

Network Forum for South of England and London AAA screening programme

14th September 2021

National Quality Assurance update

SQAS – carry out external assurance of quality and safety of English NHS screening programmes. Interim QA review process during COVID (visits largely cancelled during COVID). More flexible approach during restoration, trying to help reduce burden to programmes. Safety still a priority with recommendations and follow up as appropriate. ISQAR outcomes were very good in relation to safety. Some services struggling with infrastructure/staffing.

ISQAR process was evaluated and services find it useful. QA visits in the future to mirror ISQAR process more closely.

QA visit for services every 4-5 years unless experiencing problems. Annual prioritisation meeting to decide which services need QA visit sooner. Services identified which require additional QA support and therefore need to be prioritised.

Annual data, looking at governance arrangements, equipment, service delivery, outstanding actions from ISQAR process, approach to inequalities, staffing etc are all assessed.

Transition – PHE no longer exists. From 1st October SQAS and national programme team will be part of NHS England and Improvement. SQAS will be under medical directorate. NAAASP will be in public health commissioning and ops team. Support from DHSC team (now renamed to office of health improvement and disparities). Changes to email addresses, otherwise we shouldn't notice much change.

Rapid growth AAA

Saccular aneurysms are likely to be associated with rapid growth.

Nice definition and recommendations - Larger than 4cm and grown by more than 1cm in 1 year should be referred for further vascular surgical assessment. They have deliberately avoided the term 'rapid growth' because of the negative connotations and to avoid frightening patients.

Nationally, approx 40 men/yr are referred for rapid growth.

On average: 1.3mm/yr growth for >3cm AAA, 3.8mm/yr for >5cm AAA

Growth of >1cm/yr assoc with greater risk of rupture

Possible causes: uncontrolled risk: smoking, genetic factors, Mycotic aneurysm, saccular aneurysm, ulcer of aorta wall, inflammatory aneurysms, possible inaccurate measurements

Inflammatory- suggest measuring aneurysm wall and lumen area so both can be monitored.

Patient leaflets to be updated. Referral process to be reviewed, but suggestion that this should be done on an individual case-by-case basis.

Question asked regarding saccular aneurysm <3cm and whether these should be followed up. Good to flag with surgeon. No official guidelines about these. Treat as incidental finding then any ongoing surveillance to be guided by surgeon.

Working with community organisations

Peninsula programme gave some examples of how they have expanded screening sites during covid recovery period

98 GP practices, covering area of 120miles radius

Make use of community rooms, gp practices, fire stations, physio rooms, café, supermarket, sports rooms

Difficulty accessing GP surgeries so alternatives looked at eg rugby clubs

Application for funds to improve room. Trust commissioning team, nhs improvement bids, charitable funds, community groups.

Works well as less intimidating than GP surgery? Targeting male population

Digital mapping and venue reviews

Case study of screening programme who were asked to review their venues.

QA recommendations – venue review suggested. Used bubble mapping. Helped identify areas with no coverage. Also created a google map of venues available. Helpful for identifying nearest venue for clients. Map is shareable and can be made public.

Overlaid information from smart about postcodes of gentlemen who were invited. Found some men not being invited to nearest centre.

Overall, a useful process which helped target where to develop clinics.

Reflecting on restoration

Exceptional circumstances this year. Increase in DNA/cancellations. Some programmes closed before formal lockdown on 23rd March 2020, especially in London where pandemic started earlier. Guidance for surgeons, only operating on AAA >7cm issued shortly after. Restarting in summer 2020 then two further lockdowns Nov2020 and Jan 2021.

On resumption of screening, highest risk invited first. Largest aneurysms first, then screen positives and down from there.

London very hard hit by pandemic, very different recovery to south west area. South west concern re holiday influx. London hit early, with increased cancellations from January. Clinics starting to close from January.

Recovery progress: SW venues <5% of 2020/21 cohort left to invite. Approx 29% of London 2020/2021 cohort left to see. Some men deferring by choice. London anticipates not catching up until Nov/Dec 2022 but spring 2022 predicted for SW. Frequent recovery meetings. Considerations: Sharing of knowledge. Looking at what is feasible and safe. Unblocking issues, eg finding alternative venues, reinstating NHS venues when possible. Risk management. Recovery data and analysis.

Programmes operating at 100% capacity to facilitate recovery. National recovery of AAA screening target date set as May 2022. Many staff offering overtime, need to be conscious of keeping a sustainable level of capacity and protecting staff. Resilience and staffing are going to be key. Ongoing need to address low attendance – looking at reasons and providing reassurance.

Restoration is an ongoing challenge!

The Health Screener Diploma

Lots of interesting points raised about CST's struggling to provide all training requirements as many other demands on their time. Tips for streamlining training were discussed.

Look at amalgamating induction material. Utilising initial training procedures and reflecting on these. Incorporating compulsory training into evidence. Submitting internal observations. If well organised, 35-40 pieces of evidence could be enough to cover all assessment criteria. Eg tour of vascular department when first starting and reflecting on this to provide evidence.

Guidelines have changed. CST can now be classified as expert witness and can assess just units 14, 15 and 16 without being the main assessor. Screening techs can now train to be assessors and cover all the other units. This has proved positive for many units as screening technician assessors are more available to learners, extra training for screening techs and developing their role provides greater job satisfaction. It also reduces load on CST's and enables screening technicians to complete their training more quickly (average time has now reduced to 17 months)

New screening incident management process

SIAP process going online. PSIRF looking at moving away from defining 'serious incident' and move towards proactive approach to looking at learning from incidents. Should be finished by April 2022.

10 years of outcomes from AAA screening (London)

Options: open surgery, EVAR, not to treat (defer or no treatment) - varies from 2-20%

Use of EVAR has had major reduction on mortality (lower peri-operative risk)

NICE guidelines recommended EVAR not used initially. Now revised, but still to consider open for fit patients.

At 10 years, more than 50% of treated patients are still alive. Largely, mortality is not to do with aneurysm related problems. Reinterventions required in about 10% of patients after 3 yrs.

Deferral often related to ongoing cancer. One in 4 aneurysms are complex and one in 10 patients have complex comorbidities.

Increasing focus on managing cardiovascular disease risk factors in these patients both before and after procedure.

Minimising hospital visits

Reducing visits to AAA screening programme clinics with goal of recovering from Covid related delays ASAP.

1% of men aged 65 have an aneurysm (lower than when NAAASP was formed)

Mean diameter of AAA is reducing.

Uptake at 79% nationally, but uptake still lower in deprived areas with increased risk of these populations having AAA.

Suggestion that around 20% of men in a cohort have recent MRI/CT imaging where measurement of AAA would be possible – could these men potentially be removed from the screening if a AAA can be excluded on CT/MRI. This could help reduce programme workload.

Radiologists overworked and may not have capacity to take on extra work. ? Use of artificial intelligence. Already being used in breast screening. Pilot to see if this is possible? Possible piggy back onto cancer services scans. Benefits of reduced workload for programme and keeping staff/patients safer by reducing exposure to hospital/clinic environments. Chris Watts offered DOW as study cohort for trial.

Non-viz aortas – can we reduce these

Next meeting:

Possible face-to face meeting, Jan 2022 in reading.