NELA
National Emergency Laparotomy Audit

Sixth Patient Report of the National Emergency Laparotomy Audit

December 2018 to November 2019

EXECUTIVE SUMMARY

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

November 2020

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The National Emergency Laparotomy Audit is commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP). HQIP is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing, and National Voices. Its aim is to promote quality improvement in patient outcomes, and in particular, to increase the impact that clinical audit, outcome review programmes and registries have on healthcare quality in England and Wales. HQIP holds the contract to commission, manage and develop the National Clinical Audit and Patient Outcomes Programme (NCAPOP), comprising around 40 projects covering care provided to people with a wide range of medical, surgical and mental health conditions. The programme is funded by NHS England, the Welsh Government and, with some individual projects, other devolved administrations and crown dependencies: hqip.org.uk/national-programmes.

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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 2018–2019, the sixth year of the National Emergency Laparotomy Audit

Principal performance statistics are available here

1. **24,823** patients had emergency laparotomies in England and Wales

National **30-day mortality rate** has fallen to **9.3%** (11.8% in Year 1)

2. Improvements in care have reduced patients' average hospital stay from **19.2 days** in **2013** to **15.4 days** in **2019**

19.2 days
15.4 days

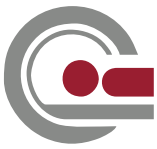
3. **84% of patients** now receive **a preoperative assessment of risk** (up from 77% last year, and 56% in Year 1)

4. **97% of high-risk patients** had **consultant surgeon** input before surgery (95% in Year 4)

94% of high-risk patients had **consultant anaesthetist** input before surgery (88% in Year 4)

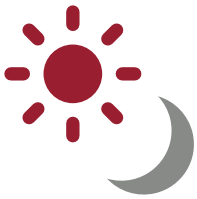
5. **85%** of high-risk patients admitted to critical care (80% in Year 4)

6. **90.5% of patients** received a preoperative CT scan

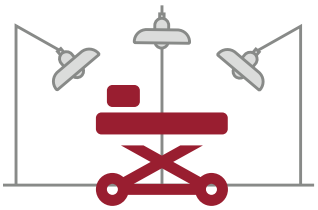


62% of these patients had their scan reported by a consultant radiologist

7. Both **anaesthetic and surgeon consultant presence** intraoperatively is at 88.5%, but only **77.4% out of hours**



8. **Over 1/4 of patients** needing the most **urgent of surgery** did not get to the operating theatre in the **recommended time frame**



9. **85% of patients** **with sepsis** reached theatres in the appropriate **timeframe**

10. **Time to antibiotics in patients with sepsis** remains poor with **79.7%** not receiving antibiotics **within one hour**

11. **56% of patients** are over the age of 65

Only 28.8% of frail patients over 65 had geriatrician input

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The NELA Project Team and Board would like to express their thanks to all clinical and non-clinical staff at all NHS trusts and Welsh health boards who collected and submitted data. We recognise that many staff are collecting and entering data in their own time and without additional resources. We commend their dedication to improving patient care. In particular we would like to thank the NELA Leads for their hard work, leadership and continued enthusiasm; without this engagement, patients would not have benefited from improved care and NELA would not be the success it has become over the last six years.

The NELA Project Team and Board would also like to thank the members of the NELA Clinical Reference Group for helping to shape the dataset and report.

The NELA key messages and recommendations; improving outcomes and reducing complications

Local clinical teams should use the data from quarterly reports, and the contemporaneous webtool, to monitor their performance and patient outcomes. They can also use their benchmarked data to raise concerns or challenge apparent gaps in care pathways.

Commissioners of care, executive teams and senior leadership teams are responsible for providing adequate resources, financial investment and infrastructure targeted to enable the following NELA recommendations to be implemented.

KEY MESSAGE 1

High-risk patients undergoing emergency laparotomy do not consistently benefit from perioperative consultant delivered care. Patient groups at risk of missing out on this include those needing surgery out of hours, and older patients (Chapter 4.4, 4.6 and 5.5).

Recommendation 1.1: Clinical teams must assess all patients' risk of death and morbidity, using validated tools, ensuring other factors such as frailty, nutritional status, are recognised.

Recommendation 1.2: Clinical Directors and Medical Directors should ensure local workforce planning facilitates the consultant presence throughout the perioperative journey 24/7. This should include the wider multidisciplinary team such as geriatricians, radiologists, physicians and emergency department doctors.

KEY MESSAGE 2

Since the introduction of the Best Practice Tariff (BPT) there has been an increase in the number of Trusts achieving the thresholds needed to be eligible for the enhanced tariff. The BPT metrics are consultant delivered care and admission to critical care after surgery for high-risk patients (Chapter 3).

Recommendation 2.1: All Trusts should use their local data to effect change; accessing and presenting it regularly to inform improvements in care pathways for many patients.

Recommendation 2.2: Clinical teams, audit teams, should use performance against the key NELA standards of care (via BPT report, excellence and exception reporting toolkit) as part of the structured review of processes of care. Use these and local outcome data to inform mortality reviews for patients who have undergone emergency laparotomy.

KEY MESSAGE 3

Patients referred from a non-surgical specialty who need emergency laparotomy should be considered to be high-risk as a matter of course (Chapter 4.1 and Chapter 7).

Recommendation 3.1: Local NELA leads should include the wider multidisciplinary team such as geriatricians, radiologists, physicians and emergency department doctors in the design and delivery of the emergency laparotomy care pathway.

KEY MESSAGE 4

Most patients who require emergency laparotomy are admitted via the emergency department (ED). Admission to ED is the start point of the care pathway for many patients (Chapter 4).

Recommendation 4.1: Medical Directors, Clinical Directors and Leads should design and implement NELA pathways of care and improvement work that includes ED teams to ensure the most rapid, seamless management of these high-risk patients.

Recommendation 4.2: Medical Directors should direct Clinical Directors to broaden the local NELA team by appointing ED physicians as NELA clinical leads.

KEY MESSAGE 5

Increased frailty is an independent marker of poor outcomes, and frail patients should be considered high-risk regardless of risk score. It is possible assessment of frailty may influence clinical decision making and processes of care. Despite this, consistent geriatrician input at hospital level remains variable with many older frail patients missing out on the care and expertise of geriatric and frailty teams (Chapter 7).

Recommendation 5.1: All clinicians who assess patients over the age of 65 must formally assess and document Frailty. Frailty scoring must be considered an integral part of a formal risk assessment.

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