MEETING DATE:	13 September 2012
AGENDA ITEM NUMBER:	Item 6.2
AUTHOR: **JOB TITLE:** **DEPARTMENT:**	Rose LeBrun Nurse Consultant/Screening Lead Public Health

North Lincolnshire Clinical Commissioning Group

REPORT TO THE CLINICAL COMMISSIONING GROUP COMMITTEE

NORTH & NORTH EAST LINCOLNSHIRE POPULATION SCREENING PROGRAMMES ANNUAL REPORT 2011

PURPOSE/ACTION REQUIRED:	Decisions for Approval
CONSULTATION AND/OR INVOLVEMENT PROCESS:	Cancer Locality Board, Humber Cervical Screening Programme Board
FREEDOM OF INFORMATION:	*Is this document releasable under FOI at this time?* YES Public

1. PURPOSE OF THE REPORT:

It is a requirement of the NHS Screening Programmes Quality Assurance processes that an annual report be compiled for population screening programmes. This report outlines uptake, coverage and achievements of the programme. It also makes recommendations that highlight issues and risks to population screening programme during this transition year and beyond. The report requires ratification and support for recommendations by the CCG Committee.

2. STRATEGIC OBJECTIVES SUPPORTED BY THIS REPORT: *(will be populated following agreement with Council of Members)*

3. IMPACT ON RISK ASSURANCE FRAMEWORK:	**Yes**	**X**	**No**	
All population screening programme risks are identified on the PCT, Cluster and SHA risk registers. There needs to be discussion with the CCGC regarding accountabilities for all population screening programmes beyond this transition year. This annual report will form part of the Trust legacy documents				
4. IMPACT ON THE ENVIRONMENT – SUSTAINABILITY:	**Yes**		**No**	**x**
5. LEGAL IMPLICATIONS:	**Yes**	**x**	**No**	
There need to be agreements and understanding where accountabilities for some of the component parts of the screening programmes will fall during and beyond March 2013. There will still be accountabilities within GP practices in relation to this.				
6. RESOURCE IMPLICATIONS:	**Yes**		**No**	**x**
7. EQUALITY IMPACT ASSESSMENT:	**Yes**		**No**	**x**
This annual report is not a policy document.				
8. PROPOSED PUBLIC & PATIENT INVOLVEMENT AND COMMUNICATIONS:	**Yes**	**x**	**No**	
When ratified this report will be a public document.				
9. RECOMMENDATIONS:				

The CCG is asked to receive the report and note the recommendations within the report. In addition, to be aware of the responsibilities of all key stakeholders in relation to screening programmes:

- Commissioners and public health experts from NELCTP and NHSNL must continue to ensure that all the Cancer Reform Strategy (CRS) directives in the NHS Cancer Screening Programmes are fully implemented during this year of transition and beyond.
- Expert Screening commissioners and Public Health screening leads from the 4 Humber PCTs need to work closely together to ensure that a central repository is developed in which to store all important information around the commissioning and delivery of all population screening programmes.
- To ensure all screening programmes meet their key performance indicators and standards during this transition year and plans are put in place to ensure this contiunues into the future.
- Risks currently identified within each individual screening programme along with risks associated with the NHS transition need to be managed throughout this year and beyond. Also ensuring that new and

emerging structures and organisations are aware of the risks that come under their accountability.

- Continue partnership working across all component parts of all screening programmes to ensure Quality Assurance mechanisms and processes continue to improve the quality of population Screening Programmes.

- Ensuring the continuation of robust audit and failsafe mechanisms across the all screening pathways to ensure the early identification of serious untoward incidents.
- To work with emerging structures and processes to ensure the development of robust service specifications are in place and monitored.

North East Lincolnshire NHS Care Trust Plus

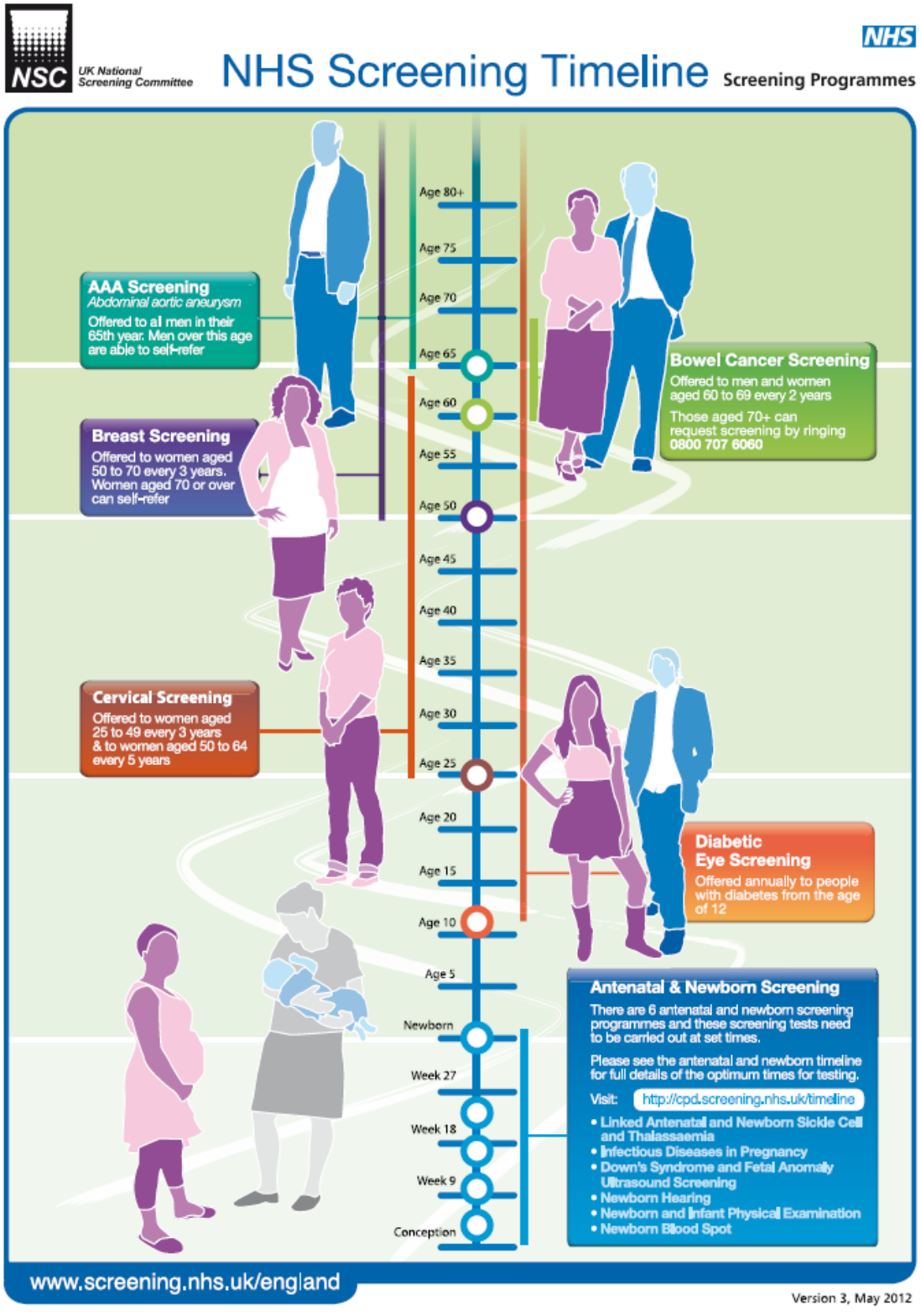
NHS North Lincolnshire

NORTH & NORTH EAST LINCOLNSHIRE POPULATION SCREENING PROGRAMMES

ANNUAL REPORT 2011

Authors:
Rose LeBrun, Marie Hancock and Phyllis Cole

June 2012



1. Source: National Screening Committee website www.screening.nhs.uk

Contents

1. Introduction

This is the combined annual report for population screening programmes across North and North East Lincolnshire for the year 2011. This report builds on the previous combined annual report (2010) and has been collated in an attempt to rationalise the number of annual reports produced relating to population screening programmes. This report outlines the population screening programmes currently available in the UK and will also show coverage for the NHS North Lincolnshire (NHSNL) and North East Lincolnshire Care Trust Plus (NELCTP) areas and incorporates performance data for the year period of 2011.

Each chapter will briefly outline the aim(s), screening provision, structure and accountability, performance data, achievements and future challenges in relation to each of the population screening programmes. Overarching recommendations will be listed at the end of the report.

This report currently excludes NHS Health Checks for vascular risk and Prostate Cancer Risk management programmes, as these are currently not NHS population screening programmes. Chlamydia screening is also not covered in this report as it is a disease management programme run by the Department of Health.

The NHS Screening Programmes

The UK has systems for making and implementing policies for population screening programmes. At the heart of this system is the UK National Screening Committee (UK NSC)[1] which gathers, synthesises and weighs evidence relating to such programmes – making policy recommendations and supporting changes and expansion within existing programmes and the implementation of new programmes.

Whilst screening has the potential to save lives or improve the quality of life through early diagnosis of serious conditions, it is not a fool-proof process and requires risk management processes to reduce the risk of doing more harm than good.

Screening can reduce the risk of developing a condition or its complications but it cannot offer a guarantee of protection. In any screening programme, there is a minimum of false positive results (wrongly reported as having the condition) and false negative results (wrongly reported as not having the condition)[1]. The UK NSC is increasingly presenting screening as risk reduction process to emphasise this point.

NHS Screening Programmes are population health programmes, which invite large numbers of apparently healthy individuals for screening and if their screening test is positive offer further diagnostic investigation. A screening programme encompasses the whole system or programme of events necessary to achieve risk reduction for individuals who have participated in the screening process.

Public Health experts oversee the functionality and co-ordination of population screening programmes at a local level, ensuring there is the provision of safe, effective, equitable and accessible population screening programmes which are provided in line with national standards.

In the UK currently the NHS screen for 33 conditions across the life course (18 antenatal, 10 newborn and 5 adult). Page 2 shows the NSC screening timeline in pictorial format. Each programme is seen and managed as a whole pathway. This includes identifying the eligible cohort of people and offering the screen (a lot of work goes in to ensuring people offered screening understand the implications and can make an informed choice); and ensuring those who receive a diagnosis following screening, get the care and treatment they need.

Cancer Screening Programmes

- NHS Breast Screening Programme
- NHS Cervical Screening Programme
- NHS Bowel cancer screening Programme

Antenatal & Newborn

- NHS Fetal Anomaly Screening Programme
- NHS Infectious Diseases in Pregnancy Screening Programme
- NHS Sickle Cell & Thalassaemia Screening Programme (linked antenatal & newborn programme)
- NHS Newborn & Infant Physical Examination Screening Programme
- NHS Newborn Bloodspot Screening Programme
- NHS Newborn Hearing screening programme

Other Adult Screening Programmes

- National Diabetic Eye Screening Programme
- NHS Abdominal Aortic Aneurysm Screening Programme

References

2. National Screening Committee website www.screening.nhs.uk

2. NHS Breast Screening Programme (NHSBSP)

2.1 Aim

The NHS Breast Screening Programme (NHSBSP) provides breast screening every three years for all women in the UK. The programme aims to detect and treat breast cancer early. Vigilance against the onset of disease is one of the first lines of defence in tackling breast cancer and breast screening is an important method of detecting abnormalities at an early stage, allowing treatment when the cancer is most likely to be curable[1].

2.2 Objectives

- Identify and invite eligible women for mammographic screening (currently women aged 50-70 years but age extension to 47-73 ongoing.)
- Carry out high quality mammography, including 2 views of each breast at every screening visit, for those women attending for screening.
- Implement the Cancer Reform Strategy requirements around digital mammography, extending eligible age range and implementing family history screening[2].
- Provide services that are acceptable to those women who receive them.
- Follow up all women who are referred for further investigations.
- Minimise the adverse effects of screening – anxiety, radiation dose and unnecessary investigations.
- Diagnose cancers accurately.
- Make effective and efficient use of resources for the benefit of the whole population.
- Encourage the provision of effective and acceptable treatment that has minimal psychological or functional side effects.
- Evaluate the programme regularly and provide feedback to the population served and those working in the programme.
- Enable those working in the programme to develop their skills and potential and find fulfillment in their work.
- Support audit and research.

2.3 Screening Provision

Humberside Breast Screening Service (HBSS) provides the Breast Screening Programme for four PCTs; NHS East Riding of Yorkshire (NHSERY), Hull PCT (HPCT), NELCTP and NHSNL. The service headquarters are located at the Breast Care Unit at Castle Hill Hospital in Hull. This hospital is part of the Hull and East Yorkshire Hospitals NHS Trust (HEY) and the Breast Screening Service provision is the responsibility of this trust. Breast screening for NELCTP and NHSNL is currently provided by the use of mobile screening units placed at strategic position within the community and at a static venue offering digital mammography within Crowell Primary Care Centre, Cromwell Road, Grimsby.

The Breast Screening Service organise invitations by eligible women registered at a GP practice. It takes three years for the HBSS to complete a circuit (or round) of all of the eligible women in each GP practices in what was the Humberside area; this is

known as a screening round. HBSS are currently undertaking screening round 8, which means the NHS Breast Screening Programme has completed 7 full screening rounds from the inception in 1988.

The Cancer Reform Strategy (CRS) requires the NHS Breast Screening Programme to extend the eligible age range for women to be screened, to include women aged 47-73. HBSS commenced the process of extending the age range in February 2011, using a nationally agreed and ethically approved randomisation process. This process needs to be managed carefully and sensitively. Women aged over 70 can elect to be screened by contacting Humberside Breast Screening Service (HBSS).

2.4 Quality Assurance

The NHSBSP is governed by nationally agreed guidelines, standards and targets that are evidence based. The programme is monitored through a national quality assurance network, North East, Yorkshire and the Humber Quality Assurance Reference Centre (QARC) is the organisation that monitors the performance of HBSS[3].

Quality Assurance is a fundamental aspect of all NHS screening programmes and the overall aim is to maintain minimum standards, review the performance and outcomes of the screening programmes, share good practice and encourage continued improvements within the screening programmes. Action plans are developed to address areas identified by QARC for further development.

2.5 Commissioning and Governance

NHS East Riding of Yorkshire currently co-ordinate the commissioning arrangements for breast screening on behalf of the four PCTs served by HBSS. A Service Specification has been developed and agreed that clearly outlines the service to be provided and the outcomes expected and the monitoring and reporting arrangements.

HBSS is governed by the Humberside Breast Screening Programme Board and is comprised of senior representatives from all of the organisations that form component parts of the programme. The programme board is responsible for the on-going development, refinement and implementation of both breast screening commissioning and service provision and also oversees the implementation of the QARC action plan. Meetings of this group continue to be held bi monthly.

2.6 Performance Data/Coverage

The **coverage** is the proportion of women resident and eligible at a particular point in time, who have had breast screening with a recorded result at least once in the previous 3 years, the target for this rate is 70% (see table 1). Increasing the length of the screening cycle over 36 months decreases the effectiveness of the screening programme. Evidence suggests this may lead to a rise in the number of women who are diagnosed with breast cancer between screening appointments, known as interval cancers.

To date the coverage rate has been used by the Care Quality Commission (CQC) as a performance indicator to assess if a primary care organisation is commissioning a service that offers breast screening every 3 years to eligible women

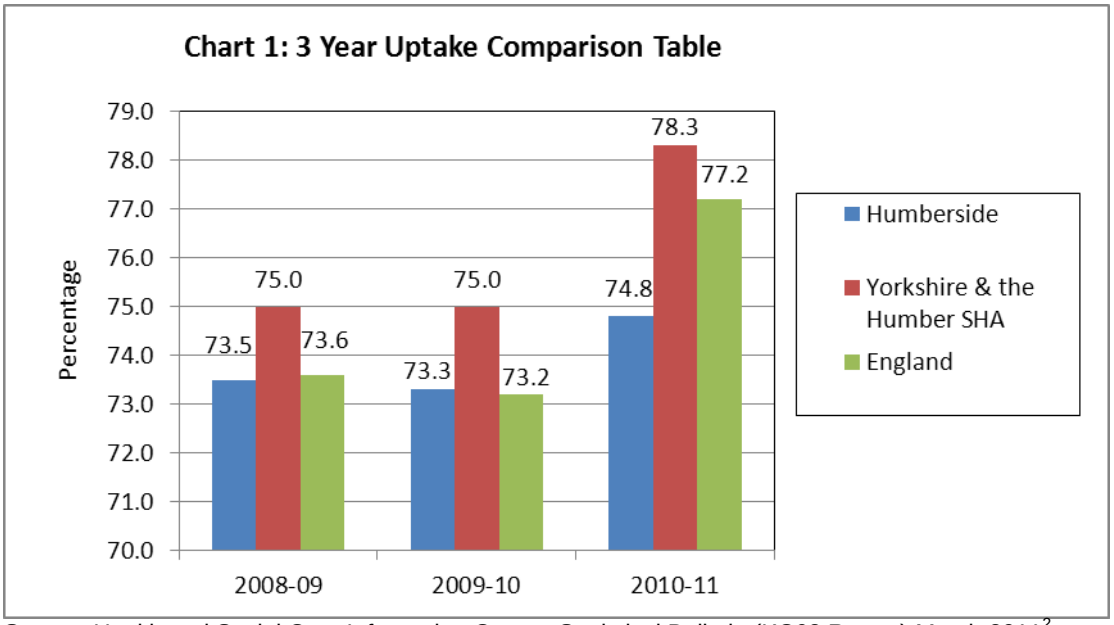
The **uptake** of the breast screening programme is the proportion of eligible women invited for screening with a screening test result recorded. The NHSBSP minimum standard for this is 70% with the ultimate target of 80% (see chart 1 and chart 2). The table below demonstrates the coverage rate of the NHSBSP for women aged 50-70 and makes a comparison by PCT, HBSS, Strategic Health Authority (SHA) and England.

Table 1: Breast Screening age 50-70 Coverage rate Comparison 2008-2011				
Organisation	**Target**	**2008/09**	**2009/10**	**2010/2011**
NELCTP	70%	76.1%	76.4%	77.1%
NHSNL	70%	79%	81.3%	80.9%
HBSS	70%	73.5%	73.3%	74.8%
SHA	70%	78.2%	78.7%	78.5%
England	70%	76.5%	77.2%	77.4%

Source: Health and Social Care Information Centre; Statistical Bulletin (KC62 Report) March 2011[2]

Table 1 shows the coverage data for the years 2008/09, 2009/10 and 2010/11. NHSNL and NELCTP have both exceeded the 70% target for coverage. The latest data shows there has been an improvement in NELCTP however NHSNL shows a small decline. For the years 2009/10 and 2010/11 both PCTs have a higher coverage rate than both the SHA and England coverage rates. The mobile units which cover both areas were not screening large numbers of women in 2010-2011 as this was the end of round 7 with round 8 beginning in Dec 2011. HBSS should be congratulated for their performance against this target as it is the result of very hard work on their part.

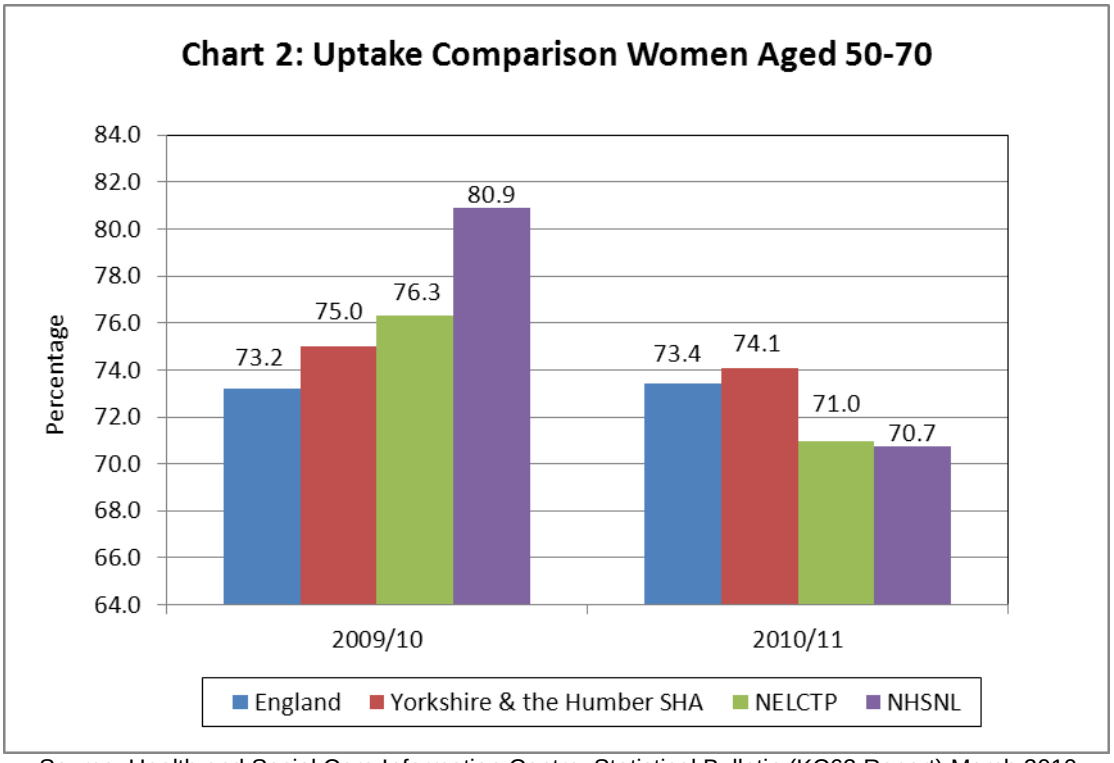
Chart 1: below shows the uptake rate for HBSS compared to the SHA and England average.



Source: Health and Social Care Information Centre; Statistical Bulletin (KC62 Report) March 2011[2]

Chart 1 shows HBSS at 74.8%, SHA 78.3% and England 77.2%. There is an improvement for HBSS in 10/11 however HBSS uptake remains lower than both the SHA and England. (This is for women aged 50-70 years). Work is ongoing at GP practice level, to improve this further and will be explained in the Cancer Health Trainer and Cancer Community Champions sections.

Chart 2: below compares the breast screening uptake rate for 2009-2011 for NHSNL and NELCTP compared to the SHA and England average.



Source: Health and Social Care Information Centre; Statistical Bulletin (KC62 Report) March 2010

Chart 2 shows a marked reduction in the screening uptake rate in NELCTP with the uptake rate down by over 5%. This is even more marked in NHSNL with a reduction of more than 10% on the 2009/10 rate. The reason for this reduction is due to the mobile screening unit doing minimal work in Northern Lincolnshire during 2010/11. The result was that in both areas only a small numbers of women were called for screening, these being identified via the failsafe process as being at being due a screen. These women are offered a first appointment to go to the nearest screening site which often means travel either to the nearest mobile unit or the breast screening unit in Hull. The travel element does have an impact on the uptake rate as seen in chart 2.

Breast screening uptake by GP practice is presented in Appendix 1. NELCTP has a wide distribution in uptake across the GP practices with 71% of practices have an uptake of 70% or above and 13% of practices have an uptake of 80% or over, which is a great achievement. However 29% of practices are under 70% for uptake of breast screening. In NHSNL 85% of practices have an uptake rate of over 70% with 20% having an uptake of 80% and above, once again this is a great achievement. There are 15% of practices with a breast screening uptake rate below 70%. This information shows that while some GP practices should be congratulated for their excellent uptake rate, other practices need to look at ways to support women to attend for breast screening.

2.7 Achievements

The cancer screening health trainers who have been funded by grants from the local authorities in both North and North East Lincolnshire, are now working very effectively with GP practices linked to HBSS plan for screening. The Health trainers are doing promotional events both in the community and within GP practices to raise awareness of the importance of attending breast screening. They are also being proactive in contacting women who did not attend their last appointment and offering advice and support to encourage and enable attendance for appointments. This work is proving to be very effective and has some excellent feedback from women and also from the QARC.

A number of volunteer community Cancer Champions have been trained in both North and North East Lincolnshire who are taking the Local Awareness and Early Detection of Cancer Initiative (LAEDI) messages out to family, friends, workplaces and the local community. This includes promoting the importance of participating in cancer screening programmes.

2.8 National Review

In October 2011 Professor Sir Mike Richards announced a review of the evidence underpinning breast screening. The review is being carried out by Professor Richards himself, in partnership with Harpal Kumar, Chief Executive of Cancer Research UK. The review report is expected in 2012 and will be presented to experts from each side of the argument, including the Advisory Committee on Breast Cancer Screening.

2.9 Future Challenges

- Ensure the local NHSBSP continues to provide a safe, effective and efficient service for the eligible population and ensure the required programme developments and Key performance Indicators continue to be implemented and achieved, during the implementation of the NHS reforms and beyond.

- The CRS requirement to extend the age range of women eligible for breast screening from 47-50 and 70-73 years is ongoing using a nationally agreed randomisation process. Within the round 8 plan GP practices will be randomised for eligible women to either receive the 47-50 year or 70-73 year extension. This is a challenging undertaking and needs to be managed with due care and discretion.

- The CRS requirement for digital mammography for breast screening has initially been introduced at the CHH site and at the new site at Cromwell Primary Care Centre Grimsby. Plans for the installation of more digital mammographic equipment will continue over the next few years.

- Family history screening within the NHSBSP- is currently provided from a variety of venues for women from the Humberside area. The genetic component is provided by Leeds General Infirmary, with some local provision at DPOWH Grimsby. This service is currently under review in line with the Cancer Reform Strategy recommendations and will be managed by HBSS in the future with local provision continuing to be available via Breast care services at DPOWH.

- Maintaining and increasing uptake of breast screening appointments – In both North and North East Lincolnshire funding grants from the Local Authorities provide additional Health Trainer resource. This was a two year grant with year one having now been completed. Securing future funding will be a challenge with commissioning moving to Clinical Commissioning Groups in April 2013.

- To recruit more Cancer Community Champions volunteers to raise awareness of breast cancer signs and symptoms and to promote breast cancer screening,

References

1. http://www.cancerscreening.nhs.uk/breastscreen/index.htm

2. NHS Cancer Reform Strategy, December 2007; Department of Health

3. http://www.neyhqarc.nhs.uk/

4. Effect of NHS Breast Cancer Screening Programme on Mortality from Breast Cancer in England and Wales, 1990-8: Comparison of Observed with Predicted Mortality. BMJ 2000:665-669

5. Health and Social Care Information Statistical bulletin KC62; Breast Screening Programme, England:2008/09, 2009/2010 and 2010/2011 (March 2011)

   http://www.ic.nhs.uk/webfiles/publications/breast_screening/Breast_Screening_Programme_Tables_2008_09.xls

   http://www.ic.nhs.uk/webfiles/publications/breast_screening/Breast_Screening_Programme_Tables_2009_10.xls

   http://www.ic.nhs.uk/webfiles/publications/breast_screening/Breast_Screening_Programme_Tables_2010_11.xls

3. NHS Cervical Screening Programme (NHSCSP)

3.1 Aim

The aim of the NHS Cervical Screening Programme (NHSCSP) is to decrease the incidence of invasive cervical cancers. This will be achieved by preventing the development of invasive cervical cancers through cytological testing of women at regular intervals and by treating asymptomatic pre-invasive disease diagnosed[1].

3.2 Objectives

- Identify and invite eligible women for cervical screening.
- Carry out high quality cervical screening services that are acceptable to those women attending for screening.
- Ensure that women receive the results of their screening test within 14 days of the sample being taken, in line with the Cancer reform Strategy[2].
- Follow up all women who are referred for further investigations.
- Minimise the adverse effects of screening – anxiety and unnecessary investigations.
- Diagnose cancers accurately.
- Make effective and efficient use of resources for the benefit of the whole population.
- Encourage the provision of effective and acceptable treatment that has minimal psychological or functional side effects.
- Evaluate the programme regularly and provide feedback to the population served and those working in the programme.
- Enable those working in the programme to develop their skills and potential and find fulfillment in their work.
- Support audit and research.
- To implement Human Papilloma Virus (HPV) triage and test of cure in line with NHSCSP requirements[3].

3.3 Screening provision

Cervical Screening is available to all women, who have a cervix and who are between the age of 25 -65 years. Invitation letters are sent to women aged 24½ years to ensure she screened and the result entered on the database by the age of 25 years. Subsequently the intervals between invitations are as follows:

- 25 - 49 years cervical screening every 3 years
- 50 – 65 years cervical screening every 5 years

The NHS Connecting for Health (CfH) 'Exeter', call and recall system invites eligible women registered with a GP within NHSNL and NELCTP to attend for cervical screening. It also keeps track of any follow-up investigation, and, if all is well, recalls the woman for screening at the appropriate time interval. The system generates Electronic Prior Notification Lists (EPNLs) and non-responder cards for GP practices and issues result letters for women who have attended for screening. This service is provided by East Riding and Northern Lincolnshire Patient Data Services.

Cervical screening samples are mainly taken in GP practices predominantly by practice nurses. A relatively small number of tests are also taken in hospital gynaecology clinics and Contraception and Sexual Health (CASH) services.

Across the Northern Lincolnshire area laboratory services for the local NHSCSP are provided by Path Links which is part of Northern Lincolnshire and Goole Hospitals NHS foundation Trust (NLAG). Path Links undertake cytology of screening samples, HPV testing and histology of biopsies taken during colposcopy. Path Links also contribute to the process of monitoring the local programme by running a comprehensive failsafe system.

Path Links provide valuable information to clinicians who take samples, this enables audit of performance. A direct referral process from Path Links to Colposcopy services is in place within NLAG. This ensures that women who have a screening result that requires further investigation have timely appointments for colposcopy.

Colposcopy services for Northern Lincolnshire are mainly provided by NLAG. Littlefield Surgery in NELCTP also provides a colposcopy service out of Freshney Green Primary Care Centre. A colposcopy is performed by a gynaecologist or a nurse colposcopist, and with the aid of a colposcope it enables a magnified view of the cervix. The colposcopist can then decide if treatment is required

3.4 HPV Triage and Test of Cure

The governments "Improving Outcomes: a strategy for cancer," set out how Human Papilloma Virus (HPV) testing would be incorporated into the NHSCSP during 2011/12[4]. The relationship between HPV and cervical cancer has been understood for a long time and as a result of experience gained from the HPV Sentinel Sites Project provided the evidence base to support this[4]. In line with National Programme requirements HPV testing was implemented into the local programme from 26th March 2012.

HPV testing is being introduced into the programme as a second line screening. It is a two stage implementation phased in over 2 years. In year 1 there will be "HPV triage" of women with a first result showing low grade abnormality, followed by "HPV test of cure" if the woman requires treatment. In year 2 test of cure will extend to all women currently in the system being followed up for abnormalities. This will mean women with abnormal results will not have to have unnecessary tests, some of which continue annually for nine years. There will also be huge efficiencies within the system with less samples being processed and eventually fewer colposcopies required.

The implementation of HPV testing into the programme affected every component part of the programme and has been a huge piece of work for all involved. Path Links have had to agree to centralise the sample preparation and cytology service to one site in Lincoln. This is a huge logistical undertaking that impacts upon staff and laboratory equipment. The centralisation process is still ongoing and is being overseen by the Programme Board. There is also a significant change to the patient care pathway and local training has been delivered to all local sample takers, supported by national information packs to GP practices and CASH services to support the implementation. All of the organisations and individuals who have worked together locally to ensure the successful implementation of HPV testing within the programme are to be congratulated for their hard work and dedication.

3.5 Quality Assurance

All component parts of the local NHS Cervical Screening Programme are quality Assured every three years, this is undertaken by the North East, Yorkshire and the Humber Quality Assurance Reference Centre (QARC) this was last undertaken in November 2011. A final report has been issued and the resulting action plan is currently being progressed.

3.6 Commissioning and Governance

The Northern Lincolnshire Cervical Screening Programme is governed by the multidisciplinary Northern Lincolnshire Cervical Screening Programme Board which meets quarterly and has membership that reflects all component parts of the local programme and QARC. The representation is in line with NHSCP guidance. The remit of this Board is outlined in further detail within the cervical screening district Policy[5]. Commissioning is also agreed via the Programme Board and fed into the Local Commissioning processes. Service Specifications have been developed and agreed locally for all component parts of the local NHS Cervical Screening Programme for 2012/13.

3.7 Performance Data/Coverage

The effectiveness of the programme can be measured by the **coverage**. This is the percentage of women in the target age group (25 to 64) who have been screened in the last five years. If overall coverage of 80% can be achieved, the evidence suggests that a reduction in death rates of around 95 per cent is possible in the long term. The latest data has just been published by the Department of Health (DH) for the year 2010/11 and is summarised in table 2 below[6].

Table 2

	2009/10			2010/11		
	25-49 3 yearly	50-64 5 yearly	25-64 5 yearly	25-49 3 yearly	50-64 5 yearly	25-64 5 yearly
NELCTP	78.2%	80%	81.6%	78.2%	79.8%	81.8%
NHSNL	77.9%	79.8%	81.2%	78.1%	79.6%	81.4%
SHA	76%	79.9%	80.2%	73.9%	78.8%	79.9%
England	74%	78.9%	78.9%	73.7%	78%	78.6%

Source: Health and Social Care Information Centre; Statistical Bulletin (KC 53 Report) 2009/0 &2010/11

Table 2 shows that for year 2010-2011, in the NELCTP and NHSNL 25-64 age group screened within a five year period there is a small increase in the overall coverage rate. This is a real success for both PCT areas when it is compared to the England and SHA average whose overall rate has decreased over the last 2 years. When the 25-49 year age group is looked at over a three year period NELCTP has stayed the same with 78.2% and NHSNL has had a marginal increase this is again better than the England and SHA averages which have both decreased. However the 50-64 year age group at five yearly screening there has been a small decrease across all areas.

Charts 3 and 4 below show the Cervical Screening Programme coverage split by ages for both NELCTP and NHSNL

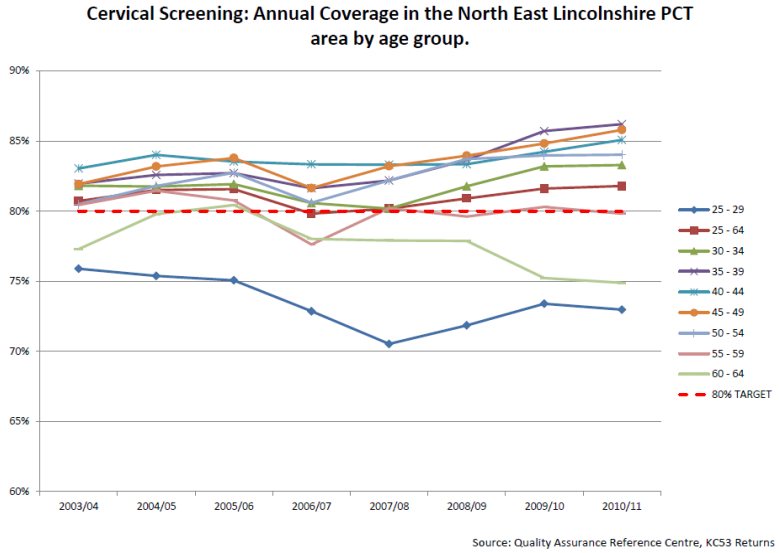


Chart 3

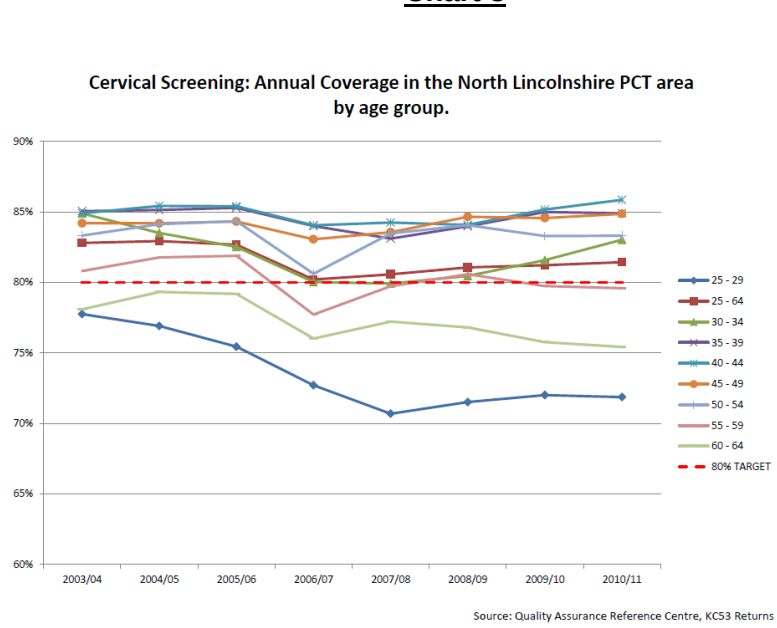


Chart 4.

Chart 3 and 4 show a similar picture for both NHSNL and NELCTP. Coverage remains at its lowest in the 25-29 year age group in both NHSNL and NELCTP. Overall 25-54 age group there is a slight increase in both PCTs from 2009.

Cervical Screening uptake by GP practice for NHSNL and NELCTP is in Appendix 2 and shows that for NELCTP there is a wide distribution in uptake across the GP practices from 60%-90%%. In NHSNL the distribution gap for GP practices is slightly

narrower from 74%-94%. This clearly shows that for some GP practices there is a lot of work to be undertaken in relation to promoting the importance of cervical screening and supporting women to attend.

In 2009 a sharp increase in screening coverage of around 3% occurred in women under the age of 35. In 2010 coverage increased in this age group again by 1.5%. The increase in attendance for screening was 70% higher than expected. This increase was around the time period when reality TV star Jade Goody was diagnosed and died from cervical cancer. The increased coverage of cervical screening translated into 370 women who had a test result of suspected neoplasia. A recent published paper in the Journal of Medical Screening, concluded it was likely that this pattern of increased screening had resulted in a number of lives saved[7]. A fitting tribute to a brave woman who allowed her terminal illness to be viewed by the nation to raise awareness of the importance of cervical screening.

3.8 Cervical Screening Results

The Cancer Reform Strategy (CRS) outlined only one directive relating to the NHS Cervical Screening Programme and this being that 100% of women receiving the result of their screen within 14 days of the sample being taken by December 2010[2]. With change in government this was reduced to 98%, the timescale however remained the same. Path Links laboratory network have worked extremely hard Implementing the 14 day Turn Around Time (TAT) for result letters, using LEAN methodology and service redesign to ensure this outcome was achieved. Continued attainment of this target also requires sample takers to ensure that screening samples are submitted to Path Links in a timely manner with appropriate attention to documentation. This is an area where some improvements can still be made.

Table 3 below shows the performance of Path Links against this 14 day TAT target for Quarters one – four of year 2011/2012.

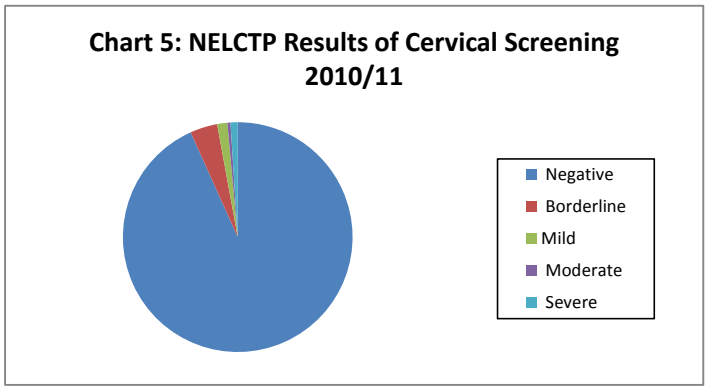
Table 3

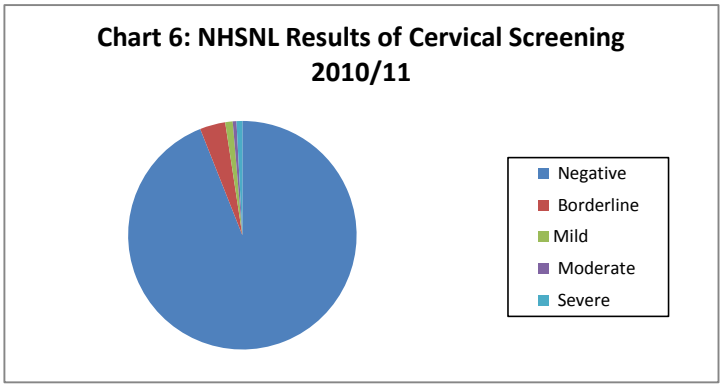
	Quarter1 April-June 11	Quarter 2 July-Sep 11	Quarter 3 Oct-Dec 11	Quarter 4 Jan-March 11
No. of samples	1648	17789	16346	19543
Results by 14 days	16461	17785	16334	10450
Percentage	**99.96%**	**99.98%**	**99.98%**	**99.52%**

Source: NEYH QARC data 2011/12

Table 3 clearly shows that Path Links are consistently achieving over the 98% target. Once again congratulations must go to our colleagues in Path Links for all of their hard work. The future challenge for Path Links is maintaining achievement of this target during the implementation of HPV triage and test of cure and throughout the process of centralisation of screening cytology and HPV testing services.

Chart 5 and 6 below show cervical screening in both NHSNL and NELCTP in relation to the type of result received for the year 2010/11.





Source: Health and Social Care Information Centre; Statistical Bulletin (KC 53 Report) 2010-2011

Both charts clearly show that year 2010/11 the majority of cervical screening samples have a negative result, for NELCTP 9,100 women were screened and 93.3% had a negative result. In NHSNL 8,900 women were screened and 94% had a negative result. This ultimately means that in NHSNL 6.7% and in NHSNL 6% of women screened required further investigations.

3.9 Achievements

- The percentage of women aged 25-49 (with a recorded result every 3.5years) has increased 0.2% for NHSNL, NELCTP remained the same this is a great achievement when England and SHA rates both reduced.
- Overall the percentage of women aged 24-64 (with a result recorded every 5 years) has increased by 0.2% for NHSNL and NELCTP, England and the SHA both had a reduced coverage.
- Path Links continues to achieve the Department of Health Cancer reform Strategy (CRS) target of 100% of results issued within 14 days.
- Following the review of cervical screening sample taker training in 2008. Mentorship training is now commissioned for York Hospitals NHS Foundation Trust. One band 7 WTE has been recruited and work is on-going to recruit a team of mentors working across the region.
- An e learning package has been developed for sample takers to undertake in conjunction with attending for a local 3 yearly update.
- 3 yearly Sample taker update training continues to be provided by the PCTs. Several sessions are planned in both PCTS in 2012. Sample takers are encouraged to complete the learning package prior to attending the yearly updates.

- QARC have developed a regional sample taker database/ learning management tool which uses the unique sample taker code. This will be automatically linked to the cytology results and enable individual funnel plotting of sample takers results. It will underpin the future establishment of quality assurance processes in primary care and the further development of clinical governance arrangements in the cervical screening programme which will we move to a CCG commissioning / Public Health England model in April 2013.
- Maintaining and increasing uptake of cervical screening appointments remains a priority. In both North and North East Lincolnshire funding grants from the Local Authorities provide additional Cancer Health Trainer resource. This was a two year grant with year one now completed. Securing future funding will be a challenge with commissioning moving to Clinical Commissioning Groups in April 2013.
- A number of Cancer Community Champions have been trained to assist the cancer team with community engagement.

3.10 Future Challenges

- The Department of Health CRS (2007)[2] set a challenging target for the NHSCSP to implement a 14 day Turn Around Time (TAT). Path Links are currently achieving this target, as outlined above. However sample takers in primary care must ensure that samples are correctly labelled, paper work is accurately completed and samples are submitted in a timely manner, to enable Path Links to continue to consistently achieve the 100% target. The implementation of HPV testing may impact on this and will require close monitoring.
- This report shows that women aged 25-29 are the least likely to attend for their screening appointment. Work must continue to promote the importance of screening and to support women to attend for cervical screening. Cancer health trainers and cancer community champions can support this work however challenges remain regarding future funding when commissioning moves to the CCGS in April 2013.
- Following the introduction of HPV testing in the sentinel sites they saw a large initial increase in the number of referrals to colposcopy particularly in year 2 of the phased implementation. This may result in capacity issues for colposcopy providers and will have an impact in year 2013/14. This will require ongoing monitoring.
- Following the QARC review in 2011 one recommendation was for the District Screening policy to be updated. A review is planned for 2012 with the aim of developing an electronic, more user friendly format.

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2. NHS Cancer Reform Strategy, December 2007; Department of Health
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4. Moss SM et al., HPV Testing as a triage for borderline or mild dyskaryosis on cervical cytology: resultsfrom the sentinel sites studies, British Journal of Cancer (2011)

5. District Cervical Screening Policy
http://nww.nelctp.nhs.uk/publichealth/documents/details.aspx?DocumentID=9141

6. Health and Social Care Information Statistical bulletin; Cervical Screening Programme, England: 2009-2010 (October 2010)

7. Lancucki L et al "The Impact of Jade Goodey's Diagnosis and Death on the Cervical Screening Programme." J Med Screen 2012:1–5 DOI: 10.1258/jms.2012.012028

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4. NHS Bowel Cancer Screening Programme (NHS BCSP)

4.1 Introduction

About 1 in 20 people in the UK will develop bowel cancer during their lifetime. It is the third most common cancer in the UK and the second leading cause of cancer deaths with over 16,000 people dying from it each year[1].

Regular bowel screening has been shown to reduce the risk of dying from bowel cancer by 16%[2]. The NHS Bowel Cancer Screening Programme (NHSBCSP) is now fully implemented nationally; this means that all people in the country 60 and over will have received an invitation to be screened. In NHSNL and NELCTP area people can expect to receive their first invitation around their 60th birthday and every two years thereafter. This will now continue up to the age of 75 years following the extension of the screening age range.

4.2 Aim

The aim of the NHS BCSP[3] is to detect bowel cancer at an early stage (in people with no symptoms), when treatment is more likely to be effective.

Bowel cancer screening can also detect polyps which are not cancers, but may develop into cancers over time. They can easily be removed, reducing the risk of bowel cancer developing.

4.3 Screening objectives

- Identify and invite eligible men and women for screening
- Enable people to make an informed choice about whether or not to participate in the screening programme
- Provide clear information quickly to people with either normal or abnormal results
- Minimise anxiety among participants in the programme
- Diagnose a significant proportion of cancers at an early stage
- Make the best use of screening resources
- Maintain minimum standards of screening and continually strive for excellence
- Involve and give feedback to the population covered by the programme
- Develop the staff who deliver the screening service
- Continue research into screening for, diagnosis and treatment of colorectal cancer

4.4 Screening provision

The Bowel cancer screening programme originally offered screening to men and women aged 60-70 years in the Northern Lincolnshire area, from mid-year 2008. In August 2010, the bowel cancer screening age range was extended and now the programme will offer two further screening invitations to people currently in the programme, effectively screening up to the age of 75 years. This is in line with the requirements of the NHS Cancer Reform Strategy requirements[4]. People aged 75

and over who are currently not in the Bowel Cancer Screening Programme but would like to be screened, can request a screening kit by telephoning **0800 707 60 60.**

Call and recall and sample testing, for the bowel cancer screening programme, is organised by the programme hub laboratory which is based in Gateshead. The Open Exeter system is used to identify and invite people eligible for screening; this is done via their date of birth. People will receive their first invitation around their 60th birthday and every two years up to the age of 74 years. Participants are first contacted by letter followed 2 weeks later by a Faecal Occult Blood test (FOBt) kit. Participants complete the screen at home and post it to the hub for testing and results are obtained within 2 weeks.

People with a positive result will be given an appointment to meet with a Specialist Screening Practitioner (SSP) who will assess and counsel clients and then arrange for further investigations which is usually a colonoscopy. This next part of the screening process is managed by HEY Bowel Cancer Screening Centre, but is locally delivered within Grimsby and Scunthorpe hospitals for ease of access.

4.5 Quality Assurance

National standards in place for the Bowel Cancer Screening Programme and all component parts of the programme are monitored by the North East, Yorkshire and the Humber QARC. HEY Bowel Cancer Screening Centre and Gateshead Hub had Quality Assurance visits within 2010 and the resulting action plan implementation is being overseen by the programme board.

4.6 Commissioning and Governance

Hull PCT currently co-ordinate the commissioning arrangements of the Bowel Cancer Screening programme on behalf of the 4 Humber PCTs served by the HEY programme. A Service Specification has been developed and agreed that clearly outlines the service to be provided but also the outcomes expected and the monitoring and reporting arrangements.

The local screening programme is governed by the North East Yorkshire and Humber Clinical Alliance (NEYHCA) Bowel Cancer Screening Programme Board which comprise of key strategic personnel from all component parts of the local programme along with representation from the Gateshead Hub and QARC. The Programme Board meets four times a year.

4.7 Performance Data/Coverage

At present the data relating to the uptake of the Bowel Cancer Screening Programme is supplied by the Screening hub at Gateshead. Currently this data is limited in the information the NHSBCSP will allow access to. This proves a challenge to the PCTs as it prevents the identification of geographical data at a meaningful level to inform targeted work. The national target for uptake of Bowel Cancer Screening is 70%, chart 7 below shows the uptake for both NHSNL and NELCTP from the commencement of the programme mid-year 2006 to year end 2011.Chart 8 and 9 compares screening uptake by gender across age ranges for both PCTs.

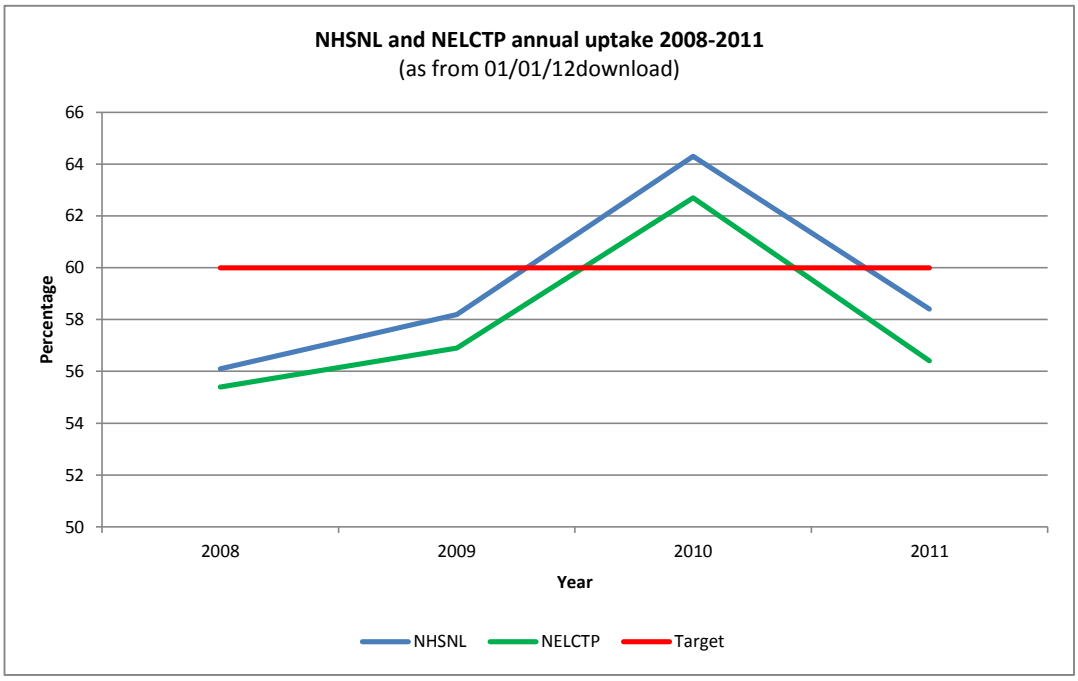

Chart 7

(Source: Gateshead Bowel Cancer Screening Programme Hub)

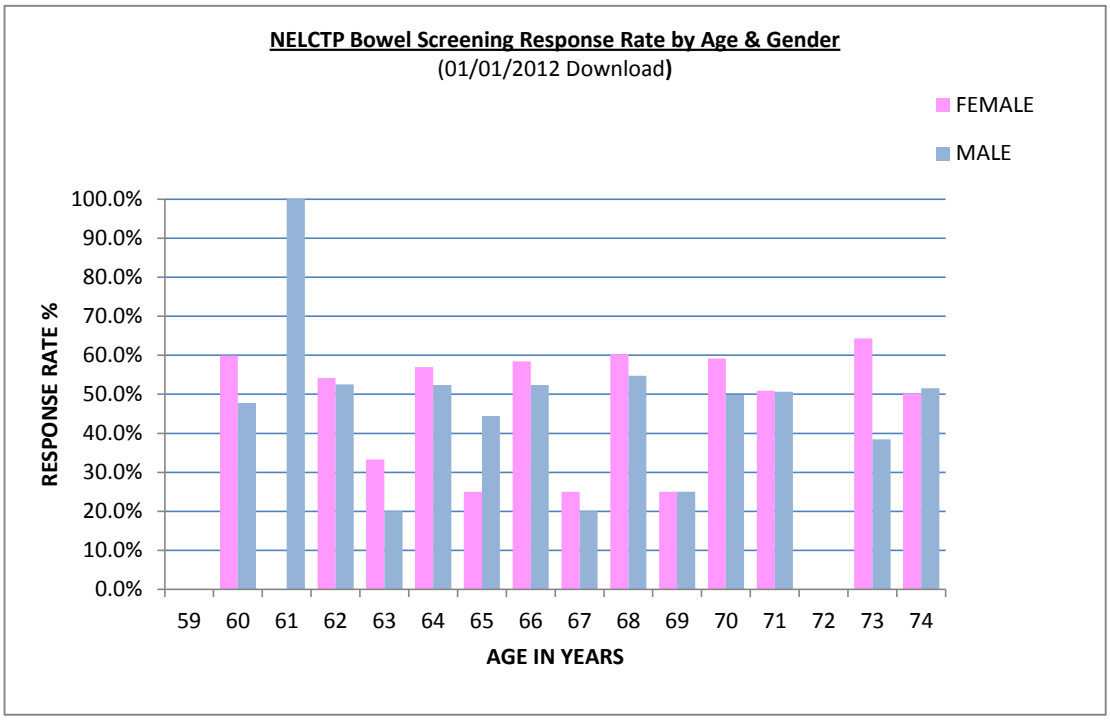

Chart 8

(Source: Gateshead Bowel Cancer Screening Programme Hub)

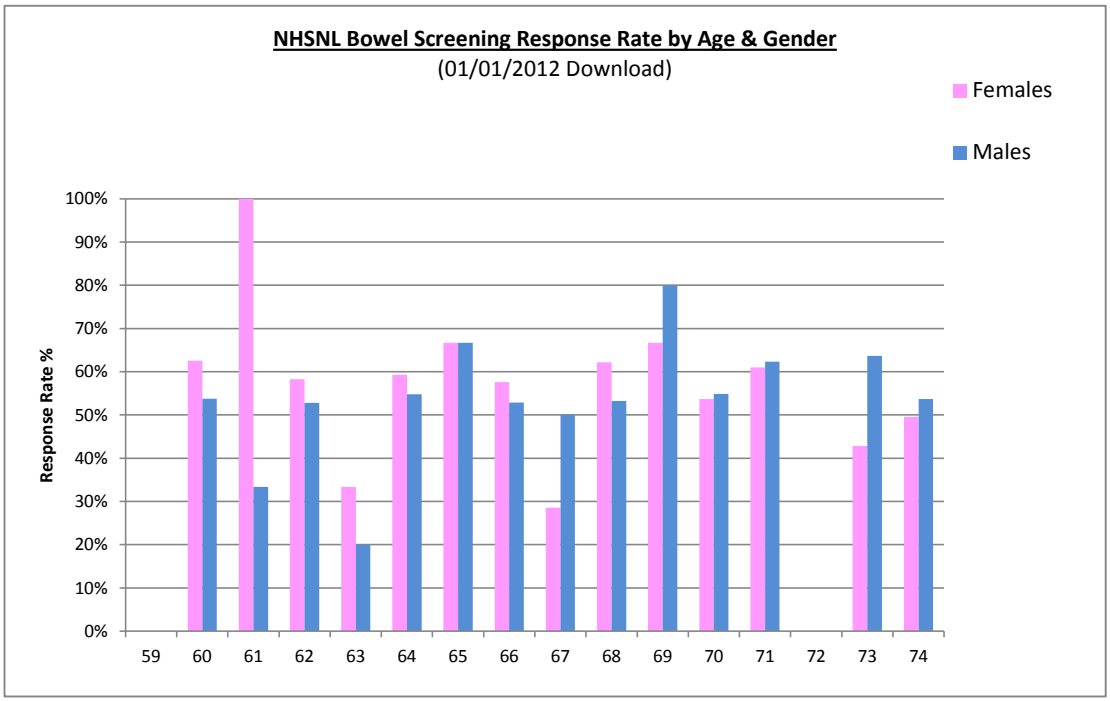

Chart 9
(Source: Gateshead Bowel Cancer Screening Programme Hub)

Chart 7 above shows that from the commencement of the NHSBCSP in 2008 both PCTs have followed a similar trend for uptake. NHSNL have always had just over a 1% better uptake. The figures for 2011/12 only show the first 3 quarters and it is expected that for quarter 4,the uptake will be better as there was a national bowel cancer campaign during this time. Neither organisation is achieving the national target of 60% consistently; therefore more work needs to be done around raising the awareness of the eligible population to the benefits of returning their screening sample.

Chart 8 and 9 compares the Bowel Cancer Screening uptake between male and female for NHSNL and NELCTP. For clarification screening appointments commence at the age of 60 and continue every 2 years on an even number birthday e.g 60, 62, 64 etc. Therefore on chart 8 and 9 you will see a variation in uptake for the odd birthday years e.g. 61, 63, 65. The numbers screened on odd birthdays are small and will reflect mainly people who did not participate initially and have requested a kit at a later date and returned it. Overall apart from post 70 years the women have a larger uptake. After 70 years the men have a greater uptake.

Screening uptake by GP practice in both NHSNL and NELCTP is shown in appendix 3. For NHSNL has a distribution of 43%-65% and for NELCTP this apparently varies form under 20% to 100% although the data available does not give the numbers behind the percentage in some cases it may reflect small numbers also the and practice that achieved 100% is questionable.

4.8 Flexible Sigmoidoscopy Screening

The NHS has decided to introduce Flexible Sigmoidoscopy (flexi sig) Screening for all men and women when they reach the age of 55years. This follows a randomized

controlled trial which concluded that flexi sig was a safe and practical test which when offered once to appropriate age group conferred substantial benefit[6].

Flexi sig is a way of looking at the inside of the bowel by using a thin flexible instrument called an endoscope. This is inserted into the rectum and guided around the lower part of the bowel. This enables the clinician to look at the lower bowel which is where most bowel cancers develop.

The practicalities of introducing this screening programme are still to be worked out. The programme board has this as a standing agenda item to ensure that all developments are disseminated. Commissioners need to be aware that this is happening and ensure they are involved in the process of planning for implementation.

4.9 Achievements

- The Local programme has now commenced the roll out of the age extension screening people up to the age of 74. This is currently 50% complete and is due to be fully implemented over the next 2 years.
- The Local Authority funding for additional Health Trainer capacity within NHSNL and NELCTP is being utilised to promote and support participation in the Bowel Screening Programme.
- In NELCTP the Cancer Collaborative volunteers continue to work very hard promoting the NHSBCSP within the area.
- Numbers of staff working within the HEY programme have increased there is now more specialist screening practitioner capacity and a programme manager/screening colonoscopist has taken up post. This meets one of the QARC recommendations.

4.10 Future Challenges

- Ensure the age extension continues to be implemented.
- Ensure more activity is planned to raise the awareness of people about the importance of returning the completed screening test.
- Ensure the continuation of a safe, effective and efficient NHSBCSP during the implementation of the NHS reforms.
- Ensure that plans are developed within all of the component parts of the NHSBCSP locally to proceed with implementation of flexible Sigmoidoscopy screening.

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3. http://www.cancerscreening.nhs.uk/bowel/index.html
4. NHS Cancer Reform Strategy, December 2007; Department of Health
5. Cochrane Database of Systematic Reviews, 2006. Screening for colorectal cancer using the faecal occult blood test: an update
6. Atkin, Edwards Et Al Once Only Flexible Sigmoidoscopy Screening in Prevention of Bowel Cancer: a multicentre randomised controlled trial. The Lancet. Vol 375 no.9726, pp 1624-1633

5. Antenatal & Newborn Screening Programmes

Antenatal and Newborn Screening Programmes consists of 7 different screening programmes that are undertaken during the antenatal and early newborn period. The National Screening Committee (NSC) currently recommends the offer of:

Antenatal screening:

- Sickle Cell and Thalassaemia
- Infectious Diseases (Hepatitis B, HIV, Syphilis, Rubella)
- Blood for haemoglobin, group, rhesus & antibodies as early as possible or as soon as a women arrives for care, including labour
- Fetal Anomaly (Down's syndrome screening & fetal anomaly ultrasound 18 – 20+6)

Newborn screening:

- Newborn Blood Spot screening for disorders; Phenylketonuria (PKU), Medium Chain Acyl CoA Dehydrogenase Deficiency (MCADD), Cystic Fibrosis (CF), Congenital Hypothyroidism (CHT) and Sickle Cell (SC)
- Newborn and Infant Physical Examination (NIPE)
- Newborn Hearing Screening Programme (NHSP)

5.1 Aims

- To offer screening to all pregnant women
- To allow parents to make informed choices concerning their pregnancy outcome
- To offer appropriate interventions to the woman and reduce the risk of onward transmission of infectious diseases
- To ensure that women who screen positive/high risk are given appropriate information and support, and that appropriate services are made available without delay
- To ensure that women who screen positive/high risk are given appropriate information and support to make the decision whether or not to have a diagnostic test, and that appropriate services are made available without delay
- To minimize harm and anxiety following a diagnosis of a Down's syndrome fetus and manage the pregnancy according to the wishes of the parents
- To offer screening for all newborns
- To ensure completeness of screen for all infants up to one year of age in relation to newborn bloodspot screening

5.2 Screening provision

- Northern Lincolnshire & Goole Hospitals NHS Foundation trust deliver through hospital and community based midwifery and paediatric service at Diana Princess of Wales Hospital, Grimsby (DPoW), Scunthorpe General Hospital (SGH) and Goole District Hospital
- Screening laboratories are based at Sheffield Children's Hospital and Northern General Hospital

- Health Visitors
- Child Health Records Department (CHRD)
- Co-ordinators for Newborn Hearing Screening in post at Acute Trust for NE Lincs and community based model within N Lincs
- North East Lincolnshire Care Trust Plus (NELCTP) & NHS North Lincolnshire (NHSNL) Public Health based Screening Co-ordinator in post in line with national standards

5.3 Commissioning and Governance

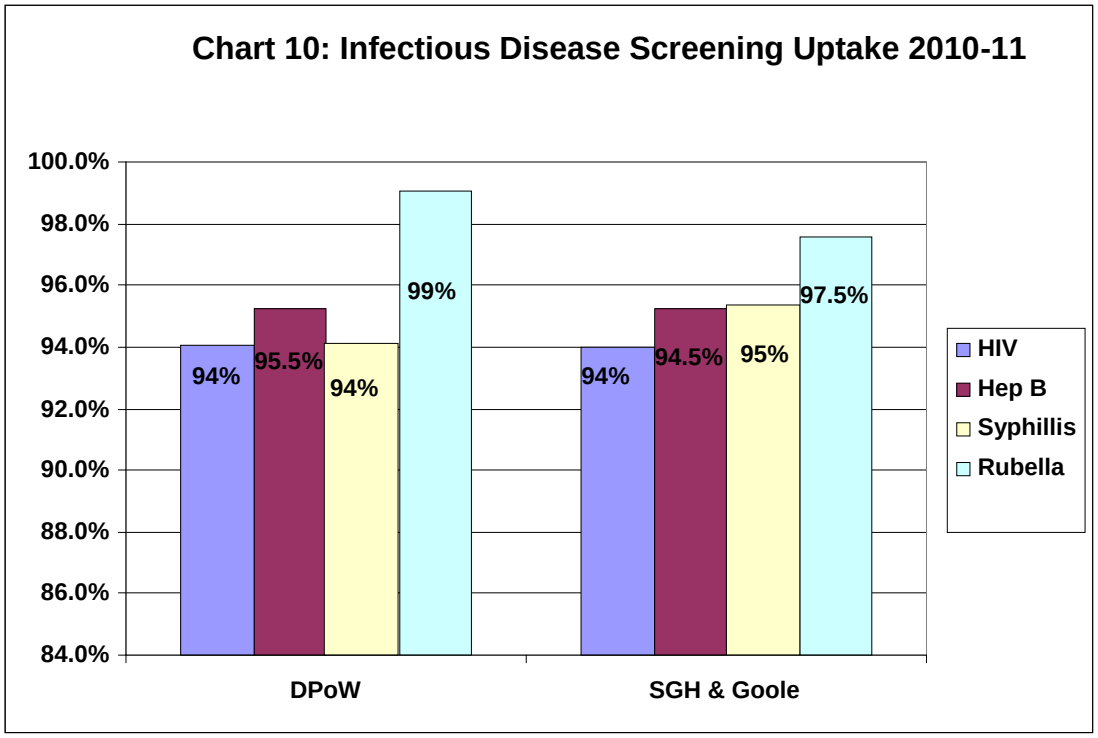
NELCTP& NHSNL led (cross site)

- Clinical Screening Steering Group (CaSSG). Commenced June 2008 meets twice yearly
- Newborn Blood Spot Screening Committee Steering Group meets twice yearly
- Consists of key screening stakeholders from all organisations to oversee implementation, changes and quality assurance of screening programmes

Regionally led Meetings

- Sub regional strategy group, incorporating commissioners, regional screening team, PCT screening leads and local screening co-ordinators to identify issues, develop action plans and share learning and good practice in a "Do Once And Share" model. Quarterly Key Performance Indicator data requirement for performance management

5.4 Data Collection

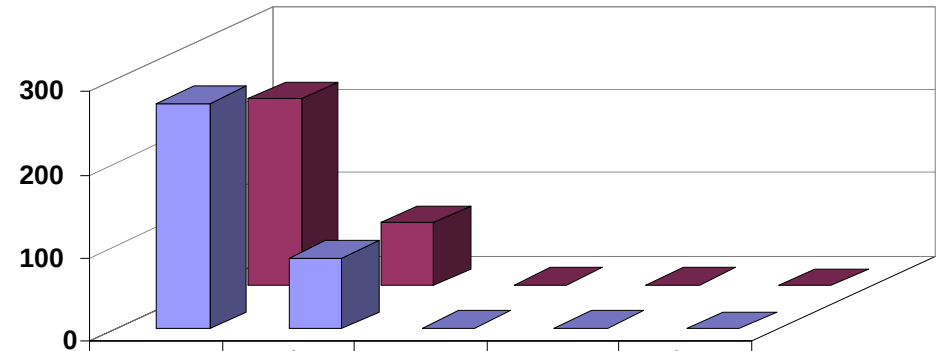


Source: Cicconia Maternity Information System (CMIS)

- DoH set an uptake target of 90% for HIV screening

- Policy in place for provision of postnatal MMR vaccination to Rubella non-immune women identified by antenatal screening

Chart 11: Sickle Cell & Thalassaemia Screening 2010/11

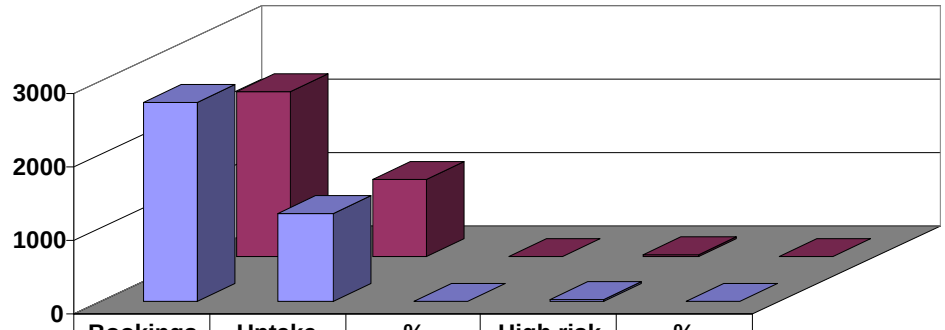


	Bookings	Numbe screened FO	Scree positiv	Partne Tests/result	Number at ris pregnancie
DPo	291	73	18	18	1
SGH &	243	67	21	18	0

Source CMIS/Path Links

- DPoW **25.3%** & SGH **27.6%** of overall bookings selectively screened by Family Origin Questionnaire

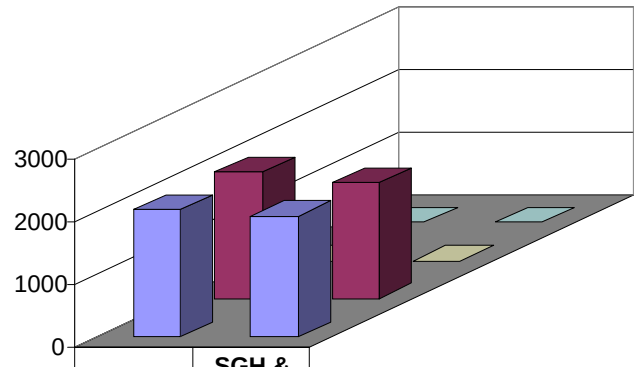
Chart 12: Down's Syndrome Screening 2010/11



	Bookings	Uptake	%	High risk	%
DPoW	2912	1144	39.2%	44	3.8%
SGH & Goole	2245	1060	47.20%	41	3.8%

Source: Sheffield Immunology Lab

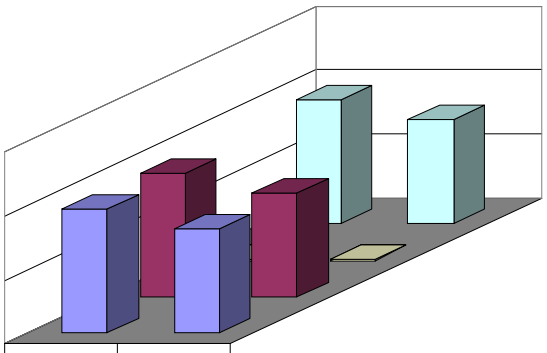
Chart 13: NHSP coverage 2010/11



	DPoW	SGH & Goole
Total babies	2717	2022
4 week completed screens	2487	1861
%	98.1%	98.2%
Standard	>95%	>95%

Source: NHSP Quality Standards Headline Report A & C

Chart 14: Newborn Bloodspot Screening 2010/11



	NE Lincs	North Lincs
Total births & resident babies	1913	1623
Tests offered	1913	1623
Declines	2	1
Total tests	1911	1622

Source: CHRD (NELC & NHSNL)

- Performance measures **Standard 1**- completeness of offer, **Standard 9** – completeness of uptake and **Standard 8** - timely identification of babies for whom the CHRD has not received notification of specimen received in lab, screening test result or decline

5.5 Achievements

- Implementation of early pregnancy combined NT & biochemical testing for Down's syndrome screening as primary test at SGH site from April 2010 with second trimester biochemical 'Triple Test' as secondary test on offer
- Implementation of normal results letter to parents in line with newborn blood spot screening national standards
- Implementation of bar code labels for Newborn Bloodspot Screening and mandatory use of NHS numbers for screening in line with newborn blood spot screening national standards
- Participation in external quality assurance reviews for newborn hearing screening programme

5.6 Future Challenges

- To continue to meet the standards of the UK National Screening Committee & Department of Health 2007- 2010 model of best practice recommendations for Down's syndrome screening
- Meet the developing external quality assurance mechanisms requirements
- Improving and auditing failsafe mechanisms across the screening pathways
- Meeting the recommendations from the external quality assurance reviews for NHSP
- Implementation of NIPE standards and proposed IT infastructure to support the programme
- To implement the forthcoming fetal anomaly screening standards review outlining exist gaps within current service provision
- To work with Commissioners to develop and embed service specifications for all screening programme in line with quality assurance processes
- To consider the gap analysis recently undertaken in line with revised Infectious disease screening standards

References

1. UKNSC (2007), Antenatal Screening - Working Standards for Down's Syndrome Screening 2007 http://fetalanomaly.screening.nhs.uk/standardsandpolicies accessed Feb 2012

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4. UKNSC (2008), Newborn blood spot screening in the UK Policies and standards http://newbornbloodspot.screening.nhs.uk/standards#fileid10827 accessed Feb 2012

6. NHS Diabetic Eye Screening Programme (NHSDESP)

6.1 Aim

The primary aim of the programme is to facilitate early identification and treatment of sight threatening diabetic retinopathy through a systematic programme of screening using digital retinal photography[1,2]. This is followed by a two- or three- stage image grading process to identify the changes of sight-threatening diabetic retinopathy in the retina. Effective treatment can then be undertaken at the appropriate stage during the disease process.

6.2 Objectives

- Identify and invite eligible people with type 1 and type 2 diabetes for screening on an annual basis
- Provide screening close to people's homes via mobile screening units, utilising GP practices, community clinics and hospitals.
- Enable people to make an informed choice about whether or not to participate in the screening programme
- Provide clear information quickly to people with either normal or abnormal results
- Minimise anxiety among participants in the programme
- Diagnose changes in the retina at an early stage
- Make the best use of screening resources
- Maintain minimum standards of screening and continually strive for excellence
- Provide timely treatment interventions for people diagnosed with diabetic retinopathy
- Involve and give feedback to the population covered by the programme
- Develop the staff who deliver the screening service

6.3 Screening provision

The Diabetic Eye Screening Programme is offered to everyone above the age of 12 years with a diagnosis of type 1 or type 2 diabetes, this is done on an annual basis.

The Humber Diabetic Eye Screening Programme is provided and managed by HEY and provides the screening for the eligible population of NHSNL and NELCTP. The screening photography is undertaken using mobile screening units placed in strategic locations utilising GP practices and community facilities as a base. This ensures that screening is provided at a local level. Each mobile screening unit has a ramp attached to enable access for people in wheelchairs.

For individuals who are identified as requiring monitoring, further investigation and treatment this is provided by the ophthalmology departments of both Grimsby and Scunthorpe hospitals.

6.4 Quality Assurance

The Quality Assurance process for this screening programme is via the national programme and there is a Regional Quality Assurance lead who co-ordinates the QA

visits. The HEY programme had a Quality assurance visit in 2009 and an action plan is being implemented and monitored by the local programme board.

6.5 Commissioning and Governance

Hull PCT co-ordinate the commissioning of the Humber Diabetic Eye Screening Programme, on behalf of the four Humber PCTs. A comprehensive Service Specification including key performance indicators is in place for this programme.

The governance of the local programme is undertaken by the Humber Diabetic Eye Screening Programme Board, which comprises of key personnel from all component parts of the screening programme, commissioners and public health leads for the 4 PCTs. The programme board meets bi monthly.

6.6 Performance Data/Coverage

During the 2011 following the change over to the new version of the Orion database serious problems were identified with the data HEY Diabetic Eye Screening Programme gave the following statement for this annual report:

“In 2011 a Serious Untoward Incident was declared last year in the Hull Diabetic Eye Screening Programme, as a number of data quality issues were highlighted. As a result of this, a comprehensive data quality review has been undertaken by the service. On-going work to perform a data cleansing of the whole system has been progressing well and is being monitored by the programme board. However it was felt that it would be inappropriate to produce a report based on current data, as this could give a misleading profile of the service. It is anticipated that following completion of the data cleansing, together with the Planned IT system upgrade in June 2012 to Digital Health from the Orion system. The service has given assurance that the data will be ready for reports from September 2012.“

The NHSDESP director acknowledges there has been a problem with the programme software throughout the programme. A national IT solution has been developed which will be funded nationally and this will be available from October onward to upgrade the current software.

6.7 Achievements

- There has been an improvement in the accuracy of GP practice registers of people with diabetes.
- All of the screening practitioners have now gained a certified qualification in line with National guidance.
- HEY have now appointed a programme manager and a failsafe co-ordinate for the North Bank service. Resource for the same post in Northern Lincolnshire area is still to be identified.

6.8 Future Challenges

- Ensure that the IT solution is safely installed with current data mapped accurately.
- Resource needs to be identified to provide a failsafe co-ordinator to work within NLAG, to ensure the robustness of the IT systems and processes across Northern Lincolnshire.

- Reducing the number of people who DNA for their screening photography appointment is a priority. GP practices need to be more proactive in ensuring eligible people with a diagnosis of diabetes, understand the importance of attending for screening.
- There continues to be an issue around venue configuration, to enable the screening programme to be delivered in a more efficient way, this particularly related to NHSNL and will require GP practices to agree key screening sites and venues to be utlised by the programme.

References

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2. National Screening Committee website www.screening.nhs.uk

1. English National Screening Programme for Diabetic Retinopathy, 2009." *Essential elements in developing a diabetic retinopathy screening programme."* Workbook 4.3,

7. Abdominal Aortic Aneurysm Screening Programme

71 Aim

The aim of the National Abdominal Aortic Aneurysm Screening Programme (NAAASP) is to reduce Abdominal Aortic Aneurysm (AAA), related mortality by 50% by providing a systematic population based screening programme for the male population during their 65th year, and on request for men over 65[1, 2].

7.2 Objectives

- Identify and invite eligible men to the AAA screening programme
- Provide clear, high quality information that is accessible to all
- Carry out high quality ultrasound on those men attending for initial or follow up screening
- according to national protocol
- Minimise the adverse effects of screening - anxiety and unnecessary investigations
- Identify AAAs accurately
- Enable men to make an informed choice about the management of their AAA
- Ensure appropriate and effective management of cardiovascular risk factors identified through screening
- Ensure high quality diagnostic and treatment services
- Promote audit and research and learn from the results

Ruptured AAAs account for 1.36% of deaths in men aged 65+ in England and Wales. This equates to approximately 150 deaths per year in men aged over 65 in the North East. Prevalence is six times greater in men than in women. As most ruptured AAAs occur in older people, the prevalence is likely to rise in line with an increasingly ageing population.

About half of deaths from ruptured AAA occur before admission to hospital, and there is also significant mortality following emergency treatment. Overall, a ruptured AAA carries a risk of mortality of between 65-85% compared to a mortality risk of between 5-7½% for elective surgery.

7.3 Screening Provision

The Eastern Yorkshire and Humber AAA Screening Programme (EYHAAASP) covers the geographical area of East Riding of Yorkshire, Hull, Scarborough, North and North East Lincolnshire with a catchment population of 1 million. The screening programme is provided by HEY, which is also the dedicated vascular center for the population cohort. During 2012/13 Permission has recently been given to expand coverage of the NEYNL programme to the Harrogate, York, Selby regions and the remainder of Ryedale.

The AAA screening programme is delivered at locations, usually GP practices and primary care centers within North and North East Lincolnshire. Although there are still some issues around use of premises as central venues and standardised affordable costs.

The programme invites all men in their 65th year to attend for an ultrasound scan of their upper abdomen to determine if they have an aortic aneurysm. Men found to have an aortic diameter of between 3.0cm and 5.4cm (around 5%) will be invited for regular surveillance appointments. Men with an aortic diameter of 5.5cm and above will be referred directly to Vascular Services for specialist assessment. Men over the age of 65 who have not previously been screened or treated for an AAA can request to be screened by contacting their local screening office.

The results of the screen are communicated to the participant verbally immediately after the scan. A written result is sent shortly afterwards to both the participant and their General Practitioner.

7.3 Commissioning and Governance

NHS East Riding of Yorkshire leads the commissioning of the North East Yorkshire and North and North East Lincolnshire National AAA Screening Programme on behalf of the four PCTs. A comprehensive Service Specification is in place for this programme.

The governance of the local programme is undertaken by the Programme Board, which comprises of key personnel from all component parts of the screening programme, commissioners and public health leads for the 4 PCTs. The Programme Board currently meets quarterly.

7.4 Quality Assurance

A Quality Assurance process has now been devised and piloted at a national level for this new screening programme.

7.5 Uptake

Chart 4 below shows the uptake of AAA Screening in NHSNL, NELCTP, EYHAAASP and England.

Chart 4			
PCT	**Total Number of Eligible Men**	**Number of Eligible Men Tested**	**No Men with Aorta >= 3cm**
NHSNL	727	642 (88.31%)	3 (0.41%)
NELCTP	922	824 (89.37%)	7 (0.76%)
EYHAAASP	6,466	5,668 (87.6%)	68 (1.05%)
England	109,431	89,543 (81.3%)	1,239 (1.13%)

Source: NHS AAA Screening Programme Activity Report up to end of February 2012

Chart 4 shows that NHSNL achieved 88.3% uptake and NELCTP 89.3% this is marginally better than the average for the local programme (87.6%) and a lot higher than the England average which was 81.3%. During the 2010/11 time period 3 (0.41%) men in NHSNL and 7 (0.76%) men in NELCTP were put on annual surveillance. This percentage of men is lower than the proportion in the local programme cohort (1.05%) and the England average (1.13%).

Chart 5 below show the number of men in each PCT area that self referred for AAA screening.

Chart 5			
PCT	**No of Patients who Self Referred**	**Percentage of Offered Subjects Tested**	**No Patients with Aorta >= 3cm**
NHSNL	43	100.00%	2 (4.65%)
NELCTP	32	100.00%	0 (0.00%)

Source: NHS AAA Screening Programme Activity Report up to end of February 2012

Chart 5 shows that all of the men that self referred attended their appointment and in NHSNL 2 more men were identified as requiring annual surveillance.

The 2 tables above show a very promising start for the uptake of this new screening programme both in relation to the uptake figures and the men identified for surveillance.

7.6 Achievements

EYHAAASP managed to screen virtually the entire cohort within the screening year which is a great achievement given on-going difficulty locating reasonably priced and suitable venues in NLPCT and NELPCT regions.

The programme had the lowest rate in England, for men who did not attend (DNA) their appointment (16.8%).

The programme only had 16 men whose aorta could not be visualised; these men have since gone on to be successfully screened.

The programme received 65 self referrals requests from Northern Lincolnshire men aged 65+ age group, two of whom are now in 12 monthly surveillance.

There have been 2 successful open repairs of AAA undertaken on NELPCT men.

7.7 Issues

- NHSNL and NELCTP will need to work with the programme manager to identify suitable venues from which to provide this screening programme within the local area as this issue still has not been fully resolved.

- This relatively new screening programme should continue to be promoted widely within North and North East Lincolnshire to ensure that eligible men understand the importance of attending for their screening appointment.

References

aaa.screening@nhs.uk
National Screening Committee website www.screening.nhs.uk

8. Recommendations

Within this annual report each screening section has ended with a section outlining the current issues for that programme. The recommendation section does not intend to combine all of these issues into one long list, Key recommendations will be highlighted, that are a common thread throughout all population screening programmes at this present time. It is crucial to ensure the maintenance of safe, effective and efficient population screening programmes that meet standards and Key Performance Indicators, throughout the NHS transition period and beyond. Ensuring that all key stakeholders are aware of their responsibilities in relation to screening programmes.

- Commissioners and public health experts from NELCTP and NHSNL must continue to ensure that all the Cancer Reform Strategy (CRS) directives in the NHS Cancer Screening Programmes are fully implemented during this year of transition and beyond.
- Expert Screening commissioners and Public Health screening leads from the 4 Humber PCTs need to work closely together to ensure that a central repository is developed in which to store all important information around the commissioning and delivery of all population screening programmes.
- To ensure all screening programmes meet their key performance indicators and standards during this transition year and plans are put in place to ensure this contiunues into the future.
- Risks currently identified within each individual screening programme along with risks associated with the NHS transition need to be managed throughout this year and beyond. Also ensuring that new and emerging structures and organisations are aware of the risks that come under their accountability.
- Continue partnership working across all component parts of all screening programmes to ensure Quality Assurance mechanisms and processes continue to improve the quality of population Screening Programmes.
- Ensuring the continuation of robust audit and failsafe mechanisms across the all screening pathways to ensure the early identification of serious untoward incidents.
- To work with emerging structures and processes to ensure the development of robust service specifications are in place and monitored.

9. Conclusion

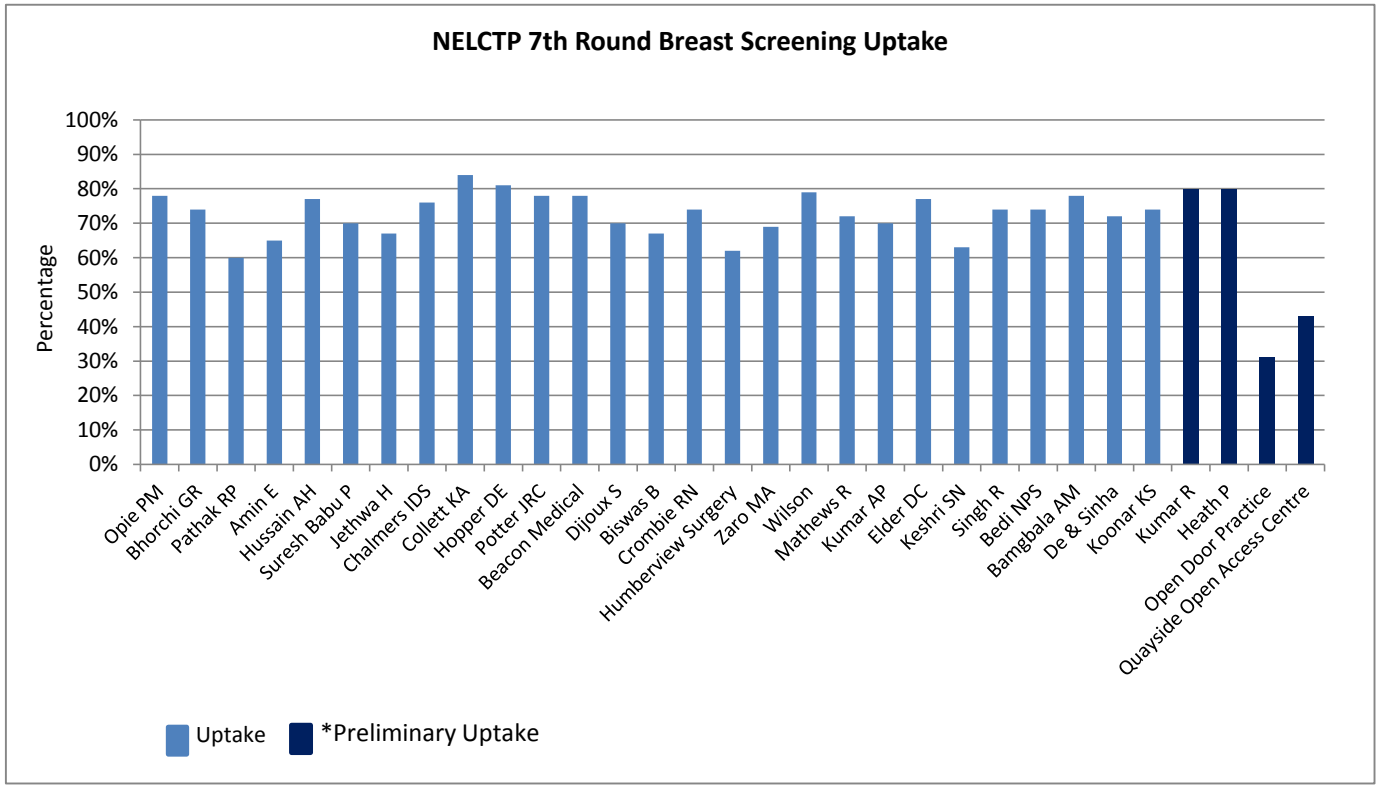
This annual report for NHS Population Screening Programmes within North and North East Lincolnshire highlights just how many screening programmes are now functioning in the area and the volume of well people that attend screening appointments during a year,

Population Screening Programmes are excellent examples of partnership working in action. The achievements highlighted within this report show that all of the organisations who form component parts within each screening programme have worked exceptionally hard over the last year to deliver some real results for the area.

All population screening programmes are national programmes; they are continually being monitored, evaluated and developed. As a result national guidance around changes and developments within screening programmes is constantly being cascaded for implementation at local level. This ensures that all population screening programmes are delivered consistently across the country and are of high quality being as safe, effective and efficient as possible.

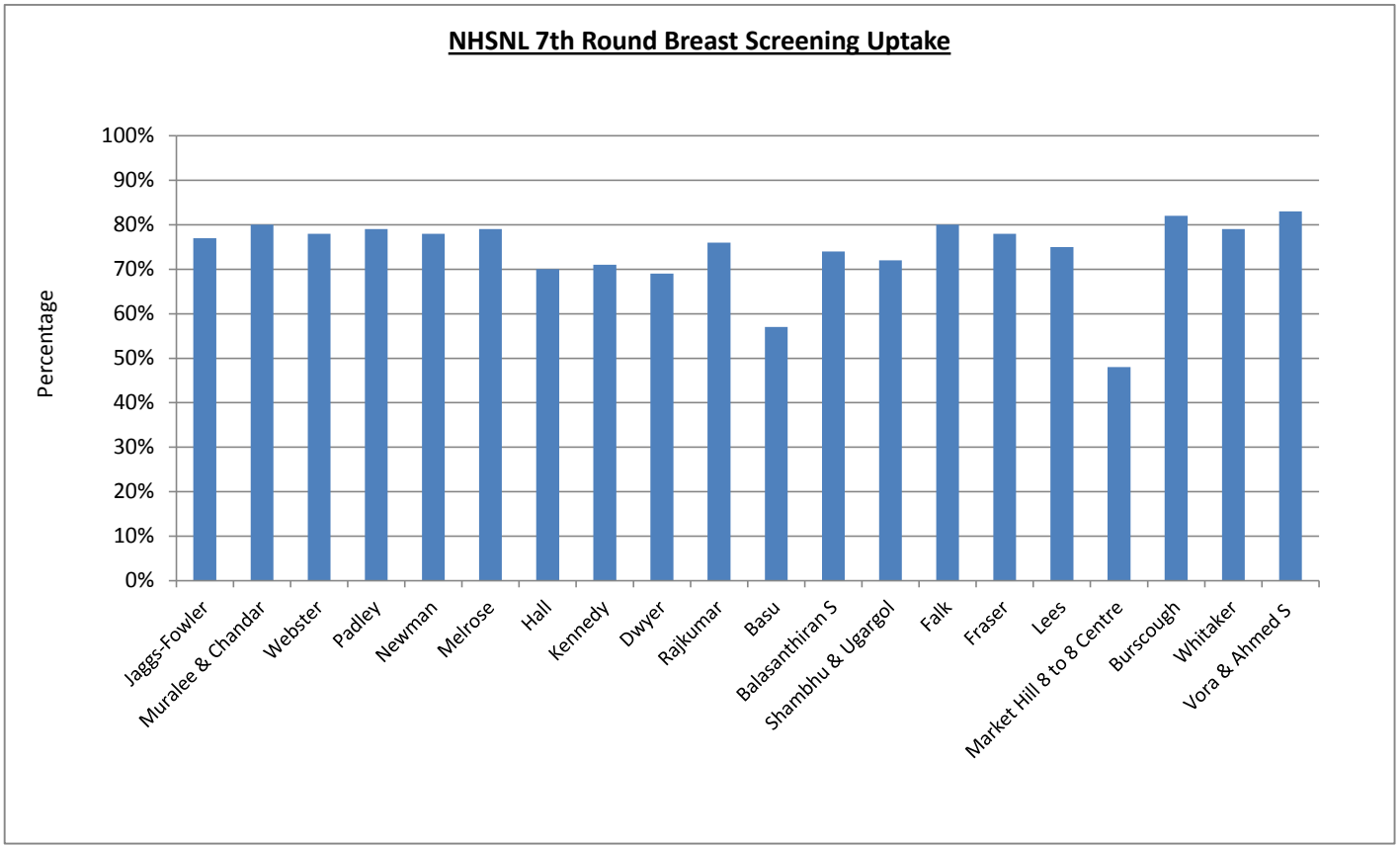
The Recommendations within this comprehensive report are all really important issues within each individual screening programme. When they are all put together it makes an enormous amount of planning, implementation and risk to manage. In addition to the daily work of co-ordinating and ensuring that population screening programmes are safe and effective for the local population. What is becoming apparent during this period of transition while the NHS Health and Social Care Reforms are implemented is that the screening expertise across the four Humber PCTs is very small. Work is ongoing to ensure that this scarce resource is functioning as a team to best serve the needs of population screening programmes.

Appendix1



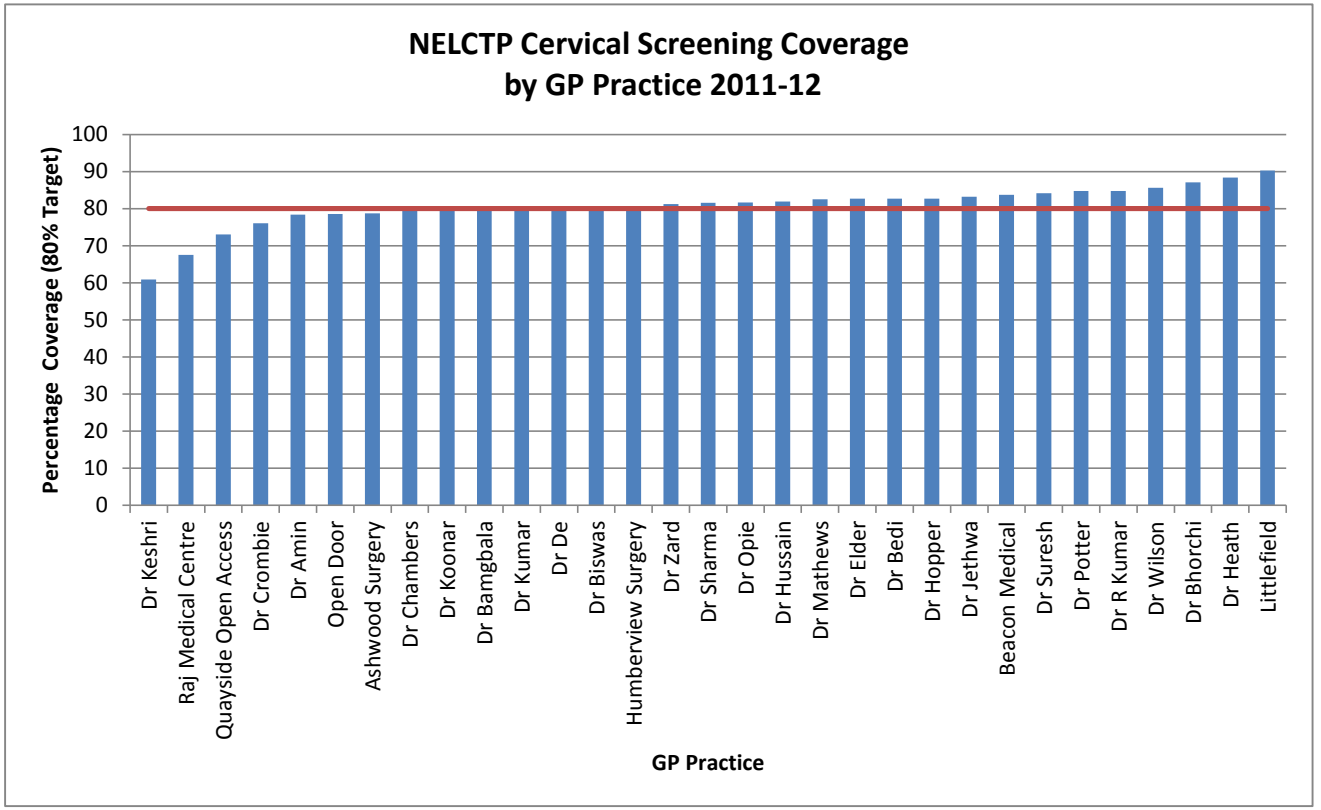
*Preliminary uptake is based on raw data not yet ratified by the NHSBSP

Source: HBSS live round plan

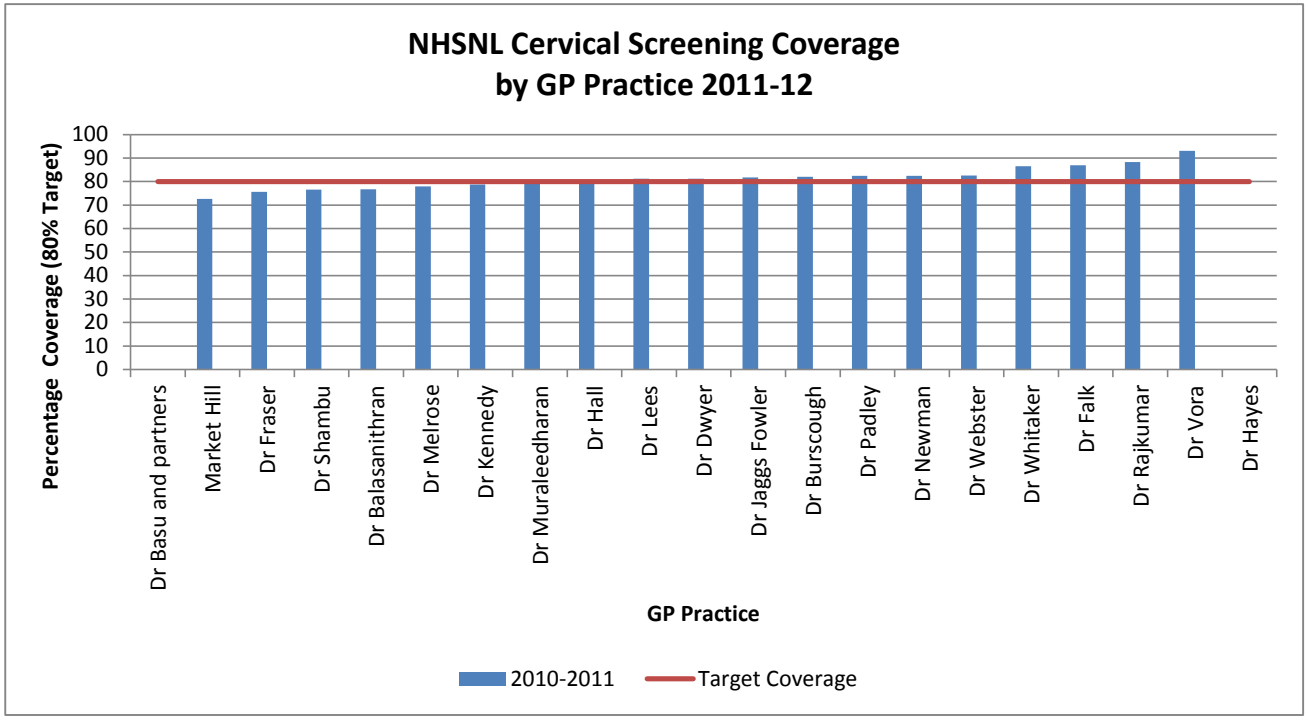


Source: HBSS live round plan

Appendix 2.

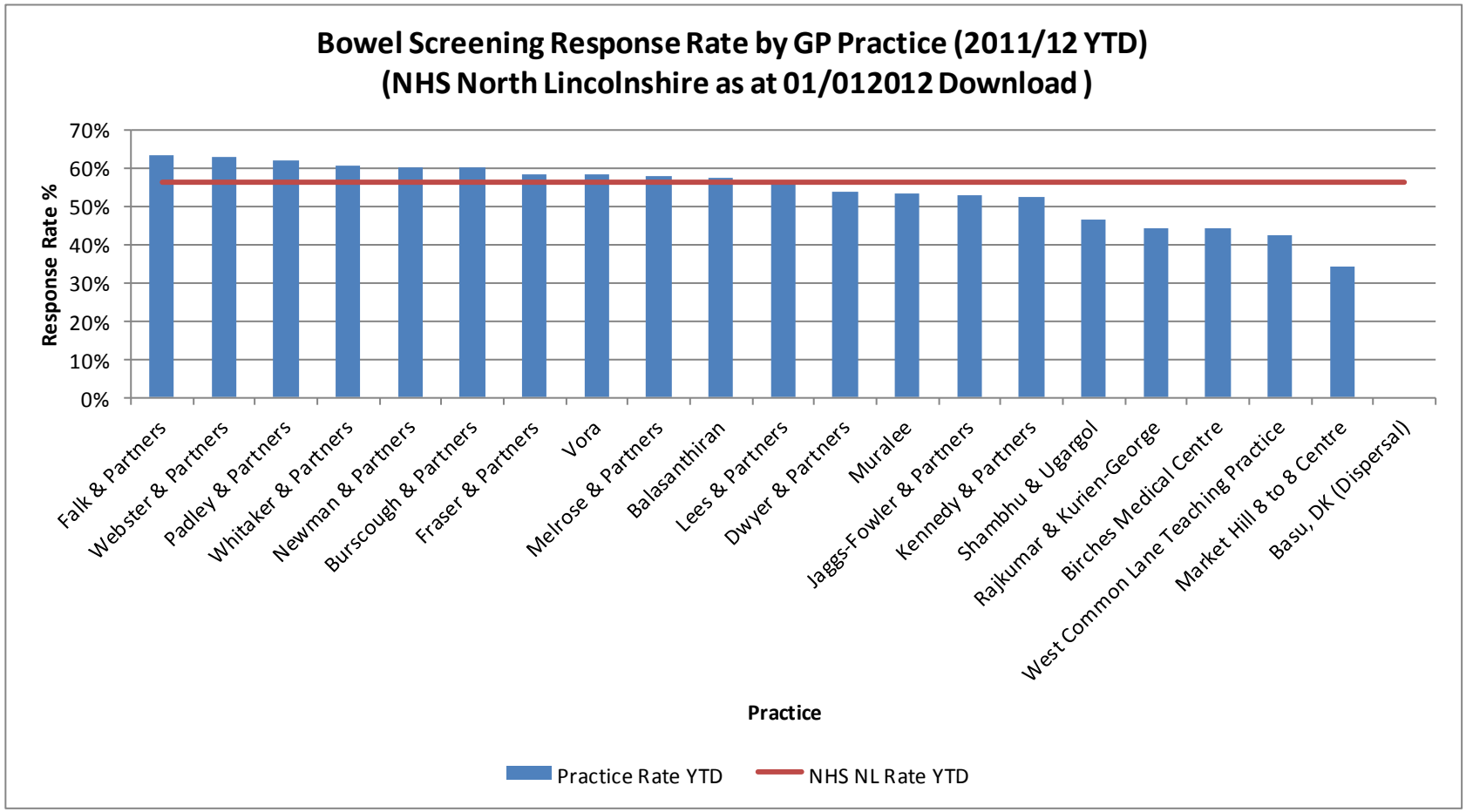


Source: Exeter Database KC53 Report 2008/09

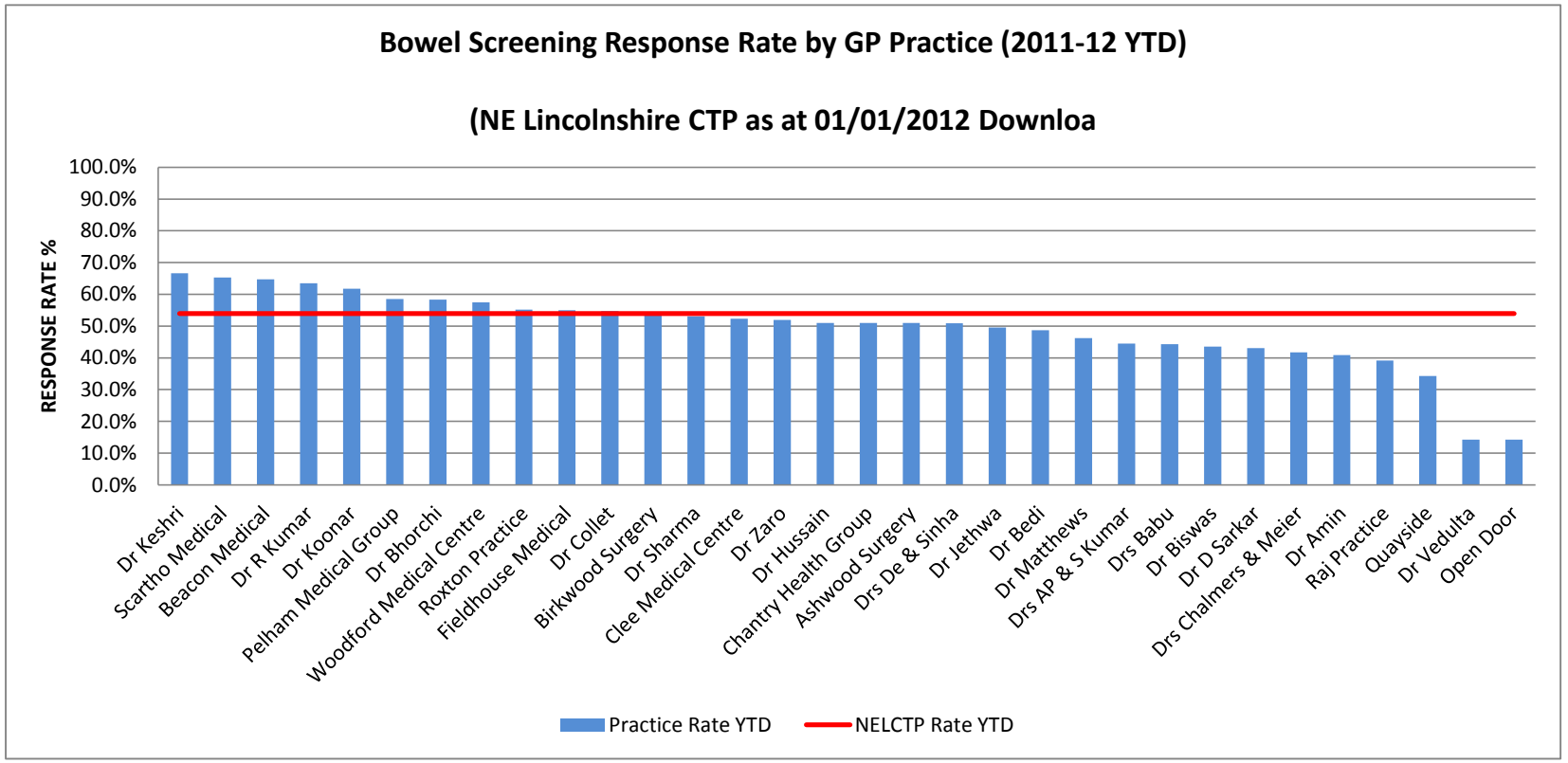


Source: Exeter Database KC53 Report 2008/09

Appendix 3



Source: Gateshead Bowel Cancer Screening Programme Hub Data 2010/11



Source: Gateshead Bowel Cancer Screening Hub data 2011/12