

4. Surgery

Elective surgery >> Delays to operation

Waiting times

21% of patients spent more than 12 weeks on the waiting list for elective AAA repair.

18 patients admitted as an emergency, had been on the waiting list for either open or endovascular repair.

Figure 4 shows the time between the patient being placed on the waiting list and the date of their operation for the 382 patients for whom these data were available.

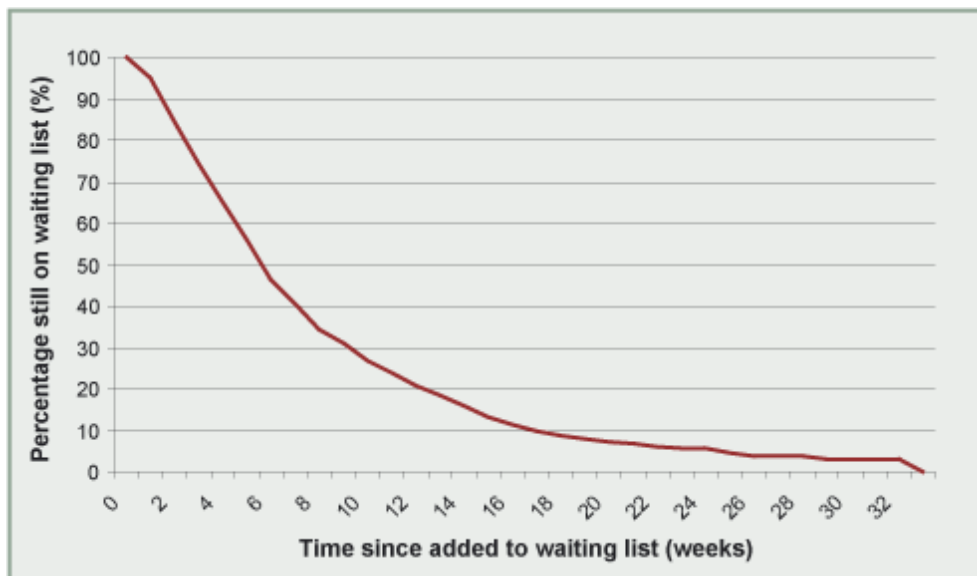


Figure 4. Time between patients being placed on the surgical waiting list and the date of their surgery $n=382/434$

Once on a waiting list, the median wait to surgery was five weeks. However, 141 patients waited longer than five weeks and 21% (80/382) of patients on whom NCEPOD had data waited more than 12 weeks. This is far too long. In contrast, the majority of women with breast cancer can expect their operation within 31 days of receiving the diagnosis² and Trusts are judged on their ability to meet this target. If the target for treatment of a cancer patient is four weeks from diagnosis then all necessary investigations must be done within this timeframe. NHS guidelines for how quickly a non-cancer patient should be seen in clinic or how soon after diagnosis they should be treated have progressively improved but lag behind guidelines for treating patients with cancer. Furthermore, when Trusts insist that patients cannot be put on a waiting list until all necessary preoperative investigations have been performed, the true time a patient has to wait for their surgery is hidden.

For patients with an AAA the true time from diagnosis to treatment includes: the time between the first appointment in the consultant's clinic and the completion of any referrals to other consultants; the time taken for all necessary investigations to be performed and reported; and the time between going on a waiting list and actually having the AAA repaired.

The present study only collected data on the last part of this journey. In meetings with advisors, anecdotal evidence was heard that the need to meet centrally-set cancer targets has disadvantaged patients who do not have cancer but have conditions which are equally, if not more

immediately, life threatening. Examples were cited of patients with cancer being given priority for radiological investigations and critical care beds. As a result, patients with aortic aneurysms face great uncertainty about how soon they will be treated whilst knowing that their condition is life threatening. In addition, they know that they can be cured with surgery but that they have one chance in twenty (or worse) of not surviving the operation. They know that if the aneurysm ruptures before admission the probability of survival is much reduced. One can imagine the state of mind of these patients whilst they wait.

Of patients who were admitted as an emergency with an aortic aneurysm, 13 were on the waiting list for elective open repair and five were on the waiting list for endovascular repair. Three of these patients died giving a mortality rate of 17%; three times the rate for elective open repair. To these numbers must be added an unknown number of patients on the waiting list who died in the community from rupture of their aneurysm without reaching hospital.

It is clear that there are real risks in waiting for elective aortic aneurysm surgery. Policy must be changed so that patients with an aortic aneurysm have equal priority with all other patients with serious clinical conditions for diagnosis, investigation and treatment. The setting of priorities does not seem to have taken into consideration the risk of death while on a waiting list.

Cancellations

One in 25 patients had their original operation cancelled because there was no ward bed available.

One in six patients had their original operation cancelled because there was no critical care bed available.

One of the reasons patients waited so long for their operations was that an earlier date for their operation was arranged and then cancelled.

Bed availability

One in twenty five (4%, 17/410) of patients had their original operation cancelled because there was no ward bed available. NCEPOD did not collect data on the reasons why beds were not available but there is good anecdotal evidence that admissions for elective surgery are commonly cancelled because of pressure on hospital beds, especially from emergency admissions.

One in six (17%, 71/415) of patients had their original operation cancelled because there was no critical care bed available. Cancellation of aortic aneurysm repair for lack of a critical care bed was not an occasional unexpected event but a regular systematic feature of the practice of vascular surgery seen in this study. The study has also highlighted the number of patients going to a Level 3 bed when most patients undergoing an aneurysm repair can be safely managed in a Level 2 bed.

NCEPOD has expressed concern in the past about the inadequate number of staffed critical care beds, and considerable resources have been allocated in recent years to expand the provision of critical care resources, with a subsequent increase in bed numbers. However, it appears that a continuing shortfall of such beds still hampers the admission of many patients requiring elective complex surgery and Trusts must act to ensure that cancellation of major elective surgery for lack of critical care beds becomes a rare event.