

**LEICESTER, LEICESTERSHIRE AND RUTLAND
PCT CLUSTER BOARD MEETING**

Front Sheet

Title of the report:	Maintaining Safe Screening Services during the Transition
Report to:	Leicester, Leicestershire and Rutland PCT Cluster Board
Section:	Public
Date of the meeting:	12 January 2012
Report by:	Anna Follow, LNR Cancer Services Screening Co-ordinator
Sponsoring Director:	Deb Watson, Director of Public Health and Health Improvement
Presented by:	Deb Watson, Director of Public Health and Health Improvement

Report supports the following corporate objective(s) 2011 – 2012:			
Handing over a good legacy	√	Deliver the six identified transitional strands of work	
Manage Providers' performance against updated health goals and identified health inequalities		Develop and maintain an energetic stakeholder engagement programme throughout the transition	
Deliver agreed performance targets against the six identified transformation work streams			

EXECUTIVE SUMMARY:

1. PCTs are responsible for commissioning, managing performance and ensuring that programmes meet nationally set quality standards. The screening pathways are often complex and involve multiple providers across primary and secondary care and are supported by a range of different clinical and non clinical data management systems. Without robust arrangements, it is likely that serious programme failures will arise.

Following the publication of Healthy Lives, Healthy People, it is clear that screening will be a core responsibility of Public Health England (PHE) but the commissioning of programmes will be mandated to the National Commissioning Board (NCB). This is likely to take place at differing levels of the system but there will be a need to recognise that screening services are interdependent with other NHS services e.g. ante-natal and new born screening and maternity services.

2. During the transition Public Health will lead the oversight and co-ordination of National Screening Programmes, but is heavily dependent, at PCT cluster level, on expert support from other directorates/departments. As commissioning and other

directorate functions are devolved to Clinical Commissioning Groups, at a time when there is a lack of clarity over the roles of the NHS Commissioning Board and Public Health England, there is a risk that the interdependencies with public health in relation to screening are overlooked or not prioritised as highlighted in the paper.

RECOMMENDATIONS:

The PCT Cluster Board is requested to support the following recommendations:

1. The Board recognises and supports the need to mitigate potential screening risks during the transition to new structures
2. The LLR Cluster will ensure that the transition governance and accountability structure will provide assurance that screening risks and serious incidents are understood and managed according to National Screening Committee guidance
3. The Directors of Public Health in partnership with other cluster directors will identify named roles/individuals to deliver existing support functions
4. Risk assessment of screening programmes will be managed throughout transition, by reports from each screening lead to the Director of Public Health and inclusion as appropriate onto the LLR cluster risk register. Directors of Public Health have agreed to submit a bi-monthly transition risk assessment for Screening Programmes to the Strategic Health Authority.

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 BOARD MEETING**

Maintaining Safe Screening Services during the Transition

Introduction

This briefing paper sets out the LLR Cluster responsibilities and associated risks with the commissioning of national screening programmes during transition. Recommendations are made to enable the risks to be managed or mitigated and provide assurance to the Board on the safety and quality of these services during this period.

1. Objectives of paper

- 1.1 To set out Primary Care Trust (PCT) responsibilities and functions during transition
- 1.2 To provide information on risks in screening programmes during transition
- 1.3. To describe the approach to mitigating risk

2. PCT responsibilities and functions

Until April 2013, PCTs will commission the following National Screening Committee (NSC) recommended population wide screening programmes:

NSC non– cancer screening programmes	Conditions screened for
Antenatal - Fetal anomaly screening programme (FaSP)	Down's syndrome screening - DSS Fetal Anomaly screening by ultrasound (USS)
Antenatal – Infectious disease screening in Pregnancy Programme (ID)	Rubella HIV Syphilis Hepatitis B
Linked Antenatal and Newborn - Sickle cell and Thalassaemia Screening Programme (SC&T)	Sickle cell and Thalassaemia
Newborn - Newborn and Infant physical exam (NIPE) - at birth within 72 hours and at 6 – 8 weeks	Holistic examination including:- Developmental dysplasia of the hips Cardiac abnormalities Congenital cataracts Undescended testes in males
Newborn - Newborn bloodspot programme (UKNBSP)	Cystic Fibrosis (CF) Medium Chain Acyl CoA Dehydrogenase Deficiency (MCADD) Congenital hypothyroidism (CHT) Phenylketonuria – (PKU) Sickle Cell Disorders (SCD) - (Linked with AN SC&T programme)
Newborn - Newborn hearing (NHSP)	Congenital hearing deficit
Adult - Diabetic retinopathy (DR)	Diabetic retinopathy
Aortic Abdominal Aneurysm	Aortic Abdominal Aneurysm in males

	aged 65
Cancer screening programmes - Adults	
Bowel cancer	Bowel cancer
Breast cancer	Breast cancer
Cervical cancer	Cervical cancer

PCTs are responsible for commissioning, managing performance and ensuring that programmes meet nationally set quality standards. This latter duty includes ensuring that quality concerns are appropriately investigated and managed. To do this effectively requires programme governance and co-ordination of the screening pathway by individuals with competency in screening. Public health leads this process supported by other PCT functions, such as commissioning, finance and information, communications and clinical governance. For cancer screening, the role of PCT employed co-ordinators is particularly important. The screening pathways are often complex and involve multiple providers across primary and secondary care and are supported by a range of different clinical and non clinical data management systems. Without robust arrangements, it is likely that serious programme failures will arise.

3. Future Commissioning arrangements under NHS reforms

Following the publication of Healthy Lives, Healthy People, it is clear that screening will be a core responsibility of Public Health England (PHE) but the commissioning of programmes will be mandated to the National Commissioning Board (NCB). This is likely to take place at differing levels of the system but there will be a need to recognise that screening services are interdependent with other NHS services e.g. ante-natal and new born screening and maternity services.

Public Health England will provide public health advice and quality assurance of screening programmes however the details of how this will be delivered at PCT level is yet to be shared.

The role of the Director of Public Health in screening programmes has not yet been fully defined but it is anticipated that the need to work in partnership with the National Commissioning Board will be integral to ensuring that screening programmes are based on and deliver population needs.

Health and Wellbeing Board scrutiny of health services will also encompass screening.

Further detail regarding the interrelationships between PHE, the NCB and Clinical Commissioning Groups at varying levels is expected through Public health reform updates.

4. Transition Risks

Public Health leads the oversight and co-ordination of National Screening Programmes, but is heavily dependant upon PCT cluster level on expert support from other directorates/departments. Appendix 1 illustrates the generic activities associated with all screening programmes. Using bowel

cancer screening as an example it highlights how these elements require input from multiple directorates. As commissioning and other directorate functions are devolved to Clinical Commissioning Groups, at a time when there is a lack of clarity over the roles of the NHS Commissioning Board and Public Health England, there is a risk that the interdependencies with public health in relation to screening are overlooked or not prioritised.

The resulting risks include;

- 4.1. The overall loss of capacity from the management cost reductions may result loss of critical commissioning and contracting expertise and local commissioning memory
- 4.2. Changes to governance and accountability arrangements that may fully not be understood by stakeholders
- 4.3. Loss of expert knowledge regarding data collection and analysis
- 4.4. Slippage in service developments or performance monitoring plans
- 4.5. Loss of capacity to adequately identify and respond to clinical screening Incidents
- 4.6. The pace of change at PCT cluster/.CCG level locally is significantly different to emerging developments in the NCB and PHE. This can lead to lack of concordance between their respective structures and processes and result in loss of co-ordination across the whole system.
- 4.7. Professional isolation of public health screening staff

5. Assurance

Given the complexities of the screening programmes and the lack of detailed guidance to date on future arrangements, the LLR Cluster Board will wish to assure itself that the interdependencies of the systems continue to work effectively during the transition period.

6.Recommendations

6.1.The Board recognises and supports the need to mitigate potential screening risks during the transition to new structures

6.2. The LLR Cluster will ensure that a transition governance and accountability structure will provide assurance that screening risks and serious incidents are understood and managed according to National Screening Committee guidance¹

6.3 The Directors of Public Health in partnership with other cluster directors will identify named roles/individuals to deliver existing support functions.

6.4 Risk assessment of screening programmes will be managed throughout transition, by reports from each screening lead to the Director of Public Health and inclusion as appropriate onto the LLR cluster risk register. Directors of Public Health have agreed to submit a bi-monthly transition risk assessment for Screening Programmes to the Strategic Health Authority. The October submission is attached as Appendix 2, for information.

Appendix 1

Generic activities associated with screening programmes, with bowel screening in Leicester, Leicestershire and Rutland illustrating that input is required from several directorates to manage screening programmes effectively.

Activity	Directorate (or subdivision)	Description
Strategy/future planning		
Ensure NSC policy informs local decision making	PH	Enacted via PH contribution to Board and other decision making forums
Planning implementation of new programmes, or extension/developments to existing programmes	Service development Contracts PH	Contribution dependent on the initiative and actions required
Securing implementation of funding for new programmes	Finance PH Service development	
Delivery of the screen		
Ensure systems in place to identify target population (e.g. GP register, child health register, diabetic register)	Primary care Contracts	Requires up to date GP register and contract with bowel screening hub (for which LLR is associate commissioner)
Inviting/reminding people	Contracts Primary care	Contract with "screening hub" to manage call/recall (act as associate commissioners) Activities within primary care to support uptake.
Consenting for test	Contracts	Via contract with hub as above
Performing the screening test	Contracts Primary Care	Via contract with hub as above plus additional activities in primary care to support test completion
Transport of sample/image etc	Contracts	Via Contract with hub (as above)
Interpretation of screen	Contracts	Via Contract with hub (as above)
Communication of screen results	Contracts	

Follow up of screen		Via Contract with Kettering (for which LLR acts as an associate commissioner)
Ceasing people from the programme	Contracts Primary care	Via Contract with hub (as above) and contribution from primary care
Training of screeners	Contracts	Not relevant for screen itself but requirement for appropriate accreditation of colonoscopists within contract with Kettering
Accreditation of screeners	Contracts	Not relevant for screen itself but there is a requirement for appropriate accreditation of colonoscopists within contract with Kettering
Monitoring		
Determination of KPIs	PH Contracts Performance	Performance indicators include those nationally dictated, those around contract performance and others related to inequalities and local issues
Reporting of KPIs	Performance PH Informatics	Mainly via performance and some specific to local PH issues such as equity audit
Review of KPIs and implementing remedial action	Performance Contracts PH	Action required is dependent on issue and led by the appropriate directorate
Governance		
Internal QA	Contracts PH Quality	Elements of provider QA within contracts. PCT QA led by PH and quality.
External QA	PH	PH linkages via SHA and Cancer Network to Regional QA team
Governance of the programme	PH Corporate governance	Ensuring appropriate structures and reporting within PCT and Local Authority (latter particularly around contribution to inequality reduction)
SI management	PH Quality Contracts Communications	Providers to fulfil contract requirements of SI management and, notified to PH for involvement as required

Population interventions		
Increasing population uptake	PH Contracts Communications	Involves elements of making test more acceptable (via contracts) and PH population interventions.
Monitoring inequalities and taking action to rectify	PH	Liaising with other directorates as appropriate
Co-ordination		
Co-ordination of the pathway/programme across multiple providers and agencies	PH Contracts	Via LNR bowel screening board and structures within this

Appendix 2: Transition Risks for Screening Programmes Stock take: October 2011

Transition Risks for Screening Programmes Stock take: October 2011	
PCT Cluster: LLR	Date: October 2011
<p>Please outline the approach taken/ or will be taken to assess risks for screening programmes. E.g. named lead for co-ordinating risk assessments identified.</p>	<p>Screening programme leads across the cluster will meet before the end of November and agree the process that will be used to complete a risk assessment for each programme and the timescale for how often this will be repeated. The cancer screening co-ordinator (Anna Follows) will convene the meeting but this will include cancer and non-cancer screening programmes</p>
<p>Is the national generic risk register consistent with current risks within the cluster?</p> <p>Are there other issues that you want to highlight in addition to those identified at the 11 October workshop?</p>	<p>Yes</p> <p>The loss of capacity/staff through redundancy and the impact of the movement of staff between different organisations-commissioning hubs, Clinical Commissioning Groups between now and 2013. All this at a time when screening programmes are evolving and expanding e.g. age extension of bowel screening</p>
<p>How will the cluster mitigate risks during transition? Do you have examples of actions taken already that you can share?</p>	<p>Each of the programmes has a group that go by various names (e.g. advisory group, steering group, board) and for which the reporting structures are variable. Some of the groups have LNR, rather than LLR remit. The terms of reference of each of these groups will be reviewed and reporting structures agreed with the new cluster structures. The revised terms of reference will then need to be agreed by each of the groups. This process will be complete by 1 March 2012</p>

<p>How will the cluster assess the governance structures for screening programmes during transition?</p> <p>Do you have examples of actions taken to strengthen arrangements?</p>	<p>The process described above will provide clarity around the governance arrangements.</p> <p>The Cluster management structure is fully in place and should be stable up to April 2013. This should provide more certainty about existing structures.</p>
<p>How will the cluster assess the adequacy of commissioning functions and public health support for screening programmes during transition?</p> <p>Do you have examples of actions taken to strengthen arrangements?</p>	<p>The terms of reference for each of the groups described above will include the requirement to develop an annual work plan and maintain a risk register with clarity around how this risk register feeds into the Cluster register</p>
<p>Please outline the approach planned to make the cluster board aware of its continuing responsibility for screening?</p>	<p>A paper will be taken to the Cluster Board for information before the end of December 2011.</p>
<p>Please feedback any issues specific to screening programmes highlighted by the public health costing exercise.</p>	<p>The cost exercise highlighted the lack of clarity over costs when these are subsumed within the work plans of other directorates (e.g. communications and quality support) or within other, broader, provider contracts (e.g. midwifery). Lack of robust commissioning arrangements for some key aspects of antenatal and newborn screening were highlighted</p>
<p>Any other comments</p>	<p>Where screening is part of a broader pathway of care, risks to other parts of a pathway may impact adversely on screening (e.g. current sustainability risk in paediatric audiology on the Newborn Hearing Screening Programme)</p>
<p>Form completed by</p>	<p>Dr Sue Ellerby – Deputy Director Public Health and Anna Follows LNR cancer Services Screening Co-coordinator</p>