

Abdominal aortic aneurysm, improving outcomes for patients: learning from the project

Key findings

The elective infrarenal AAA mortality rate has decreased significantly since the baseline measure of 7.5% in 2008. In March 2012 the overall UK AAA mortality rate was 2.4% with open aneurysm repair at 4.3% and endovascular aneurysm repair at 0.9%.

Data are now entered in a much more timely way to the National Vascular Database with delays reduced from six to less than four months. The quality and comprehensiveness of these data (correlated with Hospital Episode Statistics) was improved as a result of the programme. There has also been a 69% increase in the number of surgeons registered to the NVD.

The project demonstrated the value of working as a multi-disciplinary team including anaesthetists, radiologists and specialist nurses as a critical part of a successful team approach. However, more work needs to be done to embed this approach as a model for care delivery.

A collaborative approach, where teams can share learning of what works and what fails, helps teams avoid repeating mistakes and speeds up implementation of what works.

Successes

The project built a network of seven regional patient groups across the UK. Patients provided new ideas and suggestions for improvements such as telephone follow-up and practical and specific AAA recovery information. They also contributed to significant developments in written information for patients both pre and post-operatively.

Patient feedback was particularly beneficial as a way of engaging clinicians in the whole process of improving the quality of care for patients, even when they had doubts about the mortality data figures. Information from the patient groups is being used to make recommendations on AAA Patient Reported Outcome Measure (PROMS) to be submitted to the national PROMS programme.

In some units length of stay has been reduced through improvements in preoperative assessment, introduction of discharge planning and protocol led discharge. Some units found that risk scoring patients enabled them to reduce usage of high dependency units

by transferring patients straight to vascular wards after surgery. However, nationally there is no change in length of stay; it is likely that any overall change in length of stay will only become evident some years after the end of the project.

Best practice standards developed by the programme, such as multi-disciplinary meetings and formal risk assessment of patients, are proposed for the new National Vascular Registry which will maintain focus on quality of care.

Challenges

Lack of quality improvement experience was a major obstacle to delivery of the project.

A national project delivered regionally requires lots of time on the ground by the core team to set up and run meetings. This was difficult to manage within the two year length of the programme.

The initial care pathway that was developed was found to be too lengthy in practice and needed to be adapted to make it more practical.

Large external agendas, such as service reconfiguration in specific regions, had an impact on the engagement and progress of quality improvement work within those regions.

Engagement with Scotland was a lengthy process, suggesting that some form of standard cooperation agreement for running UK-wide initiatives would facilitate such projects.

Measuring the outcomes of implementing best practice protocols proved difficult. There was an absence of baseline measures and, since interventions were targeted at salient issues within each region, it made it difficult to set an overall measurement plan.

Advice to others doing similar projects

- Set clear targets against which progress can be measured.
- Map best practice interventions to national initiatives and try to get some of your goals adopted as national policy (eg quality accounts).
- Be prepared to deal with lack of quality improvement knowledge among clinicians and local bureaucratic and management obstacles.
- Don't assume that high engagement at regional quality improvement events translates into action at a local level.
- Allow enough time to ensure the right best practice protocols have been selected and the core team is trained in quality improvement.
- Obtain baseline measures prior to implementation.
- Develop a plan for local measurement to include: what (eg mortality, length of stay, patient satisfaction), who (team member tasked with data capture) and when (regular intervals for measurement, eg monthly, quarterly).