When NELA was commissioned in 2011, the title of ‘National Emergency Laparotomy Audit’ seemed like the natural choice. Looking back on progress over the last four years, I probably wish we’d called it NELQIP, or even NELPQIP, i.e. the National Emergency Laparotomy (Perioperative) Quality Improvement Project. For in order to truly bring about improvement in the quality of care, we need to think of NELA not as an audit, but as a perioperative quality improvement project.

NELA is a Perioperative Audit

There is no denying that anaesthetising a patient for a high-risk surgical procedure is more than just a technical skill, it is also one that requires a high degree of expertise. But our role extends outside this restricted intraoperative view of how our expertise can benefit patients.

We are already involved in the delivery of perioperative care for emergency patients, and feel the frustrations that arise when we do not have the opportunity to provide sufficient input. Our expertise in optimising patients in the perioperative period is recognised when we are asked for advice from surgeons as to whether a patient is fit for surgery, or if anything else can be done to improve their condition.

Conversely, we are unfortunately all too familiar with finding ourselves in the situation of having a patient ‘delivered to us, for both elective and emergency surgery, as a fait accompli, with an expectation that we will anaesthetise them for their proposed surgery. The frustrations exist because:

- The surgery as proposed is not always appropriate.
- We wish we’d had the opportunity to have had earlier input into the decision making process.
- The need for critical care input has not been considered early enough.
- We haven’t had the opportunity to suggest where improvements might be sought in order to optimise the patient before surgery.

For patients undergoing emergency laparotomy, one of the key areas where improvements in care might be found is in the delivery of better perioperative care. Hence NELA collects data both on patient outcomes and some of these perioperative processes of care that impact on outcomes. In addition to comparing delivery of care against standards, the dataset also allows us to begin to address relevant research questions.

Defining the evidence base for better emergency laparotomy care

The recent James Lind Alliance Anaesthesia and Perioperative Care Priority Setting Exercise has highlighted areas of perioperative medicine that are relevant to provision of emergency laparotomy care, i.e.

- How can patient care around the time of emergency surgery be improved?
- How can we improve communication between the teams looking after patients throughout their surgical journey?
- What outcomes should we use to measure the ‘success’ of anaesthesia and perioperative care?

How can we improve recovery from surgery for elderly patients?

We may not yet have the evidence base to fully know how processes of care affect outcomes, but the NELA dataset of 20,000+ patients annually provides a rich resource to begin to answer some of these perioperative questions identified in the James Lind Alliance Priority Setting Exercise. For instance, regarding the
first two questions, data from the First NELA Patient Report shows that preoperative assessment of risk is associated with improved delivery of subsequent standards of care, such as the presence of consultants for high risk cases, and admission to critical care. The EPOCH trial, based on the NELA dataset, will also provide valuable insight into how improvements in care can be facilitated in hospitals.

Quality Improvement, not Audit

Whilst the aim of ‘audit’ is to improve patient care by comparing care against standards, anyone who has read national audit reports or other guidelines will often see the same recommendations crop up year after year. The audit process generally involves:

- Collecting data for a period of time.
- Analysing it against standards of care.
- Discovering that ‘we could be doing better’.
- Presenting the results at a departmental audit meeting.
- Asking everyone to ‘please do better’.
- Re-audit again in several months’ time (and discover that not much has changed!).

The problem is that the traditional model of ‘clinical audit’ operates on timeframes that are too long, and does not address the underlying reasons why things don’t happen as they should. Quality improvement science aims to address this by emphasising the use of local data to drive small-scale changes, carried out on short timescales.

As an audit, NELA compares actual provision of care against standards of care. However, the real improvements in care will only arise if we view NELA as a quality improvement project that allows clinicians to see the results of making small-scale changes. These changes will need to be made in the whole range of pre-, intra- and postoperative areas of care, i.e. perioperative care.

Within NELA, we have a role in leading these changes in perioperative care. Taking ownership of this issue will allow us to be formally involved in designing a service that’s fit for purpose, namely one that allows patients to receive the best possible care.