

## **COMMISSIONING AND MANAGING SCREENING PROGRAMMES IN THE NHS IN ENGLAND**

### **Purpose**

1. This paper is intended to be used as a best practice guide. The aim is to clarify the existing roles and responsibilities in the NHS to ensure that consistent and appropriate commissioning and performance management arrangements for screening programmes are in place.

### **Background**

2. The organisational context in which screening programmes are commissioned and managed has changed over the last two years. Strategic Health Authorities (SHAs) have been created, Regional Directors of Public Health (RDsPH) have moved into Government Offices for the Regions (GORs) and Primary Care Trusts (PCTs) have become established. This paper has been developed in conjunction with SHA and other colleagues in the light of these changes.
3. This paper summarises:
  - Features of a national screening programme.
  - Existing responsibilities for screening programmes in the NHS.
  - Existing guidance on collaborative commissioning arrangements.
  - Arrangements for implementing new national screening programmes.
  - The signposts to more detailed information and local contacts within the NHS.

### **Features of a national screening programme**

4. A screening programme invites people to undergo tests and then further investigations if their screening test is positive to achieve early detection of a condition. Screening programmes need to be organised to cover defined populations usually larger than single PCTs to function effectively and to monitor and maintain quality and safety measures. One to two million population is optimal for some programmes, for example. Individual pathways through a screening programme can involve contact with several health care organisations, so the set of services that make up a programme must be co-ordinated.

5. The requirement that there should be more benefit than harm at reasonable cost is common to all screening programmes. The criteria used by the UK National Screening Committee (NSC) to assess the viability, effectiveness and appropriateness of a screening programme are available at [www.nsc.nhs.uk](http://www.nsc.nhs.uk)
6. Quality management is designed to minimise errors and produce continuous improvement in the outcomes achieved. There are national and local components, including:
  - Error prevention, and effective management of error.
  - Year on year performance improvement.
  - Setting and resetting core and developmental standards.
  - Maintaining clear responsibility for different aspects of screening and the flow of information between those involved in running the programme components.
  - Production of an annual report on the programme
7. Quality assurance (QA) systems support programme providers in clinical governance so that core processes are met for safety, and in developing the programme performance for better outcomes for patients. Several activities are involved; the balance will depend on the nature of individual programmes. These include:
  - Accredited training programmes and continuing professional development of staff.
  - Standardised calibration of equipment e.g. for newborn hearing screening machines.
  - Participation in national laboratory QA schemes such as NQASS.
  - Re-grading of a sample of images with feedback to check consistency of interpretation in X ray and retinal photography based programmes.
  - Monitoring of standardised outcome and performance information with feedback of comparative information to local services from national analysis.
  - Information resources for patients.
  - Site visits for peer review.
  - Supporting management of adverse incidents.

### **Delivering a programme.**

8. Health care professionals and managers are responsible for their own standard of practice in contributing to the service.
9. The service manager for each component of the programme is responsible for delivery and quality of the service they manage.
10. The screening programme manager is responsible for ensuring that the set of services that make up a programme are co-ordinated across

organisational boundaries, and meet overall quality requirements. The programme manager is usually one of the service managers within the programme.

11. PCTs are responsible for ensuring that their population is covered by programmes of good quality and sometimes for elements of provision. Whilst not the sole responsibility of public health, there is an important role for public health in maintaining the programme perspective across the population and engaging all parties in relevant fora.
12. A range of organisations e.g. PCTs, hospital trusts, optometrists, private sector providers, may be involved in delivering services and take responsibility for their component of the service and its clinical governance.
13. For established programmes, there will be a small national team, (who will work in partnership with staff in local programmes) to:
  - Develop quality assurance of the operation of programmes to agreed benchmarks
  - Monitor effectiveness of quality assurance
  - Work with Royal colleges, professional bodies, the NHS and public to support programme developments, including training and information, review and provide technical and IT advice and support.

### **Collaborative Commissioning, and managing performance**

14. PCTs are responsible for securing and funding population screening programmes. Because of the features outlined above, PCTs are required to collaborate for commissioning arrangements and nominate a lead person for screening programmes as appropriate. Specialised services commissioning may be appropriate for some elements of programmes. Screening programmes are excluded from practice based commissioning.
15. SHAs are required to ensure that commissioning arrangements are robust, and to monitor performance against national standards. Annex A gives extracts from the formal guidance. Annexes B and C provides local examples of collaborative commissioning arrangements in Greater Manchester and Bedfordshire and Hertfordshire SHA.
16. SHAs are also responsible for managing performance of screening programmes, taking action on QA recommendations and for oversight of Local Delivery Plan (LDP). There is also an important developmental role for SHAs in arranging effective implementation arrangements for new screening programmes, outlined below.

### **Systems for clinical governance of cancer programmes**

17. Experience of breakdown of quality of delivery of cancer screening programmes in Kent and Canterbury and in Exeter in the past,

emphasised the need to adhere to the fundamental principle of ensuring a separation of responsibilities for:

- Systems for supporting local programmes in QA and
- performance managing action on the outcome of QA findings.

18. For cancer screening programmes, which are part of the national cancer programme led by the National Clinical Director, there is a national office, which carries out the functions as outlined in paragraph 13.

19. Responsibility was given to RDsPH, for commissioning ten regional QA teams for breast and cervical cancer screening. These teams also carry out a substantial role in communication and developmental support to new initiatives within the programmes. The QA Directors are managerially responsible to the RDPH; the RDPH is personally accountable for ensuring that:

- QA systems are robust.
- QA recommendations are directed and framed appropriately.
- QA support systems (eg provision of external visits and slide exchange schemes) are commissioned and managed.

20. These arrangements pre-date SHAs and PCTs; the UK NSC recently advised that these formal accountabilities should not be changed at present. In practice, RDsPH, SHA DsPH/Medical Directors and Cancer networks are working together, taking account of local circumstances, in ways which sometimes involve delegation of responsibilities to SHAs, but which preserve the principle of separation of QA and performance management.

### **Clinical governance of new programmes**

21. As programmes are further developed, support systems for clinical governance/QA at national level, and more local level, will be specified for these programmes in consultation with SHA DsPH, RDsPH, DH policy teams and others interested.

### **Implementing new programmes**

22. PCTs are responsible for collaboratively planning and commissioning implementation. This normally includes convening a local multidisciplinary group, agreeing the lead agency, planning and securing funding in LDPs and meeting agreed timescales. The screening programme manager is usually a member of this multi-disciplinary group.

23. The SHA role is to ensure PCTs take the lead as necessary so that multidisciplinary groups and/or specialist project teams on a time limited basis are convened as needed to support PCT commissioning of implementation. Co-ordinators covering groups of SHAs to support implementation may be part of these arrangements.

24. For major programmes being rolled out, the NSC Programme Director is supported by a small national expert support team working with the NHS led by a programme manager with a widely based advisory group. This team:

- Harnesses national expertise including the “lay” perspective.
- Sets measures and specifications.
- Develops training packages and workforce opportunities.
- Carries out national procurement for equipment, such as digital cameras.
- Advises on roll out and local implementation.
- Develops information materials for patients, parents and professionals that can be used locally.
- Develops quality management systems, and
- Monitors national progress on implementation and quality improvement.

25. Examples are the newborn hearing screening programme, and retinal screening for people with diabetes.

### **UK National Screening Committee**

26. The UK NSC has two principal functions:

- To advise UK Ministers and Chief Medical Officers on screening policy.
- To ensure that screening programmes are implemented and managed to explicit standards and with continuous improvement in performance.

27. Further details are available in the NSC Director’s report which can be found at [www.nelh.nhs.uk/screening](http://www.nelh.nhs.uk/screening)

28. Below shows a table highlighting the nationally supported programmes along with their web references:

<b>Programme</b>	<b>Website</b>
Diabetic Retinopathy	<a href="http://www.nscetinopathy.org.uk">www.nscetinopathy.org.uk</a>
Downs Syndrome	<a href="http://www.nelh.nhs.uk/screening/dssp/home.htm">www.nelh.nhs.uk/screening/dssp/home.htm</a>
Sickle Cell & Thalassaemia	<a href="http://www.kcl-phs.org.uk/haemscreening">www.kcl-phs.org.uk/haemscreening</a>
Newborn Bloodspots	<a href="http://www.newbornscreening-bloodspot.org.uk">www.newbornscreening-bloodspot.org.uk</a>
Newborn Hearing	<a href="http://www.nhsp.info">www.nhsp.info</a>
Breast Cancer	<a href="http://www.cancerscreening.nhs.uk/breastscreen">www.cancerscreening.nhs.uk/breastscreen</a>
Cervical Cancer	<a href="http://www.cancerscreening.nhs.uk/cervical">www.cancerscreening.nhs.uk/cervical</a>
Bowel Cancer	<a href="http://www.cancerscreening.nhs.uk/bowel">www.cancerscreening.nhs.uk/bowel</a>

Screening Policy Team  
 Department of Health  
 August 2005

**Extract from The Primary Care Trust (Functions) (Amendment) Directions 2002**

**Population screening**

**7B.** A Health Authority may not direct a Primary Care Trust in relation to which they are the appropriate Health Authority to exercise the functions specified in regulation 3(2) of the Regulations to the extent that they consist of preparing and implementing population screening programmes unless they have approved the commissioning arrangements for such services.

**Extract from Annex 8 of HSC 2001/024 (HA Revenue Resource Limits 2002/3)**

"Ambulance services and population screening programmes should also be secured through consortia at StHA or supra StHA level, by local agreement through a lead PCT or agency arrangement.

"For screening programmes, the consortium will also be responsible for ensuring that population registers are maintained and developed, that a range of front line staff and others are involved in shaping programme development and that service continuity with maintenance of the skilled workforce is achieved in 2002/03. Each PCT and NHS Trust will be accountable for delivery of parts of the programme that it directly provides. "

## THE CANCER SCREENING COLLABORATIVE COMMISSIONING GROUP

### *BACKGROUND, RATIONALE, TERMS OF REFERENCE*

#### **Introduction**

This paper discusses the impact of 'Shifting the Balance of Power' (STBoP) on national screening programmes, the rationale for commissioning cancer screening on a collaborative basis and outlines the terms of reference of the Greater Manchester Cancer Screening Collaborative Commissioning Group.

#### **Strategic Context**

##### STBoP and Screening

The organisational changes that followed STBoP resulted in modifications to the roles and responsibilities of those involved with screening services.

As of April 1<sup>st</sup> 2002, Primary Care Trusts (PCTs) became responsible for securing and funding population screening programmes. PCTs were also required to nominate a lead person for screening programmes and partake in collaborative commissioning arrangements if required.

Quality Assurance remains a region-wide function under the auspices of the Government Office.

Strategic Health Authorities (SHAs) are required to ensure that commissioning arrangements for all programmes are robust and to monitor performance against national standards. In order to guide SHAs in considering and approving commissioning arrangements, formal guidance was set out in Annex 8 of HSC 2001/024 (extracts in Annex A). It confirms that SHAs should identify screening programmes which need a collaborative approach and ensure that appropriate lead PCT and Screening Commissioning Group (SCG) arrangements are in place.

**Table 1 - Roles and Responsibilities for delivery of Cancer Screening Programmes post April 2002**

<b>SHA</b>	<b>GO/QA</b>	<b>Lead PCT/SCG</b>	<b>PCT/Trust</b>
<p>Identify screening programmes which require a collaborative approach</p> <p>Ensure Lead PCT and SCG arrangements are in place for screening programmes which need/require them</p> <p>Ensure and 'sign off' robust commissioning arrangements</p> <p>Ensure performance improvement in line with National Plan</p> <p>Monitor performance of programmes against national standards</p> <p>Assist in resolution of disputes</p>	<p>GO – Provide and manage QA function</p> <p>GO - Oversee implementation of new screening programmes</p> <p>QA Director and QARC , – to provide expertise, collate and provide data, organise visits, monitor outcomes, assist SHA/ others in problem resolution</p>	<p>To plan, shape and lead a robust streamlined coherent cancer screening programme across Greater Manchester and linked/associated areas, in conjunction with the cancer network.</p>	<p>Deliver existing programmes</p> <p>Provide a lead person in each PCT</p> <p>Receive funds</p> <p>Partake in the collaborative commissioning of screening programmes (as required)</p>

### **Cancer Screening and Collaborative Commissioning**

There are two established national cancer screening programmes (breast and cervical) and more may be established in future years (eg bowel, prostate).

In respect of the current programmes, the relevant targets in the 2003/4 LDP have been covered by all PCTs. However, there remains a need to secure effective commissioning and delivery of these programmes across Greater Manchester.

It is recognised that not all PCTs to have detailed knowledge of individual screening programmes and that only a limited number of hospitals or laboratories across Greater Manchester will be involved in providing services. Hence, to harness the limited expertise and resources across the conurbation, and to ensure high quality, consistent, comprehensive and equitable

screening services, a single group to oversee the commissioning arrangements for the nationally mandated cancer programmes is required. A similar group to cover the anticipated changes for ante/neonatal programmes has been convened.

National guidance has recommended that where collaborative commissioning arrangements are needed, a lead PCT should be identified. The Screening Commissioning Group will support the lead PCT in co-ordinating the clinicians and managers from all NHS bodies (including clinical networks) involved in the separate components of a screening programme and shaping how the programme is commissioned and developed.

### **Action to Date in Greater Manchester**

- All PCTs have a nominated screening lead
- Two lead PCTs have been identified for cancer and ante/neonatal programmes. For cancer this is Bolton PCT supported by the Collaborative Commissioning Team
- Two small working groups have considered the terms of reference for both Screening Commissioning Groups under the direction of the SHA and the lead PCT

### **Cancer Screening Collaborative Commissioning Group – Terms of Reference**

#### Objectives

The objectives of the lead PCT supported by the Cancer Screening Collaborative Commissioning Group (CSCCG) would be to:

- plan, shape and lead the development of a robust streamlined coherent cancer screening programme across Greater Manchester and linked/associated areas in conjunction with the cancer network
- ensure the delivery of high quality, consistent, comprehensive and equitable screening services
- harness and maximise use of limited expertise and resources across the conurbation
- ensure that, by following the patient journey, the whole system of screening and its consequences will be used to inform the commissioning and development of screening services and the related diagnostic/treatment services in primary, secondary and tertiary care.

## Roles/Tasks - of the Cancer Screening Collaborative Commissioning Group (CSCCG)

The CSCCG will be hosted by, and work with, the lead PCT to:

- Ensure that a vision/common understanding of cancer screening and its consequences are established for Greater Manchester (and associated areas) in line with national direction
- Ensure that strategic direction is provided and key tasks are identified
- Ensure that two standing working groups addressing the individual national population screening programmes are established and monitored. These will be the Cervical and Breast Clinical Subgroup(s) of the CSCCG. Other subgroups will be formed as required following the introduction of new population screening programmes. A further group is being established to cover colorectal cancer.
- Confirm, in collaboration with the breast and cervical clinical subgroups, if any other 'ad hoc' groups are required to fulfil key tasks, and agree the parameters for their work
- Ensure that the utilisation of resources is effective and equitable
- Ensure that the patient screening pathways are used to inform the commissioning process
- Ensure that innovative solutions are considered and implemented to enable local and national plans to be delivered (e.g. impact of technology)
- Ensure that an investment programmed is prepared and implications for primary care and acute hospital trusts considered
- Make recommendations to the PCT chief executives via the Cancer Network Board, and the collaborative commissioning processes, to ensure robust screening services are/will be in place
- Ensure that the PCT chief executives are made aware of the consequences of changes to the screening programme on the relevant diagnostic and treatment services via the Cancer Network Board
- Ensure that, in collaboration with the Regional QA Directors, Reference Centres and standing clinical subgroups ensure that;
  - Local policies and protocols are drafted/implemented in accordance with national guidance
  - There is a robust and consistent communication strategy
  - Mechanisms are in place to monitor the delivery of programmes against national standards and guidance. (e.g. that PCTs are

- able to report population coverage for cancer screening programmes).
  - Systems are in place to address potential deviation from required standards
- Alert the SHA, lead PCT and QA Director to any deviation in standard of care and oversee the management of such exceptions
- Act as a focal point for the system to raise / consider issues about cancer screening and work through clinical subgroups to ensure that such issues are resolved
- Ensure continued involvement of all PCTs in collaborative arrangements
- Ensure the coordinated involvement of clinicians and managers from all organisations in delivering the various components of a screening programme
- Support the Government Office in performing their QA function
- Make links with other Screening Commissioning Groups nationally, the National Cancer Screening Coordinator and the National Screening Committee as needed
- Ensure that the concept of supportive learning and sharing of good practice is established

### Roles / Tasks of the Clinical Subgroups

The Clinical Subgroups for breast and cervical cancer will:

- Support the CSCCG and lead PCT in their strategic role(s)
- Support PCT screening leads and commissioners in their local roles
- Identify, in conjunction with the screening commissioning group, other 'ad hoc' and standing subgroups required to fulfil key tasks and set parameters for their work.
- Prepare a map of current services, utilisation and expenditure
- Ensure that PCTs have a mechanism in place for investing in screening programmes by developing a prioritised investment plan for Breast and Cervical Screening programmes across Greater Manchester (and linked areas)
- Identify the implications for primary care and acute hospital trusts of any investment plan (including the consequences to the diagnostic and treatment services)

- Implement a modernisation programme to ensure that that patient pathways are used to inform the commissioning process
- Agree, in liaison with QA reference centre and CSCCG:
  - Local policies, protocols and service specifications for component parts of the programme – e.g. ensure robust population registers exist and that appropriate arrangements are in place with local information strategies to maintain them
  - A robust and consistent communication strategy
  - Partake, in liaison with QA reference centre in:
    - Arrangements to monitor the delivery of programmes against national standards and guidance - e.g. that PCTs are able to report population coverage for cancer screening programmes
    - Arrangements to monitor the implementation of the investment plan and its consequences
- Alert the CSCCG and QA Director to any deviation in standard of care and participate in the resolution of such exceptions
- Coordinate the involvement of clinicians and managers from all organisations in delivering the various components of a screening programme.

Ensure service continuity by:

- overseeing the development of a skilled workforce
- ensuring that education and training programmes are provided to underpin the delivery of screening programmes across Greater Manchester
- Work in collaboration with the respective Regional QA Director and QA Reference Centre
- Develop mechanisms to share good practice and expertise

#### Membership of the CSCCG

Chair – DPH Bolton

PCT commissioner from lead PCT

Chair of standing clinical subgroups (cervix and breast)

Regional QA Directors (cervix and breast)

Strategic Health Authority (inc workforce directorate)

Collaborative Commissioning Team

Workforce Development Confederation

Cancer lead from PH network

Network directors from GM, C&M (adjacent networks)

Clinical lead for Cancer Network

Chief Executive of an acute trust

Membership of the Clinical Sub Groups

Chair – to be decided by the Group

Clinicians – lead clinician for Cervix / Breast from cancer network

Other professional leads (as identified by screening programmes)

QA Manager

Lead/other PCT commissioning representation/ collaborative. commissioning

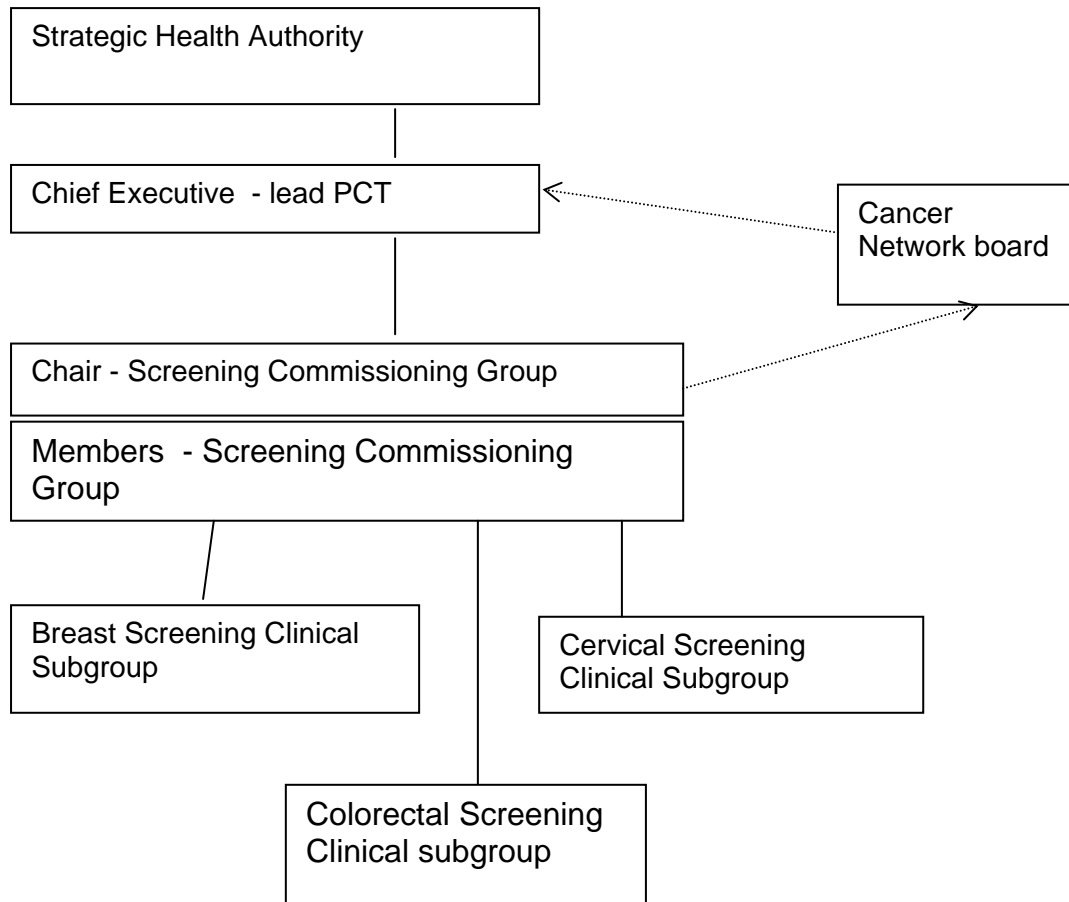
Public Health Screening lead from each of the Cancer network Sectors

Trust representatives (unless not covered above)

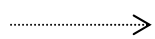
**Frequency of Meetings**

*The CSCCG should not need to meet more than three times a year. The Clinical Subgroups would define their schedule depending on the business which needs to be undertaken.*

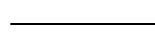
## Accountability Arrangements



### Key



Advisory



Line management accountability

## PROPOSAL FOR MANAGEMENT OF ANTENATAL AND NEWBORN SCREENING PROGRAMMES ACROSS BEDFORDSHIRE AND HERTFORDSHIRE STRATEGIC HEALTH AUTHORITY

### Background

Ensuring the delivery of high quality population screening programmes is the likely responsibility of PCTs. For these programmes PCTs need to work collectively to establish, modify and disseminate policy\* and to monitor quality and implementation. For the Breast and Cervical Screening programmes there are well established Steering Groups with clear lead PCT arrangements. However, for existing antenatal and neonatal programmes and for the new programmes to be introduced shortly, the process for their management is less clear.

### Aim

This paper aims to set out a way forward on the future management of antenatal and newborn screening programmes in Bedfordshire and Hertfordshire SHA.

### Organisation

It is proposed that existing ante-natal and neonatal programmes be considered through a common Beds and Herts Steering Group. At present several groups are working in isolation and with lack of clarity about their accountability and remit. This new group should be called the Antenatal and Newborn Screening Steering Group. It would be responsible for advising on:

- Down's Syndrome Screening Programme
- Sickle cell and Thalassaemia Screening Programme (formerly the NHS Haemoglobinopathy Screening Programme)
- MCADD (Medium Chain Acyl Coenzyme-A Dehydrogenase Deficiency) Project
- PKU and Thyroidism
- Newborn Hearing Screening Programme
- Neutral Tube Defect Screening
- Cystic Fibrosis (no schedule yet for implementation)
- Antenatal Hepatitis B and HIV screening

It is likely that for the larger single programmes eg down's screening, a sub-group would need to be formed.

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\* Defined by the UK National Screening Committee

## **Accountability**

The responsibility for planning, commissioning and monitoring the quality of screening programmes for its population rests with PCTs.

PCTs will need to work collaboratively to identify a lead PCT. It will then be the responsibility of the lead PCT to ensure the establishment of an Ante-Natal and Newborn Screening Steering Group. It will be for the Steering Group to determine the organisation of single programme sub groups.

It will be supported in this by the Public Health Network Management Team, which would propose lead PCT and management arrangements for the programme, as well as providing ongoing support to the Steering Group through the development of a Screening Coordinator role.

The Screening Steering Group would be accountable to all PCTs through the lead PCT. The lead PCT would be responsible for keeping all PCTs informed of progress and quality of the programmes.

## **Terms of reference for SHA wide Screening Steering Group**

This group should be responsible for advising on all antenatal and newborn screening programmes above and for:

- Establishing screening policy for all PCTs In the light of national advice
- Disseminating that advice
- Updating policy
- Receiving information on the uptake and quality of the individual programmes (from regional QA) and acting on that advice
- Advising on training needs of the programmes
- Advising on the investment requirements of the programmes
- Providing regular reports to all PCTs on the effectiveness of the programmes through the lead PCT

## **Membership**

The screening Steering Group should be chaired by the lead PCT with close support from a public health specialist.

The Screening Steering Group should include representation from the key professionals involved in providing the service as well as the managers commissioning the service for each PCT grouping. Specialist skills required will include public health, obstetrics, paediatrics, nursing, commissioning, lead managers of programmes.

## **The role of the Strategic Health Authority**

To ensure that robust processes are in place across all PCTs for the planning and implementation of high quality population screening programmes

To ensure clarity of policy standards for screening across PCTs

## **Recommendations**

To establish the Antenatal and Newborn Screening Steering Group for Bedfordshire and Hertfordshire.

That this group be accountable to all PCTs through a lead PCT.

That the Public Health Network be asked to identify the lead PCT and progress the development of a Screening Coordinator post in support of the lead PCT

That a position paper reflecting the above management arrangements, membership and terms of reference be prepared for consideration and agreement of all PCT Chief Executives.

**Dr M C Woolaway**  
29<sup>th</sup> November 2004