PURPOSE OF REPORT AND EXECUTIVE SUMMARY

This report provides Board members with an update on the delivery of the breast cancer screening programme commissioned for the women of Waltham Forest by NHS England (NHS E). It notes the performance, coverage and uptake of the programme against nationally set targets, describes actions being taken to improve performance and updates members on developments to the national screening programme which is led by Public Health England (PHE), and service developments and commissioning plans which are led by NHS England.

Key messages:

- Like most London boroughs, Waltham Forest does not meet breast screening uptake\(^1\) and coverage\(^2\) targets
- Between November 2013 and October 2014, breast screening coverage declined by 3% to 62%.
- The decline in coverage is a result of an NHSE-mandated managed slow-down in the Barts/Central London Breast Screening Service. This has impacted round length\(^3\) and therefore reduced coverage significantly in all boroughs served by CELBSS.
- Barts/Central London Breast Screening Service was required to reduce activity by 50% to enable review and improvement of programme management and administrative structure and processes. This impacted screen to assessment times, round length and coverage in Waltham Forest and other north central London boroughs. The trust is working towards achieving full capacity and throughput by October 2015 with support and monitoring by NHSE and PHE London Cancer Screening Quality Assurance Team

DETAILS

\(^1\) Uptake is a measure of the proportion of invitees who complete the screening test within a particular timeframe

\(^2\) Coverage is defined as the percentage of the population who are eligible for screening at a particular point in time, who have had a test with a recorded result within the appropriate screening timescale (e.g. two, three years or five years).

\(^3\) Round length is defined the proportion of women who are screened with thirty six (36) months of their previous screen. The national target is 90%.
2. INTRODUCTION

Under the Health and Social Care Act (2006 as amended) responsibility for screening programmes transferred from PCTs to a number of different organisations. Although NHS E has a clear responsibility and accountability for the delivery of the three cancer screening programmes, other partners such as PHE and Local Authorities have a role to play in supporting NHS E in this area. Within Local Authorities, Directors of Public Health (DPHs) also have a specific role in regards assurance. The Director of Public Health (DPH) is required to ‘provide information and advice to every responsible person and relevant body within, or which exercises functions in relation to, the authority’s area, with a view to promoting the preparation of appropriate local health protection arrangements’ (Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 made under section 6c (1) of the National Health Service Act 2006). In order to undertake this duty, the DPH needs to be assured that there are adequate screening plans in place in their Borough. This report forms part of this assurance process.

Set out below are a brief description of the roles and responsibilities of organisations in improving coverage and uptake of screening across London since April 1st 2013:

2.1 NHS England (NHSE)

- Commissioning of all national screening programmes described in Section 7A of the NHS Mandate
- Commissioning screening services from primary care and secondary care providers (e.g. Barts Health/Central London Breast Screening Service) to specified national standards
- Monitoring providers’ performance and for supporting providers in delivering improvements in quality and changes in the programmes when required
- Accountable for ensuring those local providers of services deliver against the national service specifications and meet agreed population uptake and coverage levels as specified in Public Health Outcomes Framework and Key Performance Indicators (KPIs)
- Work with Department of Health (DoH) and Public Health England in national planning and implementation of screening programmes and in quality assurance
2.2 Public Health England (PHE)

- Provide expert advice to NHS England in cases of screening incidents. They provide access to national expertise on screening queries.
- Provide information to support the monitoring of screening programmes

2.3 Clinical Commissioning Groups (CCGs)

- Have a duty of quality improvement (including screening services delivered in GP practices)
- Commission cancer diagnosis and treatment services

2.4 Local Authorities

- Provide information and advice to relevant bodies within its area to protect the population’s health (whilst not explicitly stated in the regulations, this can reasonably be assumed to include screening)
- Provide local intelligence information on population health requirements e.g. Joint Strategic Needs Assessment
- Provide independent scrutiny and challenge of the arrangements of NHSE, PHE and providers.

2.5 Commissioning Support Units (CSUs)

- Although not statutory, CSUs have a role to play in supporting CCG member practices in enabling them to carry out their screening work, e.g. IT support to help with call/recall

2.6 General Practitioners (GPs)
• General practices are contracted by NHSE to deliver cervical screening sample taking.
• Practices are asked to actively support the delivery of screening programmes e.g. by discussing this with patients, signposting patients to information on screening programmes etc.

3 BACKGROUND TO THE CANCER SCREENING PROGRAMMES

Screening is effective in either preventing or detecting early stages of disease at a time when there is an intervention that is effective in reducing the impact of the disease in terms of mortality or morbidity. This report focuses on breast cancer screening but NHS England is responsible for commissioning other screening programmes for cervical, bowel and non-cancer programmes e.g. for antenatal and new born screening, diabetic eye and abdominal aortic aneurysm screening.

All national screening programmes are agreed by PHE’s National Screening Committee. PHE is responsible for the implementation of new programmes. A current example of this is the extension of the breast screening programme to include women aged 47 to 73 (from the current 50-70 age cohort). Established programmes are commissioned by NHSE with support from PHE embedded staff.

4 THE NHS BREAST SCREENING PROGRAMME

4.1 Breast screening

Breast screening is a method of detecting breast cancer at a very early stage. The first step involves an x-ray of each breast - a mammogram. The mammogram can detect small changes in breast tissue which may indicate cancers which are too small to be felt either by the woman herself or by a doctor.

Studies have shown that screening reduces deaths from breast cancer by between 15 and 22%, i ii and the Advisory Committee on Breast Cancer Screening in the UK has estimated that around 1,400 lives are saved every year by breast screening. iii
The NHS Breast Screening Programme provides free breast screening every three years to all women aged 50 and over. Because the programme is a rolling one which invites women from GP practices in turn, not every woman receives an invitation as soon as she turns 50. But she will receive her first invitation before her 53rd birthday. Once women reach, 70, which is the upper age limit for routine invitations for breast screening, they are encouraged to make their own appointments. The service is now using digital instead of analogue mammography, which supports screening for women under 50.

4.2 High Risk Surveillance
The NHS Breast Screening Programme provides surveillance to women at high of developing breast cancer through regular mammography and MRI imaging

4.3 Age extension
Public Health England is currently phasing in an extension of the breast screening programme to women aged 47-49 and 71-73 as part of a randomised control trial. During the trial, 50% of eligible women in the extended age range will be invited. The extension started at selected pilot sites in 2009 and full roll out is expected after 2016. If proven to be successful, age extension will be fully implemented and all women should be invited for their first screening before the age of 50. Age extension has not yet been introduced in North Central London; this is due to the current performance issues within Barts/Central London Breast Screening Service (see section 4.5-4.6)

4.4 Barts Health/Central London Breast Screening Service (CELBSS)
Cancer screening providers deliver cancer screening programmes as per national service specifications and NHS contracts. This includes responsibility for ensuring staff are appropriately trained and supervised. NHS England is responsible for the contract management of providers. Barts Health Care Trust/Central London Breast Screening Service provides breast provides breast screening services and assessment to the eligible populations of Camden, Islington, City & Hackney, Newham, Tower Hamlets and Waltham Forest.
4.5 CELBSS- Managed Slow-down
In September 2012, a Quality Assurance visit to CELBSS highlighted concerns over leadership and management within the trust, capacity for call/recall functions, quality Management Services (QMS) and audit within the service. Since July 2013 a number of actions have been put in place to address these issues:

1. A managed, time limited, slow-down of invitations by 50%;
2. A new management structure was implemented on 18th December 2013. CELBSS now shares a management team with the North London Breast Screening Service (NLBSS) whilst the two units continue to run separate clinical services each with their own Director of Screening. Allocated time for Quality Management Systems (QMS), audit and administrative review;
3. Regular meetings between the administrative and radiographic teams to ensure a better understanding of roles and smoother running of services with particular emphasis on clinic closure;
4. A review of the Right Results Pathway has been implemented;
5. Monthly assurance meetings have been convened; between the trust NHSE and London Cancer Quality Assurance Team

4.6 Current Performance (Q3 2014/15)
Table 1 showed December roundlength\(^4\) at 37% (national standard 90% women invited within 36 months of last screening episode); this was the worst performance in England. However Q3 showed a significant improvement on the reported figure of 18% in September; the majority of women were currently being invited within 37 months and additional clinics and staff were being prioritised to support the most vulnerable boroughs (Waltham Forest)

Screen to Date of First Offered Assessment Appointment (DOFOA)\(^5\) within 3 weeks (target >90%) was achieved in Q3 (92%), but not for year to date (87%). Screen to actual

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4 Round length is defined the proportion of women who are screened with thirty six (36) months of their previous screen. The national target is 90%.
5 Women who are found to have an abnormality following screening, are invited to an assessment clinics for further examination. Ninety percent (90%) of these women should be seen in an assessment clinic within three weeks.
appointment within 3 weeks (target >90%) was also achieved in Q3 (92%) but not for year to date (87%).

The service has increased invitation rates and is now operating at 80% capacity, running clinics at all screening venues. In order to gain approval for age extension, the service needs to operate at full capacity and achieve national standards for three consecutive months.

Table 1: Breast Screening Provider Performance

<table>
<thead>
<tr>
<th></th>
<th>Repeat Examination</th>
<th>Roundlength</th>
<th>Screen to Normal</th>
<th>Screen to Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No Recall</td>
<td>No Screened</td>
<td>National Reports</td>
<td>National Reports</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>SR001 (Minimum Standard: &gt;9%)</td>
<td>SR002 (Minimum Standard: &gt;50%)</td>
</tr>
<tr>
<td>West London Breast Screening Service ECK</td>
<td>91.1%</td>
<td>103</td>
<td>80%</td>
<td>97.6%</td>
</tr>
<tr>
<td>Q4 13-14</td>
<td>9.8%</td>
<td>72</td>
<td>94%</td>
<td>97.0%</td>
</tr>
<tr>
<td>Q2 14-15</td>
<td>9.3%</td>
<td>64</td>
<td>95%</td>
<td>97.1%</td>
</tr>
<tr>
<td>Central East London Breast Screening Service PLO</td>
<td>9.1%</td>
<td>70</td>
<td>98%</td>
<td>97.6%</td>
</tr>
<tr>
<td>Q3 13-14</td>
<td>9.1%</td>
<td>75</td>
<td>99%</td>
<td>97.4%</td>
</tr>
<tr>
<td>Q4 13-14</td>
<td>9.0%</td>
<td>70</td>
<td>98%</td>
<td>97.6%</td>
</tr>
<tr>
<td>South West London Breast Screening Programme HWA</td>
<td>9.1%</td>
<td>86</td>
<td>95%</td>
<td>97.6%</td>
</tr>
<tr>
<td>Q3 13-14</td>
<td>9.1%</td>
<td>75</td>
<td>99%</td>
<td>97.4%</td>
</tr>
<tr>
<td>Q4 13-14</td>
<td>9.0%</td>
<td>70</td>
<td>98%</td>
<td>97.6%</td>
</tr>
<tr>
<td>South East London Breast Screening Services King’s GCA</td>
<td>9.1%</td>
<td>86</td>
<td>95%</td>
<td>97.6%</td>
</tr>
<tr>
<td>Q4 13-14</td>
<td>9.1%</td>
<td>75</td>
<td>99%</td>
<td>97.4%</td>
</tr>
</tbody>
</table>


The Trust has implemented the following service improvements:

- Recruitment of a substantive Director of Screening

Disclaimer: this data is unvalidated, unprocessed and for operational purposes only.
• Approval of a business case to recruit additional staff with interim agency backfill
• Service to extend the roles for Band 7 radiographers to introduce career pathway and improve retention of staff;
• Commitment to achieve roundlength target within 3 months of business case sign off; (October 2015)
• Management contract with RFH/NLBSS extended for a further year;
• Strengthening processes and pathways for sign off and payment of invoices for breast screening services (Crown) to ensure prompt payment by Bart’s Health

5. COVERAGE and UPTAKE

Coverage is defined as the percentage of the population who are eligible for screening at a particular point in time, who have had a test with a recorded result within the appropriate screening timescale (e.g. two, three years or five years).

5.1 Breast screening coverage (50-70 years)

The target for breast screening coverage is 70%. Borough coverage rates vary across London; from 55% in Tower Hamlets to 74.6% in Havering (October 2014).

Between November 2013 and October 2014, breast screening coverage across London increased by 1% to 64.5%. During the same period, coverage in Waltham Forest declined by 3%; from 65.2% to 62%. (Figure 1, Table 2) This was a result of the slow-down in activity and resultant decline in round –length (section 4.5-4.6)

Table 2: Breast screening coverage, North East Central London, 50-70, November 2013 to October 2014

<table>
<thead>
<tr>
<th>CCG</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS BARKING AND Dagenham CCG</td>
<td>62%</td>
<td>61%</td>
<td>61%</td>
<td>61%</td>
<td>64%</td>
<td>65%</td>
<td>65%</td>
<td>65%</td>
<td>63%</td>
<td>62%</td>
<td>61%</td>
<td>60%</td>
</tr>
<tr>
<td>NHS BARNET CCG</td>
<td>67%</td>
<td>67%</td>
<td>67%</td>
<td>67%</td>
<td>69%</td>
<td>69%</td>
<td>68%</td>
<td>68%</td>
<td>68%</td>
<td>68%</td>
<td>68%</td>
<td>68%</td>
</tr>
<tr>
<td>NHS CAMDEN CCG</td>
<td>58%</td>
<td>57%</td>
<td>57%</td>
<td>57%</td>
<td>58%</td>
<td>58%</td>
<td>56%</td>
<td>56%</td>
<td>56%</td>
<td>56%</td>
<td>55%</td>
<td>55%</td>
</tr>
</tbody>
</table>
NHS CITY AND HACKNEY CCG | 57% | 56% | 56% | 55% | 55% | 54% | 53% | 54% | 55% | 56% | 56% | 55%
NHS ENFIELD CCG      | 70% | 70% | 70% | 69% | 70% | 69% | 69% | 70% | 70% | 70% | 70% | 71%
NHS HARINGEY CCG    | 64% | 64% | 64% | 64% | 65% | 65% | 64% | 64% | 64% | 63% | 63% | 63%
NHS HAVERING CCG    | 69% | 70% | 72% | 73% | 74% | 74% | 73% | 74% | 75% | 75% | 75% | 75%
NHS ISLINGTON CCG   | 56% | 55% | 53% | 51% | 52% | 51% | 48% | 49% | 52% | 54% | 58% | 
NHS NEWHAM CCG      | 58% | 59% | 60% | 60% | 62% | 61% | 60% | 58% | 56% | 56% | 57% | 57%
NHS REDBRIDGE CCG   | 66% | 67% | 67% | 68% | 70% | 70% | 70% | 69% | 69% | 69% | 69% | 69%
NHS TOWER HAMLETS  | 60% | 60% | 59% | 57% | 56% | 55% | 56% | 58% | 58% | 57% | 56% | 55%
NHS WALTHAM FOREST | 65% | 65% | 64% | 64% | 65% | 64% | 63% | 63% | 62% | 62% | 62% | 

Figure 1: Breast Screening Coverage, 50-70, London, 2011/12 to October 2014

5.4 Variation in coverage by practice
Coverage in Waltham Forest practices varies from 44% to 70%. (Figure 2) There are a variety of reasons for this including list inflation, ethnic diversity and deprivation of the practice population. Practices with higher coverage also tend to employ a variety of
mechanisms to proactively support women attend screening including reminder phone calls or letters and flags on the record of non-attendees.

Figure 2: Breast Screening coverage, Waltham Forest practices October 2014 (provisional data)

5.6 Factors affecting uptake

There are a variety of population and service factors that affect breast screening coverage. The most significant being uptake and round length

- Uptake is defined as the proportion of people invited for screening who are screened within six months. The national target is 70%.
- Round length is defined as the proportion of women who are screened within thirty-six (36) months of their previous screen. The national target is 90%.
Uptake is measure of individual behavior, i.e. an individual’s response to an invitation to screening. There are varieties of factors that affect whether an individual responds to his/her invitation. These include:

- Social and demographic factors—age, ethnicity and deprivation, population turnover
- Individual factors—fear, embarrassment, previous attendance/non-attendance, poor awareness or knowledge of screening
- Organizational factors—inaccessible services, incorrect patient contact details, lost mail, quality of the service

The most significant factors affecting uptake in Waltham Forest are summarized below.

5.6.1 Deprivation

In Waltham Forest, breast screening coverage rates are lower in practices serving deprived communities (data not shown). This inverse relationship between socio-economic status and uptake is more evident when reviewed across the whole of London (Figure 3).

Figure 3: Breast screening coverage and deprivation, London, 50-70 years, 2006-2009

5.6.2 Type of invitation and previous attendance
Uptake of screening is lower in individuals who are invited for screening for the first time compared to those who have attended previously. Individuals who have been invited in the past but have never attended are unlikely to attend in the future. The longer it is since an individual last attended screening, the less likely it is that he/she will attend. Table 3 shows data from South West London but a similar pattern is seen across all breast screening services and all screening programmes.

Table 3: Uptake by previous attendance/invitation, South West London, 2012/13

<table>
<thead>
<tr>
<th>Type</th>
<th>SWLBSS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Invite</td>
<td>60%</td>
</tr>
<tr>
<td>Routine to Prev Attender within 5 years</td>
<td>82%</td>
</tr>
<tr>
<td>Routine to Previous Non Attender</td>
<td>17%</td>
</tr>
<tr>
<td>Routine to Previous Attenders more than 5 Years</td>
<td>39%</td>
</tr>
<tr>
<td>All</td>
<td>69%</td>
</tr>
</tbody>
</table>

Source: SWL Breast Screening Service

5.6.4 Population turnover

Population turnover is associated with low uptake. This affects the completeness and accuracy of GP lists which are used to identify and invite people eligible for screening. While in most cases, practices endeavour to maintain their registered lists in a current and accurate state, patients often fail to notify their registered practice when leaving the area and/or country resulting in potential duplicate registrations, ghost and ‘gone away’ patients remaining registered on the national patient registration systems (National Health Application and Infrastructure Service, NHAIS Exeter systems). New residents to the borough may also delay registering with a GP. This makes the achievement of uptake and coverage targets challenging as the population size (based on GP registers) is inflated and incorrect and patient contact details incorrect. Figure 2 shows the correlation between breast screening and internal borough migration.

Figure 2: London breast screening coverage and internal migration
5.6.5 Ethnic diversity

Certain ethnic groups are less likely to participate in screening. London boroughs or practices that are more ethnically diverse (as measured by the Simpson Index of Diversity) have lower uptake and coverage. (Figure 3) The association is likely to be confounded by other factors such as deprivation.

Figure 3: London breast screening coverage and borough diversity

5.6.5 Age

Uptake and coverage are generally lower in younger age groups. (Figures 4)
5.7 Actions to Improve Uptake and Coverage

NHSE has commissioned all breast screening providers in London, including CELBSS, to implement the following evidence-based interventions to improve uptake and coverage:

- Sending screening appointment reminders by text messaging
- Sending pre-invitation letters which are letters sent to women before they receive their official invitation letter
- Offering second –timed appointments - Women who do not attend the first screening appointment are sent a second appointment with a specific date and time as well as an ‘open’ invitation which requires the woman to contact the service to make an appointment at time of initial DNA.

NHS England will work with partners to improve uptake and coverage:
• General practices and primary care commissioners to implement a rolling programme of list cleaning
• General practices to support women attend screening e.g. the development of primary care screening guidelines
• Clinical Commissioning Groups (CCGs) as commissioners of post-screening treatment services to ensure that pathways are integrated and services meet national performance and quality standards. CCGs are lead commissioners of most screening programme hospital providers. NHSE will also work with CCGs, Clinical Support Units and Clinical Quality Review Groups, in tackling screening-related provider performance issues.
• Voluntary organisations to design and implement health promotion and awareness raising campaigns, particularly targeting ethnic minorities and deprived communities
• Services users to understand and improve their experience of services and address the barriers to attendance that they identify
• Undertake research into interventions to improve uptake and coverage
• Developing a cancer screening guide that can be used to improve uptake within general practice.

We are also in the process of finalising a strategy to improve coverage and uptake of national screening programmes. This will focus on three areas;

• Increased public awareness and engagement with screening programmes across all communities
• Increased engagement with primary care and improved reliability of data
• Working with screening providers to optimise coverage and uptake

This strategy is due to be signed off by the end of June. We are currently organising a workshop in conjunction with PHE to agree a delivery plan. One of the areas we are keen to focus on is ensuring we use social media effectively especially since our target group is those women attending for first screen i.e. the younger cohort of women.

7 SERVICE IMPROVEMENT PLANS
7.1 Breast Screening Procurement

NHS England is planning to reconfigure Breast Screening provision in London during 2015/16. We are proposing a central administration hub for London. The new service will begin in April 2016. At this stage we are expecting changes to how the programme is administered rather than to venues where local women attend for their mammograms.

This re-procurement aims to address issues that have been identified during the operation of the programme and to create a service that:

- Provide better access to women through extended opening hours e.g. evenings and weekends
- Provide a greater flexibility of choice in terms of venues for screening across London for individual women, so that for example a women living in Waltham Forest but working in Islington could have an initial mammogram in Islington during a lunch time
- Provide a single point of contact with the service for all women across London
- Build more resilience into the service through greater potential to transfer women across screening venues in the event of reduced service capacity on one area
- Support a greater use of digital technology e.g. online bookings
- Provide better alignment with breast cancer diagnostic and treatment services.

8 SERVICE PERFORMANCE AND GOVERNANCE

All Cancer Screening Programmes have Performance Boards which meet on a quarterly basis; each has representation of both the CCG and the Local Authority PH team. These groups have a remit for oversight, monitoring and coordination of programmes. There is an overarching London Screening Programmes Board, chaired by the Head of Screening, at which there is ADPH, CCG and patient/public representation.

Improving uptake of screening is driven through the following mechanisms:

London Cancer Screening Programmes Board - responsible for the strategic direction for cancer screening in London

London Coverage and Uptake Technical Group- Responsible for developing the strategy for increasing coverage and uptake across London
10. CONCLUSIONS

The Board will note that the decline in breast screening coverage in Waltham Forest is a result of a managed slow-down of the breast screening service. This reduction in activity was required to enable implementation of improvements in the programme management structure and processes and ensure provision of a safe screening programme and remove any risk to women. The provider is working towards achieving full capacity and throughput by October 2015 with support and monitoring by NHSE and PHE London Cancer Screening Quality Assurance Team.

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i Gøtzsche PC, Nielsen M. Screening for breast cancer with mammography. Cochrane Database of Systematic Reviews 2006; Issue 4.

