NELA
National Emergency Laparotomy Audit

An emergency laparotomy (emergency bowel surgery) is a surgical operation for patients, often with severe abdominal pain, to find the cause of the problem and treat it. General anaesthetic is used and usually an incision made to gain access to the abdomen. Emergency bowel surgery can be carried out to clear a bowel obstruction, close a bowel perforation and stop bleeding in the abdomen, or to treat complications of previous surgery. These conditions could be life-threatening. The National Emergency Laparotomy Audit was started in 2013 because studies showed this is one of the most risky types of emergency operation and lives could be saved and quality of life for survivors enhanced by measuring and improving the care delivered.

Executive Summary

Results from 2019–2020 – the Seventh Year of the National Emergency Laparotomy Audit

(For data about the impact of COVID-19 please refer to the Impact of COVID-19 on Emergency Laparotomy interim report).

Principal performance statistics are available here.

1. **21,846** patients who had emergency bowel surgery in England and Wales were included in the Year 7 audit

National **30-day mortality rate** has fallen to **8.7%** **(11.8% in Year 1)**

2. Improvements in care have reduced patients' average hospital stay from **19.2 days** in **Year 1** to **15.1 days** in **Year 7**

19.2 days
15.1 days

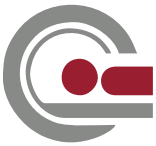
3. **85% of patients** now receive **a preoperative assessment of risk** **(up from 84% last year, and 56% in Year 1)**

4. **94.0% of patients with a high documented risk** had **consultant surgeon** input before surgery

75.5% of patients with a high documented risk had **consultant anaesthetist** input before surgery

5. **82.3%** of high-risk patients were admitted to critical care **(85.2% in Year 6)**

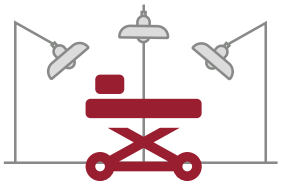
6. **92.5% of patients** received a preoperative CT scan (90.5% in Year 6)



65.9% of these patients had their scan reported by a **consultant radiologist** (62.3% in Year 6)

7. Both **anaesthetic and surgeon consultant presence** during surgery is at 90.1%, and **increased from 77.4% (Year 6) to 85.2% out of hours** (00:00 to 08:00)

8. **Almost 1/3 of patients** needing **immediate surgery** did not get to the operating theatre in the **recommended time frame**



9. **Time to antibiotics in patients with suspected sepsis** remains poor with **78.3%** not receiving antibiotics **within one hour**

10. **55.4% of patients** are over the age of 65 and **18.1% of patients** are over the age of 80.

Only 27.1% of patients 80 or over or 65 and frail had geriatrician input

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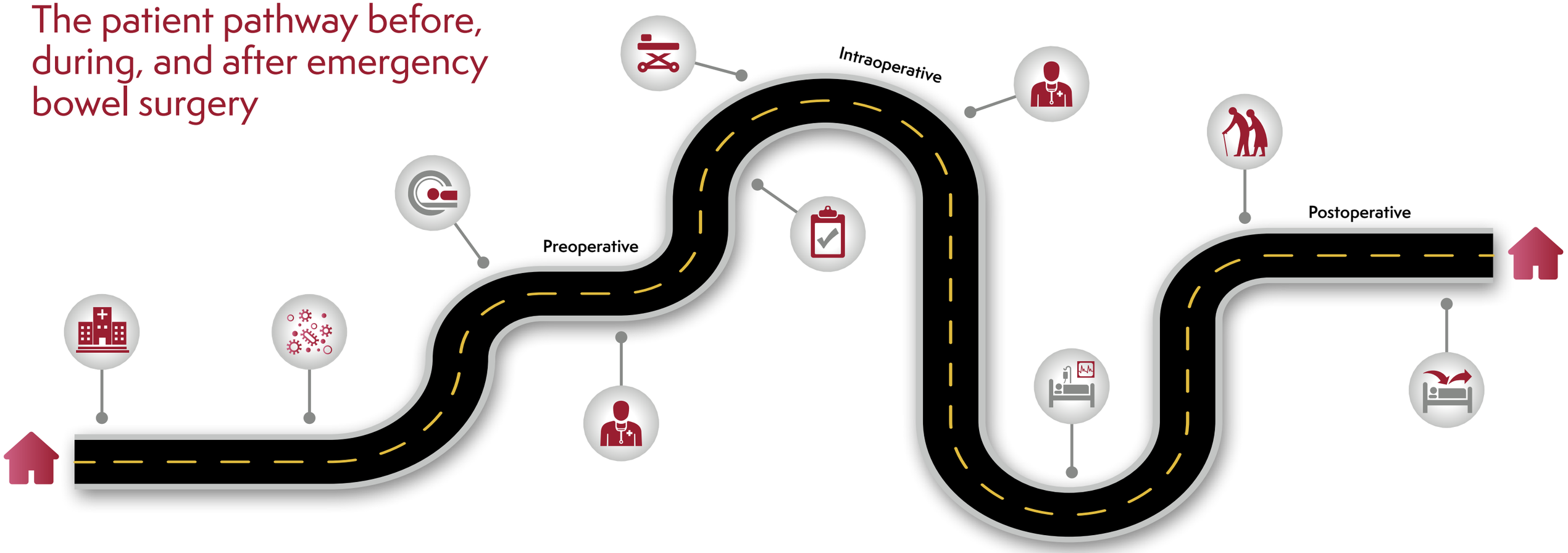
RCOA Royal College of Anaesthetists | NIAA HSRC Health Services Research Centre | Royal College of Surgeons ADVANCING SURGICAL CARE | HQIP Healthcare Quality Improvement Partnership

The patient pathway before, during, and after emergency bowel surgery



1 At home

You have probably experienced abdominal pain at home and had appointments with your GP or visited the hospital Emergency Department (ED) before.

2 Arrival

Most patients make their own way to hospital, (sometimes after being seen by a general practitioner [GP]) and are admitted to hospital after initially being seen and assessed in the ED.

3 Sepsis (blood poisoning) management

If you have signs of sepsis you should receive antibiotics within one hour of arrival to hospital.

4 Radiology

Most patients will receive a computerised tomography (CT) scan as part of the initial assessment before surgery. This helps to establish the nature of your illness and guide what operation you will need.

5 Consultant Review

Most patients will be seen by a consultant surgeon and anaesthetist prior to their operation. Any questions or concerns can be discussed. In the most unwell patients who need immediate surgery this discussion may take place with another member of the surgical or anaesthetic team in order to avoid a delay.

6 Risk assessment

The risk of death associated with emergency laparotomy surgery should be assessed and discussed with you before your operation. This enables you to be fully involved in any decisions regarding surgery and ensures that you receive the appropriate levels of care before, during and after your operation.

7 Timely admission to theatre

It is important that you have your operation in a timely fashion. How quickly you have your operation is dependent on why you need surgery. In some circumstances it may be appropriate to try alternative treatments first.

8 Consultant presence

Emergency laparotomy is often high-risk surgery. This means that in most cases, you will benefit from the expertise of a consultant anaesthetist and a consultant surgeon will be required during your operation.

9 Critical care

Many patients who have an emergency laparotomy will be cared for in the Intensive Care (ICU) or High Dependency Unit (HDU) in the initial period after their surgery. This is so they can receive specialist organ support if necessary and be monitored closely for any possible complications.

10 Frailty assessment + geriatrician review

You may be seen by a geriatrician (specialist in elderly care) during your hospital stay as part of the team looking after you to help improve your recovery after surgery.

11 Discharge

Many patients will have had a long stay in hospital after an emergency laparotomy. During this time your teams should be helping prepare you for leaving hospital. You may feel tired, be unsure about what you can or can't do – now is the time to ask questions and seek answers from the team looking after you. It is important you know how and where to get help if needed after discharge.

12 Recovery

There will be an additional period of recovery required after discharge. Your GP and community nursing teams should be able to help advise you and provide support.

For more details on National Standards please visit our website.