

Screening Programmes

Abdominal Aortic Aneurysm

NHS Abdominal Aortic Aneurysm Screening Programme
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Gloucester
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Pre-implementation assessment of quality assurance standards (Vascular Services)

(Programme name)

Aim

- During the pre-implementation phase of a new local screening programme a framework for monitoring and managing quality assurance (QA) standards aims to assure patients, providers and commissioners that the new NHS AAA Screening Programme (NAAASP) will provide care of the highest possible standard.
- The QA process aims to facilitate a clear, unambiguous and reliable measurement against standards set out by the Vascular Society of Great Britain and Ireland defined in the 'Framework for improving the results of elective (EL) AAA repair'. The initial process will provide the baseline for each screening programme highlighting high quality standards as well as the need for corrective and preventative action.
- A plan for continued QA monitoring will be agreed.

QA framework

1. It is the responsibility of the Clinical Director of each Local Screening Programme to put in place and monitor QA standards to ensure the best possible care and best possible results for EL AAA repair.
2. The NAAASP must ensure that trained and competent personnel conduct the QA assessment in an independent way prior to the implementation of the screening programme, to verify compliance with expected standards and requirements of vascular services.
3. Findings must be documented
4. As part of the local screening programme implementation, processes are put in place and maintained for review of QA standards to ensure continuous and systematic improvement of the screening programme (see Annex 1)
5. All AAA surgery data (both screened and non screened patients) must be reported to the NVD and a plan for continued QA monitoring of vascular services will be agreed between the QA Lead of the NAAASP and the Commissioning Unit.

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6. Any deviation from the required standards of quality and safety may result in a delayed start date for the local screening programme. A documented investigation, including an implementation plan for corrective and preventative actions needs to be agreed with the NAAASP Director prior to the programme start date.
7. Corrective and preventative actions must be documented, initiated and completed in a timely and effective manner.
8. Preventative and corrective action will be assessed for effectiveness after implementation.
9. The fate of non-conforming results is decided in accordance with the NAAASP Standard Operating Procedure (SOP) (see Annex 2).

Plan for QA assessment:

Desk based QA:

- Please complete the QA template and return it to the QA Lead by (date).
- Agree date for QA visit with NAAASP QA Lead
- Local Director, Programme Manager (if appointed) and a representative of Commissioning Unit (Lead PCT) should be able to attend.
- Documentation: Business Case and desk based QA.

The QA visit:

- Visit by QA Lead NHS AAASP, Dr Birgit Whitman
- Review the desk based QA report and documented evidence provided
- Discuss each application domain with a view to identify compliance
- Sample audit

Post QA visit:

- Agree findings
- QA Lead to provide written summary of the visit
- Identify corrective / preventative action required
- Agree next QA assessment

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Summary of Local Screening Programme settings

Contact for QA: Director / Programme Manager / Commissioning Unit	Commissioning Unit	Local Screening Programme	Phase 1: Start date	Anticipated Screening for yr 1

Standards:

1 Standard not met	2 Standard partially met
3 Standard almost met	4 Standard fully met or exceeded

From the moment an AAA has been detected via the screening programme it is essential to ensure the best possible care to achieve best possible results for EL AAA repair. The Vascular Society of Great Britain and Ireland has defined this in the 'Framework for improving the results of elective AAA repair'. (Ref: Framework for improving the results of elective AAA repair)

VSS Framework criteria		QA result	Evidence provided by:			
			Commissioning Unit (PCT)	Local Screening Programme	Delivery Unit (1-x)	Surgeon (1-x)
Pre-operative	1. All patients should undergo standard preoperative assessment and risk scoring, including cardiac, respiratory, renal, diabetes, peripheral vascular disease, as well as CT angiography to determine their suitability for EVAR.					
	2. Each hospital should have defined pathways for the correction of significant medical					

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	risks (cardiology / renal / respiratory) before intervention.					
	3. All patients should be seen in pre-assessment by an anaesthetist with experience in elective vascular anaesthesia. At this stage, medication should be reviewed and optimised for the intervention.					
	4. All elective procedures should be reviewed preoperatively in an MDT that includes surgeon(s) and radiologist(s) as a minimum. Ideally, a vascular anaesthetist should also be involved to consider fitness issues that may affect whether open repair or EVAR is offered.					

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	Facility to offer both procedures should be available either in house, or by referral through an agreed pathway.					
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VSGBI Framework criteria		QA result	Evidence provided by:			
			Commissioning Unit (PCT)	Local Screening Programme	Delivery Unit 1- x	Surgeon 1-x
Operation	1. Interventions should be undertaken (or supervised) by Consultant Surgeon / Radiologist / Anaesthetist with training and expertise in elective vascular procedures and a routine clinical practice in this specialty.					
	2. Open AAA repair should include the following components: normothermia, cell salvage, rapid infuser, easy access to blood products (within 1 hour) and availability of haemostatic agents including glue.					
	3. EVAR should only be undertaken in a					

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	sterile environment of theatre standard, with optimal imaging facilities. A range of rescue stents and devices should be immediately available, together with the expertise to deploy them.					
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VSS Framework criteria		QA result	Evidence provided by:			
			Commissioning Unit (PCT)	Local Screening programme	Delivery Unit 1- x	Surgeon 1-x
Facilities	1. There is a 24/7 on call rota for vascular emergencies covered by consultant vascular surgeons, to ensure adequate postoperative care.					
	2. There is a critical care facility with ability to undertake mechanical ventilation and renal support, and with 24 hour on-site anaesthetic cover.					
	3. A minimum number of AAA procedures are undertaken. It is recommended that hospitals undertaking fewer than 33 elective AAA interventions per year (100 over three years) should not					

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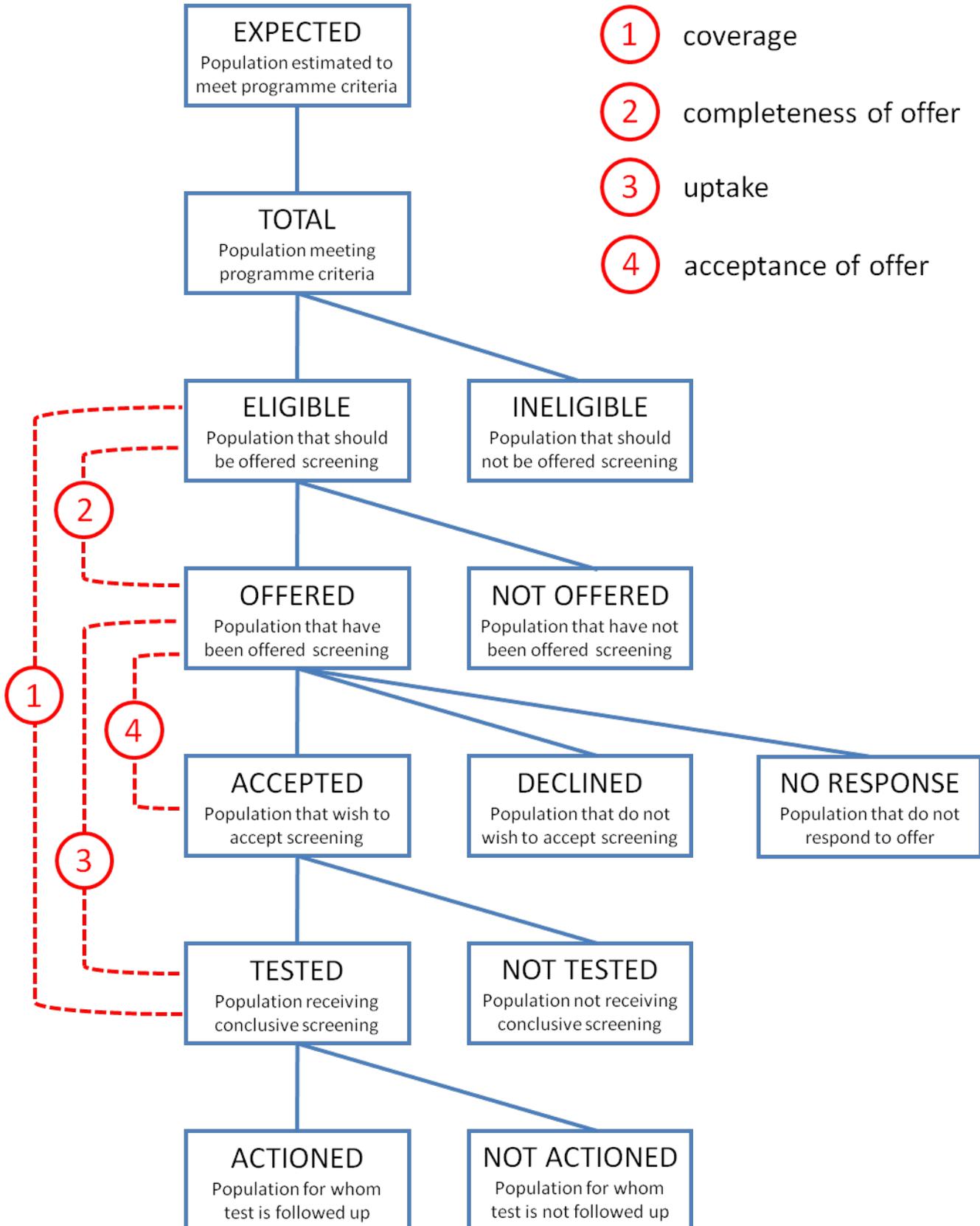
	continue to offer these procedures.					
	4. Specialists undertaking aortic intervention should submit all their procedures to the National Vascular Database, and undertake regular review of their practice and outcomes (morbidity and mortality meetings).					

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<p>All AAA surgery should be recorded on the NVD. Please complete the consent form at the end of this document</p> <p>Time period 1/4/2010 – 31/3/2011</p> <p>* Complication that extend the hospital stay, re-operation or re-admission within 30 days.</p>	<p>QA result</p>	<p>Commissioning Unit (PCT)</p>	<p>Primary Provider Unit (Local Screening programme)</p>	<p>Delivery Unit 1 - x</p>	<p>Surgeon 1 – x Please complete consent for NVD data access (Annex 3)</p>
<p>No of all EL AAA repairs:</p>					
<p>30 day morbidity</p>					
<p>30 day mortality</p>					
<p>No of screen detected EL AAA repairs (if applicable)</p>					
<p>30 day morbidity</p>					
<p>30 day mortality</p>					
<p>No of all EM AAA repairs:</p>					
<p>30 day morbidity</p>					
<p>30 day mortality</p>					
<p>No of screen detected EM AAA repairs (if applicable)</p>					
<p>30 day morbidity</p>					
<p>30 day mortality</p>					

Annex 1: The QA pathway



CONSENT

National Vascular Database (NVD) data to be shared with the National Abdominal Aortic Aneurysm Screening Programme (NAAASP)

I declare that the Abdominal Aortic Aneurysm data that I submit to the NVD can be made available to the NAAASP annually or more frequently if required. I understand that this data will be shared with the Commissioning Unit and the NAAASP Implementation Group.

Signature:.....

Name:.....

Position:.....

Date:.....