Supporting Table 3 Trends in NELA Key Standards over time

Key Standard	Key Process Measure	Year 6 (Dec 18–Nov 19)	Year 7 (Dec 19–Nov 20)	Year 8 (Dec 20–Nov 21)	Year 9 (Dec 21–Mar 23)
Hospitals which admit patients as emergencies must have access to both conventional radiology and CT scanning 24 hours per day, with immediate reporting	Percentage of patients who received a preoperative CT report by an in-house consultant radiologist	62.3 N=24,823	65.9 N = 21,846	58.3 N=22,132	54.0 N=27,863
An assessment of mortality risk should be made explicit to the patient and recorded clearly on the consent form and in the medical record	Percentage of patients in whom a risk assessment was documented preoperatively	84.0 N=24,823	85.0 N = 21,846	86.8 N=22,132	84.6 N=27,863
Trusts/Health Boards should ensure theatre access matches need and ensure prioritisation of access is given to emergency surgical patients ahead of elective patients whenever necessary[1]	Percentage of patients arriving in theatre within a time recorded as appropriate for the urgency of surgery – this metric assesses the interval between decision to operate, and arrival in theatre	73.8 N=20,562	70.6 N = 18,172	71.8 N=18,263	67.1 N=23,424
Each high-risk patient should be reviewed by a consultant surgeon, anaesthetist, intensivist[2]	Percentage of patients with a preoperative risk of death ≥5% who had input from a consultant surgeon AND consultant anaesthetist prior to surgery		64.4 N=10,538	69.1 N=10,572	68.4 N=13,368
	Percentage of patients with a preoperative risk of death ≥5% who had input from a consultant surgeon prior to surgery		85.4 N=10,538	86.4 N=10,572	86.1 N=13,368
	Percentage of patients with a preoperative risk of death ≥5% who had input from a consultant anaesthetist prior to surgery		67.9 N=10,538	71.5 N=10,572	71.4 N=13,368
	Percentage of patients with a preoperative risk of death ≥5% who had input from a consultant intensivist prior to surgery		31.1 N=10,538	34.0 N=10,572	34.2 N=13,368
Each high-risk patient should have a consultant surgeon, anaesthetist present in theatre during surgery	Percentage of patients with a preoperative risk of death ≥5% for whom BOTH consultant surgeon and consultant anaesthetist were present in theatre	88.5 N=11,894	90.1 N = 10,525	91.3 N=10,572	90.4 N=13,368
	Percentage of patients with a calculated preoperative risk of death ≥5% for whom a consultant surgeon was present in theatre	94.8 N=11,894	96.3 N=10,525	96.4 N=10,572	96.0 N=13,368
	Percentage of patients with a preoperative risk of death ≥5% for whom a consultant anaesthetist was present in theatre	92.3 N=11,894	93.1 N=10,525	94.1 N=10,572	93.6 N=13,368

All high-risk patients should be admitted to critical care postoperatively	Percentage of patients with a postoperative risk of death ≥5% who were directly admitted to critical care postoperatively	85.2 N=11,970	82.3 N=10,442	79.1 N=10,537	80.3 N=13,326
Each patient aged 65 or over and frail (Clinical Frailty Scale [CFS] ≥5) or 80 or over should have multidisciplinary input that includes early involvement of geriatrician teams[3]	Percentage of patients aged ≥65 years and frail or ≥80 years who were assessed by a member of the geriatrician-led multidisciplinary team during any part of the perioperative pathway.	28.4 N=8,268	27.1 N=6,192	31.8 N=6,167	33.2 N=7,728
Timeliness of antibiotic administration*	Median [interquartile range (IQR)] time (hours) between hospital arrival and antibiotic administration amongst those with suspected sepsis on admission.	3.5 [1.4–8.0] N=6,188	3.0 [1.1–6.5] N=4,030	3.0 [1.2–6.8] N=4,067	3.1 [1.4–6.5] N=3,688[1*]
Frailty assessment in patients aged 65 and over*	Assessment of frailty using a validated scoring system in all patients aged over 65	87.1 N=12,126	91.8 N=12,098	86.5 N=12,245	84.8 N=15,332
Median [IQR] postoperative length of stay*		10 days [7–18 days] N=22,069	10 days [6–18 days] N=19,876	10 days [6–18 days] N=20,090	11 days [6–19 days] N=25,275
Unplanned return to theatre (proportion)[5]*		5.0 N=24,823	4.8 N=21,638	5.3 N=21,920	5.5 N=27,518
Unplanned admission to critical care (proportion)*		2.9 N=24,792	3.2 N=21,715	3.1 N=21,983	3.0 N=27,518
In-hospital mortality rate[6]*		9.7 N=24,823	9.0 N=21,846	9.2 N=22,132	9.3 N=27,863

RAG Rating: Standards of care are rated Green: ≥85%, Amber: 55–84%, Red: <55% except for the proportion of patients aged 65 or over and frail or 80 or over who were assessed by a member of a geriatrician-led team, which is rated Green: ≥80%, Amber: 50–79%, Red: <50%. Font colours represent RAG ratings.

[1] In previous years, patients with missing data (date of decision to operate OR date of arrival in theatre) were excluded from analysis. NELA updated the definition of this metric in Year 8 so that these patients are now included in the analysis. The numbers for Years 6 and 7 have been updated accordingly, which is why they may differ from previous reports.

[2] Between Years 6 and 7, there was a change in question wording—Year 6 asked about perioperative involvement of a consultant anaesthetist and intensivist, whereas from Year 7 onwards, NELA asked about preoperative involvement of these consultants. We have therefore removed the figures for Year 6 to avoid direct comparison.

[3] Question wording around geriatrician input has varied over the years and therefore results between years are not directly comparable.

[4] Starting in Year 9, suspected sepsis and infection are reported independently. Therefore, a lower number in Year 9 will have had suspected sepsis due to this delineation.

[5] In previous annual reports, this process measure included unplanned returns to theatre only. In Year 8, NELA updated the definition to also include patients who had both planned AND unplanned returns to theatre.

[6] This is in-hospital mortality rather than 30-day mortality data derived via the Office for National Statistics.

*Not RAG rated.