



# Eleventh Patient Report of the National Emergency Laparotomy Audit

23 April 2024 to 31 March 2025

October 2026

# Contents

|                                    |   |                                                                 |   |
|------------------------------------|---|-----------------------------------------------------------------|---|
| 1 Executive Summary/Overview       | 2 | 10 Management of intra-abdominal infection                      | 6 |
| 2 Introduction                     | 3 | 11 Postoperative critical care admission                        | 6 |
| 3 Key messages and recommendations | 3 | 12 Older patients and those living with frailty                 | 7 |
| 4 Main findings                    | 4 | 13 Outcomes                                                     | 7 |
| 5 Case ascertainment               | 4 | 14 Health inequalities (geography, sex and admitting specialty) | 8 |
| 6 Radiology                        | 4 | 15 Outliers                                                     | 8 |
| 7 Risk assessment                  | 5 | References                                                      | 9 |
| 8 Consultant delivered care        | 5 |                                                                 |   |
| 9 Theatre timeliness               | 5 |                                                                 |   |

ISBN: 978-1-900936-44-6

NELA Project Team. 11th Patient Report of the National Emergency Laparotomy Audit.  
Royal College of Anaesthetists (RCoA) London 2026.

## © 2026 Healthcare Quality Improvement Partnership (HQIP)

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 and the Royal College of Nursing. 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 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.

Whilst the Royal College of Anaesthetists has endeavoured to ensure this document is as accurate as possible at the time it was published, it can take no responsibility for matters arising from circumstances which may have changed, or information which may become available subsequently.

All enquiries in regard to this document should be addressed to the: National Emergency Laparotomy Audit, Royal College of Anaesthetists, Jubilee House, 20 Queen Elizabeth Street, London SE1 2LS ([nela@rcoa.ac.uk](mailto:nela@rcoa.ac.uk)).

Report compiled by the project team of NELA, and in particular:

Mr Edwin Clark, NELA Surgical Lead  
Dr David Saunders, NELA Anaesthetic Lead  
Dr Edmund Gerrans, NELA Anaesthetic Fellow  
Mr Aiman Al-Eryani, Senior Data Analyst  
Ms Christine Taylor, NELA Project Manager

**[nela.org.uk](https://nela.org.uk)**



Information correct as at October 2026

Design and layout by the Royal College of Anaesthetists.

# 1 Executive Summary/Overview

The eleventh annual report of the National Emergency Laparotomy Audit (NELA) examines care received by NHS patients across 163 hospitals in England, 11 in Wales, 1 in Isle of Man, and for the first time seven hospitals in Northern Ireland, admitted between 24 April 2024 and 31 March 2025 and who underwent emergency laparotomy (EmLap). The report once again highlights that many clinical teams were able to provide high quality care, but challenges persist in meeting certain standards.

30-day mortality was 8.1% (11.7% in Year 1). The reduction in mortality potentially represents over 900 additional survivors per year after EmLap compared to Year 1. Median postoperative stay in hospital remains unchanged since last year's report at 10 days.

There is wide variation between hospitals in both processes and outcomes of care. Risk-adjusted 30-day mortality ranges from 0% to 18.4% between hospitals that submitted at least 10 patients. More remains to be done to reduce disparity and ensure all patients benefit from the highest standards of care. Key messages and specific recommendations are within the [Line of Sight table](#) and [Section 3 below](#).

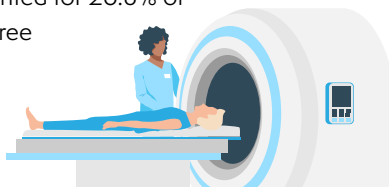
## RECOGNITION OF THE NEED FOR EMERGENCY LAPAROTOMY AND ADMISSION UNDER GENERAL SURGERY

**13.6%** of patients admitted through emergency departments were not initially admitted **under the care of a general surgeon**. Achievement of all time-related standards was worse for patients not admitted under general surgery. Mortality more than doubled for patients not admitted under general surgery (**6.4% vs 13.7%**).



## DIAGNOSTIC IMAGING

**91.9%** of all non-elective patients had a CT scan following admission to hospital. For patients with the most time-critical pathologies, **98.9% of scans were reported by a senior radiologist and 46.6% were reported within one hour**. Verbal discussion was documented for 26.8% of patients. Only 13.0% met all three sub-components of the composite CT standard.



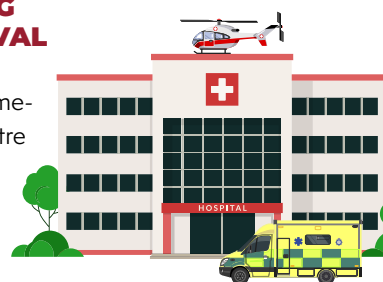
## INFECTION MANAGEMENT

**15.0% of patients** with suspected sepsis and/or septic shock, and **33.5% of patients** with suspected infection, received antibiotics within the one and three-hour targets, respectively.



## TIMELINESS OF ARRIVING IN THEATRE FROM ARRIVAL AT HOSPITAL

**10.8%** of patients with the most time-critical pathologies arrived in theatre within **six hours of arriving at hospital** (median 15.0 hours).



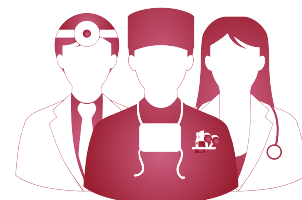
## RISK ASSESSMENT

**80.0%** of patients had a formal risk assessment preoperatively and **64.5%** had a further evaluation of mortality risk at the end of surgery. **51.9%** of patients were high-risk.



## CONSULTANT DELIVERED CARE

**89.2%** of high-risk patients had both consultant anaesthetist and consultant surgeon present in theatre.



## CRITICAL CARE FOR HIGH-RISK PATIENTS

**76.1%** of high-risk patients were admitted directly to critical care postoperatively.



## SPECIALIST CARE FOR OLDER PATIENTS AND THOSE LIVING WITH FRAILITY

**39.6%** of patients aged 65 and older and living with frailty, or over 80, received specialist postoperative input.



Royal College of Anaesthetists, Jubilee House, 20 Queen Elizabeth Street, London SE1 2LS  
[nela@rcoa.ac.uk](mailto:nela@rcoa.ac.uk) [nela.org.uk](http://nela.org.uk)

## 2 Introduction

The eleventh annual report of the National Emergency Laparotomy Audit (NELA) examines care received by NHS patients in England, Wales, Isle of Man, and Northern Ireland, admitted for emergency laparotomy (emergency bowel surgery; EmLap) between 24 April 2024 and 31 March 2025. An overview of the audit methodology can be found [here](#).

### Important changes made for Year 11

- 1 The eleventh NELA annual report includes data and analysis from patients undergoing emergency laparotomy in Northern Ireland for the first time.
- 2 Following guidance from the Healthcare Quality Improvement Partnership (HQIP) the [outlier policy](#) has been expanded to include case ascertainment in addition to mortality.
- 3 This is the first annual report of NELA to be published since the advent of the NoLap audit – examining standards of care and outcomes for patients who meet the criteria for an emergency laparotomy (bowel ischemia and/or bowel perforation), but who do not undergo surgery. NELA has [recently published](#) the first report into standards of care and outcomes for this patient group. Identification of patients in the NoLap cohort can be challenging, and case ascertainment rates were variable during the audit year. We have added analysis of case ascertainment in the NoLap audit to our existing [RAG table](#) of performance related to the EmLap arm of NELA.

## 3 Key messages and recommendations

### Message 1: The potential need for emergency laparotomy is not always recognised or considered on arrival at hospital leading to failure to meet time critical standards, and higher mortality

- a Across all hospitals, the care received by many patients requiring emergency laparotomy failed to meet time-related standards (delivery of antibiotics, CT scanning and theatre timeliness) as also **highlighted in last year's report**. For example, the **median time to theatre for patients with septic shock** was 9.9 hours ([Table 10.2](#)).
- b Timeliness was even worse in those not admitted initially under the general surgical team ([Table 3.1](#)) and their mortality was higher as urgency increased – 6.4% vs 13.7% for all patients and 8.0% vs 20.8% for those with the most time critical pathologies ([Table 3.2](#), [Table 9.2](#), [Table 10.3](#), [Table 13.2](#) and [Table 14.2](#)). The presenting symptoms and signs in patients requiring emergency surgery are varied, but **a low index of suspicion that patients may require laparotomy is required** as described in the Royal College of Emergency Medicine (RCEM) [Advisory Statement \(2024\)](#), as the consequences of not considering it may be severe.

#### Recommendation 1

Key organisations including Health Boards in Wales, DHSC in England and the DoH in Northern Ireland should work with Royal Colleges of Anaesthetists, Emergency Medicine, Nursing, Radiologists and Surgeons, alongside Specialty Associations, to utilise NELA data and examples of best practice to draw up universal care pathways to rule in or out the need for emergency laparotomy on arrival at hospital. This should speed up delivery of care as well as increase the proportion of patients requiring surgery being admitted under the correct specialty.

### Message 2: Case ascertainment for NELA remains low in many units

All patients undergoing emergency laparotomy should have their data entered in the NELA database (and for those who meet the criteria for an emergency laparotomy [bowel ischemia and/or bowel perforation], but who do not undergo surgery, recorded in the NoLap register). A significant number of units failed to enter representative data onto either register.

#### Recommendation 2

Care Quality Commission, NHS Performance and Improvement in Wales, The Regulation and Quality Improvement Authority Northern Ireland should ensure case ascertainment data are assessed in quality assurance processes.

## 4 Main findings

Year 11 data are available for 21,324 patients admitted between 24 April 2024 and 31 March 2025 who underwent emergency laparotomy. Characteristics of the population can be found in [Table 4.1](#). Summary data for the main standards of care are shown in [Table 4.2](#). Individual hospital performance indicators rated Red, Amber, Green (RAG) are available [here](#).

## 5 Case ascertainment

Of 187 hospitals in England, Wales, and Northern Ireland identified as performing at least 10 eligible operations, 181 (96.8%) submitted data to NELA. Case ascertainment was 72.9% in England, 86.4% in Wales, and 56.9% in Northern Ireland. Overall case ascertainment was 73.2% ([Table 5.1](#)).

Run charts showing historic and contemporaneous data, including case ascertainment, are available at hospital- and national-level from [https://rcoa.shinyapps.io/nela\\_standards](https://rcoa.shinyapps.io/nela_standards) in addition to [https://rcoa.shinyapps.io/rag\\_tables](https://rcoa.shinyapps.io/rag_tables).

There remain large numbers of patients undergoing emergency laparotomy for whom data are not submitted to the audit. This loss of patient data degrades the findings of every NELA report and prevents a precise assessment of the quality of care in some units. The approximate number of missing patient data sets is 5,074 for England and Wales for Year 11.

One of the major changes to Year 11 was the addition of an [outlier process](#) based on case ascertainment for those units with poor engagement. Some hospitals with Emergency Departments (EDs) and emergency general surgery services for their population continue to not submit data to NELA. Hospitals identified as outliers based on case ascertainment are noted in [Section 15 below](#).

### QI Tip

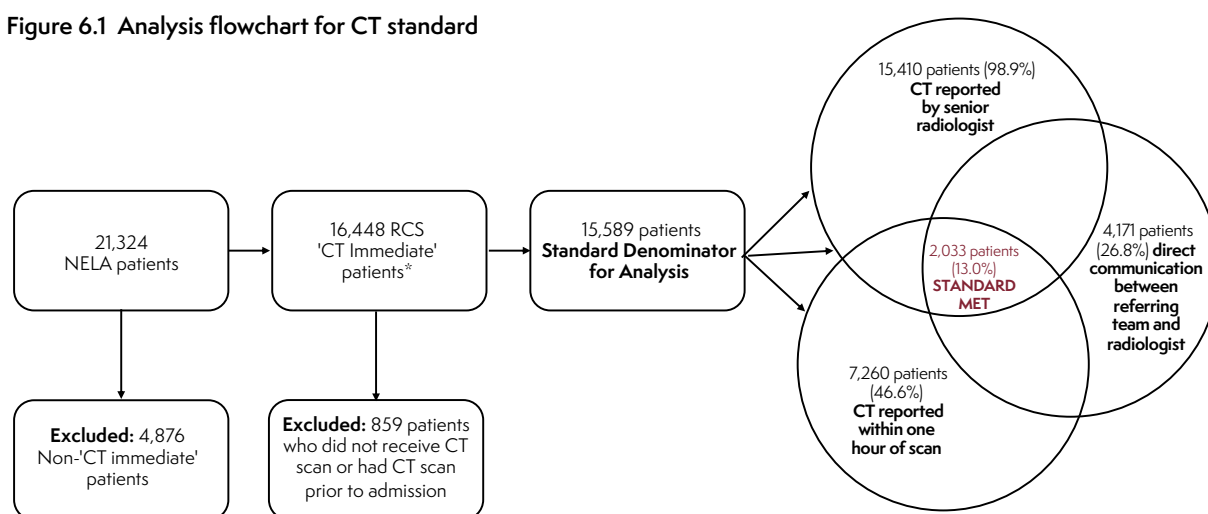
Local teams should review hospital theatre records and unit NELA databases to ensure that all eligible cases have been correctly entered on a regular basis.

## 6 Radiology

*Audit Standard: Proportion of patients requiring immediate surgery who had a CT scan that was reported by senior radiologist within one hour and communicated with the surgical team before surgery.*

There were 15,589 patients who required immediate surgery and were included in our [calculation of this standard](#). Of these, only 13.0% (England [E] 13.6%, Wales [W] 8.9%, Northern Ireland [NI] 7.4%) of patients met the composite standard ([Table 6.1](#)). 95% of non-elective patients had a preoperative scan. Of these, around half received a report within an hour of scan. The main shortfall in meeting the composite audit standard for CT scanning was around evidence of direct verbal communication between the referring team and reporting radiologist (Figure 6.1).

Figure 6.1 Analysis flowchart for CT standard



\*'CT Immediate patients' are patients requiring urgent surgery with suspected haemorrhage, sepsis of surgical origin, tender bowel obstruction, peritonitis, perforation, or ischaemia. See <https://bit.ly/NELA-CT-Comp>.

Median time to CT scan for patients admitted through the ED under general surgery was 6.0 hours (interquartile range [IQR] 4–10 hours) compared to 40 hours (IQR 11–152 hours) for patients not admitted under general surgery ([Table 9.2](#)), but in whom it transpired they had an urgent surgical pathology.

#### QI Tip

Local teams should assess local pathways regarding: criteria for CT scanning, personnel authorised to request CT scans, and scanning and reporting capacity to ensure the correct pathways and facilities are in place, so that **all patients who might have a need for emergency surgery have a timely CT and are admitted under general surgery where appropriate.**

## 7 Risk assessment

*Audit standard: Proportion of patients in whom a risk assessment was documented preoperatively AND postoperatively.*

Overall, completion of formal risk assessment has declined, with only 60.3% (69.3% Year 10) of patients having a risk assessment documented both preoperatively and postoperatively (E: 60.8%, W: 62.2%, NI: 42.7%) ([Table 7.1](#)). There was wide variation between hospitals in compliance with this standard ([Figure 7.1](#)).

68.4% (73.6% Year 10) of patients aged 65 or over had a formal assessment of frailty recorded preoperatively ([Table 7.2](#)). Mortality risk and observed in-hospital mortality both rise with increasing age decile and clinical frailty scale (CFS) ([Table 7.3](#) and [Table 7.4](#)).

The overall numbers of patients who died within 72 hours of surgery (including those who died within the theatre suite) was 3.0% (644) ([Table 7.7](#)). This is comparable with the rate of early postoperative death as reported by Javanmard-Emamghissi et al.<sup>1</sup> 87.3% of this group of patients had a formal risk assessment, which was higher than the overall rate of preoperative risk assessment at 80%.

#### QI Tip

Local teams should review cases at combined M&M meetings (surgery, anaesthetics and critical care) where patients died in theatre or within 72 hours of surgery, especially where no risk assessment was made. Particular attention should be given to any cases where an 'open and close' laparotomy was performed to assess the decision making that led to this scenario.

## 8 Consultant delivered care

*Audit Standard: Proportion of high-risk patients (risk of death of  $\geq 5\%$ ) with consultant surgeon and consultant anaesthetist present in theatre.*

Of 11,058 high-risk patients, 89.2% had both consultant surgeon and consultant anaesthetist present in theatre (E: 89.3%, W: 89.9%, NI: 84.0%) ([Table 8.1](#)).

#### QI Tip

Local teams should review processes and outcomes of care for any high-risk patients where consultants were not present in theatre, particularly when no risk assessment was made.

## 9 Theatre timeliness

*Audit Standard: Proportion of patients with 'RCS immediate' pathology arriving in theatres within six hours of arrival at the hospital/Emergency Department.*

11,576 patients had indications for surgery compatible with 'RCS Immediate' pathology ([Table 4.1](#)). 10.8% (E: 10.6%, W: 12.3%, NI: 11.0%) of these patients arrived in theatre within six hours of arrival at hospital (median 15.0 hours [IQR 8.6–29.7 hours]; [Table 9.1](#)). All hospitals performed poorly against this metric ([Figure 9.1](#)).

Patients not admitted under general surgery experience marked delays in arriving in theatre (median 98.0 hours [IQR 35.0–239.0 hours]; [Table 9.2](#)).

#### QI Tip

Where significant delay in accessing theatre has occurred, local teams should examine hospital records and local NELA data to examine how the delays occurred. Was the recognition of need for emergency laparotomy missed?

## 10 Management of intra-abdominal infection

**Audit Standard:** *Proportion of patients with suspected infection or sepsis who have antibiotic administration within the correct clinical timeframe.*

As stated in national guidelines,<sup>2,3</sup> patients with sepsis or infection should receive antibiotics within one or three hours of recognition, respectively. Only 33.5% of patients with suspected infection received antibiotics within three hours of first suspicion (median 3.0 hours [IQR 1.0–6.3 hours]). For those with suspected sepsis or septic shock, only 15.0% met the target of one hour (median 2.6 hours [IQR 1.0–6.1 hours] ([Table 10.1](#)). As seen in [Figure 10.1](#) and [Figure 10.2](#), this performance varies widely between hospitals.

Surgery to control the source of infection is an essential step in the management of these patients. NELA-adopted timeliness standards<sup>2,3</sup> state that surgery in such circumstances should be underway within six hours of arrival at hospital. The target for those with suspected infection, sepsis or septic shock was met only 14.9% of the time for those with infection (median 12.1 hours [IQR 7.4–24.4]), 19.4% for those with sepsis (median 11.2 hours [IQR 6.7–26.1]) and 27.1% for those with septic shock (median 9.9 hours [IQR 5.6–23.9]); ([Table 10.2](#)).

Median time to antibiotics for patients with suspected infection is slower in those not admitted under general surgery (three hours vs four hours) and for those with suspected sepsis and septic shock (two hours vs four hours). The median time to theatre for definitive source control is considerably longer (22 hours vs 98 hours) when not admitted under general surgery ([Table 10.3](#)).

### QI Tip

Local teams should review cases where patients have died and infection management standards were not met. Are local diagnostic and management pathways adequate to ensure early diagnosis and management of infection including the need for antibiotics as well as the need for surgery?

## 11 Postoperative critical care admission

**Audit Standard:** *Proportion of high-risk patients admitted directly to critical care postoperatively.*

76.1% of high-risk patients were admitted directly to critical care (CC) postoperatively ([Table 11.1](#)). High-risk patients who did **not** go to CC had a high observed mortality rate (4.2% for the 17.5% who went to a ward; [Table 11.2](#)). Patients cared for initially in a post-anaesthesia care unit (PACU) had a notably high mortality rate (9.2%). It is important to recognise a binary categorisation into low-risk or high-risk may mask a much more complex clinical picture, with continuums of risk and need for complex interventions following surgery. Higher mortality rates for low-risk patients cared for in PACU or CC compared to those admitted to a ward does not mean care was suboptimal; it is likely the groups of patients are not matched in terms of risk profile. NELA does not collect data around interventions provided to patients in CC.

This standard has not changed since the inception of NELA, although the definition of being at high risk of postoperative complications has been refined over time. Performance against the standard improved up until the COVID-19 pandemic, which caused disruption in the ability of hospitals to deliver critical care resources to EmLap patients ([Figure 11.1](#) and [Table 11.3](#)). Performance has never returned to the pre-pandemic level, and importantly there is wide variation in the ability of hospitals to provide CC resources to all high-risk EmLap patients ([Figure 11.2](#)). Some units have expanded the availability of enhanced care (level 1) beds<sup>4</sup> or PACU resources for EmLap patients ([Figure 11.1](#)). Significant variation is seen at devolved nation level ([Figure 11.3](#)), with a greater use of PACU beds in Northern Ireland than in England or Wales. Median CC length of stay (LOS) is shown in [Table 11.2](#).

### QI Tip

Local teams should use exports of locally collected NELA data to investigate processes and outcomes of care for high-risk patients who were not admitted to critical care. Consensus pathways of care around optimum placement for postoperative elective and emergency patients should be agreed, especially in hospitals with a shortfall in critical care bed capacity.

## 12 Older patients and those living with frailty

*Audit standard: Proportion of patients aged 65 or older and frail, or aged 80 and older, who receive postoperative assessment and management by a member of a perioperative team with expertise in comprehensive geriatric assessment (CGA).*

Of the 11,785 patients aged over 65, 68.4% (73.6% Year 10) had a formal frailty assessment recorded following admission ([Table 12.1](#)). 33.6% (35.9% Year 10) were living with frailty (CFS $\geq$ 5). As demonstrated consistently across previous NELA analyses,<sup>5</sup> increasing frailty was associated with a markedly higher risk of postoperative mortality. Notably, patients aged 65 or older without a recorded frailty assessment had a mortality rate of 11.1%, almost double that of patients who are not living with frailty, suggesting that the absence of assessment does not equate to absence of frailty or of risk ([Table 7.4](#)).

NELA does not validate CFS scoring performed at hospital level, but the dataset continues to show that a sizeable proportion of patients with high frailty scores [CFS 7–8], who would typically be expected to have very limited physiological reserve, survive emergency laparotomy.

Provision of comprehensive geriatric assessment (CGA) varies greatly ([Figure 12.1](#)). Of the 5,329 patients over 65 and living with frailty, or over 80 regardless of frailty status, 2,111 (39.6%) received postoperative review by a perioperative team with expertise in CGA, most commonly a geriatrician-led service ([Table 12.1](#)). The respective rates varied by country (E: 40.3%, W: 41.7%, NI: 13.0%) potentially reflecting different levels of service maturity and the investment in perioperative CGA models of care.

Previous NELA analyses have suggested a possible association between specialist geriatric input and reduced length of stay (LOS). In this year's data, however, no clear trend is observed when LOS is examined by decile of specialist assessment (median 13 days [IQR 8–22] for 0–10% and 16 days [IQR 9–27] for 90–100%; [Table 12.2](#)) likely reflecting the complexity of the population. The longer LOS in hospitals with higher rates of specialist review may reflect targeted involvement in the most complex, multimorbid, or socially vulnerable patients rather than a lack of benefit.

### QI Tip

Local teams should review cases where postoperative death or prolonged LOS (>60days) occurred in patients over 80, or over 65 and living with frailty, who did not receive specialist perioperative CGA. This may identify missed opportunities for CGA-based optimisation, rehabilitation planning, or early multidisciplinary intervention.

### Delirium

Delirium assessment was only carried out in 23.6% of patients preoperatively and 20.5% postoperatively ([Table 12.3](#)). Delirium rates were slightly higher postoperatively than preoperatively.

The rates for those over 65 are higher than those under 65. Rates increase postoperatively in the older age group ([Table 12.4](#)). Again, as almost four out of five patients do not receive pre or postoperative delirium assessment, more data are required for more detailed analysis of the implications.

## 13 Outcomes

### Mortality

Combined 30-day mortality was 8.1%, including in-hospital and out-of-hospital deaths. The drop in mortality from 11.7% in Year 1 potentially represents 900 extra survivors from emergency laparotomy per year. 30-day in-hospital mortality was 7.4% (7.4% in England, 8.5% in Wales and 5.9% in Northern Ireland). The rate was 7.1% for women and 7.9% for men. Combined 30- and 90-day mortality, mortality by sex and country are displayed in [Table 13.1](#). In-hospital mortality is displayed in [Table 14.1](#).

Mortality is higher for patients admitted as an emergency through ED, when not admitted under general surgery: 13.7% versus 6.4% for those admitted under general surgery ([Table 9.2](#)).

### QI Tip

Local teams should review cases where postoperative death has occurred and the patient was not initially admitted under general surgery, to see whether an opportunity for earlier diagnosis and management was missed.

## Length of stay (LOS)

The median postoperative LOS for patients who survived to hospital discharge was 10 days (also 10 days in year 10). Postoperative LOS is 4 days longer for RCS immediate category patients not initially admitted under general surgery ([Table 13.2](#)).

## Days Alive Out of Hospital (DAOH)

DAOH is a patient-centred outcome measure that captures both survival and healthcare utilisation within a single metric.<sup>6</sup> Rather than focusing solely on mortality or hospital readmission, DAOH reflects the number of days a patient is both alive and not admitted to hospital during a defined follow-up period. For this report, NELA has analysed [DAOH at both 30- and 90-days](#).

# 14 Health inequalities (geography, sex and admitting specialty)

There is wide variation in mortality between hospitals. For hospitals with at least 10 emergency laparotomies, 30-day risk-adjusted mortality ranges from 0% to 18.4%.

In-hospital mortality was higher in men than in women: 7.9% vs 7.1% respectively, a finding repeated across all nations ([Table 14.1](#)). The parsimonious risk score (PRS) does not account for sex, and it is not known if the cases are matched in other regards, but the higher mortality rate for men warrants further investigation.

The consequences of the failure to diagnose the potential need for emergency laparotomy (and therefore admission under general surgery) have been discussed above. This shows the stark difference in mortality, LOS and timeliness standards.

1,501 women (14.1%) and 1,236 men (13.0%) were not referred to general surgery from the ED ([Table 14.2](#)). The reasons behind the greater rate of failure to diagnose the need for EmLap, or consider the potential need for EmLap in women, are not clear from the data recorded in the audit and warrant further investigation.

The complete early pathway of care from arrival in ED, through diagnostic CT, and admission under general surgery is complex. When the diagnosis of requiring EmLap was not made and the patient was admitted initially to a specialty other than general surgery, both sexes were far slower in all the timeliness standards and had a subsequent higher observed mortality ([Table 3.2](#), [Table 9.2](#), [Table 10.3](#), [Table 13.2](#) and [Table 14.2](#)).

## 15 Outliers

The NELA [outlier policy](#) was changed for Year 11 and now includes both mortality (as previously) and new for Year 11, case ascertainment.

NELA defines three different levels of potential outliers based on mortality:

- Alert: hospitals with a risk-adjusted mortality rate above the 95% control limit
- Alarm: hospitals with a risk-adjusted mortality rate above the 99.8% control limit
- Double alert: hospitals flagged as alert for the current year, and an alert or alarm in either of the two previous reporting cycles.

NELA defines two different categories of potential outliers based on case ascertainment:

- Alert-level: hospitals with a case ascertainment between 1–54%
- Alarm-level: hospitals with a case ascertainment of 0% when national data indicates eligible operations being performed at that hospital.

NELA considers those hospitals with both a case ascertainment greater than 90% and a risk-adjusted mortality below the 95% control limit to be positive outliers.

Alarm level outliers are subject to formal notification and data reviews. Responses received from alarm-level outliers can be found [here](#).

## Mortality Outliers

Alarm-level: none.

## Positive outliers for Mortality

Stepping Hill Hospital.

## Case Ascertainment Outliers

Alarm-level: Airedale General Hospital, Cheltenham General Hospital,\* Churchill Hospital, Dewsbury and District Hospital,\* King's Mill Hospital, Royal Stoke University Hospital, Ysbyty Gwynedd.

## References

- 1 Javanmard-Emamghissi H et al. Quantitative futility in emergency laparotomy: an exploration of early-postoperative death in the National Emergency Laparotomy Audit. [Tech Coloproctol 2023;27:729–738](#).
- 2 Bion J et al. Academy of Medical Royal Colleges Statement on the Initial Antimicrobial Treatment of Sepsis. [AoMRC, 2022](#).
- 3 The high-risk general surgical patient: raising the standard. [RCS Eng, 2018](#).
- 4 Levels of Care Guideline. [ICS, 2021](#).
- 5 Ninth Patient Report of the National Emergency Laparotomy Audit. NELA Project Team. [RCOA, 2024](#).
- 6 Spurling LJ, Moonesinghe SR, Oliver CM. Validation of the days alive and out of hospital outcome measure after emergency laparotomy: a retrospective cohort study. [Br J Anaesth 2022;128\(3\):449–456](#).

---

\*The NELA project team have discussed case ascertainment with these sites. While coding suggests that they are eligible for the audit, local responses have indicated otherwise. NELA do not have concerns about their engagement with the audit.

## National Emergency Laparotomy Audit (NELA)

Royal College of Anaesthetists, Jubilee House, 20 Queen Elizabeth Street, London SE1 2LS

**[nela.org.uk](http://nela.org.uk)**



Information correct as at October 2026

Design and layout by the Royal College of Anaesthetists