

# 1 EXECUTIVE SUMMARY

The tenth annual report of the National Emergency Laparotomy Audit (NELA) examines care received by 23,560 NHS patients in 176 hospitals across England and Wales admitted for emergency laparotomy (emergency bowel surgery, EmLap) between 1 April 2023 and 23 April 2024.

The report shows that clinical teams in many different hospitals were able to provide high quality care against a challenging background, with demand for access to emergency care frequently exceeding capacity.<sup>[1]</sup> **30-day mortality fell to the lowest level in ten years of audit (8.1% compared to 11.7% in Year 1), and postoperative length of hospital stay fell back to a median of 10 days (compared to 11 days in Year 9).** This reduction in mortality represents around 1,150 fewer deaths per year amongst the estimated 32,000 patients who undergo emergency laparotomy, whilst a fall in median length of stay of one day could represent potential annual financial savings of more than £10million.<sup>[2]</sup>

There was evidence of wide variation between hospitals in both processes and outcomes of healthcare: more remains to be done to reduce disparity and ensure all patients benefit from the highest standards of practice. Key messages and specific recommendations are within the [Line-of-Sight table](#).

## DIAGNOSTIC IMAGING

**22,024 (93.5%)** patients had a CT scan preoperatively ([see Table 7.3](#)). Of **16,538** with the most time-critical suspected pathologies, **98.7%** had a CT report delivered by a senior radiologist and around half of these had a CT report within an hour of the scan ([see Table 7.1](#)). In **24.7%** of patients, direct communication took place between referring and reporting teams. **12.4%** of patients had a CT scan and report that met all three sub-components of best practice ([see Table 7.1](#)).



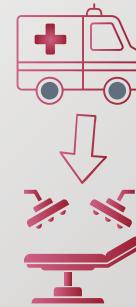
## INFECTION MANAGEMENT

Only **15.4%** of patients with suspected sepsis, and **36.8%** of patients with suspected infection received antibiotics within timeliness targets of one or three hours, respectively. In both groups, **around 25%** of patients **waited more than 5.8 hours** until they first received any antibiotics ([see Table 10.1](#)).



## TIMELINESS OF ARRIVING IN THEATRE FROM ARRIVING AT HOSPITAL

Only **1,381 (8.4%)** patients with the most time-critical suspected pathologies arrived in theatre within the six-hour target. **75% waited more than 10.2 hours** before arriving in theatre ([see Table 9.1.1](#)).



## RISK ASSESSMENT

**19,160 (81.3%)** patients had a formal risk assessment preoperatively, and **16,328 (69.3%)** had a further evaluation of mortality risk at the end of surgery.



## CONSULTANT DELIVERED CARE

**12,456 (52.9%)** patients were high-risk. Consultant surgeon presence in theatre for these patients was **96.4%** and presence of a consultant anaesthetist was **92.3%** ([see Table 6.2](#)).



## CRITICAL CARE FOR HIGH-RISK PATIENTS

**77.6%** of high-risk patients were admitted directly to critical care postoperatively ([see Table 11.1](#)).



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

**5,918** patients were aged 80 or older, or 65 or older and living with frailty. **35.5%** of these received specialist postoperative input into their care ([see Table 12.2](#)), which is associated with both a reduction in mortality, and, when delivered in hospitals with sufficient resources to provide this service to the majority of older patients, a reduction in length of stay.



## POSTOPERATIVE LENGTH OF STAY

**8.1%** of patients died within 30 days of surgery and median **postoperative length of stay** for survivors was **10 days**.



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