NELA+

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2026 Patient Report of the National Emergency Laparotomy Audit around Standards of Care for Patients who do not Undergo Emergency Laparotomy ('NoLap' cohort)

April 2024 to April 2025

May 2026

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1 Overview

In its first year, the NoLap audit includes records on 943 patients from 91 hospitals (826 [87.6%] from England, 44 [4.7%] from Wales and 73 [7.7%] from Northern Ireland) representing approximately 50.6% of sites submitting operative NELA data. Among these patients, 58.6% were women and 41.4% were men.

Bowel condition	Number of patients, n (%)
Bowel perforation	459 (48.7)
Bowel ischaemia	330 (35.0)
Bowel perforation and ischaemia	58 (6.2)
Not stated*	96 (10.2)

*Not explicitly indicated by user in Q6.15

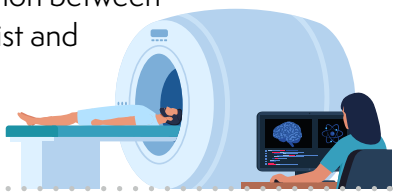
OUTCOMES

Median **length of stay** from date of hospital admission was **10 days** (range 0–384 [IQR 5–20] days).

Mortality at 30 days following admission was **80.2%**.

CT SCANNING

Overall, **919 (97.5%) patients had a CT scan** following admission. In 48.1% of patients, a report was issued within one hour of scanning. For **36.6%** of patients, there was a record of direct communication between reporting radiologist and a member of the referring team.



RISK ASSESSMENT

72.3% received a formal assessment of mortality risk prior to a decision not to proceed with surgery.

CARE OF THE OLDER PERSON

85.8% of patients aged 65 or older had a formal assessment of frailty performed.

ADVANCE CARE PLANNING

579 (61.4%) NoLap patients did not have any form of pre-existing advance care plan available prior to the decision not to operate.

While 160 (72.1%) patients discharged from hospital alive had a do not attempt cardiopulmonary resuscitation (DNACPR) in place, only around a third **(83, 37.4%)**, had any type of formal advance care plan documented.

END-OF-LIFE CARE

80.3% of patients who died in hospital had a documented end-of-life care plan.

62.6% of patients who died in hospital received direct input from a member of the palliative care team.

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2 Introduction

The National Emergency Laparotomy Audit (NELA) Project Team was commissioned by Healthcare Quality Improvement Partnership (HQIP) to expand the scope of the NELA to include patients who meet the criteria for an emergency laparotomy, but who do not undergo surgery. This new group of patients, referred to as the 'NoLap' cohort, represent a clinically complex and high-risk population. Studies published in this field have been limited by short data collection periods and relatively small sample sizes and provide only a snapshot of practice.[1,2]

The aim of this audit is to examine the standards of care delivered and outcomes for NoLap patients. The inclusion of NoLap patients within the NELA dataset enables sustained and standardised collection of data on NoLap patients to provide valuable insights into variations in clinical care and outcomes for high-risk patients managed without surgery.

This is the first patient report from the NoLap audit, which examines the care received by NoLap patients admitted to hospitals in England, Wales and Northern Ireland between 24 April 2024 and 31 March 2025. In its first year, the audit focussed on patients presenting with radiological and/or clinical suspicion of bowel perforation or bowel ischaemia that would ordinarily warrant emergency surgical intervention, but for whom a decision was made not to proceed with surgery.

The operative component of NELA receives data on patients who have surgery from around 180 hospitals, and the identification of eligible cases using theatre records is reasonably straightforward. Identification of NoLap cases brings significant methodological challenges because there is no well-defined event around which to organise data collection.

Audit methodology can be found here.

3 Key Standards

Key audit standards were established following a virtual nominal group technique consensus meeting, which reviewed published standards of care for surgical patients, existing NELA audit standards[3] for operative patients and existing literature on NoLap.[1,2,4–6] Notably, NELA standards – covering preoperative risk assessment and CT imaging – are currently derived from Royal College of Surgeons of England (RCS) guidance.[7]

Table 3.1 Summary of compliance with key standards (Red, Amber, Green ratings indicate level of compliance with audit metrics, as defined here)

Key standard	Associated Process Measures	Compliance n (%)
Risk assessment	Proportion of patients with a formal risk assessment of mortality.	682 (72.3%)
CT scanning and reporting	Proportion of patients who had a CT scan that was reported by senior radiologist and communicated with the team in the correct time scale (composite metric).	167 (18.3%)
Care of the older person	Proportion of patients aged 65 or older for whom a formal assessment of frailty was documented.	718 (85.8%)
Advance care planning	Proportion of patients where the admitting team attempted to ascertain the presence of an advance care plan preoperatively.	906 (96.1%)
End-of-life care	For those patients who died in hospital, proportion of patients where an individualised end-of-life care plan was documented.	576 (80.3%)
	For those patients who died in hospital, proportion of patients who received direct input by a member of a palliative care team.	449 (62.6%)

4 Recommendations and Key Messages

Key message 1: Risk assessment

In 27.7% of cases, there was no formal assessment of risk documented, despite this being recognised as a key aspect of surgical decision making. Prior to a decision not to operate, many patients will need to be managed in an identical manner to operative NELA cases, receiving appropriate national standards of care, including risk assessment.

Recommendation 1

The Royal College of Anaesthetists, Royal College of Emergency Medicine, Royal College of Nursing, Royal College of Radiologists, and Royal College of Surgeons of England should continue to collaborate in developing and updating consensus pathways for patients with acute abdominal conditions who do not undergo emergency surgery. Pathways should address risk assessment, standardised decision-making, and comprehensive documentation of care, ensuring that the needs of non-operative patients, as highlighted by the NoLap audit, are explicitly considered.

Key message 2: Frailty Assessment

Frailty assessment was documented in 85.8% of patients aged 65 or older, reflecting strong adherence to holistic evaluation. In NoLap decision-making, these assessments provide key insight into physiological reserve and help identify when non-operative management is in the patient's best interests.

Key message 3a: Advance care planning

Six in ten NoLap patients had no advance care plan in place prior to hospital admission, and around a quarter were discharged without any documented formal advance care plan. Given the age profile, multimorbidity, and higher prevalence of frailty of this population, proactive advance care planning is essential; both in the community/primary care setting and elective secondary care pathways including outpatient reviews. A multiprofessional approach toward recognising patients who may benefit from advance care planning can support shared decision-making, reduce uncertainty for patients and their families during acute deterioration, and ensure treatment aligns with patients' goals and preferences.

Key message 3b: End-of-life care

Only 80% of patients who were recognised to be dying had an individualised end-of-life care plan documented.

Recommendation 2

Integrated Care Boards (ICBs) in England, Welsh Health Boards and Integrated Care System Northern Ireland (ICS NI), should consider system level initiatives aimed at increasing the uptake and quality of end-of-life care training, including but not limited to, recognition of dying and the use of individualised end-of-life care plans and advance care planning.

5 Demographics and decision-making

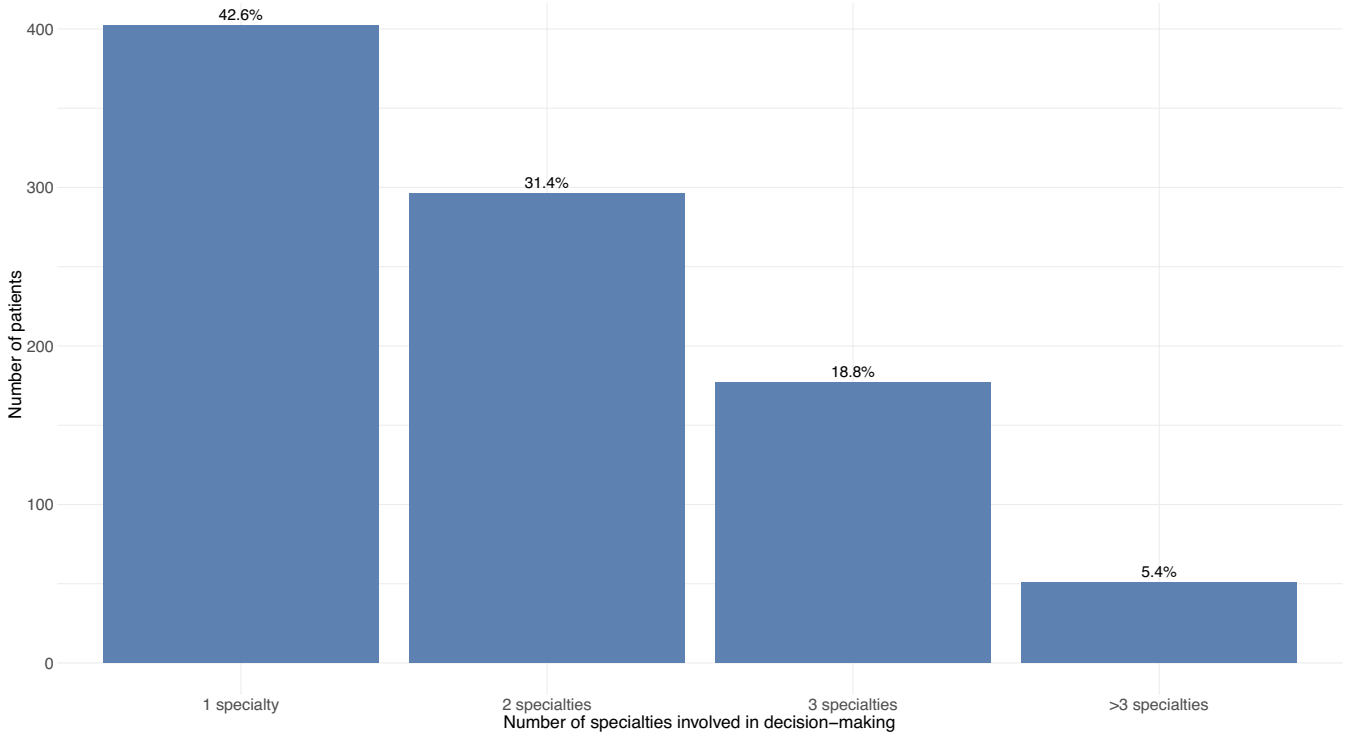
Who are NoLap patients?

943 patients were included in these analyses from 91 hospitals. Patient characteristics are summarised in Table 5.1.

Who was involved in the NoLap decision-making process?

In most cases, 895 (94.9%), general surgery was involved in the NoLap decision-making process, followed by patient and next-of-kin involvement in 63.3% and 55.5% of cases, respectively. More than one specialty contributed to decision-making in 55.6% of cases. Among cases where only a single specialty was involved, general surgery was the sole specialty in 96.4% of cases. Further detail can be found here.

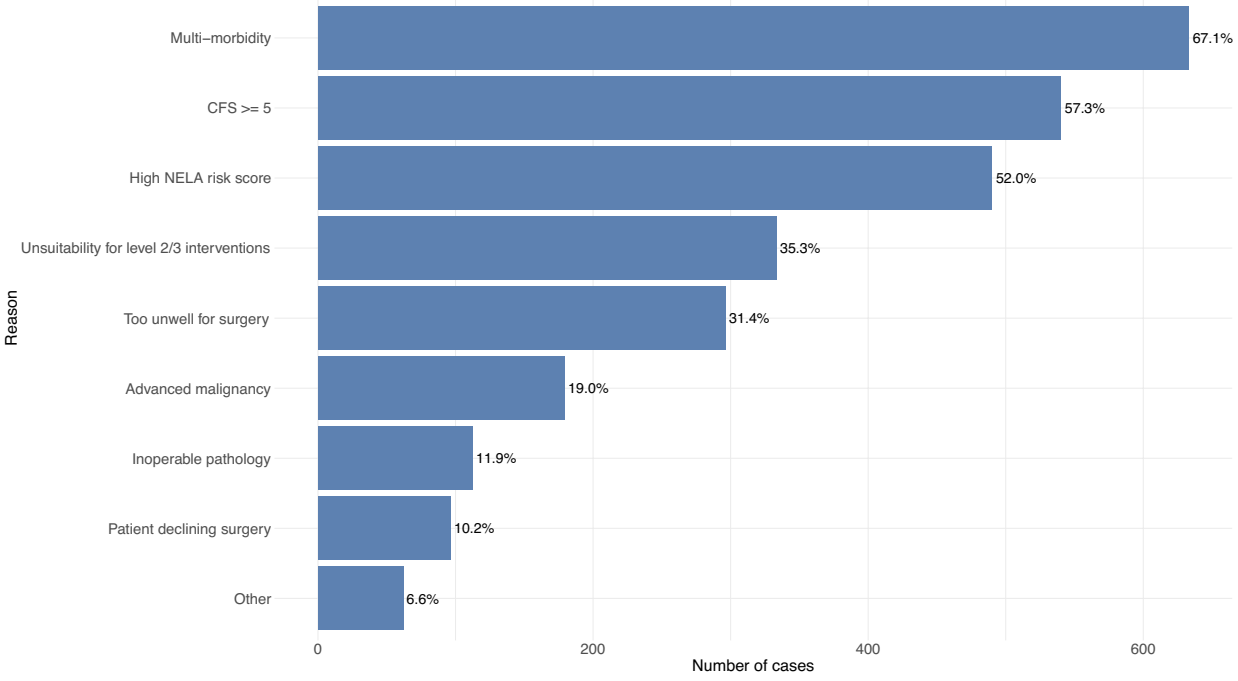
Bar chart 5.1 Number of specialties involved in the decision not to operate



Why was a NoLap decision made?

In most patients, more than one reason was given as the basis for making a decision not to operate (see bar chart 5.2 below and bar chart 5.3 available here). This finding highlights the complexity of the NoLap patient group. The patient declining surgery was recorded as a contributing factor in 10.2% of cases.

Bar chart 5.2 Documented reasons for decision not to operate



6 Key Standard 1: Risk assessment

Process measure

Proportion of patients in whom a risk assessment was documented prior to non-operative decision.

72.3% of cases were documented as having a formal risk assessment prior to a decision not to operate. For comparison, the Year 10 NELA report of operative cases found that a formal pre-operative risk assessment was documented in 81.3% of patients.

98% of NoLap patients would have been categorised as high risk if surgery had been undertaken (see Table 5.1 and bar chart 6.1 for distribution of NoLap patients across different risk deciles by bowel pathology). In some cases, patients can be categorised as high-risk irrespective of the NELA Parsimonious Risk Score (PRS). NELA categorises patients as high risk if:

1 the patient has a PRS of 5% or greater
2 the patient is living with frailty, defined by a Rockwood Clinical Frailty Scale (CFS) of 5 or more
3 indicated from clinical assessment based on other conditions not included in PRS
4 there is an absence of any form of formal risk assessment.

There may be situations – such as where a pre-existing advance care plan or agreed ceiling of treatment is available – where a formal risk assessment is not deemed clinically appropriate.

7 Key Standard 2: CT scanning and reporting

Process measure

Proportion of patients who had a CT scan that was reported by senior radiologist and communicated with the team in the correct time scale.

919 of 943 (97.5%) patients had a CT scan performed. A small proportion of patients (1.4%) did not have CT scan performed because they were either too unwell to undergo imaging or there was a pre-existing advance care plan (see Table 7.1). A breakdown of seniority of the reporting radiologists is shown in Table 7.2.

Overall, 18.3% of patients met this composite standard, which is comparable to the 12.4% observed in the NELA Year 10 report among patients presenting with 'RCS Immediate' pathology (see Table 7.3 below).

Table 7.3 Compliance with CT scanning standard: comparison between NoLap patients and 'RCS Immediate' patients who underwent emergency laparotomy (Reference made to Table 7.1 in Year 10 NELA Report)

Standard	NoLap patients, n (%)	'RCS Immediate' patients in year 10 NELA report (3), n (%)
CT report by ST3+ radiologist, including consultant or outsourced service	901 (98.9)	16,316 (98.7)
Report within one hour of CT scan	438 (48.1)	8,111 (49.0)
Direct communication by phone or in person between referring clinician and reporting radiologist	333 (36.6)	4,077 (24.7)
All three subcomponents of composite measure met	167 (18.3)	2,058 (12.4)

Compared to the operative patients analysed in the year 10 NELA report, direct communication between referrer and reporting radiologist was recorded in a greater proportion of NoLap cases (36.6% vs 24.7%), although due to methodological differences between the audits, these groups may not be directly comparable. See Tables 7.4 and 7.5 for breakdown of CT scanning and reporting standards by bowel pathology.

QI suggestion: Clinical teams directly responsible for patient care should proactively seek expert radiology input following urgent CT imaging, particularly where findings are critical to determining whether surgery is appropriate. Likewise, radiologists should proactively and promptly communicate any serious or time-critical findings to the referring clinical team to support decision-making.

8 Key Standard 3: Care of the older person

Process measure

Proportion of patients aged 65 or older for whom a formal assessment of frailty was documented.

Of 837 patients aged 65 and over, 85.8% had a documented CFS assessment, greater than the proportion in the year 10 report of NELA (73.6%).[3]

Within the NoLap cohort, frailty was common: 73.5% of patients were living with frailty (CFS ≥ 5) with an additional 6.7% vulnerable to frailty (CFS 4). A full breakdown of CFS categories is provided in Table 8.1.

Frailty assessment was not recorded in 14.2% of cases. Frailty assessment is well recognised as an important aspect of surgical risk assessment, providing a holistic measure of a person's physiological resilience, independently predicting how well they may withstand and recover from surgical intervention.[8] Frailty assessment should be undertaken for all patients aged ≥65 years to enable clinical teams to identify vulnerable patients and to guide individualised shared decision-making.

The mortality rate is similar across all categories of frailty, with a mean mortality rate of 77.7% (see Table 8.2).

9 Key Standard 4: Advance care planning

Process measure

Proportion of patients in whom staff have proactively identified advance care plans to support the decision-making process.

For 906 patients (96.1%), clinical teams proactively attempted to identify the presence of an advance care plan.

In most cases (579, 61.4%), there was no documented Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) or advance care plan (ACP) in place at the time of a decision not to operate (see Tables 9.1 and 9.2).

Among patients who survived to hospital discharge, 160 patients (72.1%) had a DNACPR order in place and 83 patients (37.4%) had a formal ACP documented. Notably, 1 in 4 patients were discharged with neither a DNACPR order nor an ACP in place (see Table 9.3).

Why is Advance Care Planning important for NoLap patients?

Advance Care Planning supports discussions about patient values, treatment preferences, and decision-making in the event of clinical deterioration. What has likely been a difficult decision not to operate has been made during this hospital admission. For a patient who survives to discharge, the ongoing absence of an ACP that would ensure their future wishes are considered, shared, and documented may well be a significant missed opportunity to avoid a re-admission to hospital in the future.

Click here to read more about background and definitions on advance care planning.

Click here to read more about John's journey in hospital.

10 Key Standard 5: End-of-life care

Process measure

Proportion of patients who were recognised to be dying who have an individualised end-of-life care plan documented.

There were 576 patients (80.3%) recognised by the clinical team to be dying who had an individualised end-of-life care plan documented. While the majority received end-of-life care planning, 1 in 5 of these patients did not. This suggests that, even in patients where the likely outcome was death, the deterioration or terminal phase was not consistently recognised or documented in advance, highlighting an important area for quality improvement. For comparison, from the 2025 National Audit of Care at the End of Life (NACEL), the average number of all adults (aged 18 and above) who died in an acute hospital from any cause who had a documented end-of-life care plan was 84% (Key findings at a glance).

QI suggestion: Clinical teams should ensure that patients recognised as being in the last days of life have an individualised end-of-life care plan in place, in line with NICE guidance (Care of dying adults in the last days of life).

Pragmatic steps include early senior decision-making to recognise dying, use of local standardised end-of-life care or treatment escalation plans, timely prescribing of anticipatory medications and daily review of symptom control and hydration decisions. Local audit and MDT review can be used to support consistent implementation across services.

Process measure

Proportion of patients who died in hospital, who received direct input by a member of a palliative care team.

62.6% of patients who died received direct input by a member of their local palliative care team. In some cases, patients may have already had an advance care plan in place indicating their wishes on dying. In others, end-of-life care needs might have been managed effectively by clinical teams without the need for additional specialist palliative care input, and the apparent shorter length of hospital stay amongst those who did not receive palliative care input might reflect a group of patients who died before specialist care could be delivered (Table 10.1 below).

Table 10.1 Post-admission median length of stay

Direct input by member of palliative care team	Median length of stay (LOS) (interquartile range [IQR]), days
Yes	4 [2–9]
No	2 [1–6]

11 Outcomes

Length of stay (LOS)

Median LOS following decision not to operate was 8 days (range 0–384 [IQR 4–18] days).

Median LOS from date of hospital admission was 10 days (range 0–384 [IQR 5–20] days).

Mortality

Of the 943 patients included in analyses, in-hospital mortality was 76% with a median predicted mortality risk score of 41.0% (IQR 24.4–58.8%) based on the NELA PRS. Fewer than 10 patients were still in hospital 60 days following admission.

Linked Office for National Statistics (ONS) data were obtained for patients receiving care in England and Wales; mortality data for Northern Ireland was obtained via the Honest Broker Service. A small proportion of records did not indicate a date of decision to not operate, which is used as the start of follow-up for mortality calculations. This left 919 patients for the analysis.

Table 11.1 Overall 30-day and 90-day mortality and by pathology

	Mortality rate (%)*			
	Overall N=919	**Bowel Ischaemia N=321**	**Bowel Perforation N=451**	**Both N=56**
30-day mortality	80.2	86.9	77.2	89.3
90-day mortality	86.7	92.2	84.0	94.6

*91 patients had neither bowel ischaemia nor bowel perforation as a diagnosis.

12 Case ascertainment and outlier policy

Establishing a robust and reproducible methodology for identifying the NoLap cohort has been challenging, and further work is ongoing to refine the case ascertainment process. The proposed methodology is currently being piloted in a small number of hospitals to assess feasibility, consistency, and reliability before wider implementation.

Given that this represents the first year of the NoLap audit, no outlier policy has been applied at this stage.

13 References

Click here for references used in this report.

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