Year 1 NoLap

- Patients aged 18 years and over
- Diagnosis of bowel perforation or suspected bowel ischaemia, for which surgery is indicated
- DID NOT undergo abdominal surgery (laparoscopic or open) during this hospital episode



NoLap documents

Exclusion criteria for Year 1 NoLap

- Patients under 18 years of age
- Patients who undergo emergency or elective abdominal surgery (laparoscopic or open) during this hospital episode
- Patients whose bowel perforation or ischaemia management involved/included interventional radiology or endoscopic procedures (drainage of collection, stent insertion or removal)
- Patients who are excluded from NELA (see NELA exclusion criteria)



NoLap documents

Key Standards

- Risk assessment
- Frailty assessment
- CT scanning/ reporting
- Advance care plan (including treatment escalation plan)
- Recognition of end-of-life care needs



NoLap documents

Case ascertainment (clinical)

- Ways to capture cases vary between Trusts
- We suggest: Appoint a NoLap lead, can be anyone from different specialties
- Daily checks with oncall surgical registrar to capture these patients
- Open to suggestions

Case ascertainment (audit)

Only completed records on HES/ PEDW data will be included- assuming that these are patients who have been discharged and definitive decision has been made

↓

Diagnostic codes to identify patients presented with bowel ischaemia or bowel perforation

AND

NO EmLap OPCS code

NO IR code

↓

No LAP

Outlier policy

- HQIP Outlier Guidance document published Jan 2024.
- For first year, to allow for testing and embedding of the process, we won't be enforcing the outlier analysis.
- Participation from all trusts will be monitored.

Useful documents for NoLap



NoLap documents



Standards

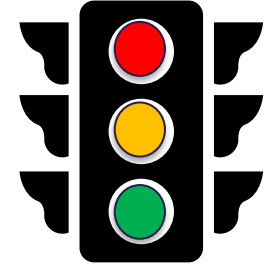


Standards

- Source of standard

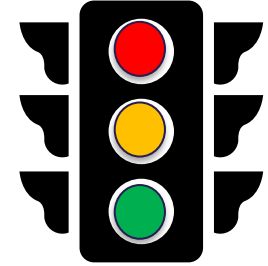
Standards

- Source of standard
- RAG rating



Standards

- Source of standard
- RAG rating
- Process Measure



Standards for No Lap

- 1 Risk Assessment
- 2 Frailty Assessment
- 3 CT scanning & reporting
- 4 Advance Care Planning
- 5 End of Life Care

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- 1 Risk Assessment
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- 5 **End of Life Care**

Risk Assessment

Risk Assessment

“Proportion of patients in whom a risk assessment was documented prior to non-operative decision”

Risk Assessment



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Risk Assessment



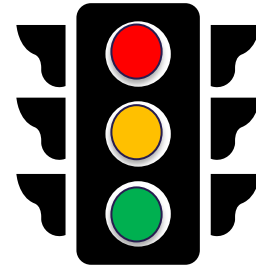
“Proportion of patients in whom a risk assessment was documented prior to non-operative decision”

Risk Assessment

<55%

55-84%

>/= 85%



Proportion of patients with a formal assessment of mortality risk

Frailty Assessment

Frailty Assessment

“Proportion of patients aged 65 years or over in whom a formal assessment of frailty was documented”

Frailty Assessment



“Proportion of patients aged 65 years or over in whom a formal assessment of frailty was documented”

Frailty Assessment



Centre for
Perioperative Care



Guideline for
Perioperative
Care for People
Living with Frailty
Undergoing Elective
and Emergency
Surgery

September 2021

“Proportion of patients aged 65 years or over in whom a formal assessment of frailty was documented”



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National Emergency
Laparotomy Audit

Frailty Assessment



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British Geriatrics Society
Improving healthcare
for older people

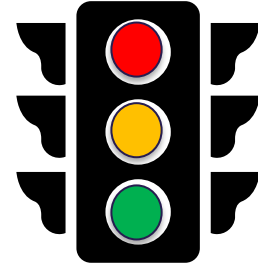
Guideline for
Perioperative
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Surgery

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<40%

40-74%

>/= 75%



**Proportion of patients aged 65
years or over in whom a
formal assessment of frailty
was documented**

CT scanning & reporting

CT scanning & 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”

CT scanning & reporting



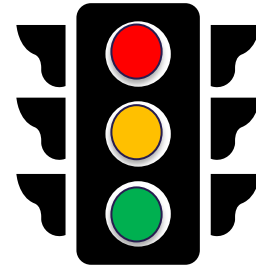
“Proportion of patients who had a CT scan that was reported by a senior radiologist and communicated with the team in the correct time scale”

CT scanning & reporting

<55%

55-84%

>/= 85%



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.

Where appropriate, proportion of all patients who undergo CT scan and 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.

Advanced Care Plan



Advanced Care Plan

Proportion of patients in whom staff have proactively identified advance care plans to support the decision-making process preoperatively”

Advanced Care Plan



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Advanced Care Plan



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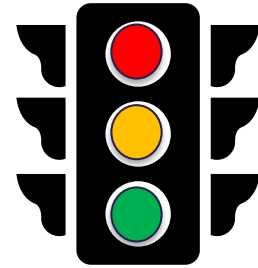
Guideline for Perioperative Care for People Living with Frailty Undergoing Elective and Emergency Surgery

September 2021

<55%

55-84%

>/= 85%



Proportion of patients where the admitting team attempted to ascertain the presence of advance care plan preoperatively.



End-of-Life Care

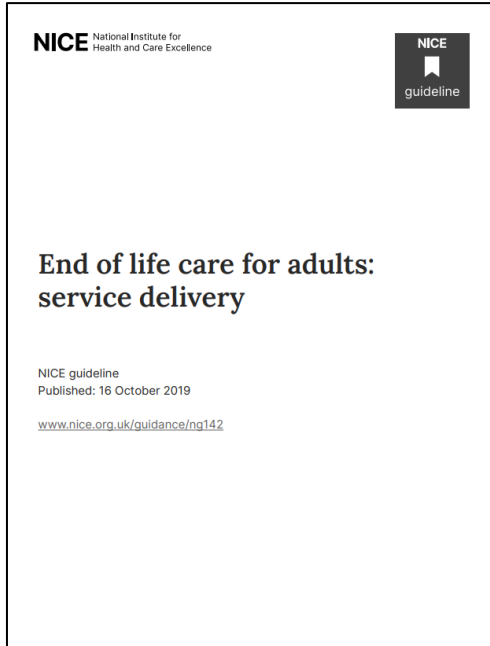


End-of-Life Care

“Proportion of patients in whom assessment to identify need for end-of-life care is documented”

“Proportion of patients requiring end-of-life care who are referred to palliative care team”

End-of-Life Care



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End-of-Life Care



CARING FOR
PATIENTS
NEARING THE
END OF LIFE



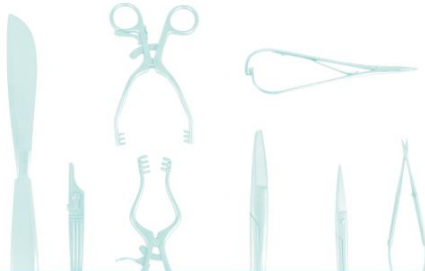
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10

CARING FOR
PATIENTS NEARING
THE END OF LIFE

A Guide to Good Practice



www.rcseng.ac.uk/standardsandguidance



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Improvement Partnership



“Proportion of patients in whom assessment to identify need for end-of-life care is documented”

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End-of-Life Care



CARING FOR
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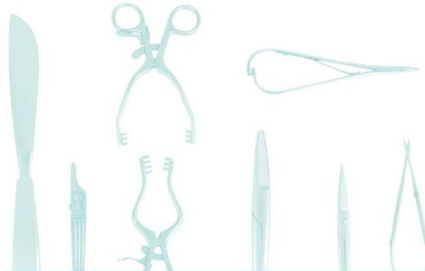


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CARING FOR
PATIENTS NEARING
THE END OF LIFE

A Guide to Good Practice

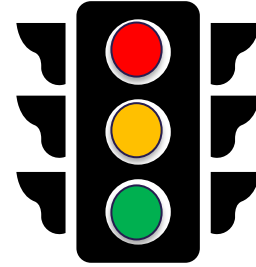


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CR&
Centre for Research and
Improvement Partnership

<55%
55-84%
>/= 85%



For those patients who died in hospital, proportion of patients with documented assessment to identify need for end-of-life care.

For those patients who died in hospital, proportion of patients requiring end-of-life care who have formal referral to palliative care team documented.



NoLap documents

Any questions?