NHS England

NCL Joint Health and Oversight Scrutiny Committee

Review of Adult Immunisation and 7a Screening Programmes

3rd February 2017

The immunisation section of this report has been omitted

Adult Screening Programmes

Purpose

The purpose of this paper is to provide an overview of uptake, coverage and performance of the Adult Screening Programmes, namely Diabetic Eye Screening and Abdominal Aortic Aneurysm Screening Programmes for the North Central London patch.

Diabetic Eye Screening Programme

The paper will present data from the period between 1st of December 2015 and 30th November 2016, for all the five CCGs which make up North Central London (Barnet, Camden, Islington, Enfield and Haringey. However, reference will be made, where applicable, to data before this time period.

The source of data to prepare this report has been OptoMize reporting tools as well as writing specific SQL queries to obtain data from OptoMize. Furthermore QMS GP data extraction information has been used to complement the ethnicity of the invited population where there were no specific data was available on OptoMize.

Estimated Diabetes Prevalence: NCL DESP

Estimates of the number of people age 16 years or older who have diabetes (diagnosed and undiagnosed) adjusted for age, sex, ethnic group and deprivation.

Region/ CCG	2013	2015	2016	2017	2018	2019	2020
England	TBC	3,921,071 (8.4%)	3,976,419 (8.5%)	4,032,506 (8.5%)	4,089,864 (8.6%)	4,147,109 (8.7%)	4,204,334 (8.7%)
London	TBC	664,041 (8.9%)	677,273 (8.9%)	690,782 (8.7%)	703, 916 (9.0%)	716,906 (9.1%)	730,575 (9.1%)
NHS Barnet	23,364 (8.5%)	27,073 (8.6%)	27,670 (8.6%)	28,300 (8.7%)	28,871 (8.7%)	29,540 (8.8%)	30,140 (8.9%)
NHS Camden	13,757 (6.2%)	14,871 (6.7%)	15,252 (6.7%)	15.565 (6.7%)	15,959 (6.8%)	16,355 (6.8%)	16,693 (6.9%)
NHS Enfield	19,174 (8.4%)	23,480 (9.4%)	23,931 (9.5%)	24,461 (9.5%)	24,867 (9.6%)	25,409 (9.7%)	25,824 (9.7%)
NHS Haringey	13,666 (7.6%)	22 411 (9.3%)	22,950 (9.4%)	23,470 (9.5%)	24,019 (9.6%)	24,484 (9.6%)	24,957 (9.7%)
NHS Islington	10,491 (6.5%)	15,032 (7.6%)	15,419 (7.6%)	15,725 (7.7%)	16,067 (7.7%)	16,422 (7.7%)	16,748 (7.8%)
NCL Total	80,452	80,456	105,222	91,972	109,783	112,210	114,362

Table 7 Source: APHO Diabetes Prevalence Model section of the YHPHO website (www.yhpho.org.uk)

Context

The National DESP screens all diabetic patients aged 12 + annually, with the aim of preventing sight loss from preventable retinopathy.

Following a successful re-procurement of the London Diabetic Eye Screening programmes in London are now delivered by five Provider organisations, to an eligible population of approximately half a million people.

The Programme in NCL is delivered by North Middlesex University Hospital, who are responsible for delivering screening service to approximately people living with diabetes across North Central London. Programmes are contracted to deliver a national service specification, containing nationally agreed Key Performance Indicators and Programme Quality Standards.

In London, commissioners have developed a set of enhanced indicators that Providers will be measured against in subsequent contract years.

The eligible population is identified through data extraction solutions from GP registers that aim to update monthly.

Oversight of performance

NHS England (London) Commissioners deliver the oversight and performance management function for the DESP contracts.

The primary forum in which this takes place is the quarterly Programme Board, chaired by the commissioner.

Programme Boards are multi-disciplinary, with representation from the following groups (in addition to NHSE commissioners):

- Patients
- Public health England Quality Assurance Team
- CCG commissioners & Quality leads
- Local Authority Public health strategists
- Clinicians
- Hospital Eye service managers and failsafe leads

NCL-DESP uptake

Below is a table (table 8) summarising uptake of Diabetic Eye Screening Services across NCL between 2012 and 2016

Year	Uptake
2012- 2013	74.5%
2013-2014	78.9%
2014-2015	85.0%
2015-2016	85.1%

Table 8

a. Indian population seem to have the highest rate of uptake and attendance at 91.2%.
b. All known ethnicities have an uptake of 80% or above.

c. As in the previous health equity audit, undertaken in July 2013, uptake skews down in the groups with no ethnicity data, as the programme is less likely to have seen the patient to collect that information. However, the extent of this is now much less as NCL-DESP has collected data on the ethnicity for 90.4% of the invited population within the reporting period.

NCL DESP is currently working with QMS to facilitate a more accurate upload of ethnicity data. However, the programme is continuously trying to improve intake in groups identified through methods like DNA Audits to have a low uptake. Provision of translation services have been proved to increase uptake in the Turkish Community, however the cost of providing such services, makes it difficult for the programme to invest in long term language and geography.

Uptake by Gender (table 9)

Gender	#invited	#screened	uptake
Unknown	39	23	59.0%
F	30681	25916	84.5%
M	36667	31250	85.2%
Total	**67387**	**57189**	**84.9%**

NCL-DESP Uptake by Ethnicity

Table 10 shows uptake by Ethnicity, where this was recorded:

Ethnicity	#Invited	#Screened	Uptake
A: British	18710	16379	87.5%
B: Irish	1277	1088	85.2%
C: Any other White background	10478	8943	85.4%
D: White and Black Caribbean	308	253	82.1%
E: White and Black African	246	198	80.5%
F: White and Asian	205	171	83.4%
G: Any other Mixed background	513	424	82.7%
H: Indian	5237	4776	91.2%
J: Pakistani	997	843	84.6%
K: Bangladeshi	2515	2172	86.4%
L: Any other Asian background	4093	3627	88.6%
M: Caribbean	3834	3298	86.0%
N: African	5255	4235	80.6%
P: Any other Black background	1559	1297	83.2%
R: Chinese	841	752	89.4%
S: Any other Ethnic group	4857	4010	82.6%
Unknown	2269	1459	64.3%
Z: Not stated	4193	3264	77.8%
Total	**67387**	**57189**	**84.9%**

Table 10

Where ethnicity data was not recorded on OptoMize, it was supplemented from QMS; there are still some patients where it's not recorded either with the programme or the GP.

Uptake by Age

Age Group	Invited	Screened	uptake
0-14	113	96	85.0%
15-19	345	287	83.2%
20-24	513	412	80.3%
25-34	1947	1523	78.2%
35-44	4875	4086	83.8%
45-54	11730	9863	84.1%
55-64	16652	14140	84.9%
65-74	15964	13660	85.6%
75+	15248	13122	86.1%
Total	**67387**	**57189**	**84.9%**

Table 11 Source: NCL DESP

a. 88.4% of NCL-DESP diabetic patients (59,594) are over 45 years old and 85.2% of this population has attended screening.
b. Of note is that uptake in the 25-34 age group is78.2%. This might be an area that can receive some focus and may be extra phone call reminders.
c. Previous analysis of DNA data showed lower uptake in the working age population which was vastly improved by an increase in out of hours and weekend clinics.

Uptake by Index of Multiple Deprivations (IMD)

IMD Quintile	Invited	Screened	uptake
Unknown	146	106	72.6%
1 (most deprived)	24652	18634	75.6%
2	19148	15467	80.8%
3	11817	11438	96.8%
4	8378	8325	99.4%
5	3246	3219	99.2%
Total	**67387**	**57189**	**84.9%**
1 (most deprived)	**24652**	**18634**	**75.6%**
Quintiles 2-5	**42589**	**38449**	**90.3%**

Table 12 Source: Official Statistics; English indices of deprivation 2010

https://www.gov.uk/government/statistics/english-indices-of-deprivation-2010
http://dclgapps.communities.gov.uk/imd/imd-by-postcode.html
http://www.apho.org.uk/resource/view.aspx?RID=111277

Each patient is mapped via their postcode to the LSOA (local small output area) used in the national dataset. Data from the London Health Observatory was then used to identify which quintile of deprivation each LSOA falls into.

a. IMD has divided the whole country in to five levels in terms of level of deprivation. 1 is the most deprived (20% of the country), then 2 (the next 20%), 3, 4 and 5 (the final 20% which are the most affluent).
b. In the cohort of patients invited for screening in this reporting period, 24,652 (36.6%) live in the most deprived areas of England. The uptake in this cohort is 75.6%.
c. The uptake in the less deprived group (quintiles 2-5) is 90.3%.
d. It is apparent that level of deprivation is directly correlated with uptake.
e. During a HEA conducted by NCL-DESP in July 2013 it was established that uptake of the screening test in the Most Deprived Quintile was 73.8%, compared with 76.6% in the non-deprived group. Therefore whilst we have managed to increase the uptake of the non-deprived group to 90.3% from 76.6%; the deprived Quintile has been increased by a much smaller margin.

Uptake by CCG

NCL-DESP has achieved an uptake of over 80% for all CCGs

CCG	Invited	Screened	Uptake
Barnet	17862	15605	87.4%
Camden	8420	6984	82.9%
Enfield	17410	15080	86.6%
Haringey	14021	11638	83.0%
Islington	9670	7880	81.5%
Total	**67383**	**57187**	**84.9%**

Table 13 Source: OptoMize PPR

DNA rates by CCG

CCG	Total No of Appointments due	Total Number of DNA Appointments	DNA Rate
Barnet	24645	8470	34.4%
Camden	13023	5795	44.5%
Enfield	24534	8857	36.1%
Haringey	20088	8083	40.2%
Islington	14571	6461	44.3%
Total	**96861**	**37666**	**38.9%**

Table 14 Source: RDS Operational Performance Report on OptoMize

a. Booking appointments: The high DNA rate is the result of patients being offered multiple appointments in a year when they DNA (for example, in Barnet, there were 8470 DNAs, relating to 4607 patients: 1011 patients DNAd between 3 and 7 appointments in the

reporting period, 1057 patients DNAd 2 appointments, and the remaining 2539 DNAd a single appointment).

b. Clinic efficiency and slot utilisation: In order to reduce wastage of clinic slot resources, NCL-DESP overbooks the clinic according to the historical DNA analysis of each of the clinics. This has meant that according to a detailed audit conducted in October 2016 looking at a three month data from 1st April 2016 to 30th September 2016, the overall clinic slot utilisation at 13 clinic sites and our Mobile Screening Unit (MSU) is over 95%. This point to a highly efficient usage of available clinic slots.
c. Actual uptake: In terms of uptake and reaching to the "hard to reach" patients, since the overall annualised uptake is around 85%, the proportion of those who were invited and not screened is around 15%.

GP practice

NCL-DESP operates using a single collated list for call and recall. In order to facilitate the maintenance of an accurate Single Collated List, NCL-DESP successfully engaged the 227 GP practices within its catchments to sign up to the QMS Electronic data transfer service. The Electronic Data Transfer service does not nullify the routing referral methods used by GPs to refer diabetic patients into the programme, but it acts as a failsafe mechanism to ensure that all patients with diabetes are referred to the programme. In addition to this, NCL-DESP actively cleanse data every month using the national SOP and also actively compares its data with CQRS although this is only done annually as CQRS is not updated regularly.

In light of learning from incidents, relating to the Single Collated List, an escalation protocol has been developed to support process of ensuring all stakeholders submit lists in a safe and timely manner. The Escalation Protocol is endorsed by PHE and the Medical Directorate provides a clear and standardised escalation process for all to follow and is being implemented successfully across the NCL patch and London.

The NCL-DESP maintains regular contact with GPs through a range of forums, including the

- Programme website
- Routine GP mailing
- Access to GP meetings to raise specific issues or to alert of new developments.

Uptake by GP practice for each CCG in NCL is shown in Appendix 1

Inequities and inequalities in uptake

The retinal screening programme is an important means to reducing eye complications among people with diabetes and consequently, ensuring universal equity of access to the programme is a key government priority.

Uptake in NCL DESP is currently at 55232 over 64872, making it 85.1%. NCL-DESP continues to work closely with GPs and other stakeholder to improve uptake in the hard to reach groups.

Patient satisfaction with the existing services

NHS England is committed to ensuring that providers improve user involvement in all the programmes through a range of activities, including:

- Recruiting suitable patients who can be patient representatives on the programme board,
- Patient forums/groups.
- undertake regular client satisfaction survey,
- routine monitoring of compliments and complaints
- to implement required improvements patients.

Patient engagement ensures that patients are placed at the centre of all the services that NHS England commissions and that the patients' voices are heard and reflected in service planning, design and delivery. Appendix 2 shows a recent patient satisfaction survey report by the NCL DESP.

NHSE has recommended quarterly Patient Experience Surveys, with findings and analysis shared at Programme Board Meetings. Developing a strategy for public engagement:

Work in Progress

Screening in Prisons and secure units

NHS E L is currently developing protocols for the screening of people with diabetes who are in prison and secure settings, working in conjunction with Prison health officers, NHSE commissioners and DESP programme leads

The programme is trying to establish the numbers and location of 'halfway houses' or hostels run by the Probation Service, for prisoners preparing for release into the community.

London referral pathway for pregnant women with diabetes:

Commissioners for Adult screening and ANNB screening have worked with service providers to design and deliver a pathway that ensures women with diabetes are referred for enhance screening, as per national guidance. The teams are currently trying to identify the right links to support implementation – i.e. diabetes midwives in all London maternity units

An Implementation action plan will be developed by commissioners and to be circulated to wider stakeholders before the end of September

Co-commissioning of Optical Coherence Tomography (OCT)

DESP providers across London are seeking support from CCGs for the development and implementation of OCT within the DESP. This is in response to the ongoing issues with capacity, in many Hospital Eye Services.

OCT is an enhanced form of imaging which can help to cut the amount of patients who are referred into HES to access enhanced imaging where images taken in the programme are deemed unclear for screeners to conclude a safe outcome. It is possible to implement OCT cameras within the Screening Programmes and in programmes where this has been available, it helped to cut the amount of referrals into HES and also improved patient experience, as it meant the enhanced images can be taken on the same day without patient having to make a separate trip to a hospital site.

Diabetic Eye Screening Programme Leads met in October 2014 and developed an OCT Protocol. Most are working towards developing Business Cases in order to present to CCG HES Commissioners and HES Eye Service Managers, in order to gain their support to agree to fund the specialist OCT Cameras. NHS England feels that although the purchase of Cameras involves an initial Capital outlay, this will provide future cost savings by cutting the large amount of referrals into the HES specifically for OCT only.

An equity analysis which describes the differential uptake of adult screening .

This report will look at the data provided by NCL DESP for routine digital screening uptake during the period between 01/12/2015 to 30/11/2016

Abdominal Aortic Aneurysm Screening (NAAASP)

Purpose

The National Aortic Abdominal Aneurysm Screening Programme (NAAASP) aims to reduce deaths from ruptured aneurysms through early detection of men at risk. The UK National Screening Committee (UKNSC) recommended implementation of a systematic population screening programme, in March 2009, following evidence that ultrasound screening of men in their 65th year could reduce the rate of premature death from ruptured AAA by up to 50 per cent.

Context

The North Central London (NCL AAASP) was implemented in 2010. The London AAA Programmes are aligned to the Strategic Planning Groups structure. Currently, the five London AAA screening programmes are delivered by NHS Trusts that are also vascular network centres or hubs. All aspects of the service, both clinical and administrative, are coordinated by these Trusts.

All London programmes use the nationally commissioned IT system, Surveillance Management and Referral Tracking (SMaRT), to manage the eligible cohort population. Each local service coordinates screening for the population in its area and organises invitation letters, screening and surveillance clinics, results letters and referrals to the appropriate vascular network. The local screening services ensure GPs are informed when men from their practice have been screened and of the outcomes of their screening test.

Men with a screen detected aneurysm of 5.5 cm and above are referred into the vascular centre for surgery, whilst those with aneurysms measuring between 4.5 and 5.4 cm are put on quarterly surveillance; those with aneurysms measuring between 3.0 and 4.4 cm are recalled for surveillance on an annual basis.

Throughout England, each commissioned Provider is responsible for delivering a service to the local population that delivers against the Public Health England (PHE) Service Specification (No.23), Ref[1], and other agreed national quality requirements.

Oversight of performance

NHS England (London) commissioners deliver the oversight and performance management function for the AAA contracts.

The primary forum in which this takes place is the quarterly Programme Board, chaired by the commissioner.

Programme Boards are multi-disciplinary, with representation from the following groups (in addition to NHSE commissioners):

- Local Authority Public health strategists
- Clinicians
- Vascular Service Managers
- Patients
- Public health England Quality Assurance Team
- CCG commissioners & Quality leads

Health Equity Audit

A Health Equity Audit which was recently conducted by NHS England (2016) to support the London AAA Re-procurement process, had limitations due to poor data to facilitate some analyses. The Head of Screening at NHS England is cited as stating that, whilst it is not possible to form a comprehensive picture of all factors that influence AAA screening uptake or to comment on the relative influence of demographic and programme factors, there is a clear variation in screening uptake that is associated with deprivation and geography. Recommendation is that, Programmes should consider the clear variation by location and deprivation in their plans for improving uptake and implications for future service provision (NHSE, 2016).

Gender and age

The AAA Screening Programme in the UK is restricted to men aged 65years old within the year of screening. Men over the age of 65, who missed out on screening at 65, can attend for screening as a self- referral. There are currently no plans to screen women.

Ethnicity

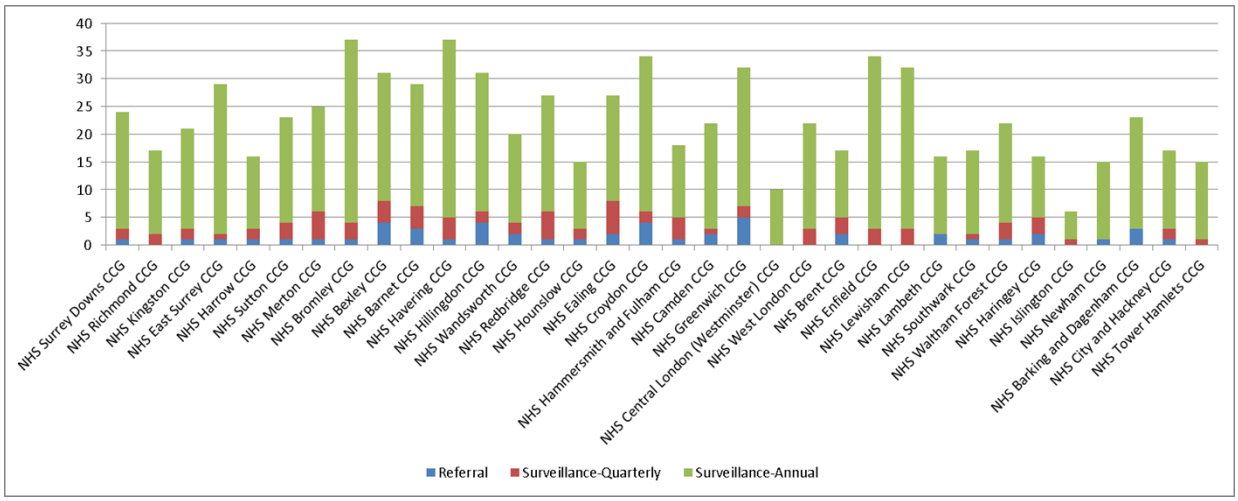
The health equity audit conducted by NHSE (2016) for the procurement, shows differences in uptake by ethnicity are also presented, this data needs to treated with caution because of concerns about data quality. Ethnicity was only available for those who attended as it is only requested and recorded at the point that men attend. Therefore for all who did not attend and some people who attended, ethnicity was not stated.

Ethnicity was estimated by using the ethnicity breakdown of the local authority from the 2011 Census and comparing that to the proportion of the same ethnic group in those who attended. The North Central London programme had a particularly high proportion of people who did not state their ethnicity (72%).

Deprivation

There is an established link between uptake of AAA Screening and deprivation and also the incidences of AAA in relation to deprivation, with deprived communities bearing an increased burden of abdominal aortic aneurysms in association with high rates of DNAs. The geographical variations in uptake of AAA screening across London that, are similar to those seen in other screening programmes. It also shows the association between uptake and deprivation scores.

Screening outcome (referral and surveillance) ordered by CCG average deprivation score (least deprived to most deprived) for years 2013/14 to 2015/16



Graph 1

Ward of residence

There is currently only CCG level data rather than Ward of residence level data. Islington is the lowest performing CCG. Factors contributing to this include:

- low GP engagement
- high level of homeless people in the borough. Suggestions have been made for the programme to look at issues affecting uptake in Islington and the NCL AAA propose, amongst other actions:
    - Mapping of locations with high % of patients with no fixed abode to see if this accounts for lower performance in a particular borough (Islington).
    - Mapping non-attendance in Islington by geography, to identify if there are areas with poor access to the Kings Cross screening venue that show higher rates of non-attendance.

Issues affecting service delivery

Towards the end of 2014-15, the NCL AAA Programme was experiencing difficulties with it's screening workforce. This led to concerns over their ability to screen the cohort during that year. The matter was escalated to NHS England and the Trust Governance Team, resulting in an Action Plan being drafted and being put in place to address the issues that were identified.

Commissioners' tight monitoring of performance along with the Trust's and Programme's commitment to addressing the identified issues has led to a transformation in how the service is delivered resulting in an increase in the uptake. NCL AAA is now a more stable and a well performing service. Uptake for 2015-16 is 77%, above the acceptable level of 75%.

Performance

Table 15 shows performance during 2016-17, against the only National Key Performance Indicator for the NAAASP. Quarterly figures are aggregated from Q1 with approximately 25% of the cohort expected to be offered screening per quarter although this will vary between local screening programmes, depending on the screening model

Regional Summary	Numerator	Denominator	Performance (%) Acceptable =/ >90% Achievable =/ > 99%
North Central London	5,224	5,267	99.2
England	281,989	285,287	98.8
London	33,631	34,406	97.7

Table 15

Patient satisfaction

NHS England is committed to ensuring that providers improve user involvement in all the programmes through a range of activities, including:

- Recruiting suitable patients who can be patient representatives on the programme board,
- Patient forums/groups.
- undertake regular client satisfaction survey,
- routine monitoring of compliments and complaints
- to implement required improvements patients.

Patient engagement ensures that patients are placed at the centre of all the services that NHS England commissions and that the patients' voices are heard and reflected in service planning, design and delivery. No recent reports on patient satisfaction surveys by NCL AAA. However, moving forward, the NHS England Commissioners have recommended that Programmes carry out Patients Experience Surveys on a Quarterly basis and share findings with the Programme Board.

Inequities and inequalities in uptake

Breakdown of performance by CCG area is shown in table 16

CCG	**PERFORMANCE =/> 85%**	**PERFORMANCE =/>75% AND <85%**	**PERFORMANCE < 75%**	**OVERALL UPTAKE PER CCG 2015-16**	**NON-PATICIPATING PRACTICES**
BARNET	18	13	27	79.32%	9
CAMDEN	6	9	19	75.91%	2
ENFIELD	13	10	23	79.73%	3
HARINGEY	17	7	16	79.14%	6
ISLINGTON	5	4	23	71.28%	2

Table 16

Whilst overall uptake for the NCL AAA Programme 2015-16 Cohort was 77%, it is clear from the data presented in the table above that, the CCG with the lowest uptake also contains the largest number of poorly performing GPs. Below is work in progress to try and tackle some of the inequalities and inequities that still exist.

Work in progress

Re-procurement and reconfiguration of the London AAAA

NHSEL commissioning intentions in 2016/17 included the intention to re-procure London NAAASP to improve the resilience of administrative functions and the screening workforce. Following a lengthy options appraisal, it was agreed that two new services, for south and North London, would be commissioned against the national specification and a London wrap-around to ensure appropriate levels of cross border cover, and the capacity to screen in any convenient location, the Re-Procurement is currently underway. Invitation To Tender will go live in February 2017, with contracts awarded in May with a four month mobilisation period beginning on 1st June 2017 and the new contracts in place by October 2017. Contracts for all current London programmes have been extended by 6 months due to some inevitable delays.

All prospective bidders will be kept up to date about the Re-Procurement Process via the designated portal.

Promoting GP Engagement

There is an appreciation within the NCL Programme that, achieving any response to an invite for screening was reliant on strong relationships with the GP practices and support from them in engaging the patients. This is something the service is trying to develop. There is ongoing work in the Programme around engagement with GPs using a range of strategies including:

- Identify poorly performing practices and investigate possible reasons as to why they may not be performing well.
- Sending pre-invitation letters in advance of drop in clinics. Based on findings so far, GP endorsement of letters seems to encourage uptake of screening.
- Ad-hoc clinics at GP Practices with historical low attendance. Recently, the programme ran 4 clinics at Faversham Practice and 7 out of the 99 patients who attended tested positive to an abdominal aortic aneurysm. They will continue to engage practices with low uptake.
- Looking at the feasibility of using use the television screens in GP premises where other to publicise the NAAASP. This would provide an opportunity to capture patients' attention whilst they are in the practice for other reasons.
- Accessing educational or training forums for doctors, for instance those arranged by the Royal College of Medicine and discuss AAA screening.
- Working with Pharmacy and GPs to raise awareness of the screening Programme and support improved uptake NCL AAA.
- Discussions with EMIS about generating alerts on eligible men's records, when they attend for GP appointments, so GPs can promote attendance.

Promoting Career Development of Clinical Skills Trainers (CST)

The programme intends to host CST workshops, as well as reviewing a programme of audits which they are looking to deliver across London.

Screening in prisons and secure units

There are a small number of patients that have been identified as eligible for screening across two secure units in North Central London. NHSE has developed some guidance for Programmes and will be appointing a Commissioning Lead for Prison screening who will help the Programmes to establish a way of working with the cohort.

Targeted work in areas of low uptake

The NCL AAA Programme has an ongoing action plan to increase uptake in areas with low uptake by using a range of strategies including:

- Identify weak spots and look at possible new clinic locations.
- Look at required versus actual capacity at clinic sites
- Increase the number of Hospital screening clinics.
- Contact Chase Farm, Barnet and Edgware hospitals and Identify contacts for hiring treatment rooms at each hospital site.
- The Programme had held a promotional event in the RFH main hospital, with 10 eligible men agreeing to be screened on the day (self-referrals)
- Maintain Saturday clinics as they are doing well with a reduced number of DNAs.
- A Men's Health Initiative, working in collaboration with Spurs Football Club to raise awareness of the AAA Screening Programme. The programme has also contacted men's clubs and societies and next step will be to arrange drop in clinics to offering opportunity to screen men in places where they socialise.
- The clinical lead for the AAA Screening Programme is planning to target marginalised communities such as, the Turkish community to promote uptake. Related to this is information that has come to light, regarding the fact that, National AAA Programme Literature does not routinely get translated into Turkish.

External Quality Assurance Visit

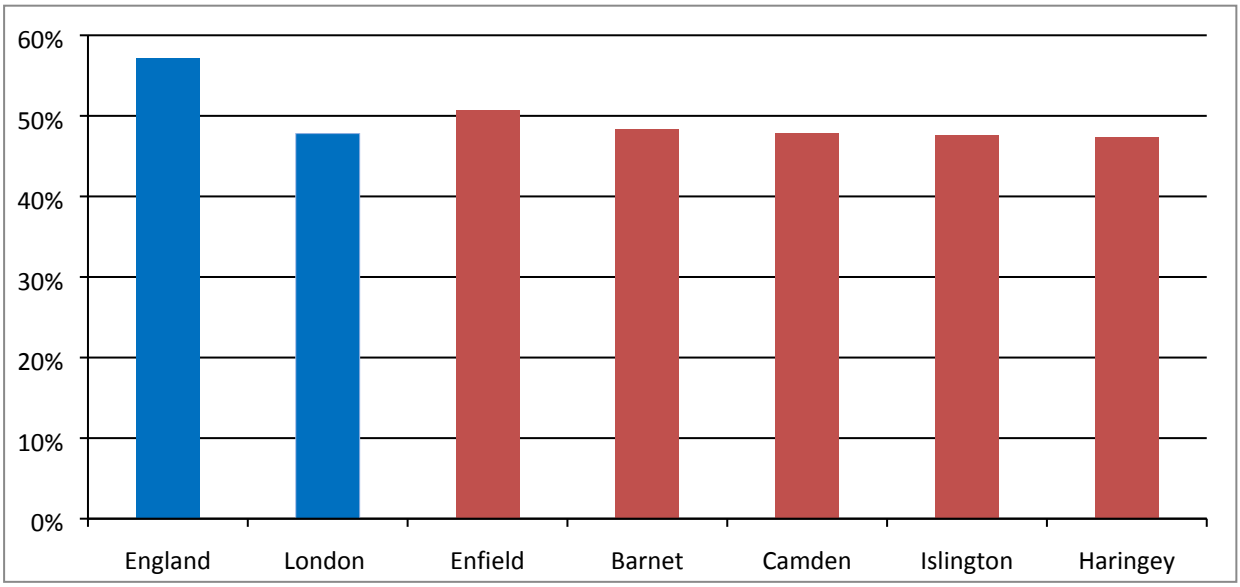
The Proposed date for the NCL AAA Screening Programme External Quality Assurance Visit is 22nd of February 2016.

Bowel Cancer Screening Programme

Coverage

Coverage is the percentage of people adequately screened in the last 2.5 years out of those who are eligible for gFOBt screening. Latest published data (up to end of March 2015) shows North Central London performs significantly below the national average for this measure; 48.34% compared to 57.1%. Performance is slightly better when compared to the London average of 47.8%. Variation in coverage across North Central London CCGs is minimal, ranging from 47.3% in Haringey to 50.7% in Enfield.

Cancer Screening –Bowel Cancer Coverage March 2015 (60-74 years) across NCL CCGs



Graph 2 Data from Public Health Profiles available at http://fingertips.phe.org.uk/profile/health-profiles

2.20iii - Cancer screening coverage - bowel cancer 2015

Proportion - %

Area	Count	Value	95% Lower CI	95% Upper CI
England	4,406,923	57.1	57.1	57.1
London region	407,429	47.8	47.7	47.9
Barking and Dagenham	6,481	39.7	38.9	40.4
Barnet	20,934	48.3	47.9	48.8
Bexley	15,566	51.8	51.2	52.3
Brent	15,339	47.4	46.8	47.9
Bromley	23,103	53.5	53.0	54.0
Camden	10,234	47.8	47.1	48.5
City of London	415	46.1	42.8	49.3
Croydon	22,073	51.1	50.6	51.5
Ealing	17,648	47.8	47.3	48.3
Enfield	17,967	50.7	50.2	51.2
Greenwich	11,421	46.2	45.6	46.8
Hackney	7,285	39.1	38.4	39.8
Hammersmith and Fulham	7,549	43.9	43.2	44.7
Haringey	11,195	47.3	46.7	47.9
Harrow	16,304	52.5	51.9	53.1
Havering	17,182	50.6	50.1	51.2
Hillingdon	16,929	52.1	51.5	52.6
Hounslow	13,039	46.9	46.3	47.5
Islington	8,692	47.6	46.9	48.4
Kensington and Chelsea	7,565	42.5	41.8	43.2
Kingston upon Thames	10,893	55.5	54.8	56.2
Lambeth	9,742	39.8	39.1	40.4
Lewisham	10,536	43.3	42.7	43.9
Merton	11,329	51.0	50.3	51.6
Newham	8,694	38.2	37.6	38.8
Redbridge	13,383	44.0	43.4	44.5
Richmond upon Thames	14,235	57.2	56.6	57.8
Southwark	9,109	39.8	39.1	40.4
Sutton	13,680	56.2	55.6	56.8
Tower Hamlets	5,698	37.3	36.6	38.1
Waltham Forest	10,835	44.5	43.9	45.2
Wandsworth	13,034	49.4	48.8	50.0
Westminster	9,340	41.8	41.2	42.5

Source: Health and Social Care Information Centre (Open Exeter)/Public Health England

Table 17

Published data is only available at Practice level for the age range 60-69 years. There is significant variation for coverage between practices across the North Central London footprint, ranging from 27.4% to 62% as seen in the table below. NHSE are working with Primary Care Commissioners and CCGs to address variations in coverage at a practice level.

CCG	Lowest	Highest	Percentage of Practices ≥ England Average (57.8%)
Barnet	31.7% (Alder JS (The Surgery	61.9% (Oakleigh Road Health Centre)	1.34%
Camden	36.8% (Somers Town Medical Centre	56.5% (West Hampstead Medical Centre)	0%
Enfield	33.5% (East Enfield Practice)	62% (Abernethy House)	3.43%
Haringey	27.4% (West Green Road Surgery)	61.7% (The Muswell Hill Practice)	1.8%
Islington	33.4% (Archway Medical Centre)	57.8% (The Miller Practice)	0.36%

Table 18 Data extracted from National General Practice Profiles available at ***https://fingertips.phe.org.uk/profile/general-practice***

Bowel Cancer Screening Service for NCL

NHSE commissions UCLH to deliver bowel cancer screening to the NCL population. Performance against KPIs (national standards) is monitored on an ongoing basis with reports submitted quarterly to the London Bowel Cancer Screening Programme Board. KPIs are generally met by UCLH with a minimal numbers of breaches. In line with all London Screening Centres, uptake continues to fall significantly below the national average for the NCL population. Additionally UCLH, along with the majority of London centres, regularly breaches the target for colonoscopy uptake (the percentage of participants with an abnormal gFOBt who then go on to have a colonoscopy). The majority of breaches are for patients who do not attend an initial SSP assessment. For those who do, according to an internal audit conducted by UCLH, co morbidities are the most significant reason for declining colonoscopy.

The national Bowel Cancer Screening System facilitates a service user questionnaire completed 30 days post screening. In addition the centre provides a service user feedback report to the quarterly London Bowel Cancer Screening Programme Board. The majority of feedback is positive with minimal numbers of complaints. Feedback is discussed at the quarterly Programme Board meetings providing an opportunity for learning across the London programme.

Bowel Scope

University College London Hospitals NHS Trust is currently rolling out bowel scope screening to the populations of North Central London. Bowel scope is offered as a one off screen at 55 years when participants are invited to attend an accredited screening centre for a flexible sigmoidoscopy. Roll

out is being implemented in a phased approach that includes delivery at satellite sites to improve accessibility for those invited to attend. Roll out for UCLH has been slow with only Haringey currently live for bowel scope. Within Haringey 18 practices out of 45 are currently live. This population is served by a satellite service at the Whittington Hospital. Delay to roll out has largely been as a result of the loss of JAG (Joint Advisory Group) accreditation at UCLH, which has prevented this site from going live with bowel scope in line with national standards. Additionally failure to recruit further accredited scopists to operate at the Whittington site has prevented faster roll out for the population of Haringey. JAG accreditation was reinstated at UCLH at end of November 2016 and revised plans for roll out for this site are now being developed with the aim of starting invitations to the Islington population by Spring 2017.

Coverage and Uptake

Data on ethnicity and socio economic status is not routinely collected as part of the national bowel cancer screening system. However in line with other screening programmes uptake tends to be lower in those from more deprived backgrounds along with those from particular minority ethnic groups. In addition there is evidence that uptake tends to be higher in those who attended a previous screening episode. The likelihood of uptake in those who have completed one previous screening episode for bowel cancer screening is almost double than for those who have received an invitation for the first time (prevalent round).

NHSE hosts a Task and Finish Group, which includes Transforming Cancer Services Team, Researchers at UCL, Screening Centres and the London Hub. This group works on a Pan London level to plan the delivery of evidence-based activities across the bowel cancer screening pathway

- to increase the uptake of bowel cancer screening in London
- to reduce inequalities in bowel cancer screening uptake between and within London boroughs, and by different communities

Current initiatives include General Practice Endorsement of pre invitation letters along with enhanced reminder letters. A randomised controlled trial by University College London highlighted the effect of GP endorsement of bowel cancer screening in improving uptake.[1] The addition of GP endorsement to the standard bowel cancer screening invitation letter increased the odds of participation in the gFOBt screening programme by 7%. This translates into a 1.7% relative increase in the probability of screening and a 1% absolute increase. Although the intervention significantly affected uptake overall, no effect was seen between socio-demographic groups.

A recent London Trial of FIT (Faecal Immunochemical Test) demonstrated an increase in uptake of 8.3% overall and this was across all population groups with a greater increase seen in the most deprived compared to the least deprived. Following a ministerial announcement in Spring 2016 FIT will replace the current gFOBt as the primary test for bowel cancer screening in Spring 2018.

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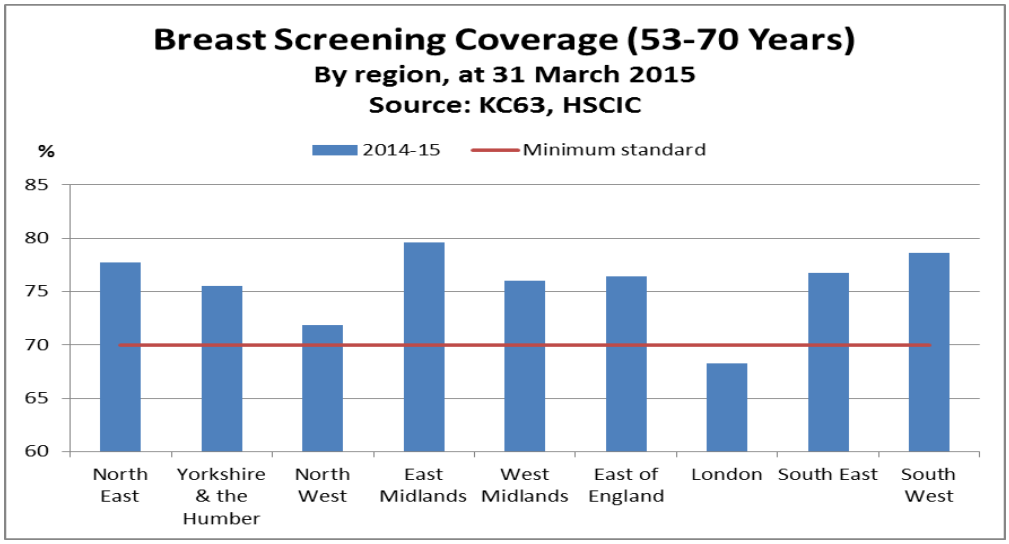
[1] Raine R, Duffy SW, Wardle J, Solmi F, Morris S, Howe R, Kralj-Hans I, Snowball J, Counsell N, Moss S, Hackshaw A, von Wagner C, Vart G, M McGregor L, Smith SG, Halloran S, Handley G, Logan R F, Rainbow S, Smith S, Thomas M C and Atkin W *Impact of general practice endorsement on the social gradient in uptake in bowel cancer screening* British Journal of Cancer 114, 321-326 (02 February 2016) | doi:10.1038/bjc.2015.413

Breast Cancer Screening Programme

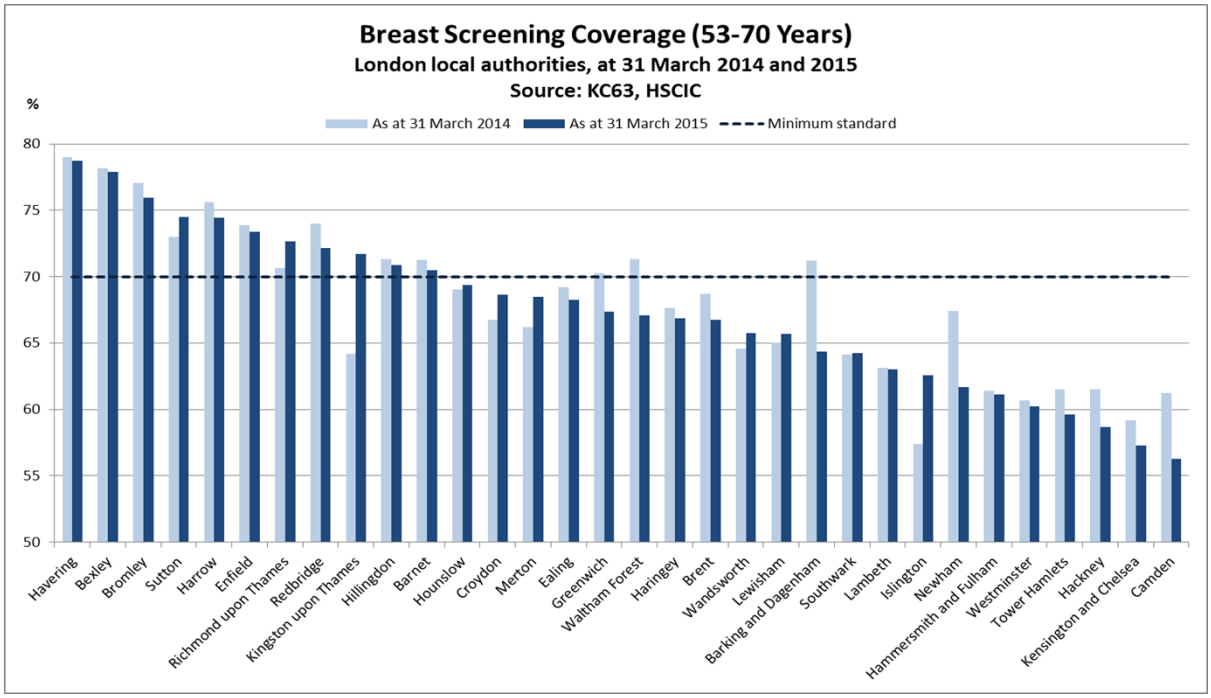
Coverage



Graph 3

Breast screening coverage in London was 68.3% (at 31 March 2015) the lowest of the regions in England. From 2010/11 the coverage in London is fairly stable, closely matching the overall trend in England.

Breast screening coverage nationally has fallen for the last four years. Barnet and Enfield have coverage over the minimum standard



Graph 4

Comparative Coverage by CCG 2013 - 2015

	2013-2014			*2014-2015*			
Local authority	**Eligible pop**	**Women screened**	***Coverage***	**Eligible pop**	**Women screened**	***Coverage***	***Difference***
Barnet	**32,764**	**23,349**	***71.3***	**33,991**	**23,963**	***70.5***	***-0.8***
Camden	**16,131**	**9,880**	***61.2***	**16,728**	**9,416**	***56.3***	***-4.9***
Enfield	**27,879**	**20,600**	***73.9***	**28,790**	**21,119**	***73.4***	***-0.5***
Haringey	**19,566**	**13,234**	***67.6***	**20,534**	**13,727**	***66.9***	***-0.7***
Islington	**14,182**	**8,140**	***57.4***	**15,156**	**9,484**	***62.6***	***5.2***
Source KC63, HSCIC							

Table 19

Table 19 above shows that apart from Islington all other authorities have experienced a decline in coverage.

Improving Uptake

The breast screening units in North London (NLBSS) hosted by Royal Free Hospital and Central and East London (CELBSS) hosted by Bart's Health are responsible for screening women in North Central London. Table two below shows the uptake for each breast screening service. Uptake looks at the percentage of women who attended for breast screening from the total of women invited to attend.

Uptake	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	Trend
Barking, Havering, Redbridge & Brentwood	75.4	70.4	73.3	73.0	66.6	75.3	72.9	66.0	73.3	67.0	63.3	
Central & East London	48.4	52.8	52.5	52.5	55.6	53.1	61.1	60.6	56.7	57.3	58.0	
North London	61.6	62.7	59.3	59.0	59.9	62.2	64.6	65.2	66.7	66.4	64.7	
South East London	..	..	..	..	..	..	..	64.1	62.9	61.2	65.8	
South East London (Kings College Hospital)	59.3	62.2	61.6	59.3	60.9	60.5	59.8	..	..	..	..	
South East London (Queen Mary's Sidcup)	67.1	65.6	70.8	67.7	64.9	69.5	64.6	..	..	..	..	
South West London	67.4	65.4	61.7	64.5	64.5	62.2	66.4	64.9	64.4	66.7	61.6	
West of London	56.1	58.4	53.9	56.0	56.5	56.4	58.9	58.4	57.4	58.4	61.5	
Whipps Cross	70.2	..	..	..	..	..	..	..	..	..	..	

Table 20 Source: KC62, NHS Digital

.Both breast screening services have implemented 3 uptake initiatives to improve uptake and these have been mainstreamed into regular practice.

- Pre-invitation letters
- Text message reminders
- Second timed appointments

Over the last 10 years, the administration of the breast screening service had been identified as a weakness, both through QA processes and clinical incidents/SIs. As a result, there have been discussions about how the configuration of the breast screening programme in London could be changed to strengthen the administrative function and ensure equity across the service. As part of the new model of service for breast screening across London from March 2017, the administration for the service has transferred to the London Breast Screening Hub hosted by the Royal Free Hospital. This means a centralised administration unit for the whole of London. It also means a single point of contact for women and better access through extended opening hours. Women may not realise any change in the service as the screening will remain provided by CELBSS and NLBSS. What they may notice is a new telephone number and the opportunity to make an appointment outside of

NC London more easily than had previously been the case. The Breast Screening Hub is also looking at other opportunities to increase the uptake. There are planned initiatives with the hub to improve uptake through extending opening times of the call centre. The Hub will be working closely with GP practices, reintroducing information packs for GPs and creating a website.

In 2015/16 NHSE commissioned Community Links, a voluntary organisation, to promote uptake through community engagement in 3 boroughs in London. The work involved telephoning women who had received an invitation to attend for breast screening. One of the boroughs included was Camden. The work has seen an increase in uptake for Camden during 2016/2017. This can be seen below in table 21 and table 22.

Overview of Coverage and Uptake in April2015

CCG	Number of practices	Practices with coverage over 70%	Practices with coverage under 60%	Practices with uptake over 70%	Practices with uptake under 60%
Barnet	72	25	10	12	40
Camden	39	0	35	3	26
Enfield	55	24	5	17	20
Haringey	54	7	15	1	31
Islington	38	0	21	0	26

Table 21 Source Open Exeter via NHS England cube

Overview of Coverage and Uptake in March 2016

CCG	Number of practices	Practices with coverage over 70%	Practices with coverage under 60%	Practices with uptake over 70%	Practices with uptake under 60%
Barnet	72	19	10	1	41
Camden	39	0	21	0	19
Enfield	55	23	7	14	17
Haringey	54	2	17	2	29
Islington	38	0	31	2	24

Table 22 Source Open Exeter via NHS England cube

A feasibility study will be undertaken shortly to determine whether extending the work telephoning women invited for mammography across London to improve uptake

Performance

In July 2013 CELBSS were instructed by NHS England (London) Head of Screening and the Director of Quality Assurance, London, to implement a managed slow-down of invitations to 50% to redress issues of quality within the service. It was also recommended that the Trust commissioned a management team from the North London Breast Screening Service to improve administrative functions within the breast screening service. There was a managed slowdown of the round length and monthly assurance meeting to monitor performance. There was a need to recruit locum radiologists and for substantive posts to be advertised. By October 2015 2016 the minimum standard for round length had been achieved.

In quarter two, three and four of 2015/2016 CELBSS did not meet the screen to assessment KPI. This was due to a large volume of women pulled back to meet the round length target. This was addressed by balancing screening activity with assessment capacity and putting a demand and capacity model in place.

Failure to meet the minimum standards has meant that CELBSS has not taken part in the age extension trial. This is taking place in NLBSS where women aged 47-49 and women aged 71-73 are invited within a randomised trial

In quarter two NLBSS also did not meet the minimum standard for screen to assessment. This was due to staff capacity issues and an increase in workload due to an increase in women screened. This was resolved by optimising clinic slots and filling radiography and radiology posts.

Patient Surveys

Each breast screening services submits a quarterly report of how many complaints and compliments they have received. A comment form is available to clients when attending for a mammogram. These can be completed anonymously if the client prefers to not complete her personal details. The client can also submit a comment independently and through the local PALS department. Each service also offers the opportunity of communication from clients via their websites. On an annual basis each service runs a patient survey.

The compliments far outweigh the complaints that are submitted. The common themes with the complaints were the manner and negative attitude of the staff, customer care, and availability of appointments, the painful experience of mammogram, unclear signage, unhygienic changing rooms and problems parking. Each complaint was looked into and addressed and where necessary an apology was given. All were discussed at team meeting so there was shared learning. The common themes with the compliments were friendly and helpful staff and an excellent service provided.

There is no analysis available which looks at the differential uptake by age, ethnicity learning disabilities deprivation or ward of residence.

Future actions

At the moment women are invited in NLBSS by GP practice and in CELBSS by area and GP practice. In July 2016 the computer system used to produce breast screening batches was replaced with a new system called BS Select. The introduction of BS-Select has had an unanticipated (negative) impact on the Round plans of both breast screening services in North Central London. It is anticipated that in one of the London breast screening services 9-25% of the cohort will be called/recalled either early or late (reduced or increased Round length for the affected cohort by a few months or up to two years or more in some cases). This has been raised with the National Office and guidance has been sought to determine what action can be taken to mitigate the effects. An independent consultant is working with the breast screening units to quantify the impact.

There is a desire to move to delivering the breast screening programme using the next test due date, this would reduce the negative impact of BS Select it would also result in women being called at the correct time exactly three years form their last test. For services involved in the age extension trial it would not be possible to transfer to next test due date without using further software. For NLBSS

using mobile breast screening units there would have to be a move to static sites before transferring to next test due date.

Cervical Screening

Overview

The NHS Cervical Screening Programme invites women between the ages of 25 and 64 are invited for regular cervical screening under the NHS Cervical Screening Programme. Women aged 25 to 49 are invited every 3 years. After that, women are invited every 5 years until the age of 64. This is intended to detect abnormalities within the cervix that could, if undetected and untreated, develop into cervical cancer.

Coverage

Coverage of cervical screening is an effective indicator of judging the success of the Cervical Screening Programme. It measures the percentage of women in the target age group (25–64 years) who have been screened. Nationally there has been a downward trend in coverage from 2013/14 which is reflected across London. North Central London coverage is in line with the London average but lower than the national minimum standard of 80% coverage (Table 23).

NHS Cervical Screening Programme: Age appropriate coverage by age band and NC London Boroughs, 2015-16

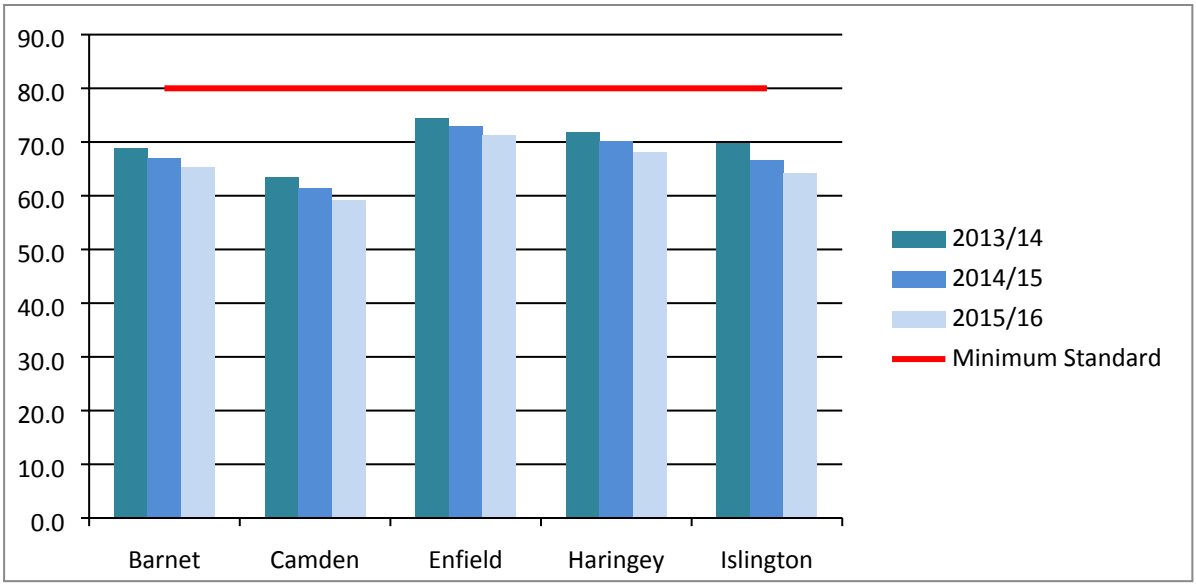
Region & Local Authority		2015-16						
		Eligible population [1]				Age appropriate coverage		
		Thousands				Percentages		
		25-49	50-64	25-64		25-49 (less than 3.5 yrs since last adequate test)	50-64 (less than 5.5 yrs since last adequate test)	25-64
	ONS Code	(000's)	(000's)	(000's)		*(%)*	*(%)*	*(%)*
London	**E12000007**	**2,002.8**	**652.8**	**2,675.3**		***63.7***	***76.3***	***66.7***
Barnet	E09000003	81.6	30.9	112.5		*61.9*	*74.4*	*65.3*
Camden	E09000007	59.6	15.6	75.1		*56.1*	*71.3*	*59.2*
Enfield	E09000010	67.4	27.4	94.8		*68.0*	*79.2*	*71.2*
Haringey	E09000014	69.2	21.0	90.2		*65.0*	*78.1*	*68.1*
Islington	E09000019	62.7	15.1	77.8		*61.5*	*74.9*	*64.1*

[1] This is the number of women in the resident population less those with recall ceased for clinical

Table 23: Source: Open Exeter system (Health and Social Care Information Centre), PHOF report.

Cervical screening coverage has worsened for all Local authorities in North Central London from 2013/14 to 2015/16 (Graph 1). There are no Boroughs in North Central London that are achieving the minimum standard of 80%. In NC London, Enfield has the highest uptake (71.2%) which is higher than London average (66.39%) with Camden having the lowest (59.2%); trends in coverage figures reflect a similar pattern across London with a slight drop in coverage rate of 1.7% from 2014/15 to 2015/16 and remain lower than the national minimum standard of 80% coverage.

Cervical Screening Age Appropriate Coverage: 25-64 Age Cohort
(3.5 years for 25-49 and 5.5 years for 50-64)



Graph 5: Source**:** Health and Social Care Information Centre

Although coverage shows a downwards trend since March 2014, both Enfield and Haringey have performed above the London average but both have also shown a reduction from March 2015 to March 2016 (1.7%) and (1.9%) respectively.

There are no Boroughs in London that are achieving the national minimum standard of 80% for coverage. However, Enfield (71.2%) and Haringey (68.1%) coverage remains higher than the London average (66.7%) in March 2016.

- Boroughs in NC London continue to not to meet the standard for cervical screening coverage and all show some deterioration in 2015/16.
- NC London coverage is in line with London's performance but shows a downward trend in 2015/16

NC London Boroughs receive their colposcopy service from six providers namely; Barnet Hospital, Chase Farm Hospital, North Middlesex Hospital, The Royal Free Hospital, Whittington Hospital and University College London Hospital. All six providers are meeting the following targets: high grade waiting times, DNAs for new patients and communication of results letters within 8 weeks.

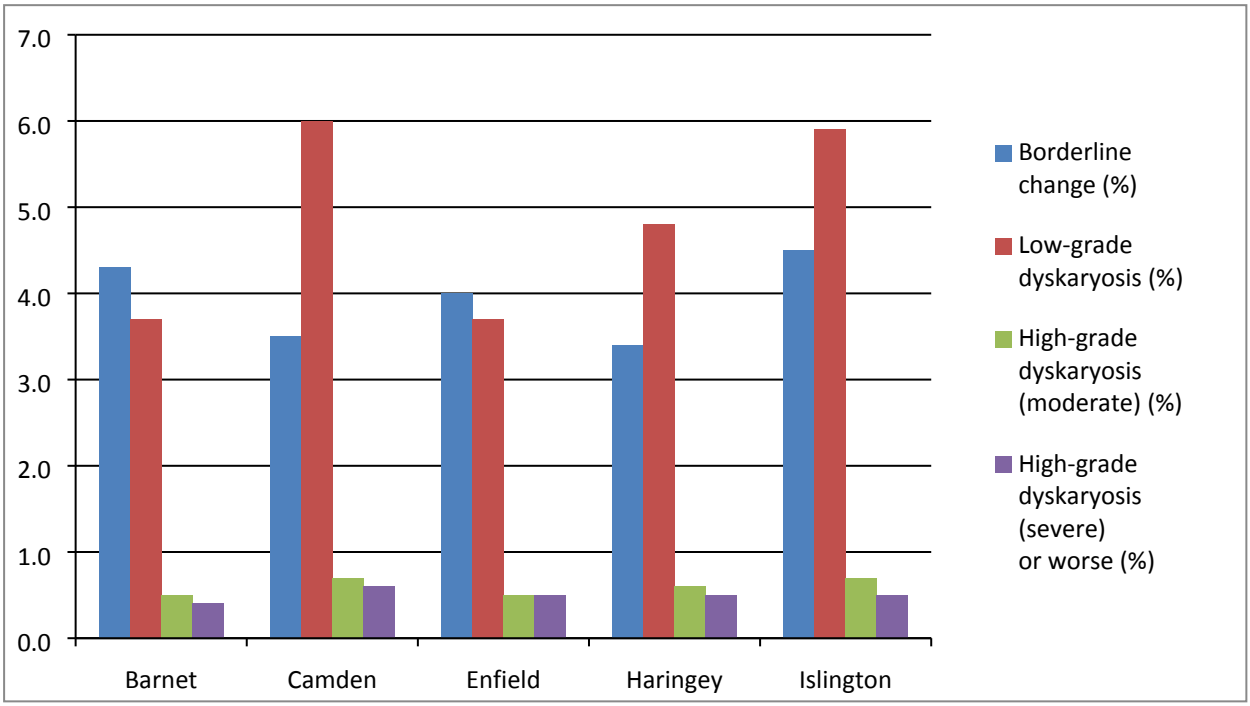
Table 24 below includes data for NC London Boroughs on the screening samples examined by the Health Services Laboratory (HSL) and Chase Farm Hospital on referrals to colposcopy units. Of samples submitted by GPs and NHS Community Clinics across NC London, the percentage of test results returned Negative ranged between 88.3% and 91.4%, the London average is 92.8% of test results returned Negative. Test results returned as High-grade dyskaryosis (severe or worse) and or High-grade (moderate) were less than 0.7%, Low-grade dyskaryosis results are highest in Camden (6.0%) and Borderline change results are highest in Islington (4.5%) see Graph 6 below.

NHS Cervical Screening Programme: Target Age Group (25-64), results of tests by NC London Boroughs, 2015-16

	Negative	Borderline change	Low-grade dyskaryosis	High-grade dyskaryosis (moderate)	High-grade dyskaryosis (severe) or worse
	(%)	*(%)*	*(%)*	*(%)*	*(%)*
London	***92.8***	***2.9***	***3.3***	***0.5***	***0.5***
Barnet	*91.1*	*4.3*	*3.7*	*0.5*	*0.4*
Camden	*89.2*	*3.5*	*6.0*	*0.7*	*0.6*
Enfield	*91.4*	*4.0*	*3.7*	*0.5*	*0.5*
Haringey	*90.8*	*3.4*	*4.8*	*0.6*	*0.5*
Islington	*88.3*	*4.5*	*5.9*	*0.7*	*0.5*

Table 24: Source: NHS Digital Cervical Screening Programme, England – 2015-2016.

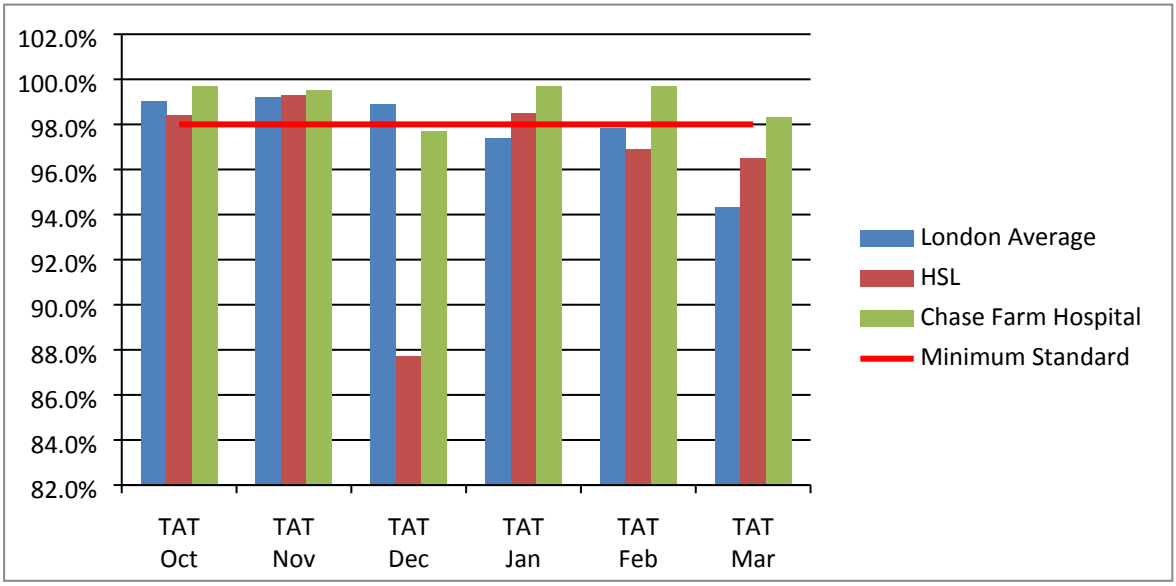
NHS Cervical Screening Programme: Target Age Group (25-64), results of tests by NC London Boroughs, 2015-16



Graph 6: Source: NHS Digital Cervical Screening Programme, England – 2015-2016.

Cervical screening Turnaround Times (TATs) the national minimum standard is 98% of women receive their cytology result within 14 days from the date of primary screen. The cytology laboratories covering NC London Boroughs regularly achieve the minimum standard, however, in November 2016 HSL breached the target (97.7%) but the London average remained at 99% see Graph 7 below.

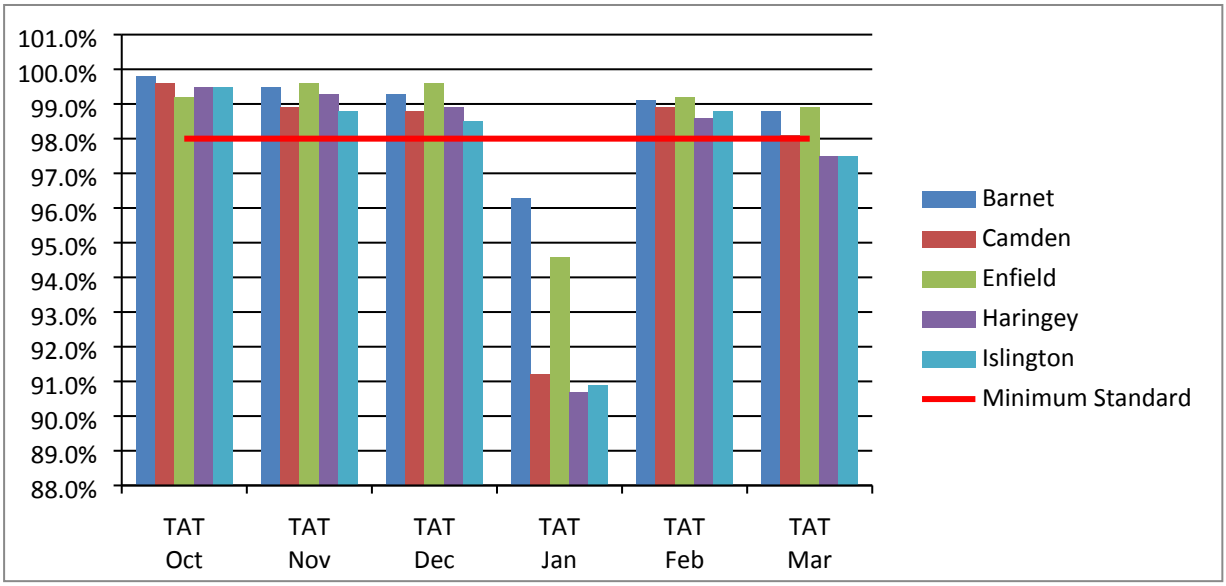
NHS Cervical Screening Programme: Turn Around Times (TATS) by Cytology Laboratory, October – March 2015-16



Graph 7: Source**:** Open Exeter

The performance in cervical screening Turnaround Times (TATs) at Borough level has seen a decline in performance since December 2015 (98.7%) of results were estimated to be delivered within 14 days achieving the national standard (98%). In March 2016 the overall TATs for London had dropped to 95.7% with only 3 of the NC London Boroughs meeting the national standard of 98% see Graph 8 and Table 25 below.

NHS Cervical Screening Programme: Turn Around Times (TATS) by NC London Boroughs, October – March 2015-16



Graph 8: Source: Open Exeter

NHS Cervical Screening Programme: Turn Around Times (TATS) by NC London Boroughs, October – March 2015-16

	Oct	Nov	Dec	Jan	Feb	Mar
London	99.0%	99.2%	98.9%	97.4%	97.8%	95.7%
Barnet	99.8%	99.5%	99.3%	96.3%	99.1%	98.8%
Camden	99.6%	98.9%	98.8%	91.2%	98.9%	98.1%
Enfield	99.2%	99.6%	99.6%	94.6%	99.2%	98.9%
Haringey	99.5%	99.3%	98.9%	90.7%	98.6%	97.5%
Islington	99.5%	98.8%	98.5%	90.9%	98.8%	97.5%

Table 25: Source: Open Exeter

From April 2016, Primary Care Support England (PCSE) has taken over the responsibility for the primary care support services delivered by NHS England. PCSE's priority is to ensure the safe and secure delivery of existing services, whilst introducing new arrangements to help create a national easy to use service for all customers. The closure of the support services based in London has resulted in an increase in the number of both laboratories and CCGs failing to meet the minimum standard.

HSL are currently conducting an audit to understand delays with results to Primary Care Support England (PCSE) since centralisation of services in Leeds. Initial investigations show that files sent at 8am and should be received and posted on that day are not being processed (i.e. results letters sent) until the following day so adding an extra day to our TATs.

Learning disabilities

Unfortunately, the screening programmes do not routinely collect data regarding numbers of patients with learning disabilities accessing the services due to the software not being programmed to collect such data.

Deprivation

The screening programmes do not routinely collect data for deprivation; this data is held by Local Authorities

GP practice

NHS England will engage with CCG commissioners to develop actions to support GP practices with low uptake of service. We will also actively participate in Strategic Transformation Plan working groups looking at cancer commissioning and prevention

Females 25- 64 yrs, attending Cervical Screening within target period 3.5 or 5.5 year coverage % (2014-15)

	GP practice average performance %	Lowest performing GP practice %	Highest performing GP practice %
Barnet	66.4	41.5	78.3
Camden	59.4	27.7	73.2
Enfield	72.8	62.3	82.2
Haringey	70.8	54.2	80.5
Islington	67.1	61.3	74.4

Table 26: Source: QOF

Ward of residence

There is currently only CCG level data rather than Ward of residence level data.
Camden is the lowest performing Borough

Service delivery issues

All services breaching national performance targets are asked to provide an exception report highlighting the reasons for the breach and remedial actions taken to prevent reoccurrence. At the Cervical Screening Programme Boards the Hospital Based Programme Coordinators (HBPC) provide an exception report on performance and alert NHSE to any issues concerning performance. When a trust breaches the same target in two consecutive quarters NHSE commissioners review the exception reports and make a decision on the issuing of contract performance notices.

North Middlesex Hospital (January 2016)

Contract performance letter sent to Chief Executive

- Consistently failed to meet the target DNA rate for follow up patients. Performance data for Quarter 2 2015/16 shows the DNA rate for follow up patients to be well above the recommended 15% at 32.38%, we note this is a rise of 12.3% on the previous quarter which is a real cause for concern and which needs to be addressed immediately.

The Trust has implemented a number of changes to address the poor performance. Reminder letters and phone calls were implemented early December 2015. Text reminders have also been reintroduced; the implementation of phone calls and letters has already had an impact on performance and DNA rates are significantly reduced.

Data validation issues caused by the interface between Medway and Compuscope, impacted on indicators reported via Cyres. There were discrepancies between the two systems which meant KPIs could not be tracked and figures reported via KC65 (extracted from Cyres) were inaccurate. The trust have now implemented a new computer system for the colposcopy department to resolve this issue

Barnet and Chase Farm (December 2015)

Despite initiatives in place to reduce follow up DNA, including texts and reminder letters, rates at Barnet and Chase Farm Hospitals breached the standard (<15%) for quarter 3

Following the acquirement of BCFH by RFH in July 2015, the PAS systems at Hampstead site and at Barnet & Chase Farm site were merged on 1st November 2015. This involved allocating new hospital numbers to most of Barnet & Chase Farm patients. As a result of the merge, old appointment history on PAS and appointments for direct referrals booked on the system for patients that had not been seen prior to the merge (approx 6 weeks) were lost.

The issue was declared a serious screening incident to ensure the Trust had taken the appropriate actions to resolve the incident and have escalated to the highest level within the organisation. Following assurance that all data had been restored on the PAS system and submission of a concise Root Cause Analysis, the incident was closed.

The Whittington Hospital (November 2016)

A Contract Performance Notice issued because the Trust had consistently failed to meet Colposcopy performance targets in Q1and Q2 2016/17. A meeting between NHSE and the Trust has taken place and a number of recommendations with timescales have been agreed to improve performance. NHSE will continue to monitor performance and take appropriate action if performance breaches continue.

Information on patient satisfaction with the existing services

NHS England is committed to ensuring that providers improve user involvement in all the programmes through a range of activities, including:

- Recruiting suitable patients who can be patient representatives on the programme board (NC London vacancy)
- routine monitoring of compliments and complaints
- to implement required improvements patients

Adverts for Patient Public Voice (PPV) representatives for Cervical Screening Programme boards have been sent out.

NC London-wide and borough specific action plan to address:

- **non-achievement of national minimum standards in the programme**
    - breaches will be managed through NHS performance frameworks

- **inequities and inequalities in uptake**

- NHSE/PHE Uptake and Coverage Manager to be appointed (social marketing)
- Commissioning CASH clinics to provide cervical screening for women who do not respond to invitation
- NC London CSP continues to work closely with GPs and other stakeholder to improve uptake in the hard to reach groups
- Engagement with pharmacies
- Integration of screening and/or screening awareness raising in other community settings
- NHSE/PHE working with Local authorities and CCG commissioners to develop a joint understanding of local population needs leading to a shared set of priorities

Table 5: Female patients (25 – 64yrs) on the Mental Health register who had cervical screening test in the preceding 5 years (2015-16)

	GP practice average performance %	Lowest performing GP practice %	Highest performing GP practice %
Barnet	66.6	27.3	100
Camden	69.2	45.5	95.5
Enfield	70.4	47.1	100
Haringey	72.5	42.9	100
Islington	68.2	41.7	100

Source: QOF

- **identified issues with service delivery**
  - monthly delayed sample reports by CCG and GP practice
  - monthly sample handling errors reports by CCG and GP practice

- **identified issues with patient experience**
  - management cervical screening incidents affecting patient or service delivery

Other actions to improve uptake and coverage:

- Introduction of Primary HPV screening
  - HPV self-testing subject to National approval
- Working with Primary care commissioning to develop action plans and ensure that private and overseas samples are recorded appropriately
- Working with Sustainable Transformation Plans (STPs) planning groups

Appendices omitted