

Reflections on NCEPOD: Knowing the Risk

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Different perspectives on 'Risk'

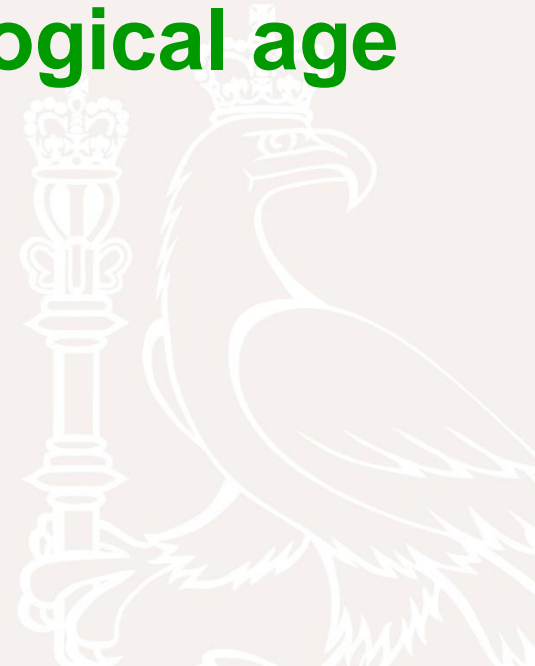
- To clinicians
- To an organisation
- To a government
- To patients



Different perspectives on 'Risk'

- To clinicians

Primary surgical problem plus co-morbidity e.g. obesity ,physiological age



Different perspectives on 'Risk'

- To an organisation

Hospitals measure risk in terms of
Mortality and Morbidity Rates - League
Tables eg Dr Foster



Different perspectives on 'Risk'

- To Governments

Comparison of outcomes with other countries

- NCEPOD “ There are concerns that UK outcomes may be less good than other countries” – comparisons made with USA



Different perspectives on 'Risk'

NCEPOD “ There are concerns that UK outcomes may be less good than other countries” – comparisons made with USA

And yet 20% of US population are uninsured and 15% of US GDP spent on healthcare cf 8% in UK!



Different perspectives on 'Risk'

- To clinicians
- To an organisation
- To a government
- **To patients**



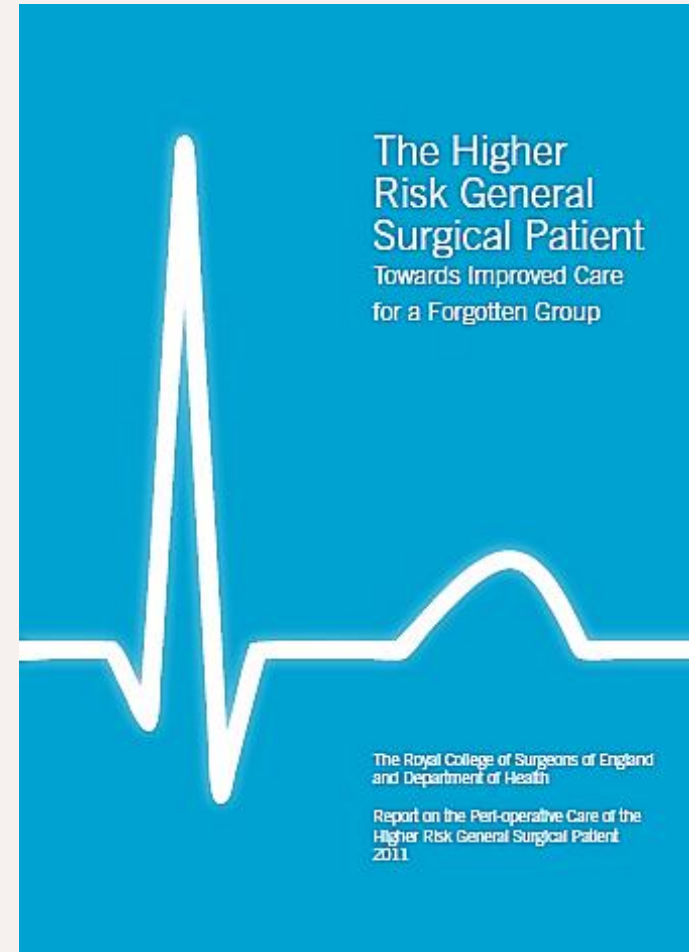
Patient information; informed consent



- **NCEPOD report: “Less than 1% of patients undergoing surgery in UK die despite an ever increasing elderly and frail population”**
- **BUT NEVERTHELESS NO GROUNDS FOR BEING COMPLACENT AND RCS IS NOT**



The higher risk general surgical patient :Towards improved care for a forgotten group



170,000 pts undergo high risk non cardiac surgery each year

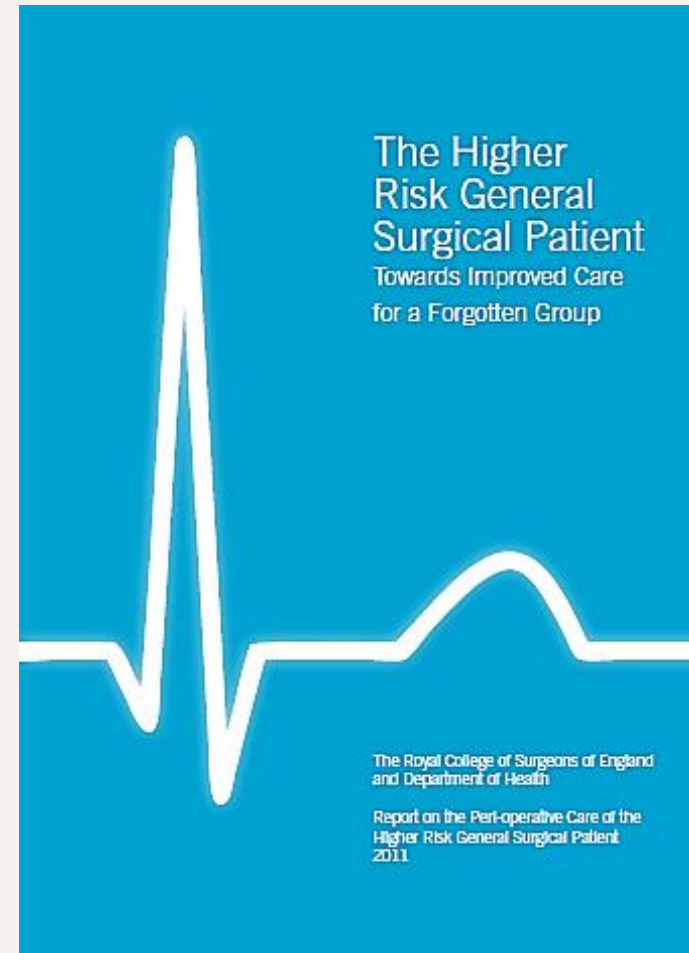
100,000 will develop complications

Over 25,000 will die (15%)

High risk group accounts for 80% of deaths but less than 15% of all patient procedures

Emergency GI surgery can reach 50% mortality in >80's

Mortality varies 3 fold between Trusts



Pre-operative assessment



Assessment

NCEPOD

All elective high risk patients should be seen and fully investigated in pre-assessment clinics

RCS

Trusts should formalise their pathways for unscheduled care. All patients should have a clear diagnostic and monitoring plan on admission

Assessment

NCEPOD

All elective high risk patients should be seen and fully investigated in pre-assessment clinics

16% /17% Trusts no anaesthetic/surgery clinics

RCS

Trusts should formalise their pathways for unscheduled care. All patients should have a clear diagnostic and monitoring plan on admission

Consideration of Mortality



Consideration of mortality

NCEPOD

**In only 37/496 (7.5%)
was there a mention of
mortality made on the
consent form**

RCS

**Each patient should
have their expected
risk of death identified
and documented prior
to surgery**

Application of Best Practice

NCEPOD	RCS
<ul style="list-style-type: none">•12% of Trusts were not compliant with NICE 50 Guidance•34% of Trusts did not have a critical care outreach team	<p>The monitoring plan must be compliant with NICE 50 Guidance for the recognition and initial response to acutely unwell patients</p>

Delay

NCEPOD

20%(1in 5) of non elective high risk patients were delayed going to theatre

RCS

Delay in interventional treatments is currently not uncommon and leads to death and avoidable complications

Delay

NCEPOD

20%(1in 5) of non elective high risk patients were delayed going to theatre

27.5 % of Trusts no dedicated emergency theatre 08.00-18.00 Mon-Fri

RCS

Delay in interventional treatments is currently not uncommon and leads to death and avoidable complications

Cause for high mortality in high risk surgical patients is multifactorial

Including:

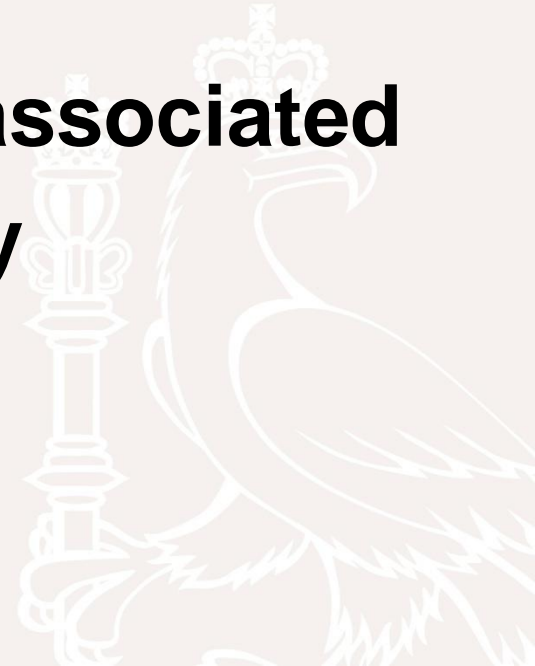
- **Peri-Operative monitoring**
- **Post-Operative patient location**
- **Staff seniority/skills/specialisation**



Peri-Operative monitoring

- **Cardiac**
- **Fluid balance**

Inadequate intra-op monitoring associated with a 3 fold increase in mortality



Post Operative patient location

- In high risk group almost 1 in 5 patients went back to the ward
- Concerns re post op location in 353/3323 (10%) cases and these had a mortality rate of 5% compared with 1.4% where there were no concerns.
- 48% of high risk patients who died never went to critical care facility

Staff seniority/skills/specialisation

RCS view: Surgical procedures with a predicted mortality of more than 10% should be conducted under the direct supervision of a consultant surgeon and consultant anaesthetist



Assessing the High Risk Hospital

Systems are inherently risky as well as the practices within them.

e.g – Availability of interventional radiology services, frequency of handover, understaffing, lack of training opportunity, failure to split emergency from elective.

**If improvement is to be attained
we need an institutional approach
with surgeons, physicians
anaesthetists, critical care teams
and managers working in
harmony...**

**...and National Standards for the
National Health Service.**

