AAA screening standards consultation report

Introduction

The NHS abdominal aortic aneurysm (AAA) screening programme is available for all men aged 65 and over in England. The programme aims to reduce AAA related mortality among men aged 65 to 74. Standards for AAA screening were introduced in 2009 and were reviewed for the first time in 2015. The screening programme undertakook a second major review of the standards between 2018 and 2019. The review group included representation from the national team, providers, commissioners, the screening quality assurance service (SQAS) and professional clinical advisors. Following the nationally agreed process for reviewing standards in PHE screening we consulted on the proposed changes to the standards.

Aim

The consultation aimed to establish if the revised standards addressed an important issue for providers and commissioners and if they were clearly defined. We also sought to establish if the standards may unintentionally disadvantage any group.

Methods

We consulted on the proposed changes to the standards with:

- AAA screening providers
- screening commissioners
- AAA screening programmes for Wales, Scotland and Northern Ireland
- SQAS

The national template survey was used. For each standard, participants were asked if the:

- rational was clear
- definition was clear
- standard disadvantages any of the eligible population

In addition, participants were asked to rate how helpful the standards are for monitoring the quality of the screening service on a scale of 1 to 5, where 1 was least helpful and 5 most helpful. They were also asked to identify any gaps in the standards.

The consultation ran for 32 days from 25 June 2019 after being announced at the national AAA screening networking day.

Consultation responses

There were 56 participants to the survey with 52 answering every question. Responses were received from 29 of the screening providers: 27 programme managers, 10 clinical staff, 2 administrators and 2 screening technicians. 7 participants were from commissioners and 6 were from SQAS. Responses were also received from the Scottish and Welsh national programmes.

Overall responses

The table below shows the % of respondents who answered:

- “yes” to the question ‘Have we clearly explained the rationale for this standard and is the definition clear?
- “no” to the question ‘Do you think this standard disadvantages any of the eligible population?’

	Have we clearly explained the rationale for this standard? (% Yes)	Is the definition clear? (% Yes)	Do you think this standard disadvantages any of the eligible population? (% No)
Standard 1	98.0	98.1	86.5
Standard 2	93.9	93.8	85.7
Standard 3	92.2	96.0	83.7
Standard 4	96.0	98.0	90.2
Standard 5	92.0	89.6	86.0
Standard 6	92.0	93.8	83.7
Standard 7	93.5	100.0	76.6
Standard 8	100.0	95.7	89.6
Standard 9	95.5	95.6	89.4
Standard 10	95.7	91.3	91.5
Standard 11	91.1	93.5	84.8
Standard 12	90.9	93.3	90.9
Standard 13	93.5	95.5	86.4
Standard 14	93.5	93.2	95.6
Standard 15	93.5	93.5	93.3

Most respondents thought the rationale and definition were clear for each standard. Standard 7 was the lowest scoring for potentially disadvantaging any of the eligible population. This standard is the proportion of men in the eligible cohort who were tested and who lived in a lower super output area (LSOA) classed as decile 1 to 3 in the index of multiple deprivation 2015. There are concerns that focusing just on men who live in deprived areas will distract from other work to reduce inequalities in attendance for other groups. The review group acknowledges that this could be an issue but commissioners and SQAS teams should be working with providers to adopt a balanced approach.

Common themes and responses

Providers have raised concerns about how men who are out of the country for a prolonged period may be affected by reducing the time after the screening year to only 2 additional months rather than 3 and the change of the surveillance definition to include men who are temporarily ineligible. For the initial screen, providers can screen men from when they receive the cohort. This is usually the November before the start of the screening year. This allows providers 17 months to the end of the screening year. Less than 0.1% of men are added to the cohort at the end of the

screening year. This may be men transferring from another provider who have not yet been invited or men entering the country. Within this group, those who spend a significant proportion of time outside the country should be a further minority. Reducing the timeframe to 2 months after the end of the screening year is estimated to reduce coverage by 1.8% nationally, if providers make no adjustments to how they screen. Only 2 additional providers would not meet the acceptable coverage threshold.

There are fewer men on surveillance and attainment of the standards may be affected to a greater extent by men who are out of the country for significant periods of time. However, the surveillance intervals are evidence based and men should be encouraged to attend on time. Increasing the timeframe or reducing the thresholds could lead to men being screened too frequently or too late and could put other men at risk. Men who are not screened within the timeframes due to being outside the country can be exception reported to commissioners and SQAS.

Providers have raised concerns about how men who live in rural areas may be affected by reducing the time after the screening year to only 2 additional months rather than 3 months. There were also concerns that the increase in coverage of the quarterly surveillance screen from 85% to 90% will affect men in rural areas and it may reduce patient choice.

We acknowledge that providers in rural areas may struggle to provide timely clinics due to various factors. The surveillance intervals are evidence based and providers should be working towards providing appropriate and timely clinics so that men in rural areas are not disadvantaged.

The acceptable and achievable thresholds have been set to account for patient choice. Men not meeting the standard can be exception reported so SQAS and commissioners are aware of the reasons why there were not conclusive tests within timeframe.

Participants have asked why the ineligible criteria for the surveillance standards have changed. Appointments where men are made temporarily ineligible up to 6 weeks (annual surveillance) or 4 weeks (quarterly surveillance) after their due date will have the appointment due date included in the denominator. The temporary ineligible status is used for men who defer screening, for example, due to being out of the country and those who may be medically unfit. In line with the initial screen, appointments for these men will be included as the men do remain eligible for screening even if they cannot attend their appointment. The same principle applies to men who decline surveillance.

General queries were received about how thresholds were set. The review group followed the PHE screening guidance on setting thresholds. They are set using the interquartile range of the past 3 years of data with the acceptable threshold set at the 25 percentile and the achievable set at the 75 percentile. This was the rationale for reducing the non-visualise standard acceptable threshold from 3% to 2%. The review group felt that 2% should be achievable for most providers. However, on review of the comments around the potential unintended consequences of reducing the threshold we have decided to retain the threshold at 3%. The standard is intended to

be supportive for providers in identifying training requirements and issues with equipment.

This was also how the threshold for the new nurse assessment standard was set. The acceptable threshold is 50%, which participants and the Screening Data Group felt was low. However, as this is a new standard and may be difficult to achieve based on patient choice and availability of nurse time, the review group felt this was appropriate and will be reviewed once the first year's data is available.

Comments were received around the change in timeframe for the time to internal quality assurance for abnormal scans. This is where an aneurysm is detected at the initial screen for cohort and self-referral men. Current guidance states this should be performed within 30 days and the NHS AAA Screening Programme proposes to change this to 21 days. This allows for clinical skills trainer (CST) annual leave but also makes sure that images for abnormal aorta are reviewed in a timely manner so men can be recalled quickly, if appropriate, referred for nurse assessment or reassured that there was no aneurysm.

Recommendations

Standard 11, non-visualised screens to retain the current acceptable threshold of ≤3.0%.