west midlands
ACADEMIC HEALTH SCIENCE NETWORK

Best Practice tariff for Emergency Laparotomy - how it will help

Edited from presentation given by Dave Murray

NELA Project Chair

At

ASGBI Emergency Laparotomy Meeting Birmingham

20/11/2018

ASGBI
Association of Surgeons of Great Britain and Ireland

NELA National Emergency Laparotomy Audit
HSRC Health Services Research Centre
NIAA National Institute of Academic Anaesthesia

What is a BPT?

Split tariff

Baseline payment + top-up payment if criteria met

will underfund your Trust (cf now)

Will provide excess funding (cf now) to develop the service

Overall: cost neutral to NHS

(unless most over perform)

The Emergency Laparotomy BPT

- **Bundled at patient level**

- **BUT**...

- it is all or nothing!!
  - Either top-up paid for ***ALL*** patients ***IF*** criteria met
  - Or not paid for any patients if criteria not met

- Criteria
  - ≥ 80% of high risk patients get:
    - 1. Consultant presence (Surgeon and Anaesthetist) **AND**
    - 2. Admission to ***recognised*** critical care (not PACU) **AND**
    - 3. Agreed and signed off pathways exist for emergency laparotomy

Emergency laparotomy pathway

This is a pre-condition for accessing the BPT

NEW Dec2018

Both for Diagnosis & Treatment

- Meet national standards
- Agreed and signed off by clinicians involved in delivery of care:
  - ED
  - Radiology
  - Surgery
  - Anaesthesia
  - Critical care
  - Elderly care
- Approved at Board/Committee level

Emergency Laparotomy Collaborative

How will data be collected for the BPT?

Collected via NELA
Quarterly BPT report

What cases will my Trust get paid for?

Paid according to HRG code

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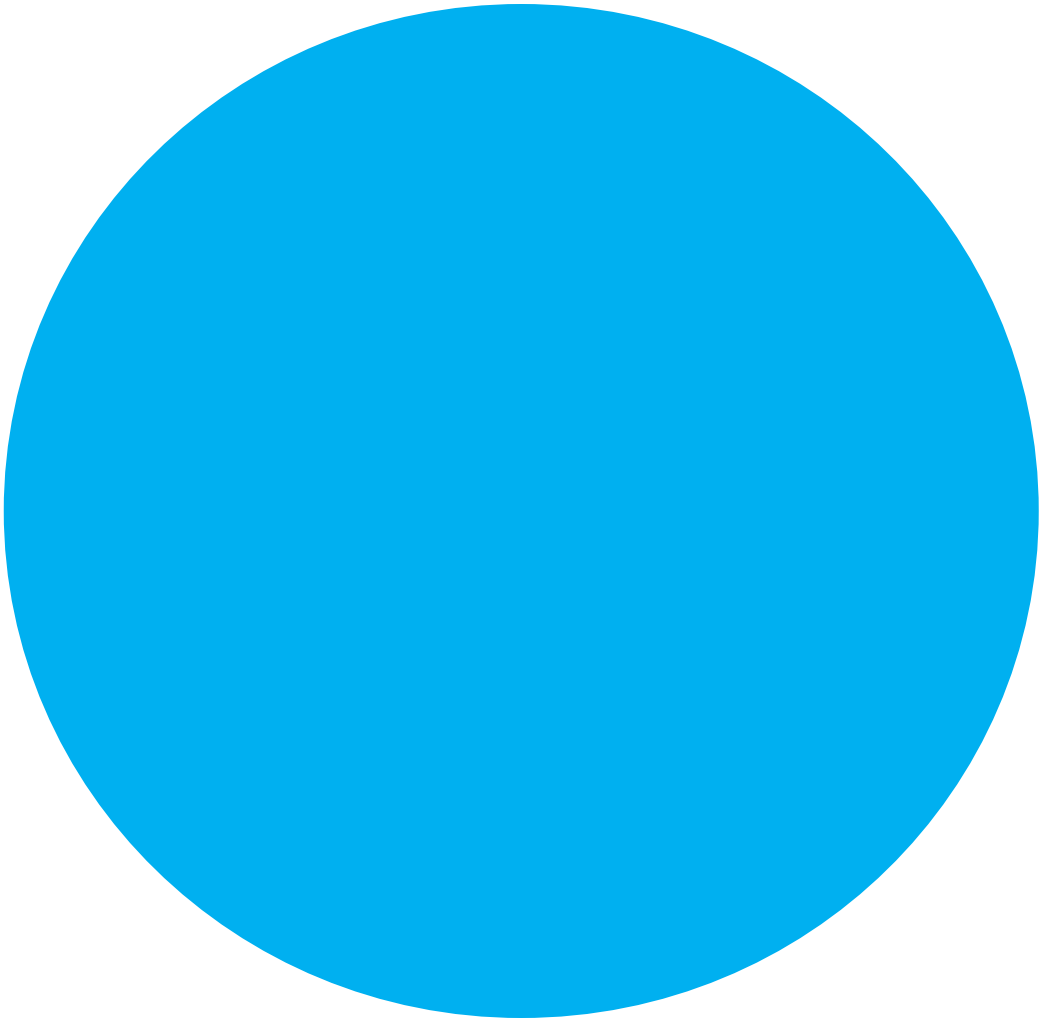
Average difference £700 x 100 patients….

HRG name	Non-BPT (£)	BPT (£)	Extra
Very Major Small Intestine Procedures, ≥19 with CC Score 8+	11,080	12,284	1,204
Very Major Small Intestine Procedures, ≥19 with CC Score 5-7	7,502	8,318	816
Very Major Small Intestine Procedures, ≥19 with CC Score 2-4	5,744	6,368	624
Very Major Small Intestine Procedures, ≥19 with CC Score 0-1	4,657	5,163	506
Complex Large Intestine Procedures, ≥19, with CC Score 9+	11,344	12,577	1,233
Complex Large Intestine Procedures, ≥19, with CC Score 6-8	8,585	9,518	933
Complex Large Intestine Procedures, ≥19, with CC Score 3-5	6,996	7,756	760
Complex Large Intestine Procedures, ≥19, with CC Score 0-2	5,994	6,645	651
Proximal Colon Procedures, ≥19, with CC Score 0-2	5,128	5,685	557
Major General Abdominal Procedures, ≥19, with CC Score 3-5	4,815	5,338	523
Major General Abdominal Procedures, ≥19, with CC Score 1-2	3,499	3,879	380
Major General Abdominal Procedures, ≥19, with CC Score 0	2,697	2,990	293

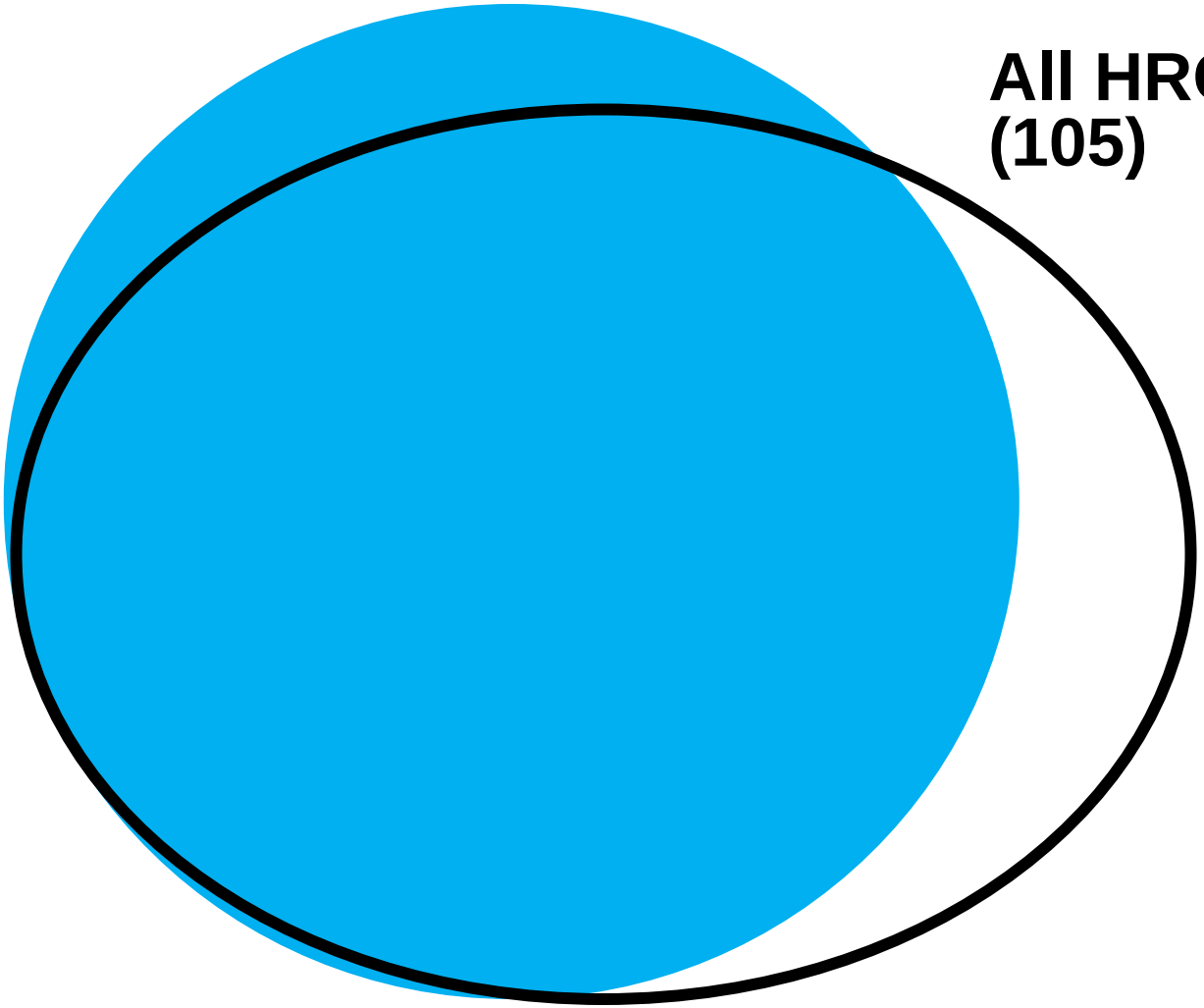
Medical records coding of comorbidity will also make a BIG impact: in 2 ways

What cases will my Trust get paid for?

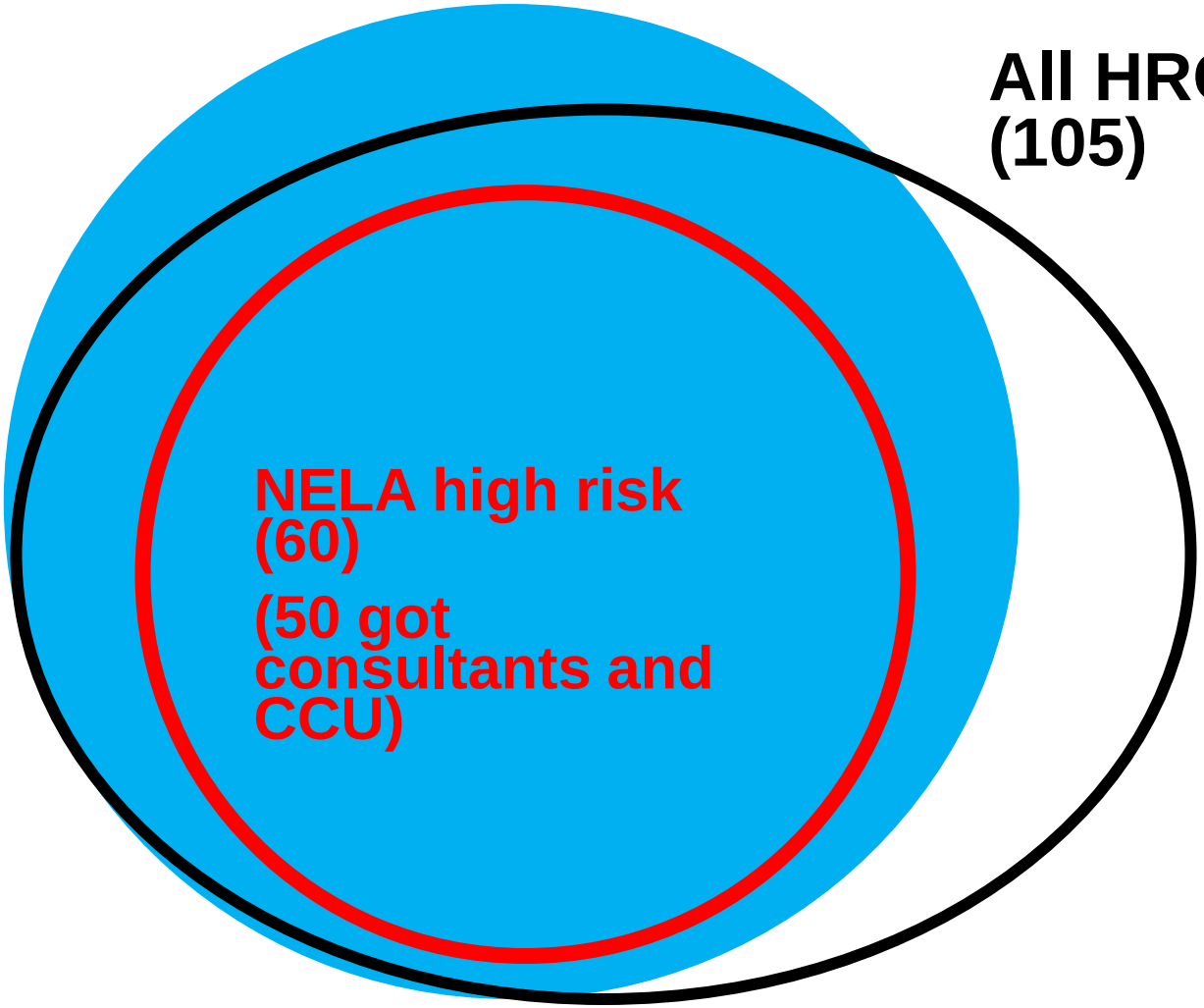
All NELA cases (100)



What cases will my Trust get paid for?



What cases will my Trust get paid for?



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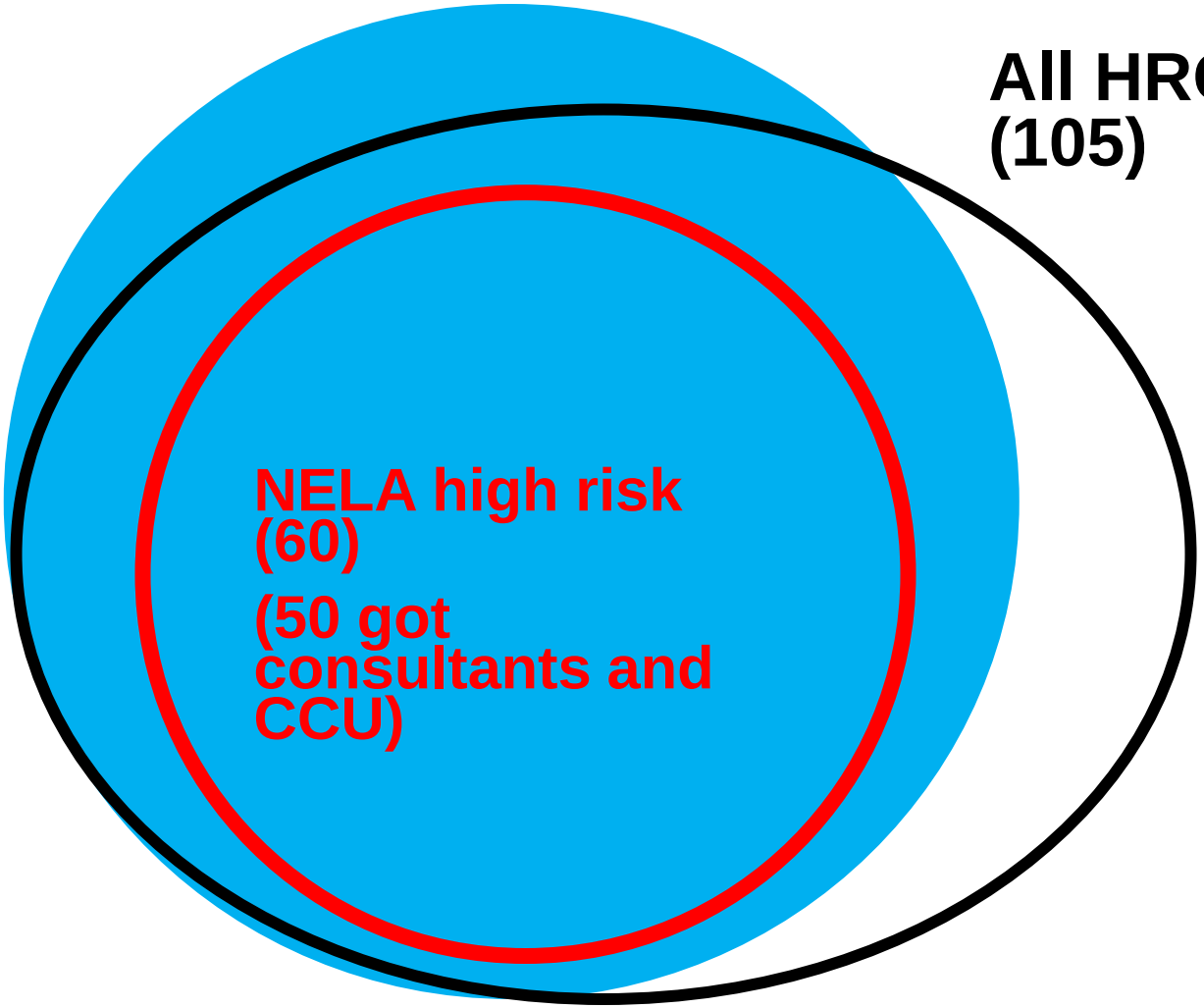
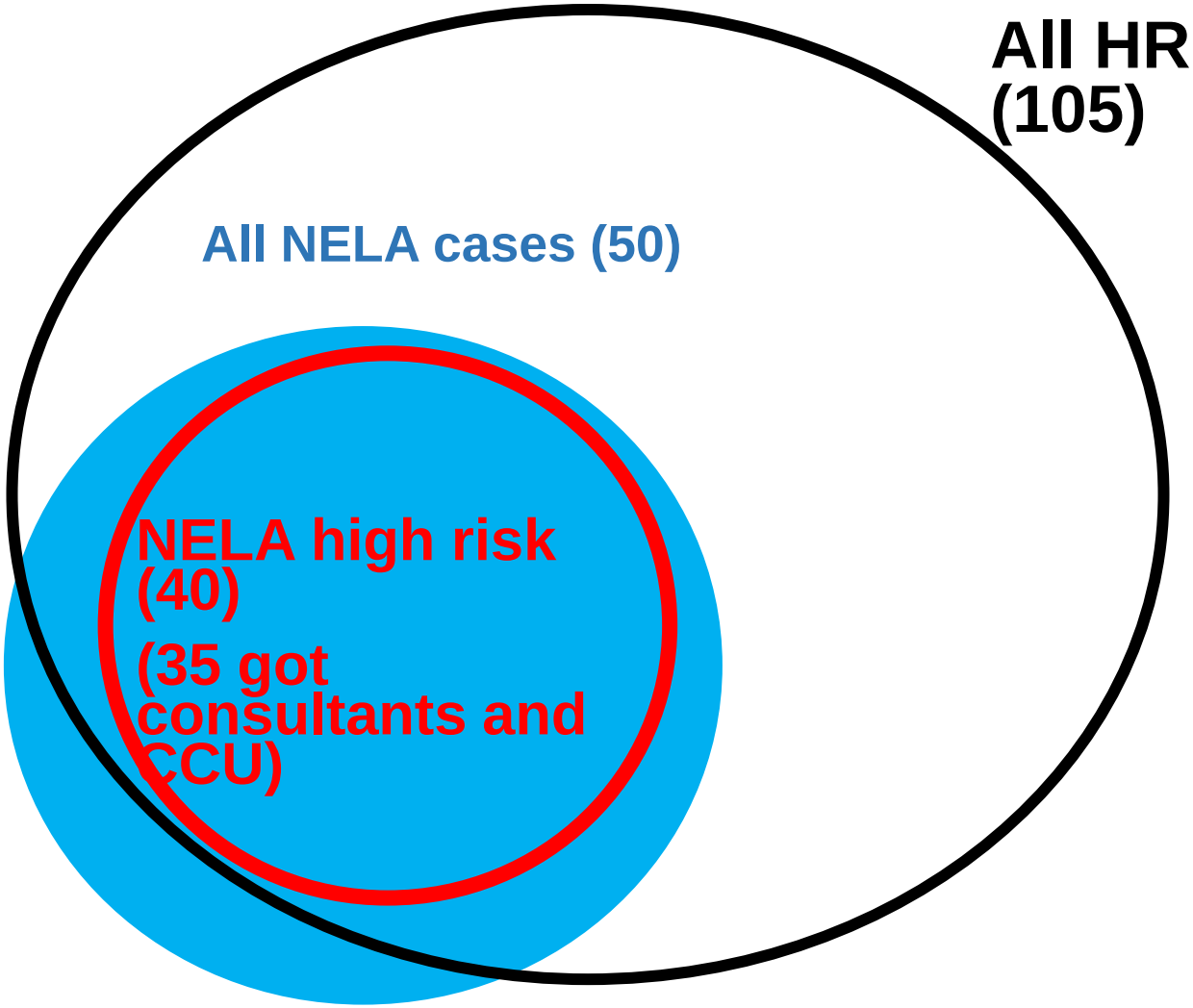


Paid for these

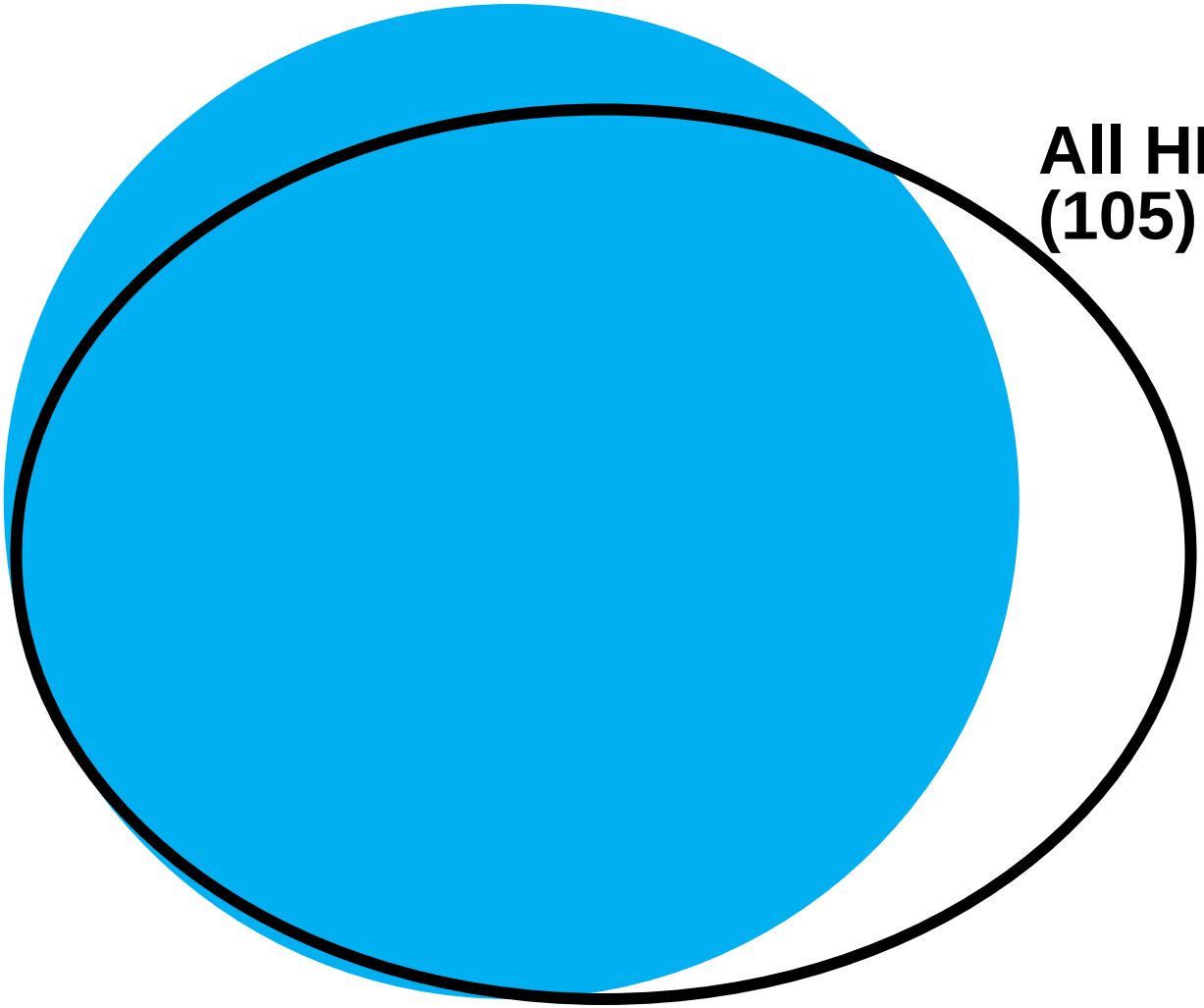
105 x £700 = £73,500

What about case ascertainment?



NOT get paid for these

What about (missing) risk assessment?



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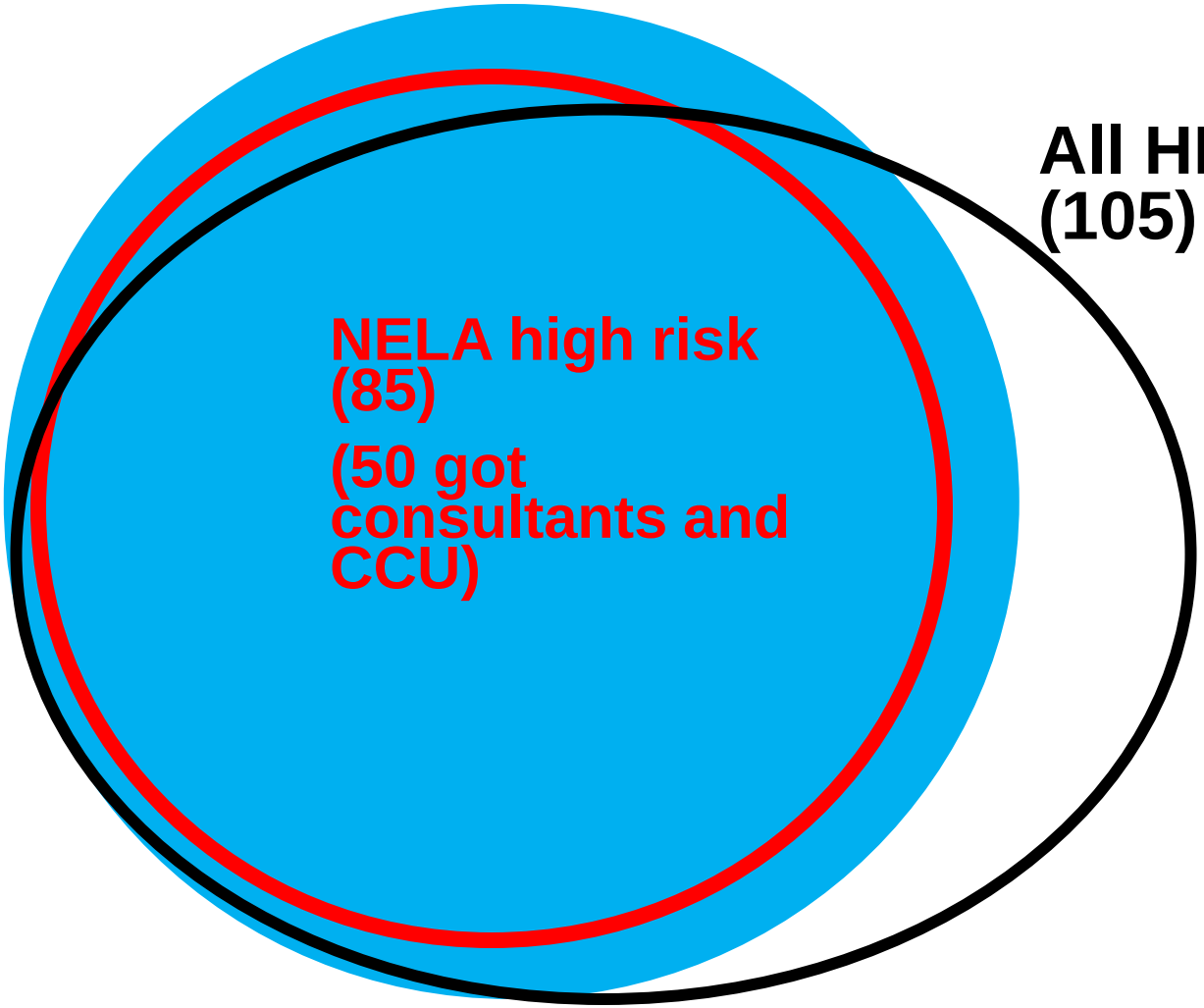
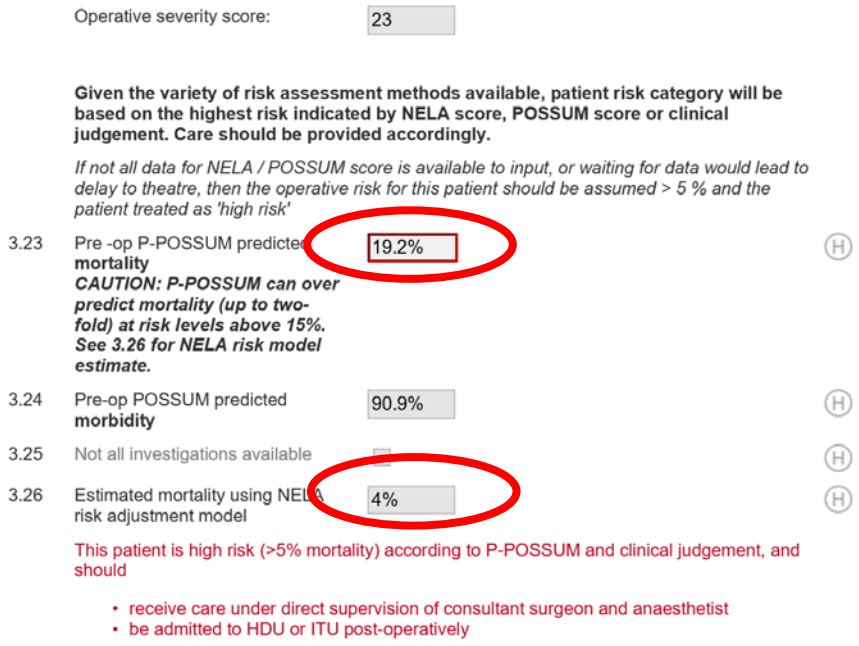


Not met criteria

Will lose £73,500

NELA vs P-POSSUM risk scores

- 1. **ASA score**
- 2. **Age**
- 3. **Gender**
- 4. **Operative severity weighting.**
- 5. **Serum creatinine**.
- 6. **Haemoglobin.**
- 7. **Continuous variables** in NELA (cf categorical in P-POSSUM)



Operative severity score: 23

Given the variety of risk assessment methods available, patient risk category will be based on the highest risk indicated by NELA score, POSSUM score or clinical judgement. Care should be provided accordingly.

If not all data for NELA / POSSUM score is available to input, or waiting for data would lead to delay to theatre, then the operative risk for this patient should be assumed > 5 % and the patient treated as 'high risk'

3.23	Pre -op P-POSSUM predicted **mortality** ***CAUTION: P-POSSUM can over predict mortality (up to two-fold) at risk levels above 15%. See 3.26 for NELA risk model estimate.***	19.2%
3.24	Pre-op POSSUM predicted **morbidity**	90.9%
3.25	Not all investigations available	
3.26	Estimated mortality using NELA risk adjustment model	4%

This patient is high risk (>5% mortality) according to P-POSSUM and clinical judgement, and should

- receive care under direct supervision of consultant surgeon and anaesthetist
- be admitted to HDU or ITU post-operatively

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Achieving the BPT

- Step 1 (easier)
  - A focus on processes to achieve standards, gets you close to 80%
    - Case ascertainment and locking
    - Risk assessment
    - Consultant delivered care
    - Post-op critical care
- Step 2 (harder)
  - Case by case reflective practice every time; gets you towards 100%
  - QI Notify-*EmLap* App? …. More later

Best Practice tariff for Emergency Laparotomy - it will help

- Correctly identify high risk
- Consultant presence AND CCU admission
- Ensure decent case ascertainment
- More money for your Trust
- Support data collection
- Support local improvement

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Actions in preparation for BPT-1

- Trust Guidelines
  - The Acute Abdomen: Diagnosis
  - The Acute Abdomen: Treatment

https://www.surgeons.org/media/25768745/rcs-report-the-highrisk-general-surgical-patient-raising-the-standard-december-2018.pdf

Actions in preparation for BPT-2

- QI project aimed at achieving BPT:
  - 1. Case ascertainment and locking in NELA
    - Aim > 80% of ‘expected cases’;
    - Source Trust NELA report
  - 2. Formal Risk Assessment prior to Emergency Laparotomy
    - Aim >80%
    - Source Trust NELA report
  - 3. Consultant Surgeon and Anaesthetist present in Theatre for high risk cases (>5% predicted mortality)
    - Aim >80%
    - Source ELC Dashboard and Run Chart Maker
    - Trust NELA reports
  - 4. Critical Care bed for high risk cases (>5% mortality)
    - Aim >80%
      Source ELC Dashboard and Run Chart Maker
    - Trust NELA reports

Questions