

NHS public health functions agreement 2016-17

Service specification No.23

NHS Abdominal Aortic Aneurysm
Screening Programme

NHS England INFORMATION READER BOX**Directorate**

Medical	Commissioning Operations	Patients and Information
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference: 04570

Document Purpose	Guidance
Document Name	Service specification No. 23 NHS abdominal aortic aneurysm screening programme
Author	NHS England (prepared by PHE)
Publication Date	05 February 2016
Target Audience	NHS England Regional Directors
Additional Circulation List	
Description	This is a service specification to accompany the 'NHS public health functions agreement 2016-17 (the '2016-17 agreement') published in December 2015. This service specification is to be applied by NHS England in accordance with the 2016-17 agreement.
Cross Reference	NHS public health functions agreement 2016-17
Superseded Docs (if applicable)	2015/16 Service Specification
Action Required	n/a
Timing / Deadlines (if applicable)	n/a
Contact Details for further information	Section 7a Programme Management Office NHS England Public Health Commissioning Central Team 4E46 Quarry House Leeds LS2 7UE 0113 8247235 https://www.england.nhs.uk/commissioning/pub-hlth-res/
Document Status	
This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet.	

Corrected version issued April 2016

Classification: Official

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities

NHS public health functions agreement 2016-17

Service specification No.23

NHS Abdominal Aortic Aneurysm Screening Programme Service specification

Prepared by Public Health England

Table of Contents

Service specification No.23	7
1. Population Needs.....	8
2. Outcomes	9
NHS Outcomes Framework Domains & Indicators	9
3. Scope	10
Aims and objectives of the service	10
Aim 10	
Objectives.....	10
Equality	11
Service Description/Care Pathway	12
Identification	14
Invitation and Inform.....	14
Test – Initial Screen.....	14
Test – Surveillance Screen.....	14
Diagnose	14
Service Model Summary	15
Failsafe Procedures	15
Results giving, reporting and recording	16
Image storage and management.....	16
Roles and accountability throughout the pathway	16
Competencies and ongoing training	16
Information technology, call and recall	17
Days/hours of operation	17
Population covered.....	17
Acceptance and exclusion criteria and thresholds	18
Acceptance criteria.....	18
Exclusion criteria	18
Interdependence with other agencies, services and providers.....	19
4. Applicable Service Standards	21
Applicable national standards.....	21
Pathway Standards	21
Applicable standards set out in Guidance and/or issued by a competent body.....	22

Applicable local standards	23
Clinical and corporate governance	23
Accountability and oversight	23
Programme board	24
Quality Assurance	24
Risk Management	24
Governance policies	25
5. Location of provider premises	26
Equipment specification	26
6. Transfer of and discharge from care protocols	28
7. Safeguarding policies	29
Annex A: Quality Requirements	30
Annex B: Reporting requirements	32
Annex C: Guidance	33

Service specification No.23

This is a service specification to accompany the 'NHS public health functions agreement 2016-17 (the '2016-17 agreement') published in December 2015.

This service specification is to be applied by NHS England in accordance with the 2016-17 agreement. This service specification is not intended to replicate, duplicate or supersede any other legislative provisions that may apply.

Where a specification refers to any other published document or standard, it refers to the document or standard as it existed at the date when the 2016-17 agreement was made between the Secretary of State and NHS England Board, unless otherwise specified. Any changes in other published documents or standards may have effect for the purposes of the 2016-17 agreement in accordance with the procedures described in Chapter 3 of the 2016-17 agreement

Service specifications should be downloaded in order to ensure that commissioners and providers refer to the latest document that is in effect.

The 2016-17 agreement is available at www.gov.uk (search for 'commissioning public health').

All current service specifications are available at www.england.nhs.uk (search for 'commissioning public health').

1. Population Needs

- 1.1. The purpose of this Service Specification is to describe the Provider's responsibilities for the delivery of the NHS Abdominal Aortic Aneurysm Screening Programme (NAAASP) (the Services). This Service Specification provides a consistent and equitable approach across England and this common national service specification must be used to govern the provision and monitoring of abdominal aortic aneurysm screening services.
- 1.2. The Provider shall at all times ensure the Services are provided in accordance with the requirements set out in this Contract, which, inter alia, includes the requirements of Guidance. Without limitation, some of the documents and information sources listed below, in Table 1, are agreed to be captured within the definition of Guidance.
- 1.3. NAAASP aims to reduce deaths from abdominal aortic aneurysms (AAA) through early detection, appropriate monitoring and treatment. Research has demonstrated that offering men ultrasound screening in their 65th year should reduce the rate of premature death from ruptured AAA by up to 50 per cent.
- 1.4. Ruptured AAA deaths account for around 2.1% of all deaths in men aged 65 and over. This compares with 0.8% in women of the same age group. The mortality from rupture is high, with nearly a third dying in the community before reaching hospital. Of those who undergo AAA emergency surgery, the post-operative mortality rate is around 50%, making the case fatality after rupture around 80%. This compares with a post-operative mortality rate in high quality vascular services of around 2% following planned surgery.
- 1.5. The target population to be screened is all men eligible for NHS care registered with a general practitioner within the commissioned screening programme boundaries. Selection will be based on year of birth. Men should be offered screening during the year – 1st April to 31st March – in which they turn 65 years. Men over the age of 65 can self-refer to the screening programme and have their information added manually to the screening management system.
- 1.6. Further detail about the population to be screened is within section 3.3 of this service specification.
- 1.7. Based on research data, for each 1,000 men screened:
 - 985 can expect to have a normal aorta
 - 14 can expect to have a small to medium aneurysm
 - 1 can expect to have a large aneurysm.

2. Outcomes

NHS Outcomes Framework Domains & Indicators

2.1. This specification will meet the following domains in the NHS Outcomes Framework.

NHS Outcomes Framework

Domain 1	Preventing people from dying prematurely	x
Domain 2	Enhancing quality of life for people with long-term conditions	x
Domain 3	Helping people to recover from episodes of ill-health or following injury	
Domain 4	Ensuring people have a positive experience of care	x
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	x

3. Scope

Aims and objectives of the service

Aim

- 3.1. NAAASP aims to reduce AAA related mortality by providing a systematic population-based screening programme for the male population during their 65th year and, on request, for men over 65.

Objectives

- 3.2. Screening is a process of identifying apparently healthy people who may be at increased risk of a disease or condition. They can then be offered information, further tests and appropriate treatment to reduce their risk and/or any complications arising from the disease or condition. Screening has important ethical differences from clinical practice as the health service is targeting apparently healthy people, offering to help individuals to make better informed choices about their health. However, there are risks involved and it is important that people have realistic expectations of what a screening programme can deliver. Within service design and delivery it should be clear that screening is being offered rather than enforced and that balanced information will be available to enable informed choice. There should be equity of access for men across a whole screening pathway where effective integration is in place across the whole of the pathway. The Provider shall ensure that its Services are provided in a way that demonstrates the above principles. The NAAASP incorporates the following:

- Inviting eligible men to the AAA screening programme using standard information provided by PHE
- Providing clear, high quality information that is accessible to all
- Carrying out high quality abdominal ultrasound on those men attending for initial or follow-up screening according to national protocol
- Minimising the adverse effects of screening, including anxiety and unnecessary investigations
- Identifying AAAs accurately
- Enabling men to make an informed choice about the management of their AAA
- Ensuring appropriate and effective management of cardiovascular risk factors identified through screening
- Ensuring referral to accredited vascular services for high quality diagnostic and treatment services
- Promoting audit and research and learn from the results. The Services will be subject to an annual PHE Quality Assurance (QA) review and effectiveness of treatment will be monitored via annual reports of a National Vascular Review

- Continuing to develop the skills of the workforce involved in screening

3.3. Providers are expected to meet the public sector Equality Duty which means that public bodies have to consider all individuals when carrying out their day-to-day work – in shaping policy, in delivering services and in relation to their own employees. <https://www.gov.uk/equality-act-2010-guidance>.

3.4. It also requires that public bodies:

- have due regard to the need to eliminate discrimination
- advance equality of opportunity
- foster good relations between different people when carrying out their activities

Equality

The objectives of the screening programme should include:

Help reduce health inequalities through the delivery of the programme

Key deliverables:

- Screening should be delivered in a way which addresses local health inequalities, tailoring and targeting interventions when necessary
- A Health Equity Impact Assessment should be undertaken as part of both the commissioning and review of this screening programme, including equality characteristics, socio-economic factors and local vulnerable populations
- The service should be delivered in a culturally sensitive way to meet the needs of local diverse populations
- User involvement should include representation from service users with equality characteristics reflecting the local community including those with protected characteristics
- Providers should exercise high levels of diligence when considering excluding people with protected characteristics in their population from the programme and follow both equality, health inequality and screening guidance when making such decisions

The provider will be able to demonstrate what systems are in place to address health inequalities and ensure equity of access to screening, subsequent diagnostic testing and outcomes. This will include, for example, how the services are designed to ensure that there are no obstacles to access on the grounds of the nine protected characteristics as defined in the Equality Act 2010.

The provider will have procedures in place to identify and support those persons who are considered vulnerable/ hard-to-reach, including but not exclusive to, those who are not registered with a GP; homeless people and rough sleepers, asylum seekers, gypsy traveller groups and sex workers; those in prison; those with mental health problems; those with drug or alcohol harm issues; those with learning disabilities, physical disabilities or communications difficulties. The provider will comply with safeguarding policies and good practice recommendations for such persons.

Providers are expected to meet the public sector Equality Duty which means that public bodies have to consider all individuals when carrying out their day-to-day work – in shaping

policy, in delivering services and in relation to their own employees

<https://www.gov.uk/equality-act-2010-guidance>

It also requires that public bodies:

- have due regard to the need to eliminate discrimination
- advance equality of opportunity
- foster good relations between different people when carrying out their activities

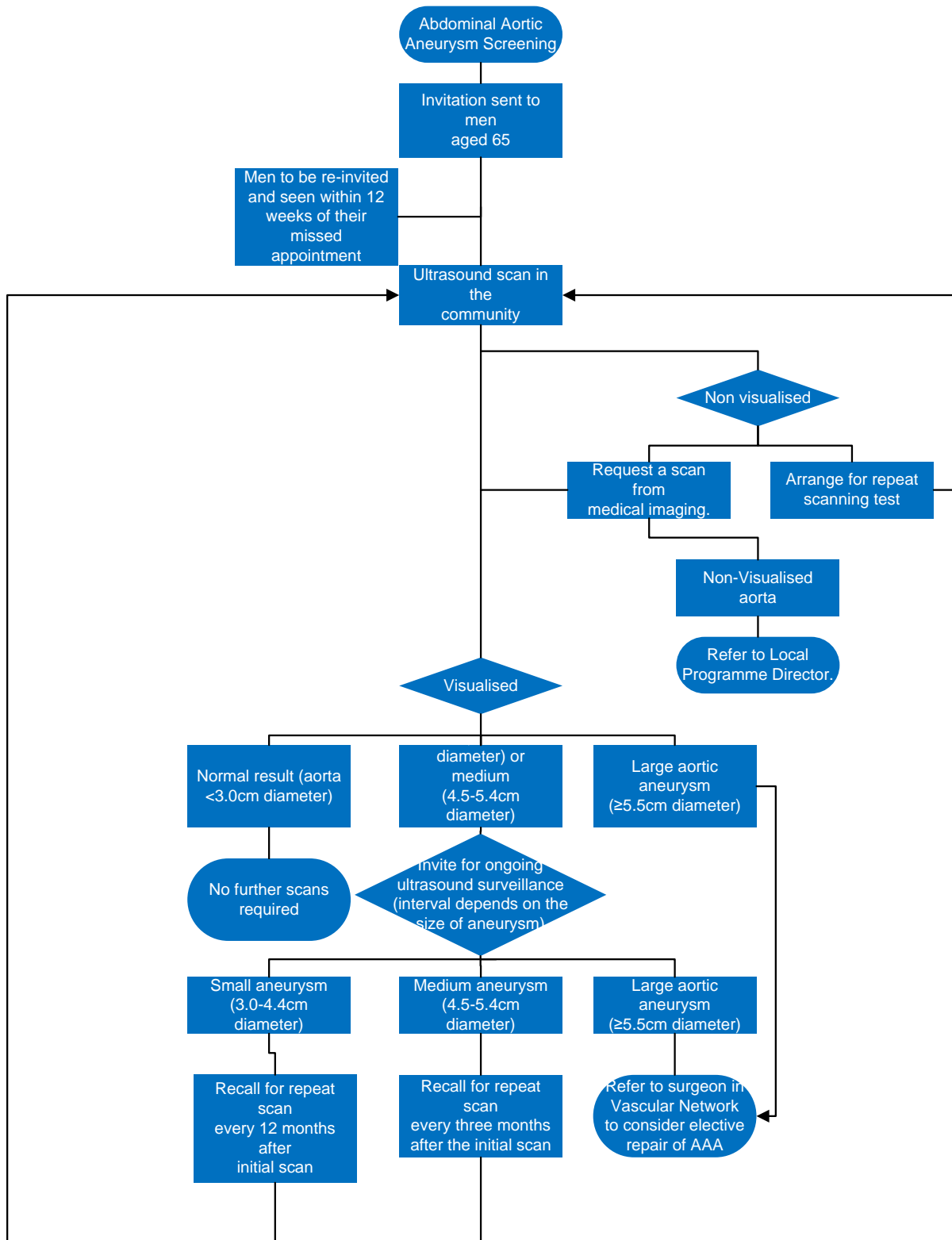
Service Description/Care Pathway

3.5. The AAA screening process is divided into the following stages:

- Identification
- Invitation
- Inform
- Test
- Surveillance
- Diagnose
- Treatment/ intervention
- Monitor outcomes

3.6. This Service Specification does not include standards for diagnosis and treatment/intervention.

3.7. The complete screening pathway is as the diagram below, based on the Map of Medicine, and can be found at: <https://www.gov.uk/government/collections/nhs-population-screening-care-pathways>).



3.8. The Provider shall provide the following components of the NAAASP and ensure
 Classification: Official

compliance with Guidance.

Identification

- 3.9. The target population to be screened consists of all men eligible for NHS care registered with a General Practitioner within the commissioned screening programme boundaries. Selection will be based on year of birth. Men should be offered screening during the year – 1st April to 31st March – in which they turn 65.
- 3.10. Cohort information will be provided to the Provider through the use of the National Screening Management System provided by PHE which has a live feed with the HSCIC for demographic updates directly from GP systems.

Invitation and Inform

- 3.11. NAAASP is based on the policies developed by the UK NSC. Appropriate information and advice are vital elements of the screening programme.
- 3.12. The Provider shall invite the eligible cohort for screening using the national screening software solution provided by PHE. The invitation should include the letter, the national screening leaflet and the local information as set out in the Guidance.

Test – Initial Screen

- 3.13. Screening by ultrasound scanning shall be offered by the Provider to all men during the year they turn 65. Men found to have a normal aorta (diameter < 3cm) will no longer be eligible to be offered the Services.

Test – Surveillance Screen

- 3.14. Surveillance by ultrasound scanning shall be offered by the Provider to all men found to have an AAA with a diameter of between 3cm and 5.4cm. The Provider shall ensure that all men in surveillance receive the national screening information regarding any subsequent surveillance or treatment that may be offered. Surveillance scans will monitor whether the aneurysm is increasing in size and may require intervention. The interval between scans will depend on the size of the aneurysm as set out in the Guidance.
- 3.15. For all men where the aortic diameter cannot be visualised the Provider should follow the guidance as set out in the national Guidance.
- 3.16. The Provider shall ensure that their nurse practitioner follows the Guidance.
- 3.17. All men identified with an aneurysm and requiring surveillance shall be offered health promotion information and advice as appropriate, relating to issues such as smoking, diet and physical activity.

Diagnose

- 3.18. Referral to a vascular surgeon to consider treatment options, including surgery, shall be offered to men found to have an aneurysm 5.5cm or larger in diameter. Patients who decline treatment or are unfit for surgery shall be offered observation under the care of the surgeon and will no longer be eligible to be offered the Services.
- 3.19. An AAA screening programme relies on a suitable vascular network for treatment patients with detected AAAs that covers a population of least 800,000. The vascular units providing the treatment must be part of a vascular network and

Classification: Official

comply with the requirements recommended by the Vascular Society of Great Britain and Ireland (VSGBI) for the treatment of AAA and will be required to provide data on the treatment and outcome of every infra-renal AAA operation or intervention to the National Vascular Registry (NVR). Submission of data to the NVR is compulsory for all surgeons wishing to participate in NAAASP. Providers must ensure that their surgeons make referrals to vascular units that fulfill the above requirements.

Service Model Summary

- 3.20. The Provider shall ensure that all aspects of the Services are provided in accordance with the Guidance.
- 3.21. The following are recommended staffing levels based on the evidence of the randomised control trials and the early experience of rolling-out AAA programmes around the country. The Provider shall ensure that it meets these recommendations with protected time for those providing input to the programme alongside their usual Trust roles or, if not, that it actively communicates to the commissioner with assurance that its workforce does not materially deviate from the recommendations set out in Guidance and summarised below.
- Programme clinical staff:
 - Director/ Clinical Lead (0.2 wte/800,000 population)
 - Lead Ultrasound Clinician (0.1 wte/800,000 population)
 - Nurse Practitioner (0.1 wte/full capacity programme i.e. 7,000 scans per year)
 - Consultants in the Vascular Units – these are not employed by the screening programme. However, there must be a “responsible doctor” for onward patient referral
 - Programme Screening Staff
 - Screening Technician (3 wte/800,000)
 - Clinical Skills Trainer (Senior Sonographer/Vascular Scientist – 0.1 wte per 800,000)
 - Programme Management, Administration and Technical Staff
 - Coordinator (1 wte/800,000),
 - Clerical Officer (1 wte/800,000),
 - Medical Physicist (5 days per year for a full capacity programme – 7,000 per year)

Failsafe Procedures

- 3.22. One of the cornerstones of an efficient and safe screening programme is the failsafe system. The Provider shall at all times operate systems and processes in accordance with the failsafe procedures in the Guidance.
- 3.23. The Provider Staff involved in the Services must be aware of the failsafe procedures, know how the systems operate and participate appropriately. These procedures ensure, as far as possible, all reasonable action is taken to offer appropriate management to the men.

Results giving, reporting and recording

- 3.24. The Provider shall ensure that all aspects providing results, reporting and recording of information in relation to the Services are conducted in accordance with the Guidance.

Image storage and management

- 3.25. The Provider should have implemented and be deploying the national image management system provided by PHE as an integrated part of their workflow.

Roles and accountability throughout the pathway

- 3.26. The Provider shall at all times ensure the Services have adequate clinical leadership. In addition the Provider shall employ a Clinical Lead who has overall clinical responsibility, professional accountability and provides strategic leadership for the Services, in accordance with Guidance. For the avoidance of doubt, the Provider shall ensure that periods during which the Clinical Lead is not available for duty that adequate cover is provided to fulfill the functions of the role.
- Programme Manager
 - The Provider shall at all times employ a Programme Manager, who will be responsible, and report directly, to the Clinical Lead for day-to-day Programme operations, in accordance with Guidance. For the avoidance of doubt, the Provider shall ensure that periods during which the Programme Manager is not available for duty that adequate cover is provided to fulfill the functions of the role.
 - Other staff
 - The Provider shall ensure that sufficient competent Screener and administrative staff are employed and available to adequately support the Services. For the avoidance of doubt, the Provider shall ensure that the above roles are staffed in accordance with Guidance.

Competencies and ongoing training

- 3.27. Providers are responsible for funding minimum training requirements to maintain an effective screening workforce including CPD where necessary.
- 3.28. In addition to its general obligations under this Contract the Provider shall only use trained, qualified and competent staff to deliver the Services who, where relevant, possess the following qualifications and competencies:
- NAAASP approved training and accreditation course for technicians
 - NAAASP approved 'fast track' training and accreditation course for QA lead, Clinical Skills, Trainer, Nurse Practitioner
- 3.29. Details of the mandatory national training framework can be found at <https://www.gov.uk/government/collections/aaa-screening-supporting-documents#training>
- 3.30. The Provider shall ensure that all roles and responsibilities are carried out in accordance with the Guidance.

Information technology, call and recall

- 3.31. Systematic screening requires call and recall information and the capture and management of ultrasound images. The Provider shall use the software provided by PHE and to ensure that the national minimum dataset is collected. The Provider shall ensure that call and recall are carried out in accordance with the Guidance.

Days/hours of operation

- 3.32. The days and hours of service operation shall be based on the needs and wants of the target population with the aim of maximising the uptake of the screening offer and in consultation with the Commissioner. Consideration of the move to 7 day services should be made, building the local evidence base, acknowledging that this will be based on local population needs.

Population covered

- 3.33. Cohort information will be provided to the Provider through the use of the National Screening Management System which has a live feed with HSCIC for demographic updates directly from GP systems. The Provider shall ensure at all times that it has systems and processes in place that allow them to access this system for the purposes of providing the Services. The Provider should invite men directly using the information and letters provided from the national screening management system. The National Screening Management System will automatically update the system with all those men registering with a GP. Regular attempts shall be made to ascertain contact up-to-date contact details whilst working with Area Teams to ascertain whereabouts of this group of unregistered men.
- 3.34. Men over the age of 65 can self-refer to the Service and have their information added manually to the National Screening Management System.
- 3.35. The Provider shall use its reasonable endeavours to ensure those eligible for the Service but who are not registered with a GP or who, in some other way find it difficult to access the Services are made aware of the Service and how to access the Service. Long-term residents in secure organisations such as prisons and men who are housebound should be given the opportunity of receiving screening once all factors regarding suitability for scanning and further diagnosis and treatment have been taken into account. The local provider should, in the first instance, liaise with the individual's GP to ascertain the circumstances to which they are housebound and understand the benefit, if any, from screening and potential treatment. Only in circumstances after a joint decision has been made by the GP and local programme director that the individual would not benefit should an invitation not be sent. This should be documented clearly within SMaRT.
- 3.36. Mental health units are at risk of not receiving an invitation to screening. These groups may also not be registered with a community-based GP practice. The Provider shall ensure it works collaboratively with other primary care providers, community service providers, National Offender Management, Health & Justice, other stakeholders and the commissioner to ensure access for groups of the

NHS public health functions agreement
population where access to screening may be restricted.

- 3.37. Men in their 65th year who already have a small AAA < 5.5 cm should not be excluded from the Services and the Provider shall offer an Initial Screen which shall be classed as their initial scan and previous surveillance scan measurements discounted. Other health care providers responsible for the care of the man, such as the GP and the vascular surgeon will be notified by the Provider, of the screening attendance. It is advised that such men will remain in the Services for the purposes of surveillance and are not scanned under two separate services.

Acceptance and exclusion criteria and thresholds

Acceptance criteria

- 3.38. The extent of the Services provided by the Provider will be defined by the list of GP practices to which it is responsible for offering screening Services. Men over the age of 65 can self-refer to the screening programme and have their information added manually to the screening management system.
- 3.39. Local commissioners and providers may wish to consider cross border screening if applicable.
- 3.40. Men and women of any age with a strong family history can be scanned under existing procedures but not within the NHS AAA screening programme, following referral by their GP to a medical imaging department.
- 3.41. For the avoidance of doubt, females with a male history would still be at an increased risk of abdominal aortic aneurysm and so would still require an invitation to the AAA screening test at <https://www.gov.uk/government/publications/nhs-population-screening-equitable-access-tips/nhs-population-screening-working-with-minority-or-hard-to-reach-groups#lesbian-gay-and-bisexual-individuals>
- 3.42. The demographic information regarding transgender individuals who are registered as male will be received in the cohort information.

Exclusion criteria

- 3.43. The following are not eligible for the AAA screening programmes:
- Those under the age of 64
 - Females
 - Men over 65 who have been previously diagnosed with an AAA,
 - Those who have previously undergone surgery for AAA repair
 - Those who are advised from their GP not to participate related to other health concerns
 - Men who requested that they are permanently removed from the NHS AAA screening programme

- Men who have already had a scan through NHS AAA Screening Programme and whose aorta was within normal limits

- 3.44. Referrals from other health professionals or the Provider (apart from other the Provider of NHS AAA Screening Programme for example a change of address).
- 3.45. In rare cases a “best interest” decision may be made by the GP, family or carer of the man to exclude men with mental incapacity from the programme. This needs to be completed in line with the principles enshrined in the Mental Capacity Act www.nhs.uk/carersdirect/moneyandlegal/legal/pages/mentalcapacityact.aspx.

Interdependence with other agencies, services and providers

- 3.46. Vascular surgical services are organisationally distinct from the Services. Responsibility for patients transfers from the screening programme to the vascular surgical service at the point of referral. The Provider shall track the progress of each referral made to a provider of vascular services and ensure action is taken to detect and rectify any delays in the man being seen for assessment or subsequent treatment. The Provider shall ensure it is also aware of all final outcomes for each man referred.
- 3.47. The NAAASP is dependent on strong working relationships (both formal and informal) between the NAAASP services provided by other providers, the information systems, ultrasonography departments, vascular services and primary care and specialist professionals. Providers must ensure accurate and timely communication and handover across these interfaces is essential to reduce the potential for errors and ensure a seamless pathway for men. It is essential that there remains clear named clinical responsibility at all times and at handover of care the clinical responsibility is clarified. The Provider shall ensure that appropriate systems are in place and in operation at all times to support an inter-agency approach to the quality of the interface between these services. The Provider shall ensure that the above systems are in place to actively support the following:
- Agreeing and documenting roles and responsibilities relating to all elements of the screening pathway across organisations
 - Providing strong clinical leadership and clear lines of accountability
 - Developing joint audit and monitoring processes
 - Agreeing jointly what failsafe mechanisms are required to ensure safe and timely processes across the whole screening pathway
 - Contributing to any NHS England Screening and Immunisation Lead’s initiatives in screening pathway development in line with UK NSC expectations
 - Meeting the national screening programme standards covering managing interfaces which can be found at:

<https://www.gov.uk/government/publications/aaa-screening-quality-standards-and-service-objectives>

- 3.48. The programme interfaces with professionals responsible for primary care including local GPs, and GPs providing services for prison populations and Armed Forces personnel. They involve the communication of information to ensure:
- The man's care record is maintained and up to date
 - Primary care is made aware of a man's failure to attend appointments
 - Primary care is made aware of a man's screening results in order to ensure integration with the overall health care of that man
 - The man has a local point of contact to discuss the consequences of being excluded from the programme
- 3.49. NAAASP interfaces with AAA treatment/management services. The interfaces which involve the referral of men for further investigation/treatment are shown in the care pathway including those with a non-visualised outcome at screening.
- 3.50. The Provider shall ensure that its information systems and operating processes are at all times compatible with the national screening management system which is funded and provided through Public Health England (PHE). The Provider is obliged to notify the National AAA Screening Programme within PHE and the Commissioner of any issues pertaining to the accuracy of the cohort identification within the national screening management system.

4. Applicable Service Standards

Applicable national standards

- 4.1. PHE, through the national screening programmes, is responsible for leading high-quality, uniform screening, and providing accessible information to both the public and health care professionals, and developing and monitoring standards. It is also responsible for the delivery of national quality assurance, based at regional level, and for ensuring training and education for all those providing screening is developed, commissioned and delivered through appropriate partner organisations.
- 4.2. Programme standards are available on the programme website [_ https://www.gov.uk/government/collections/aaa-screening-supporting-documents](https://www.gov.uk/government/collections/aaa-screening-supporting-documents)
- 4.3. The Provider will meet the acceptable and work towards the achievable programme standards. Where national recommendations for acceptable standards are not met the Provider will be expected to indicate in service plans what changes and improvements will be made over the course of the contract period.
- 4.4. The Provider shall develop a Contractual Services Development Plan in line with KPIs and the results of internal and external quality assurance checks. The plan will respond to any performance issues highlighted by the commissioners, having regard to any concerns raised via any feedback from men, family or carers. The plan will contain action plans with defined timescales and responsibilities and will be agreed with the commissioners.

Pathway Standards

- 4.5. PHE Quality Assurance (QA) systems support commissioners and the Provider in the quality and clinical governance aspects of the Services so that core processes are safe and the programme achieves better outcomes.
- 4.6. The Provider shall at all times cooperate and participate fully in national Quality Assurance processes, co-operate in undertaking ad-hoc audits and reviews as requested and as may be directed by the Commissioner, from time to time. The Provider shall act upon and implement recommendations made as a result of QA visits or reviews within a timeframe and in accordance with a plan that has been agreed by the Commissioner.
- 4.7. The Provider shall ensure that it submits the following to QA and the Commissioner within the timescales laid out in Guidance or otherwise as directed by the Commissioner or QA:
 - Data and reports from external quality assurance schemes
 - Minimum data sets as required – these may be required to be submitted to national external bodies e.g. National Vascular Registry
 - Self-assessment questionnaires/tools and associated evidence

Classification: Official

- Audits or data relating to nationally agreed internal quality assurance processes incidents and serious incidents as they occur in accordance with the policy
<https://www.gov.uk/government/publications/managing-safety-incidents-in-nhs-screening-programmes>
- 4.8. Where QA believe there is a significant risk of harm to the population, they will recommend to commissioners to suspend a service.
- 4.9. The Provider will be able to demonstrate that they have audited procedures, policies and protocols in place to ensure best practice is consistently applied for all elements of the screening programme.
- 4.10. The Provider shall, at all times comply with the UK NSC guidance 'Managing Serious Incidents in the English NHS National Screening Programme' (or updated version) as referred to in the Quality Requirements in Schedule 4 and the NHS England guidance for the management of incidents

Applicable standards set out in Guidance and/or issued by a competent body

- 4.11. Training and education for all staff groups must be conducted as required by NAAASP. The Provider shall ensure all staff groups engaged in providing the Services are trained and complete continual professional development in accordance with Guidance and in particular in accordance with the relevant NAAASP requirements. The Provider should ensure training has been completed satisfactorily and recorded and that there is a system in place to assess on-going competency.
- 4.12. The provider should ensure that all Screening Technicians and Clinical Skills Trainers (CSTs) undertake reaccreditation (or equivalent as determined by NAAASP) within the required timeframe of 24 – 30 months for both Screening Technicians and Clinical Skills Trainers as per clinical guidance and scope of practice:- <https://www.gov.uk/government/publications/aaa-screening-clinical-guidance-and-scope-of-practice>
- 4.13. Training, development and information programmes are available for the following staff groups. All training will be based around a national competency Framework:- <https://www.gov.uk/government/publications/aaa-screening-clinical-guidance-and-scope-of-practice>
- Screening Technicians
 - Clinical Skills Trainers (CSTs): these are senior practitioners who cascade practical training to other staff and provide training, support and advice to the Screening Technicians. They also provide QA through the monitoring of the quality of the images and measurements taken by the Screening Technicians
 - Programme Co-ordinators/Managers, who cascade non-clinical training

to others and clerical staff

Applicable local standards

- 4.14. The Provider shall have internal quality assurance and risk management processes in operation at all times and be able to demonstrate to the Commissioner that those processes are commensurate to the risks, quality assurance issues and best practice of the Services Documented and other evidence to support this must be in place.
- 4.15. The Provider shall:
- ensure that mechanisms are in place to regularly audit implementation of risk reduction measures and report incidents;
 - ensure that appropriate links are made with internal governance arrangements, such as risk registers
 - review and risk assess local screening pathways in the light of guidance offered by PHE Quality Assurance processes or the National Screening programme
 - Work with the Commissioner and Quality Assurance Teams to develop, implement, and maintain appropriate risk reduction measures.
- 4.16. On a quarterly basis high scoring risks will be identified and agreed between the Provider and the commissioners and plans put in place to mitigate against them. It is expected that Providers will investigate anything outside the acceptable levels.
- 4.17. Failsafe systems must be able to identify, as early as possible, people that may have been missed or where screening results are incomplete.

Clinical and corporate governance

Accountability and oversight

- 4.18. The Provider shall ensure that:
- An appropriately skilled and competent executive officer within its organisation is accountable for, and oversees, the Services.
 - The Provider's board of directors is part of the clinical governance procedures and must be responsible for receiving assurance on the quality of the Services
 - There is appropriate internal clinical oversight of the Services and have its own management and internal governance of the Services
 - An internal multi-disciplinary operational group is established, that meets monthly as a minimum. This group will ensure robust operational processes are in place between individuals delivering the Services

Classification: Official

- An annual report of AAA screening services is produced which is signed off by the organisation's board

Programme board

4.19. The Provider must:

- Ensure co-operation with and representation on the local screening oversight arrangements/ structures
- Ensure good governance of the screening programme; a screening programme board must meet at a minimum of every 6 months and at a schedule agreed with commissioners and must include programme director, co-ordinator, screener representative, surgeons, radiologists, commissioners, public health and PHE QA representative. The programme boards must consider service user engagement and involvement

Quality Assurance

4.20. The programme must participate in external Quality Assurance and have internal quality assurance processes that ensure failsafe is integral to the programme and incident management occurs in line with failsafe document/map of medicine and national guidelines for incident management (NHS England/PHE) <https://www.gov.uk/nhs-population-screening-quality-assurance>

Risk Management

4.21. The Provider must have an internal risk management process to manage the risks of running the Services. The risk management process must be reviewed and agreed at the programme board and form part of the assurance to the Provider's board of directors.

4.22. The Provider shall:

- Ensure that appropriate failsafe mechanisms are included across the NAAASP Services including the interfaces with other providers with whom the Provider interacts with in the course of providing the Services
- in a timely manner review and risk assess NAAASP screening pathways in the light of guidance offered by QA processes or the National Screening programme
- work cooperatively with the Commissioner and QA Teams to develop, implement, and maintain appropriate risk reduction measures
- ensure that appropriate links are made with internal governance arrangements, such as risk registers
- Undertake QA reviews of images and screener performance as per the guidance in the Guidance
- On a quarterly basis high scoring risks will be identified and agreed between the Provider and the commissioners and plans put in place to mitigate against

them. Risk identification must take into account failsafe mapping (please also see section 2.3 Failsafe)

Governance policies

- 4.23. The Provider must have an appropriate governance framework in place that has been approved by the Commissioner, covering the following aspects of the Services:
- Information governance/records management
 - Equality and diversity
 - User involvement, experience and complaints
 - Failsafe procedures
 - Risks & mitigation plans
- 4.24. Providers of the AAA Screening service should have undertaken and passed the NHS Information Governance Toolkit to at least “Any Qualified Provider – Clinical Services” level. Any NHS organisation providing an AAA Screening service should have undertaken and passed the Toolkit to the relevant level for their Trust type (e.g. Acute). See <https://www.igt.hscic.gov.uk/> for further information.
- 4.25. The Provider shall seek the Commissioner’s approval of the governance framework prior to the Services Commencement Date and annually thereafter.

5. Location of provider premises

- 5.1. Should the Provider wish to use any other premises in addition to the Provider Premises as out in the Contract for the provision of the Services, then it shall only do so with prior written approval of the Commissioner.
- 5.2. The Provider shall have a community based model of delivery. In choosing Provider Premises, and the frequency and availability of appointments at the Provider Premises, the Provider shall take into account the needs of the men and prospective Service Users.
- 5.3. Taking into account the needs of the individual man, the Provider shall offer each man a choice of Provider Premises from which they may conveniently access the Services within clinically appropriate timeframes.
- 5.4. The Provider shall at all times ensure the Provider Premises, or mobile venues, comply with Guidance and the obligations set out in this Contract. The Provider should operate systems and processes to satisfy it, and be able to demonstrate to the Commissioner, that the Provider Premises meet the needs of Service Users.
- 5.5. Provider Premises, unless otherwise agreed by the Commissioner, shall be within reasonable walking distance to public transport links and car parking facilities, taking into account the physical and mental disposition of Service Users. Provider Premises should have sufficient seating areas to accommodate all waiting Service Users in comfort and have toilet facilities and drinking water freely available.
- 5.6. Responsibility for staff costs incurred for travel associated with screening rests with the Provider.
- 5.7. Responsibility for costs associated for hire of screening venues rests with the Provider.
- 5.8. Responsibility for any cross-charging for referral of non-visualized screening scans into medical imaging departments or vascular laboratories rests with the Provider

Equipment specification

- 5.9. For the avoidance of doubt, in accordance with the Contract, the Provider is responsible for maintenance, calibration and purchase of replacement screening equipment which shall meet NAAASP requirements and standards. Recommendations on the timescale for replacement of ultrasound equipment are made by The Society and College of Radiographers.

- 5.10. A technical equipment specification and an approved list of equipment meeting the specification can be found within the Guidance. It is a requirement that all Providers select equipment from this list. The list of approved equipment to be used in the programme can be found at:
<https://www.gov.uk/government/publications/abdominal-aortic-aneurysm-screening-ultrasound-equipment-guidance>

6. Transfer of and discharge from care protocols

6.1. Active inclusion in the screening programme ends when:

- The scan is found to be normal
- The AAA reaches 5.5cm diameter on ultrasound and the man has been referred to the vascular unit. The Provider shall track the progress of each referral made to a provider of vascular services and ensure action is taken to detect and rectify any delays to the man being seen for assessment or subsequent treatment. The Provider shall ensure it is aware of all final outcomes for each man referred.
- The Provider Clinical Leader, with the GP, decides if referral for treatment will be considered based on other factors such as co-morbidities or symptoms etc.
- Three consecutive scans show an aortic diameter less than 3cm on ultrasound where the initial scan was 3cm or greater. In this case the man will be discharged from the Provider and the Provider shall inform both the man and GP by letter
- After 15 scans at one-year intervals the AAA remains below 4.5cm. In this case the man will be discharged from the screening programme and the Provider will inform both the man and GP by letter
- If the man declines to be in the screening programme, fails to attend consecutive appointments as per local policy, moves out of the area and becomes the responsibility of another Provider, or dies. If a man under surveillance moves out of the area, the Provider must alert the other screening provider responsible for the GP practice to which the man is then registered. For any man under surveillance who declines to continue in the screening programme the Provider must follow the 'informed dissent' process as described in the Guidance

6.2. Men over the age of 65 who have had AAA identified through routes outside the screening programme must not be referred to the Provider for surveillance. These men must stay within the care of the vascular service. Men in their 65th year who already have a small AAA < 5.5 cm should not be excluded from the Services and the Provider shall offer an Initial Screen which shall be classed as their initial scan and previous surveillance scan measurements discounted. Other Provider responsible for the care of the man, such as the GP and the vascular surgeon, whose care the man is under will be notified by the Provider, of the screening attendance. It is advised that such men will remain in the Services for the purpose of surveillance only and are not to be scanned under two separate services.

7. Safeguarding policies

- 7.1. Safeguarding vulnerable people is at the heart of all health service delivery. NHS England and the Provider are required to ensure that services provided adhere to local multi agency safeguarding policies and procedures, have appropriate training in place and arrangements to work with local authorities and partner agencies through safeguarding boards and other relevant bodies.

Annex A: Quality Requirements

Quality Requirement	Threshold	Method of Measurement	Consequence of breach	Timing	Applicable service spec.
<p>Domain 5</p> <p>Patient safety screening incidents resulting in severe harm or death</p>		<p>Exception report to be developed by the Provider along with following the appropriate guidance for managing incidents</p> <p>https://www.gov.uk/government/publications/managing-safety-incidents-in-nhs-screening-programmes</p>	<p>Depending on incident, Action plans, RCA to be developed with commissioners</p> <p>Address position at the Quarterly CRG Meetings</p>	Quarterly	A
Data requirements for AAA Screening performance metrics and National Pathway Standards	100%	Data return	Address position at quarterly CRG meetings	Quarterly	A
<p>NHS AAA Screening Programme Pathway Standards and Service Objectives</p> <p>https://www.gov.uk/government/collections/aaa-screening-supporting-documents</p>	100%	Data Return template set out in information requirements	Address position at quarterly CRG meetings	Quarterly	A

National KPIs – submission by standard national spreadsheet:					
Performance indicator	indicator	Threshold	Method of measurement	Frequency	Notes
AA2: Abdominal Aortic Aneurysm screening – coverage of initial screen	Ref 1	Acceptable level: ≥ 75.0% Achievable level: ≥ 85.0%	Ref 1	Quarterly	Extracted directly via national screening management system National quarterly submission dates: 30/6/14, 30/9/14, 31/12/14, 31/3/15
AA3: Abdominal Aortic Aneurysm screening – coverage of annual surveillance screen	Ref 1	Acceptable level: ≥ 85.0% Achievable level: ≥ 95.0%	Ref 1	Quarterly	Extracted directly via national screening management system National quarterly submission dates: 30/6/14, 30/9/14, 31/12/14, 31/3/15
AA4: Abdominal Aortic Aneurysm screening – coverage of quarterly surveillance screen	Ref 1	Acceptable level: ≥ 85.0% Achievable level: ≥ 95.0%	Ref 1	Quarterly	Extracted directly via national screening management system National quarterly submission dates: 30/6/14, 30/9/14, 31/12/14, 31/3/15
Quarterly information to supply the needs of the quarterly contract review meetings and the quarterly AAA Programme Board					
Full report on status of attainment against AAA National QA Standards	Ref 1	Must be submitted in full and according to required timescales	Ref 1	Quarterly	

Annex B: Reporting requirements

	Reporting Period	Format of Report	Timing	Application
Local Requirements				
<p>Quarterly Quality Standard Report provided by NAASP and downloaded from within the national screening management system by providers.</p> <p>data return which must include all the elements set out in the National Pathway Standards and the Quality Requirements set out in schedule 4</p>	Quarterly			All
<p>The activity report can be searched and created in the national screening management system by providers. It includes:</p> <ul style="list-style-type: none"> %age of men's records with insufficient contact details to make an offer %age of men offered screening who are tested of those tested who have an aortic diameter of <3.0cm and who are discharged from the screening programme % of those tested who have an aortic diameter 3.0-4.4cm and are Entered into annual surveillance. % of those tested who have an aortic diameter 4.5-5.4cm and are entered into a three monthly surveillance % of those tested who have an aortic diameter of 5.5cm or greater And are referred to a Vascular Surgeon. 	for commissioners to specify frequency	Report can be split by GP practice, screening clinic locality and by Local Authority. Commissioner and the Provider should agree the format, frequency of the report		

Annex C: Guidance

Guidance	Link
NAAASP Standard Operating Procedures	https://www.gov.uk/government/collections/aaa-screening-supporting-documents
UKNSC 2004 review into viability of AAA screening	at http://www.screening.nhs.uk/aaa
Non-visualisation Guidance	https://www.gov.uk/government/publications/aaa-secondary-ultrasound-screening
NHS England & Wales Cross-border operational protocol	https://www.gov.uk/government/collections/aaa-screening-supporting-documents
Protocol for reporting deaths	https://www.gov.uk/government/collections/aaa-screening-supporting-documents
Ultrasound Equipment Quality Assurance Guidance	https://www.gov.uk/government/collections/aaa-screening-supporting-documents
Failsafe's	https://www.gov.uk/government/publications/abdominal-aortic-aneurysm-screening-programme-failsafe-procedures
Screening Pathway, based on Map of Medicine	https://www.gov.uk/government/collections/nhs-population-screening-care-pathways).?next=http%3A%2F%2Fapp.mapofmedicine.com%2Fmom%2F230%2Findex.html

Pathway standards and service objectives	https://www.gov.uk/government/publications/aaa-screening-quality-standards-and-service-objectives
KPIs	https://www.gov.uk/government/collections/nhs-screening-programmes-national-data-reporting
Education and training framework	https://www.gov.uk/abdominal-aortic-aneurysm-screening-programme-overview#training
QA framework for training	https://www.gov.uk/abdominal-aortic-aneurysm-screening-programme-overview#training
Guidance on Waiting Time Standards	https://www.gov.uk/government/publications/aaa-screening-quality-standards-and-service-objectives