The Association of Directors of Public Health

Response to the Public Accounts Committee Inquiry into Health Screening

About ADPH

The Association of Directors of Public Health (ADPH) is the representative body for Directors of Public Health (DPH) in the UK. It seeks to improve and protect the health of the population through collating and presenting the views of DsPH; advising on public health policy and legislation at a local, regional, national and international level; facilitating a support network for DsPH; and providing opportunities for DsPH to develop professional practice.

The Association has a rich heritage, its origins dating back 160 years. It is a collaborative organisation working in partnership with others to maximise the voice for public health.

Summary

The ADPH welcomes the opportunity to respond to the Public Account Committee's inquiry into health screening. Our response builds on our letter to Meg Hillier dated 1st February 2019.

- Directors of Public Health have an assurance role to their local populations, through local authorities, to ensure that screening is safe and effective. Having read the National Audit Office (NAO) report[1], it is difficult to be fully assured that commissioning arrangements for screening are at all satisfactory.
- For screening to be done well, there are a significant number of fundamental processes which need to be in place; from increasing uptake of screening to ensuring the process of delivering it and checking that screening results are correct and quality assured. This process is vital and must be managed well.
- Our concerns are twofold, falling uptake (particularly inequalities in uptake) and commissioning arrangements (especially quality assurance and managing false positives and negatives). We have tried to highlight practical tangible examples where lack of attention to commissioning has been detrimental.
- It feels to us that there is no single concerted agency or person in charge of addressing the multiple system issues concerned with the performance, commissioning and governance of screening, and that the significant experience of local Directors of Public Health is not being drawn upon. If this continues we are concerned that lives may be lost.

1. Falling coverage and inequalities in coverage

1.1 We remain concerned about low coverage and uptake of breast and cervical screening particularly in high priority groups. It is apparent that uptake figures have fallen nationally although this is variable across the country.[2] [3] We acknowledge population growth plays a part, for example, colleagues in Greater Manchester have done more breast screens this year than

[1] https://www.nao.org.uk/wp-content/uploads/2019/01/Investigation-into-the-management-of-health-screening.pdf
[2] https://files.digital.nhs.uk/60/77DCCC/breast-screening-programme-eng-2017-18-report.pdf
[3] https://files.digital.nhs.uk/B1/66FF72/nhs-cerv-scre-prog-eng-2017-18-report.pdf

ever before but because of growth in the population cohort, the rate is falling.

1.2 As the NAO report notes, none of the adult screening programmes met their 'standard' coverage target during 2017-18 and the cervical screening programme also failed to meet their 'lower' threshold.

1.3 Providers are clearly focused on quality in those who access screening (timely identification of true positives with appropriate timely intervention; reduced false negatives and missed cases). However, the focus needs to be on the whole population, not just quality in those who attend, this is a critical point about the performance of the programme as a whole. It is a classic service user vs population perspective issue. Programmes are not performing if uptake is only around 70-75% and the answer will not be about technology but about human based health promotion (e.g. Making Every Contact Count, repeated reminders) with a focus on the never attenders.

1.4 One of the 'points' of screening is to detect disease early, provide treatment and reduce morbidity and mortality. There is a critical inequalities dimension to this. Uptake in screening is worst among the most deprived communities. They are also the communities at greatest risk of cancer. Poorly performing screening services increases their risk and vulnerability.

1.5 It is very hard to work with priority groups unless you have significant local knowledge and buy-in. For example, we are aware from one member that those who are blind or visually impaired are being systemically excluded from screening (bowel cancer in this case) on account of the material sent to those being invited not meeting the accessible information standard. Given that the programme is nationally commissioned, and members have picked up the relative inflexibility in alteration of invitation materials, this is likely to be an issue across areas.

1.6 Directors of Public Health have a system leadership role around inequalities in health. There is often an expectation that DsPH "sort" inequalities in screening coverage as part of a broader inequalities in health agenda. However, the resources go to NHS England (NHSE) local teams, so whilst DsPH do work on this, it becomes an additional responsibility with no resource or authority.

1.7 Fully resourcing screening, including increasing uptake, can allow things that do work to have impact, for example, reminders, ringing up non-responders, supporting ethnic minorities through interpreters, specialist workers for those with learning difficulties. There is both a published evidence base and experience of the impact of health promotion strategies to improve uptake in underserved groups, in our experience these types of initiatives tend to be short term funded, short lived and funded by end of year slippage.

Recommendation: Health promotion strategies to improve uptake, particularly in priority groups, should be properly resourced.

2. Commissioning arrangements, accountability and quality assurance

2.1 Not only have recent performance data made clear that the key screening services for England are declining in uptake, the NAO report also highlights that there are systematic issues in the

commissioning and governance of screening services in England which hamper effective performance and delivery of value for money. The issues identified in the NAO report seem to be inherent in screening programmes, as opposed to cancer screening per se.

2.2 A consequence of failing on some of the basic processes around commissioning screening is that people get incorrect results. In a worst-case scenario this may mean some people are given incorrect diagnoses and may be placed in a pathway into treatment later than they should be or are put to avoidable distress. Time, cost and energy then has to be spent doing extensive lookback investigation exercises to check through these, with significant distress and expense to those recalled for further tests.

Transparency over budget use

2.3 The NAO report highlights several seemingly systemic issues and makes clear the screening system failure is a commissioning failure. It would appear to not be a funding issue, as there has been no reduction in the Section 7A budget which funds screening, indeed there are many who suggest this budget consistently underspends.

2.4 We are aware that several of our members have asked via the Freedom of Information (FOI) Act about NHSE funding for screening and whether there is an underspend. Those FOI requests have been refused on the grounds they are too onerous to answer.

2.5 We are mindful that much of Section 7A is set nationally in terms of allocations and prices tend to be historic and block. We are also aware that any slippage is clawed back to the centre and has to be justified, this may be very transparent internally to NHSE but it is not transparent to the wider system.

2.6 We have had feedback that in some areas population growth may not always be adequately taken into account when setting budgets for screening programmes. We would like to receive clarity on this. Furthermore, we are aware of several views expressed that yearly rolling contracts and lack of budget flexibility don't allow creative incentivisation solutions to known and articulated problems.

Recommendation: The Committee should seek assurance that Section 7A funding allocated for screening and vaccination programmes is 100% spent on those programmes.

Governance

2.7 The system is fragmented, and governance is complex with no single concerted agency or person in charge of addressing the multiple system issues. Some DsPH cite significant barriers when working across multiple stakeholders involved in screening due to how services are commissioned and the screening pathways.

2.8 Commissioning arrangements for screening programmes sit across NHSE, Public Health England (PHE) Screening and Immunisation Teams, PHE Quality Assurance, Clinical Commissioning Groups (CCGs) and sometimes the DPH. The provision arrangements are equally complex. For example, for cervical cancer NHSE may technically commission, but money flow isn't via NHSE screening teams but via CCGs who hold the contractual levers for performance management of GPs.

2.9 There are examples of staff from the many organisations involved in commissioning screening collaborating to try to solve these problems. This is often through the leadership of the PHE Screening and Immunisation Coordinators using a data driven approach, combined with local intelligence to set and implement programmes to reduce inequalities in coverage in vulnerable groups. Our view is that this good work happens incidentally, often on account of the enthusiasm and goodwill of the staff involved rather than something that is hardwired into the institutional responsibilities.

2.10 A more holistic, family based and integrated approach to the design and commissioning of screening and immunisation services should be adopted. There are elements of Section 7A work that could reflect a 'whole family' approach as opposed to every member needing separate interactions. This approach could increase opportunistic screening and immunisation.

2.11 The National Screening Committee (NSC) has a key role as the body with the expertise to agree programme structures. For NSC programmes there needs to be a more robust and transparent commissioning system. More work is also needed to increase both professional and public understanding of screening on issues such as harms from screening and lack of infallibility.

DPH input into commissioning of screening and QA arrangements

2.12 We are concerned that NHSE decision making on commissioning is isolated from local place-based decision making and that the significant experience of local Directors of Public Health is not being drawn upon. Directors of Public Health have fundamental skills and experience in screening, and we feel they have not been included in working on this issue in a way which could have prevented the current situation arising.

2.13 For example, many DsPH only became aware of the problems with breast screening via the national news: "*The first I heard about problems with national screening was national news when I was driving to work. You would expect the DPH to receive information before then. In the past, I would have known long before that happened". Local Authority DPH* [4]

2.14 There is not enough collaboration locally at a strategic level to effectively improve uptake in geographical areas and population groups. Local Screening and Immunisation Teams do what they can but there is a lack of strategic support or funding. Screening needs to be part of commissioning and delivering for population outcomes led by place not a separate activity on its own. There should be an increased role for the local system in designing and supporting screening services, with stronger links to the third sector.

2.15 Some members have noted a seeming unwillingness from NHSE to engage with or report to Health Protection Boards and the DPH on screening with many DsPH finding it very difficult to get local information. A number of DsPH also report finding it difficult to get into key meetings. Greater transparency relating to the commissioning of screening programmes with the local

[4] https://www.gov.uk/government/publications/phe-stakeholder-research-2018-to-2019

system (PHE, CCGs, DPH) is essential.

2.16 We are aware that in some places there is good interface between the DPH and the screening and immunisation teams in NHSE. This is often through a screening and immunisation oversight group. Where the interface works well DsPH are invited to QA feedback and understand any implications of QA recommendations. However, we understand that this is patchy across the country.

Recommendation: The role of screening and immunisation oversight groups should be strengthened, and best practice shared.

2.17 There may be merit in exploring a shared responsibility with shared accountability (i.e. what will "we" do to improve screening in x area, rather than what PHE or NHSE or CCG will do). However, resourcing of this will be an issue for Local Authority public health teams given the significant cuts to the public health grant.

2.18 Specific DPH input into joint commissioning for screening is being explored in some areas such as Greater Manchester. This is likely to develop into a joint accountability function including shared ownership of the whole commissioning cycle, and acknowledgement that improvements in screening can be as much down to the locally commissioned third sector service building this into their touch points to the community as it can be about larger footprint comms and engagement.

Recommendation: We would recommend that DsPH have some involvement, communication or insight into the Section 7A accountability meeting, it would also be helpful for the DPH to feed in any issues or concerns.

2.19 ADPH would welcome clarification on the role of the new NHSE Regional DPH posts into the screening agenda.

Workforce

2.20 The makeup and capacity of staff teams to undertake the core processes associated with screening commissioning varies widely across the country. We are aware that staffing in both NHSE and Screening and Immunisation teams isn't always to the full complement and have heard evidence of often a tiny resource working on 40 plus programmes. Data and intelligence capacity is a key concern. Considering workforce on a bigger scale and movement between localities might act to increase resilience and skill mix.

Data sharing and performance data

2.21 The MOU between NHSE, CCGs and PHE needs reviewing and should be updated to include local government. It needs to be more dynamic and interactive with better divisions by localities and sub locality level. The protection over high level screening data that is completely anonymous seems out of step with other programmes. It is difficult to have or provide any assurance at a local authority level with data that is always a year old.

2.22 Reporting of screening uptake data needs to be more detailed, highlighting where the local issues are geographically and within population groups.

Recommendation: The MOU between agencies on data use and sharing needs to be updated, with LA early access included.

IT systems

2.23 Bowel screening has one national IT system which reduces the likelihood of serious issues occurring. However, breast and cervical screening pathways are much more complex. We understand that there is difficulty in agreeing who should design and contract for these systems. We are of the view that should be done once by a team expert in IT contracting and screening.

Richards Review

2.24 We have noted that there is a review being set up by Professor Sir Mike Richards. This need to incorporate perspectives from across the system, including independent senior expertise on screening.

Recommendation: Given their assurance role to local populations and their expertise around screening, DsPH (through the ADPH) should have a strong role in the Richards Review.

3. Conclusion

3.1 As the representative body for Directors of Public Health, the ADPH is of the view that the NAO report demonstrates unacceptable failure in a crucial public health service. Not only does this raise the issue of whether public monies spent on screening are being spent effectively, but the current performance is at risk of creating harm to patients, significant avoidable cost in treatment costs, investigations and potential litigation.

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