

3. Organisation of vascular services

Specialist on-call rotas >> Vascular surgical on-call

Only 57% of hospitals reported that there was a separate on-call rota for vascular surgery.

Vascular surgery is a specialised branch of surgery; trainees are expected to spend at least two years in a vascular surgical training post before gaining accreditation. A ruptured aortic aneurysm is a major surgical crisis. It is logical that such patients should be cared for by vascular surgeons. However, not all hospitals were organised so that a vascular surgeon was always available out of hours.

Hospitals were asked whether there was a separate vascular on-call rota for vascular surgery. Overall 57% (103/181) of hospitals had a separate rota, 43% did not. The proportion varied between units of different size (Figure 5).

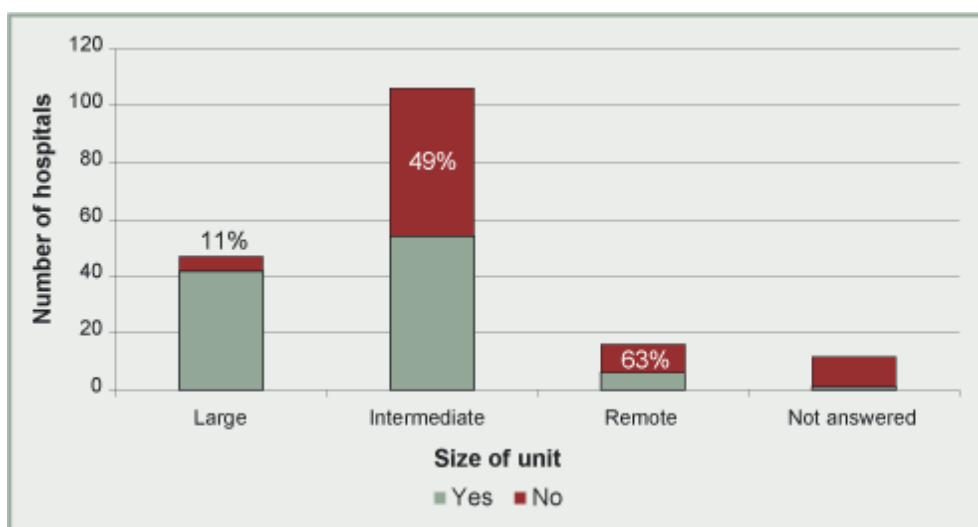


Figure 5. Separate surgical on-call rota for vascular surgery by size of vascular unit $n=181$. Percentages refer to hospitals without a separate rota.

The definitions provided by NCEPOD suggested that large vascular units would have the potential for a vascular surgical rota whereas an intermediate unit would have insufficient vascular surgeons to form an on-site emergency rota. It is notable that despite this, 51% of intermediate units had managed to organise such a rota. It is unclear as to why all large units did not have a rota. It is likely that surgeons on a vascular rota will have a more onerous on-call commitment than their consultant colleagues on a general surgical rota, both in terms of frequency of on-call and attendance required when on duty. Consultants will be deterred from establishing vascular rotas if this extra commitment is not recognised in consultant job plans. It may also be that Trust managers may be reluctant to appoint sufficient vascular consultants to form an acceptable specialist rota because there may be insufficient elective work during the working day to occupy the increased surgical capacity.

63% (64/102) of the on-call rotas were shared with another hospital or Trust. Shared rotas are obviously a common way of organising a specialist vascular rota when a hospital has limited resources to organise an on-call rota on its own. Hospitals should explore the potential for collaborating with neighbouring Trusts, so as to provide specialist on-call rotas. Financial arrangements for the payment of hospitals should be set up in such a way that there are no perverse incentives to arrange clinical services so as to maximise income for the hospital rather than promote patient care. Trusts must accept that work should be shared with other Trusts if this

will promote patient care, even if the result is a loss of income to the Trust.

It is unsatisfactory for hospitals that are able to organise vascular on-call emergency rotas, either within their own hospital or in partnership with neighbouring hospitals, not to do so. When there is not a vascular on-call rota, vascular surgeons or older general surgeons with vascular expertise will often come in to their hospital at night when they are not on-call to assist a colleague who is struggling with a ruptured aortic aneurysm. Such surgeons are to be applauded for their commitment to patient care, but Trusts should not depend on ad hoc arrangements and the goodwill of clinicians. Patients requiring emergency aneurysm repair should be treated by a surgeon who is practised in the management of this condition, working to a properly established emergency on-call rota. It is wrong to expect surgeons to carry the burden of responsibility of performing major emergency surgery outside their regular area of competence.

It should be noted that this issue is in a state of flux. On the one hand, the number of older general surgeons who had some vascular experience in their training and exposure to aortic surgery on-call is declining, and their place is being taken by newly appointed consultants in colorectal surgery and other disciplines who may have never seen a ruptured aortic aneurysm; these consultants may refuse to treat vascular emergency patients. On the other hand, these pressures may have accelerated the move to forming vascular surgical on-call rotas since NCEPOD collected its data in April 2004. A survey by the Association of Surgeons of Great Britain and Ireland in 2004 reported that 72% of Trusts (not hospitals) had a vascular on-call rota, and that 64% of vascular surgeons also participated in the general surgical on-call work ¹⁶.

There have been suggestions that despite the intuitive feeling that outcome following emergency AAA repair should be better when care is delivered by a specialist vascular surgeon, results are actually no different. NCEPOD examined the outcome of the patients in this study. The data for patients admitted as an emergency with unruptured and ruptured AAAs are analysed separately (Figures 6 and 7) because overall outcomes for the two groups are different; emergency unruptured AAAs have a mortality higher than AAAs admitted electively but lower than ruptured AAAs.

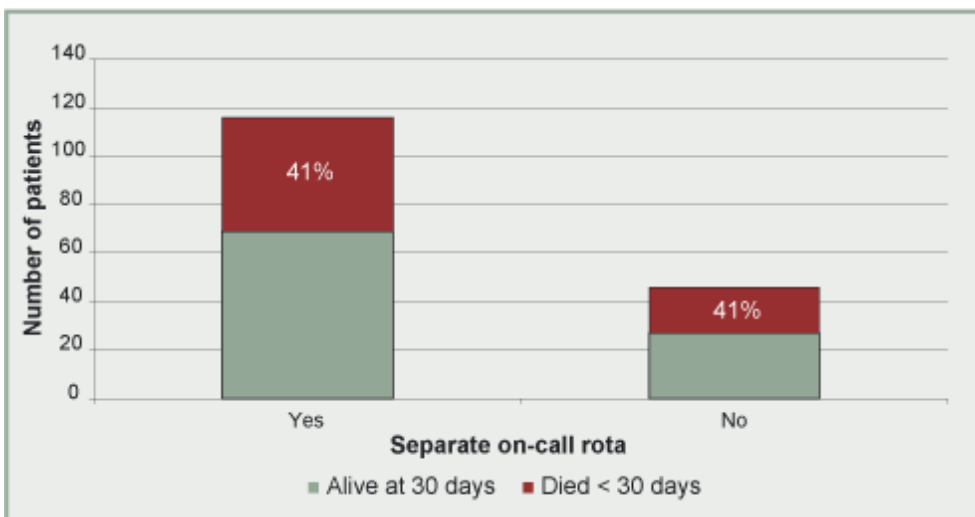


Figure 6. Outcome in ruptured emergency open procedure cases by whether or not there is a separate on-call rota for vascular surgery $n=162/168$. Percentages refer to patients who died in hospital within 30 days.

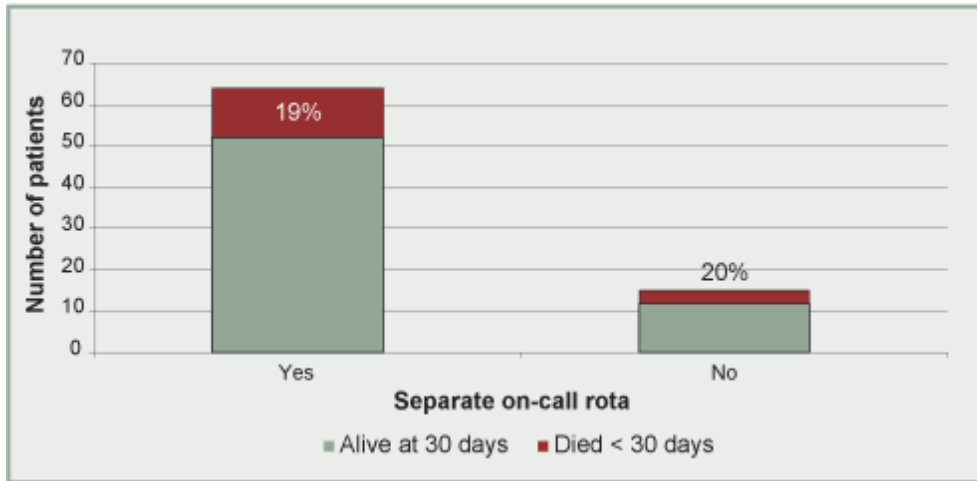


Figure 7 . Outcome in unruptured emergency open repairs by separate on-call rota for vascular surgery $n=79/81$. Percentages refer to patients who died in hospital within 30 days.

There was no difference in the outcome of surgery for ruptured or unruptured AAA between those hospitals where there was a surgical on-call rota and where there was not. Overall numbers are not large. Patients in hospitals without a formal vascular surgery on-call rota may have been operated on by vascular surgeons who attended the hospital despite being off duty. NCEPOD is unable to make a judgement as to whether or not the case-mix of the patient populations were the same.