

Vascular KPI Analysis

16 Jul 2012 - Present (procedure date)

1. Carotid endarterectomy

Data extracted from the NVD on 11 Jul 2013

Note: positive responses are expressed as a total of the responses, excluding missing data.

Performance Indicator	Count	Result (This Period)	Result (12 Months Pre-hub)	Target	Target Met	Comments
1.1 Time from first event (stroke or TIA) to carotid endarterectomy (percentage of appropriate symptomatic cases operated on within 2 weeks)	31/50	62.0%	43.6%	100% (tolerance 90%)	No	Target not met but a significant improvement on year 10/11 which was 19.2%
Non-spec Time from referral (to surgeon) to carotid endarterectomy (symptomatic cases only)	-	7 (33)	Not Known	-	-	Value expressed as median days (IQR). This indicator does not form part of the service specification KPIs but has been included for local reporting.
1.2 Percentage of patients operated on receiving antiplatelet agent at time of surgery	64/66	97.0%	98.9%	100% (tolerance 98%)	No	Tolerance to allow for patients with contraindications to antiplatelet agents
1.3 Percentage of patients operated on receiving statin therapy at time of surgery	61/66	92.4%	93.3%	100% (tolerance 90%)	Yes (w/ tolerance)	Tolerance to account for statin intolerant patients
1.4(1) Stroke rate (self-reported, 30 day): Disabling	0/66	0.0%	0.0%	2% (< 3% acceptable)	Yes	
1.4(2) Stroke rate (self-reported, 30 day): Non-disabling	0/66	0.0%	0.0%	2% (< 3% acceptable)	Yes	
1.5 Thirty day mortality	0/45	0.0%	0.0%	1%	Yes	
1.6 Post-operative length of stay	-	2 (2)	2	< 3 days (median)	Yes	Value expressed as median days (IQR). IQR not available for pre-hub data.
1.7 Number of carotid endarterectomies performed per unit per year	66	66	89	Minimum 30 cases per year	Yes	Pre-hub the Trust was performing carotid endarterectomy on asymptomatic patients, hence the greater volume of cases

Vascular KPI Analysis

16 Jul 2012 - Present (discharge date)

2. Aortic surgery

Data extracted from the NVD on 11 Jul 2013

Note: positive responses are expressed as a total of the responses, excluding missing data.

Performance Indicator	Count	Result (This Period)	Result (12 Months Pre-hub)	Target	Target Met	Comments
2.1 Elective infrarenal aneurysm mortality rate	1/97	1.0%	Not Known	3.5%	Yes	This KPI now reflects that specified in section 4 of the NHS CB's service specification for specialised vascular services
2.2 Ruptured infrarenal aneurysm repair mortality rate	4/14	28.6%	Not Known	NVD Mortality Report: 33%	Yes	This KPI now reflects that specified in section 4 of the NHS CB's service specification for specialised vascular services
2.3(1) EVAR Mortality rate: Elective	0/62	0.0%	0.0%	<1%	Yes	This KPI has been split by admission method for the purpose of local reporting
2.3(2) EVAR Mortality rate: Emergency	0/8	0.0%	33.3%	Not yet established	-	This KPI has been split by admission method for the purpose of local reporting. Emergency includes 'unplanned' procedures.
2.4 Percentage of elective patients receiving antiplatelet therapy at time of surgery (excluding temporary perioperative suspension of treatment)	71/96	74.0%	81.0%	100% (tolerance 98%)	No	Tolerance to allow for patients with contraindications to antiplatelet agents
2.5 Percentage of elective patients receiving statin therapy at time of surgery	82/96	85.4%	85.7%	100% (tolerance 90%)	No	Tolerance to account for statin intolerant patients
2.6(1) Length of stay: Elective (All) Elective (EVAR) Elective (OR)	-	6 (6) 3 (4) 8 (3.8)	5 Not Known Not Known	< 9 days (median)	Yes	Value expressed as median days (IQR). Please note that the target is in respect of both OR and EVAR combined.
2.6(2) Length of stay: Emergency (All) Emergency (EVAR) Emergency (OR)	-	14 (20.3) 10.5 (7.3) 17.5 (23.5)	9 Not Known Not Known	< 10 days (median)	No	Value expressed as median days (IQR). Emergency includes 'unplanned' procedures. Please note that the target is in respect of both OR and EVAR combined.
2.7 Number of cases operated on per year per unit	125	125	62	> 50 per unit	Yes	The target value now reflects that specified in section 4 of the NHS CB's service specification for specialised vascular services. Excludes T30.9.

Vascular KPI Analysis

16 Jul 2012 - Present (discharge date)

3. Major amputation for critical limb ischaemia

Data extracted from the NVD on 11 Jul 2013

Note: positive responses are expressed as a total of the responses, excluding missing data.

Expected Clinical Outcomes: A peri-operative mortality rate after major amputation surgery to less than 5% by 2015.

Performance Indicator	Count	Result (This Period)	Result (12 Months Pre-hub)	Target	Target Met	Comments
3.1 Thirty day mortality (data for in-hospital mortality only)	7/81	8.6%	18.8%	NVD Mortality Report (Major Amp.): 11%	Yes	Thirty day mortality data not available from NVD. Not case-mix adjusted.
3.2 Amputation rate per 100,000 population-case-mix adjusted	Amputations: 81 Population: 803,000 [†]	10.1 per 100,000	10.4 per 100,000	Range 10-76 per 100,000 depending on casemix	-	Not case-mix adjusted. The 'Amputations' figure is a count of all operations performed at RHH and the 'Population' figure is the combined population of Dudley, Walsall and Wolverhampton.
3.3 Percentage of patients operated on receiving antiplatelet agent at time of surgery (excluding temporary perioperative suspension of treatment)	52/80	65.0%	70.0%	100% (tolerance 98%)	No	Tolerance to allow for patients with contraindications to antiplatelet agents
3.4 Percentage of patients operated on receiving statin therapy at time of surgery	52/80	65.0%	60.0%	100% (tolerance 90%)	No	Tolerance to account for statin intolerant patients

[†] Source: Dudley, Walsall and Wolverhampton Health Profiles 2012 <http://www.dh.gov.uk/health/2012/06/2012-health-profiles/>

Vascular KPI Analysis

16 Jul 2012 - Present (discharge date)

4. Lower limb ischaemia: infrainguinal bypass

Data extracted from the NVD on 11 Jul 2013

Note: positive responses are expressed as a total of the responses, excluding missing data.

The data below is for lower limb arterial reconstruction only and thus does not include records where an endarterectomy or profundaplasty is recorded as the primary procedure.

Performance Indicator	Count	Result (This Period)	Result (12 Months Pre-hub)	Target	Target Met	Comments
4.1 Thirty day mortality (data for in-hospital mortality only)	3/121	2.5%	3.7%	4.2% (NVD Report 2004)	Yes	Thirty day mortality data not available from NVD. Not case-mix adjusted.
4.2(1) Post-operative length of stay: Elective	-	6 (5)	7	Elective: 8 days (median)	Yes	Value expressed as median days (IQR). Not case-mix adjusted. IQR not available for pre-hub data.
4.2(2) Post-operative length of stay: Emergency	-	9 (12.5)	12.5	Emergency: 14 days (median)	Yes	Value expressed as median days (IQR). Emergency includes 'unplanned' procedures. Not case-mix adjusted. IQR not available for pre-hub data.
Non-spec Pre-operative length of stay: Emergency	-	4 (5.5)	Not Known	-	-	Value expressed as median days (IQR). This indicator does not form part of the service specification KPIs but has been included for local reporting.
4.3(1) In-hospital graft occlusion rate: Diabetic	1/34	2.9%	0.0%	Not yet established	-	Count of records with a 'graft complication'
4.3(2) In-hospital graft occlusion rate: Non-diabetic	8/86	9.3%	4.9%	Not yet established	-	Count of records with a 'graft complication'
4.4 Ratio of prosthetic to vein grafts used	10 prosthetic, 67 vein Ratio of 1 : 6.7 (prosthetic : vein)	14.9%	22.2%	Prosthetic graft rate 0% (tolerance up to 25%)	Yes (w/ tolerance)	Following discussion with consultants this now includes fem-pop and fem-tib bypasses only
4.5 In-hospital surgical site infection rate	0/121	0.0%	0.0%	Not yet established	-	
4.6 Percentage of patients operated on receiving antiplatelet agent at time of surgery	101/120	84.2%	88.5%	100% (tolerance 98%)	No	Tolerance to allow for patients with contraindications to antiplatelet agents
4.7 Percentage of patients operated on receiving statin therapy at time of surgery	98/119	82.4%	90.4%	100% (tolerance 90%)	No	Tolerance to account for statin intolerant patients

Vascular Patient Experience Questionnaires

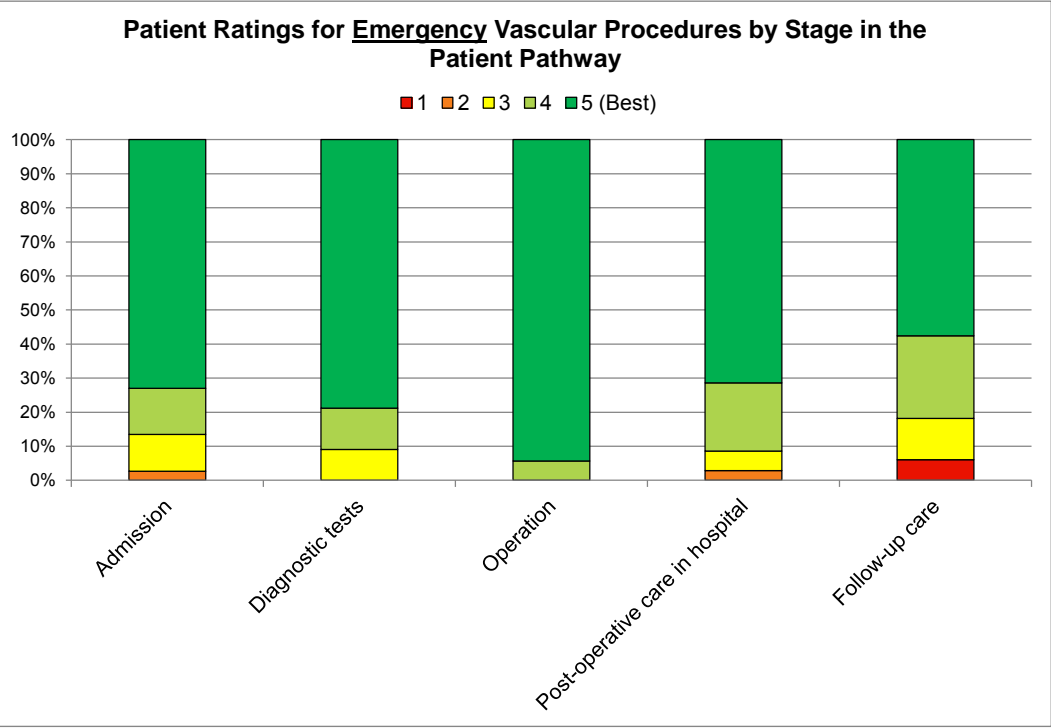
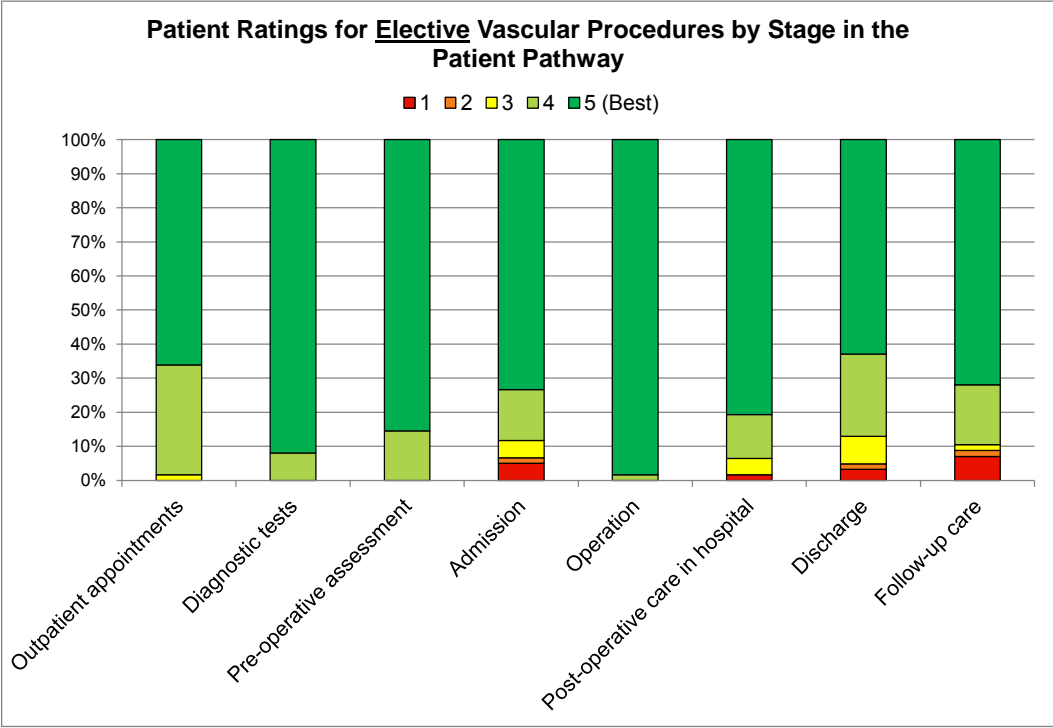
Patients discharged between July 2012 and March 2013

Elective Patients

Sample size: 104
Uptake: 62

Emergency Patients

Sample size: 119
Uptake: 38



This leaflet can be made available in large print, audio version and in other languages, please call 0800 0730510

ਜੇਕਰ ਇਹ ਲੀਫਲੈੱਟ (ਛੋਟਾ ਇਸ਼ਤਿਹਾਰ) ਤੁਸੀਂ ਆਪਣੀ ਭਾਸ਼ਾ (ਪੰਜਾਬੀ) ਵਿੱਚ ਲੈਣਾ ਚਾਹੁੰਦੇ ਹੋ ਤਾਂ ਕ੍ਰਿਪਾ ਕਰ ਕੇ ਪੇਸ਼ਟ ਇੰਫਰਮੇਸ਼ਨ ਕੋ-ਆਰਡੀਨੇਟਰ ਨਾਲ 0800 0730510 ਟੈਲੀਫੋਨ ਨੰਬਰ ਤੇ ਸੰਪਰਕ ਕਰੋ।

यदि आपको यह दस्तावेज़ अपनी भाषा में चाहिए तो पेशन्ट इनफरमेशन को-आरडीनेटर को टैलीफोन नम्बर 0800 0730510 पर फोन करें।

જો તમને આ પત્રિકા તમારી પોતાની ભાષા (ગુજરાતી)માં જોઈતી હોય, તો કૃપા કરીને પેશન્ટ ઈન્ફોર્મેશન કો-ઓર્ડિનેટરનો 0800 0730510 પર સંપર્ક કરો.

আপনি যদি এই প্রচারপত্রটি আপনার নিজের ভাষায় পেতে চান, তাহলে দয়া করে পেশেন্ট ইনফরমেশন কো-অর্ডিনেটরের সাথে 0800 0730510 এই নম্বরে যোগাযোগ করুন।

إذا كنت ترغب هذه الورقة مترجمة بلغتك الأصلية (اللغة العربية) , فرجاءاً اتصل بمنسق المعلومات للمريض
0800 0730510 على التلغون Information Co-ordinator

حسب ضرورت اعلیٰ لکھت کوئی زبان (اردو) میں حاصل کرنے کے لئے ریلوہر ہائی ٹیلیفون نمبر 0800 0730510 پر وھٹ افریشمن کو-آورڈینےٹر (گریڈ) کے لئے معلومات کی فراہمی کے سلسلے میں (نہ) کے ساتھ رابطہ کر کریں۔

Abdominal Aortic Aneurysm - AAA

Vascular Surgery

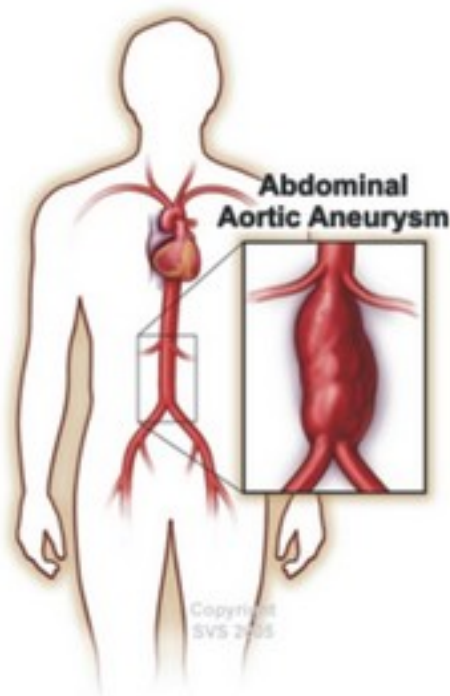
Patient Information Leaflet

This leaflet tells you about a condition known as an abdominal aortic aneurysm; it explains what the condition is, how it is monitored and briefly describes the surgical treatment options. There are separate more detailed leaflets about the two surgical options available. This leaflet is not meant to replace the information discussed between you and the doctor, but can act as a starting point for such discussion or as a useful reminder of the key points.

What is an aneurysm?

An aneurysm occurs when the walls of your arteries weaken. The pressure of blood flow can cause it to stretch and balloon out to form an aneurysm, rather like a worn car tyre.

Aneurysms can occur in any artery. They can be small and round or long and balloon-like. The most common artery to be affected is the aorta, which is the main artery in your tummy (abdomen). These are known as abdominal aortic aneurysms.



Useful web addresses

www.nice.org.uk
www.bvf.org.uk
www.circulationfoundation.org.uk
www.vascularsociety.org.uk

Access to benefits

If you require information about benefits information can be found on-

www.direct.gov.uk
www.dwp.gov.uk
or your local Benefits office.

Your comments

Patient Advice and Liaison Service (PALS) Freephone 0800 073 0510.

PALS is here to support patients, relatives or carers when they have concerns or queries. They will do their best to resolve any concerns you may have and can also give advice on making a formal complaint.

Vascular team contact details

If you require any further information regarding our services, or any queries about your management please contact Joy Lewis Vascular nurse specialist or the consultant managing your condition via the following telephone numbers.

Mr Jayatunga - Consultant Vascular Surgeon
Secretary - Alison Slater Tel no - 01384 244243

Mr Patel - Consultant Vascular Surgeon
Secretary - Joanne Webb Tel no - 01384 244021

Mrs Shiralkar - Consultant Vascular Surgeon
Secretary - Faye Langford Tel no - 01384 244246

Mr Pathak - Consultant Vascular Surgeon
Secretary - Maxine Winmill Tel no - 01384 244245

Mr Rehman - Consultant Vascular Surgeon
Secretary - Lara Golding Tel no - 01384 244176

Joy Lewis - Vascular Nurse Specialist Tel no - 01384 456111

Mark Black - Chief Vascular Scientist Tel no - 01384 456111

Darren Rhodes - Vascular Technologist Tel no - 01384 456111.

The aorta is the largest blood vessel in your body. It runs from the left side of the heart, down through the chest and into the abdomen. At about hip level, it divides into 2 arteries which deliver blood to your legs and feet (iliac arteries).

Who is at risk?

It is known that men over the age of 60 or younger men with a bother or father who have had an aneurysm or men with arterial disease (angina or heart attack), hardening of the arteries, or high blood pressure are more at risk.

About 4 in 100 men over the age of 65 will develop an aneurysm, though not all will be of significant size, and about 1 in 100 will have a large aneurysm requiring surgery. Aneurysms are about 6 times rarer in women. Smoking and high blood pressure are known to increase the size and risk, of aneurysms once they are present.

How is an aneurysm diagnosed?

Aneurysms generally take years to develop and it is rare for them to give symptoms during this time. This condition is often found by chance during a physical examination or scan for unrelated symptoms.

Occasionally, a patient may become aware of a feeling of pulsation in the abdomen. As an aortic aneurysm stretches, it can cause pain in the back of the abdomen but, the pain is not common. If an aneurysm is suspected an ultrasound scan will be performed.

An ultrasound scan of the abdomen is a painless outpatient test that will only take 10-15 minutes to do. It is used to decide whether an aneurysm is present and to measure the exact size.

The most important feature of the scan is the maximum diameter of the aorta, which is usually about 2½ cm across in adults, although this varies with your build. An aneurysm is said to be present if the artery is over 3cm across, and then the tendency is for the vessel to gradually increase over years.



What happens now?

Not all aneurysms need surgery. The size of the aneurysm will guide the surgeon on your management. Your surgeon will discuss whether you need an operation soon, or whether you should be placed onto a surveillance programme. If you are placed on the surveillance programme you will be called for scans on a regular basis to monitor the size of the aneurysm.

Flying

If you have an aneurysm and are considering a holiday which involves flying you will need to declare this condition to your travel insurance company, as some insurance companies will not provide cover for you as some airlines refuse patients with this condition as there is an increased risk of rupture at altitude. When booking a flight or holiday it is advisable to check with the airline at the same time. Some companies will provide cover as long as you have the permission of your consultant to fly.

Activity

Often the first description of an aneurysm can be frightening and many patients concerns about returning to normal life for fear of causing the aneurysm to rupture. We encourage you to resume your normal activities that you undertook before you knew that you had this condition. If we have any concerns then these will be discussed with you. You should use this opportunity to optimize your health by stop smoking and getting fitter in case you ever need to have surgery as this will reduce any complications occurring after surgery.

- Eat a healthy diet which includes keeping a low salt intake.
- Lose weight if you are overweight and exercise regularly if you are able.
- Do not smoke.
- Drink alcohol in moderation.
- If you have high blood pressure, diabetes, or a high cholesterol level, they should be well controlled on treatment.
- You may be prescribed a statin drug to lower your cholesterol level and low-dose aspirin to help prevent blood clots from forming (information relating to this medication will be provided when it is dispensed).

Additional advice for patients who have an aneurysm

Drivers

Group 1 entitlement ODL -Car, Motorcycle. The DVLA should be notified of any aneurysm that reaches 6cm or greater in diameter. Licensing will be permitted subject to annual review. Driving may be continued after a satisfactory medical (blood pressure control) or surgical treatment. An aortic aneurysm diameter of 6.5cm or greater disqualifies you from driving.

Group 2 Entitlement VOC- LGV/PCV. DVLA disqualifies you from driving if the aorta diameter is greater THAN 5.5cm. Driving may continue after satisfactory medical or surgical treatment.

Reference www.dvla.gov.uk/at-a-glance/ch2-cardiovascular.

- If the aneurysm is 3.5cm or less you will be called for a scan every 18mths.
- If the aneurysm is 3.5cm to 4cm you will be called for a scan every 12mths.
- If the aneurysm is 4cm to 5cm you will be called for a scan every 6mths.
- If the aneurysm is 5cm or greater you will be called for a scan every 3mths.

Your consultant will be informed each time you have a scan of the aneurysm size and any changes that may have occurred in its presentation.

Will I need an operation?

Surgery is only advised when it is considered the risk of the aneurysm bursting is greater than the risk of having surgery. Eventually the aneurysm may reach a size where surgery is indicated, usually when they exceed 5.5cm. Because surgery carries significant risks, the decision to operate must take into account the individual health of the patient, in particular the heart, lungs and kidneys. Before operating, most patients will need some sort of tests on these organs.

Risks of aneurysm rupture

Size of aorta	Description	Risk of rupture/year
4cm or less	not an aneurysm	no real risk
4 - 5cm	small aneurysm	about 1 in 100
5 - 6cm	AAA	about 1 in 12
6 - 7cm	large aneurysm	about 1 in 6
over 7cm	very large aneurysm	about 1 in 4 or higher

What operation will be performed?

Traditional surgery for aneurysm repair involves an incision in the abdomen and replacement of the affected section of vessel with a fabric tube. If the aneurysm extends into the pelvis, then a graft designed like a pair of trousers is used and may extend to the groins in some patients. The main risk of surgery is death or heart attack, and this is about 1 in 20 patients overall. However after a successful operation the risk of later complications is very low.

With modern technology, the risks of the operation can be markedly reduced by keyhole or endovascular surgery using a stent-graft, but not every patient or every aneurysm is suitable for this. In particular, aneurysms arising close to or above the kidneys are more difficult to treat in this way.

All patients treated by endovascular surgery need to be followed up postoperatively with regular scans to detect slippage or failures of the stent-graft. 10% of patients will require further intervention in the future.

Is surgery successful?

If aneurysms are repaired before rupture, there is a high overall chance of successful repair and a return to normal life and life expectancy. However, you should discuss the risks of surgery with your surgeon.

The risks attached to the open repair through an incision in your abdomen are of you having medical complications such as heart attack, stroke, kidney failure, chest problems, and loss of circulation to the legs or bowel, deep vein thrombosis (blood clot in the leg vein) and infection of the artificial artery. Each of these is rare, but it does mean overall that some patients may have a fatal complication from their operation. For most the risk is about 5%.

With the Stent graft the potential complications of traditional repair are greatly reduced as there is far less stress placed on the heart, less risk of haemorrhage (bleeding) or respiratory complications. The main complication associated with this type of aneurysm repair are the risk of the graft moving from the position resulting in a leakage of blood into the aneurysm meaning the aneurysm has not been sealed and complete or part occlusion (blockage) blockage of the graft by a blood clot. If this happens it may require an operation to reinstate the blood flow to the leg arteries.

What you can do to help yourself.

You should also consider what you can do to improve your general health. For example: