NHS England

Update on Section 7a Screening and Immunisation Programmes August 2017

Update to ADPH on Section 7a Screening and Immunisation Programmes in London August 2017

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Classification: External

The NHS Commissioning Board (NHS CB) was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

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1 Aim

- This update is our quarterly update primarily intended for Directors of Public Health and CCGs in London by the joint NHSE (London) and PHE Public Health Commissioning Team.
- These updates comprise of news on the latest developments, new programmes or initiatives, challenges and progress made on improving uptake and delivery of screening and immunisation programmes in London.

2 Immunisations

2.1 Maternal & Targeted Neonatal Vaccinations

- NHSE (London) is piloting delivery of season 'flu and pertussis vaccination services within maternity units across London. This is a two year project and consists of a number of different models of delivery being trialled. It is envisioned that this programme will not only bring about an extension of patient choice (seasonal influenza vaccines are already offered in pharmacy and both pertussis and 'flu vaccine are offered in GP practices) but will help ensure that advice on and offer of vaccinations are part of the maternal pathway.
- The restrictions on BCG Intervax stock orders were lifted and PHE London TB team have communicated with London TB services about reinstating their access to BCG stocks. In a letter dated 3/8/2017, the Principal Advisor wrote to CCGs about vaccinating those children in the priority group C (previously unvaccinated children aged 1 to 5 years living in areas of the UK where the annual incidence of TB is 40/100,000 or greater; or with a parent or grandparent who was born in a country where the annual incidence of TB is 40/100,000 or greater). Whilst a more systematic approach is being developed, vaccination of overlooked eligible one year olds is being dealt with on a case by case basis. NHSE (London) remains committed to investing in and growing the BCG vaccinating workforce and continues to work with all maternity providers in providing universal access with targeted follow up in the community. The six high risk boroughs in 2016 – i.e. Newham, Ealing, Brent, Hounslow, Redbridge and Harrow remain receiving universal offer up to 12 months.
- The neonatal Hep B CHIS failsafe has been underway the past three months and the ordering and storage of dried blood spot kits (DBS) for London has been resolved with a community pharmacy (with a wholesale licence) holding the account for London. The London Neonatal Hep B protocol (formerly called pathway) was delayed whilst processes around these aspects were resolved. The protocol can now be released in September.

2.2 Childhood Immunisations

- Quarter 1 2017/18 COVER is the first submission by the 4 London CHIS Hubs. This production has uncovered a number of issues around the previous collation of data including a large proportion of GP practices that had not signed data sharing agreements nor submitted vaccination data to CHIS. This

number has been greatly reduced to <10 practices across London. This is being targeted through our CHIS operational and programme board meetings as well as a deep dive of a 10% audit. Overall, London's performance on the COVER indicators continues to remain stable.

- The Principal Advisor is a member of the National Immunisations Maintenance Board and through this is working with National PHE Immunisation team to undertake an analysis to explore factors affecting the timing of receipt of vaccinations in London and to update previous vaccine coverage by ethnicity analysis. She's also leading on use of Read codes by GP practices to better reflect children who were vaccinated abroad in order to reduce the number of children recorded as unvaccinated.
- From August 2017, the 6-in-1 (Hep B containing) vaccine will replace the 5-in-1 vaccine as the primaries in the routine childhood immunisation schedule. This has been widely prepared for and communicated across London.

2.3 School Age Vaccinations

- In July 2017, NHSE (London) hosted a workshop with all School Aged Vaccination (SAV) providers. The purpose of this workshop was to undertake a deep dive into the successes and challenges that were impacting on uptake in London. A number of actions came out of this workshop including improving the return of consent forms (the biggest barrier to uptake) and an escalation process for head teachers refusing entry of SAV teams. Both of these actions are in progress. It is intended to have a follow up workshop next year.
- This coming school year, the child 'flu programme will be extended to Reception and Year 4.

2.4 Adult Vaccinations

- The 2017/18 London Flu Plan has been drafted and Flu preparedness planning meetings have commenced. This year there is a focus on care home and hospice workers and mental health workers, continued focus on improving uptake of carers in pharmacy and clinical 'at risk' groups. We are also focusing on those areas of London that had frequent A&E attendances and ambulance call-outs. There is an added emphasis on improving PPV uptake, although current stock shortages have limitations for our plans.
- We've drafted a public health CQUIN for 2017/18 for ensuring all health care workers are vaccinated with MMR and pertussis (acute and community trusts).
- We're focusing on Men ACWY this summer. We've just finished a qualitative study of GP practices and SAV on why our uptake amongst 18 year olds was only 9.9% last year. These findings will be available later this year. Related to this is the pilot study with community pharmacy delivering Men ACWY to 18-25 year olds in a bid to increase access, patient choice and to bring it in line with the health seeking behaviours of this age group. This will include mobile units to universities and as pop ups at other relevant venues. This pilot will be closely monitored and evaluated.
- The joint project with the Office of CCGs for improving uptake of Shingles vaccine uptake continues. Early monitoring checks suggest improvement

above usual monthly cumulative increases in areas where vast majority of GP practices submitted data for surveillance in ImmForm. July figures overall saw a decrease in submission by practices which the Office for CCGs and NHSE are looking at to rectify for the August submissions.

2.5 London Immunisation Board

- The Quarterly Assurance Report plus updates on the Health Inequalities Strategy, London Immunisation Plan and the evaluation of local borough partnership and plans will be available in September 2017.

3 Antenatal & Newborn Screening

3.1 London ANNB Screening P&Q Boards

LA Public Health and CCG maternity commissioners are included in the membership of the Boards, and meeting papers are circulated prior to the meetings. Please contact the ANNB screening team in NHSEL if you are able to attend or send a representative to the meeting.

Meeting	Date and Time	Venue and commissioning lead
SWL ANNB Screening P&Q Board	Wednesday 6th September, 9.30-11.15 Tuesday 28th November, 9.30-11.30	Skipton House, Lucy Smith
SEL ANNB Screening P&Q Board	Wednesday 13th September, 9.30-11.15 Thursday 27th December, 9.30-11.30	Skipton House, Colette Scrace
NWL ANNB Screening P&Q Board	Thursday 14th September 2017, 2.30-4.30 Friday 8th December, 9.30-11.30	Skipton House, Brigitte Dingle
NCL ANNB Screening P&Q Board	Monday 11th September, 10.00-12.30 tbc	Skipton House, Shona Ash
NEL ANNB Screening P&Q Board	Monday 18th September, 10.00-12.30 Tuesday 28th November, 12.30-3.00	Skipton House, Petra Charlemagne

3.2 Foetal anomaly screening (FASP, includes Down's Syndrome, Edwards' Syndrome and Patau's Syndrome)

The two components to this programme were outlined in the Dec 2015 update. The FASP KPI measures the completeness of the information provided in the laboratory request form, which is needed for the risk calculation. The acceptable target for this is 97.0% and achievable is 100%. Four maternity providers did not meet the acceptable standard in Q3 2016/17.

KPI FA1 Satisfactory completion of laboratory request forms Q3 2016/17

Area	Performance %
England	97.5
London	98.3
Highest in London	99.6
Lowest in London	94.8

Source: https://www.gov.uk/government/publications/nhs-screening-programmes-kpi-reports-2016-to-2017

NHSEL is continuing to discuss with units the use of electronic request forms, with the aim of improving on the poor performance from those units which are consistently not able to meet even the minimum standard for this KPI. These discussions include the laboratories to encourage them to incorporate electronic forms in their IT systems. Nationally, laboratory QA is being moved from the Screening Quality

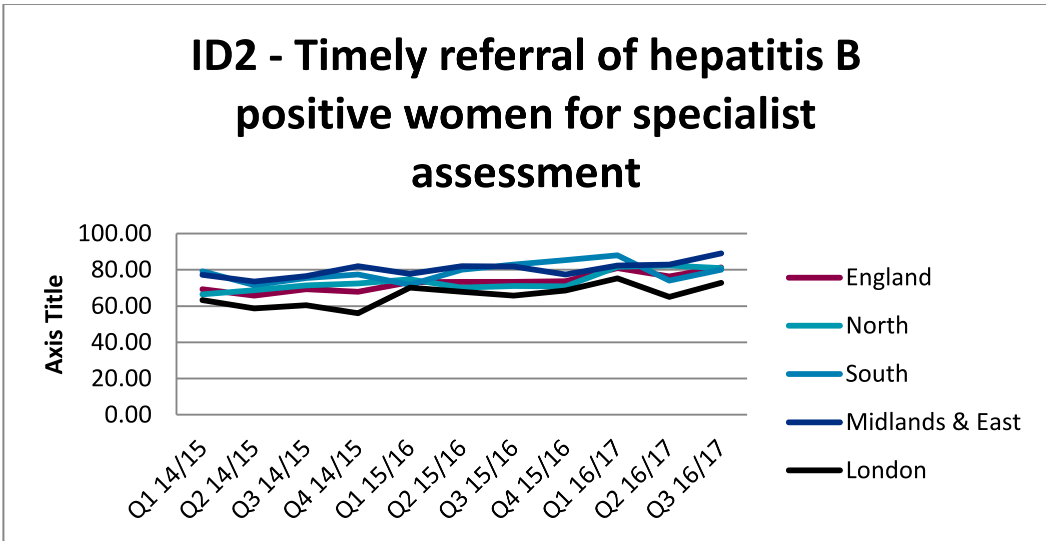
Assurance Service (SQAS) to the UK Accreditation Service (UKAS) and laboratory standards will be a focus for work in 2017/18.

Non-invasive Pre-natal Testing (NIPT) is being introduced as an evaluative roll-out from 2018. Several national groups have been established to plan this. The test will be available for women who have a primary screening risk calculation of 1 in 150 or higher. Maternity units have been asked to identify 3 leads per unit to attend national training from September, and to then cascade this training through their local maternity units.

A new KPI is being introduced from April 2016, and data collection is now being rolled out. This indicator looks at coverage of the fetal anomaly scan, which is carried out at 18 to 20 weeks gestation. The FA2 indicator measures the proportion of pregnant women eligible for fetal anomaly screening for whom a conclusive screening result is available within the designated timescale. This KPI is collected and presented 2 quarters in arrears. As a new KPI in the first year of collection, FA2 is being used by healthcare professionals and quality assurance services as an experimental indicator. In this period data quality and completeness is being improved, with the planned formal publication of data from 2017/18. Preliminary reporting across London shows 18 of the 25 (72%) maternity units were able to report on the KPI, compared to 67.6% of maternity units in England. This is a small improvement on Q2, where 16 units were able to report.

3.3 Infectious Disease Screening

Timely referral of hepatitis B positive women for specialist assessment
Women found to be Hep B positive should be referred to a liver disease specialist within 6 weeks, for full assessment, treatment if indicated, and to plan for the birth of the baby. This is a KPI, with the acceptable standard that 70% of women seen within 6 weeks and the achievable standard 90%. This standard and indicator changed in 2016 to include only women who are newly diagnosed hepatitis B positive or are already known to be hepatitis B positive with high infectivity markers detected in the current pregnancy. This means that from Q1 2016/17 the denominator is smaller, and so difficulties in achieving the target levels should be reduced. Due to small numbers, quarterly KPI data is not published for this indicator below regional level.



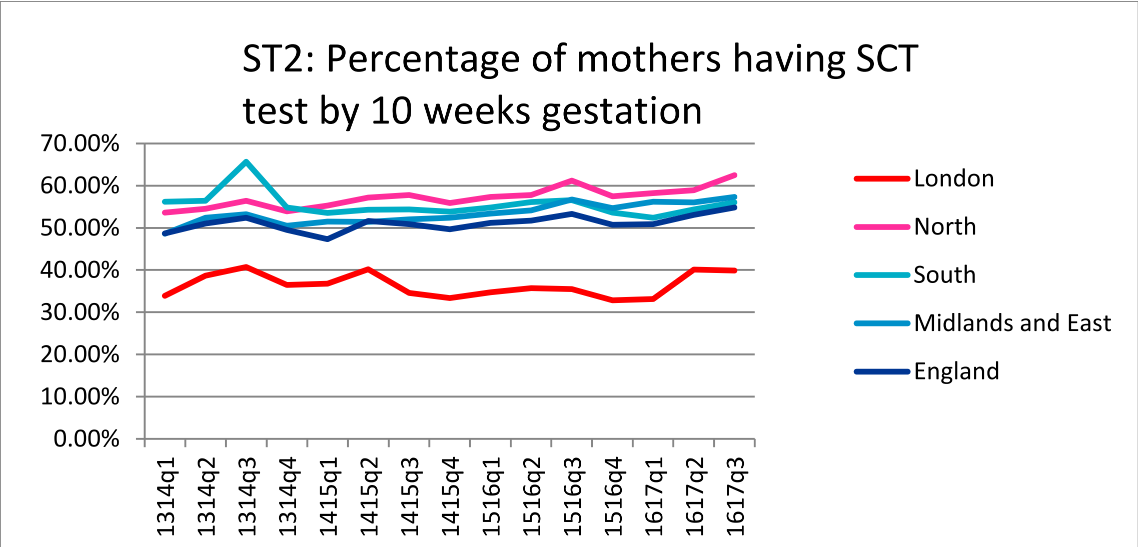
For Q3 2016/17, there were 17 women in North Region not seen within 6 weeks, 8 in South region, 11 in Midlands and East Region and 22 women in London. The new indicator does not show the total number of Hep B positive women by region, only those who need to be seen within six weeks. For the first time, this number for London is similar to other regions, with 26.0% of these women in London. Providers in London are asked to give exception reports including the reason for any woman not being seen within the 6 weeks deadline, and when those women are seen. Achieving this standard is a challenge for many units and improvement plans are in place with providers.

3.4 Sickle Cell and Thalassaemia Screening

Coverage of Sickle Cell and Thalassaemia (SCT) testing
Coverage of testing is good, with London the best performing of the four regions, and all maternity units able to meet the acceptable standard in Q3 of 2016/17.

Timeliness of Sickle Cell and Thalassaemia (SCT) testing
Timeliness of Sickle Cell and Thalassaemia screening is an ongoing issue across London. Performance is improving in some maternity providers, although this is masked by ongoing work to improve the accuracy of the reported data. One problem identified was maternity units using date of booking as a proxy for date of the result being available. This spuriously increases the proportion of women showing as having a result within the timescale, and work to improve on the data accuracy has led to a dip in the reported performance data across London.

The quarterly KPI for timeliness show improvement in performance across some trusts, with six trusts able to reach acceptable performance in Q3 2016-17, improved from 4 in Q1 and 5 in Q2. Many others are approaching the acceptable level. In contract, four trusts are below 20% of women with a result by 10 weeks, and the lowest performer has only 0.9% of women having a result by this gestation. The implication for couples of late diagnosis of affected pregnancies was discussed in the September 2016 update. London performs very poorly for this indicator compared to the other three regions, all of which are consistently able to meet the acceptable standard.



NHSEL have repeated the Health Equity Audit of early bookings in order to look more closely at the factors affecting this KPI. The report has been circulated to Directors of Public Health, and those in the boroughs served by the lowest performers will be contacted with the aim of increasing early bookings and so reducing inequalities in access to maternity care. Of the five maternity units not taking part in the audit, two had fewer than 20% of women with a result by 10 weeks gestation, and none had achieved the acceptable level. The health benefits to the mother and baby of early booking are well documented, and DsPH are asked to continue to encourage all women to book early for antenatal care.

Nationally, a new KPI will be introduced from next year which will measure the proportion of couples able to access diagnostic testing by 12 weeks gestation.

The quarterly KPI for completion of the family origin questionnaire shows variable performance across London. Some maternity units are able to consistently meet the achievable standard, while others consistently fail to reach even the acceptable standard. This is a similar issue to the Down's Syndrome laboratory request form, and again NHSEL are encouraging maternity units to commission their haematology laboratories to support use of electronic questionnaires.

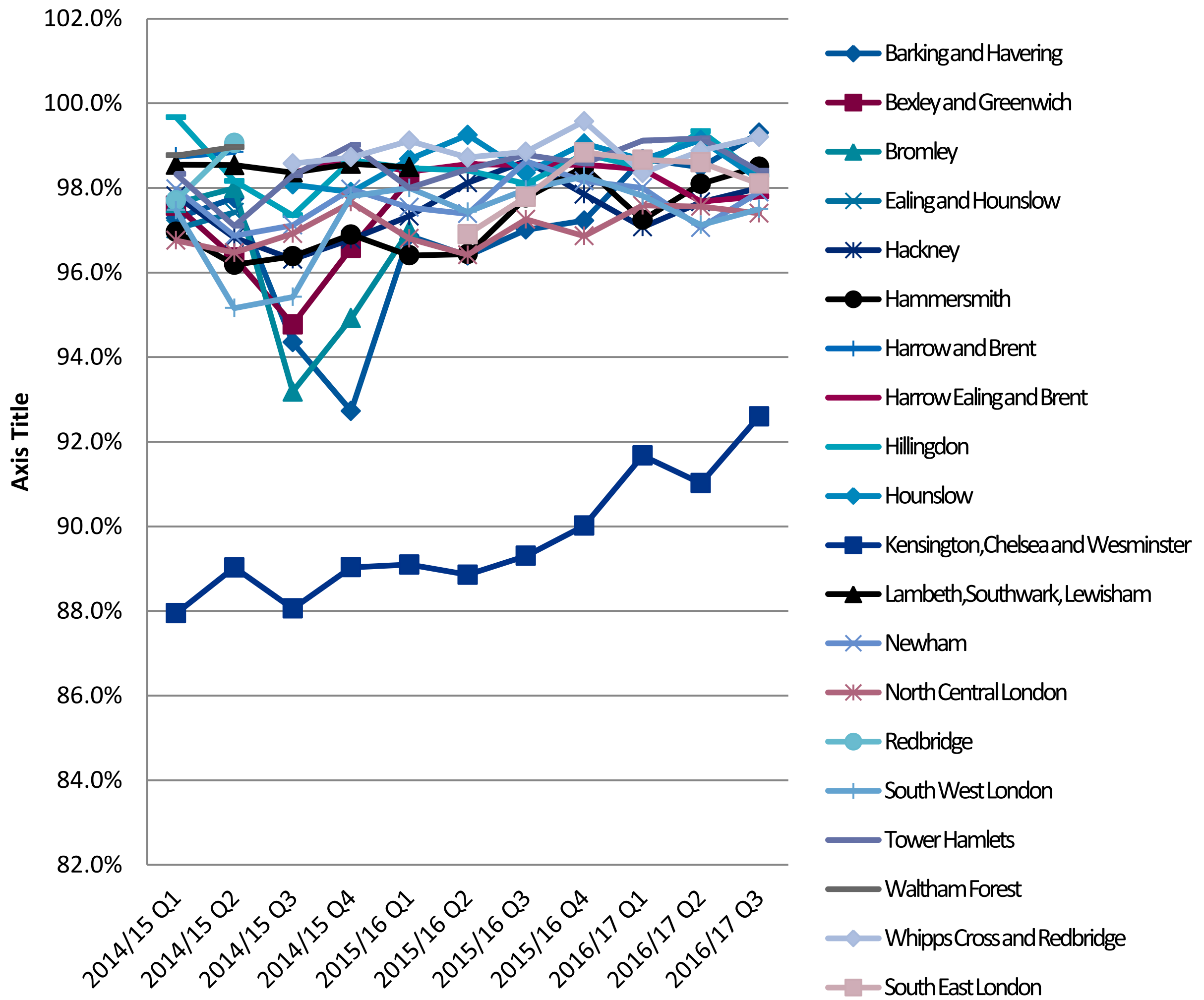
3.5 Newborn Hearing Screening

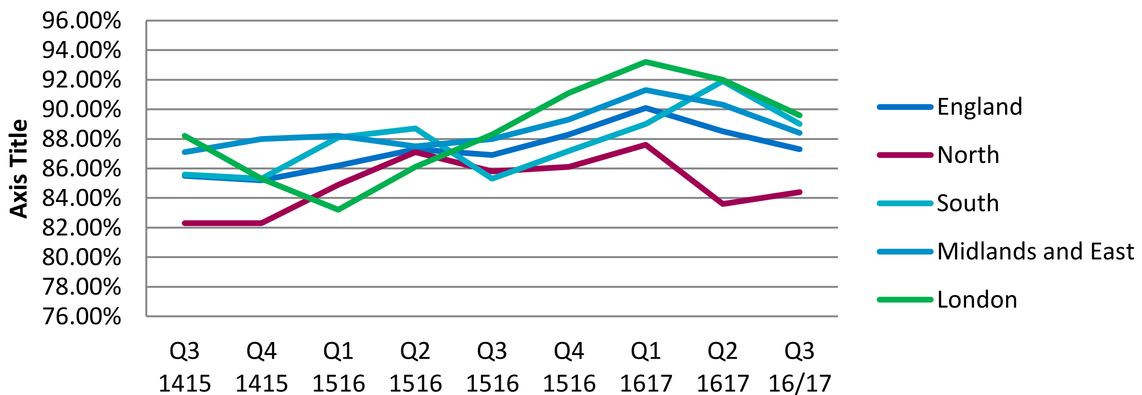
One KPI for newborn hearing screening is published quarterly by provider, KPI NH1, which measures the proportion of babies who receive a hearing screen within 4 weeks of birth. This KPI is collected by screening provider, and there have been several changes of provider sites across London.

The acceptable level for this KPI is 97%, and performance has consistently been adequate for this indicator, with the exception of Kensington, Chelsea and Westminster. This is due to the high proportion of babies born in a private maternity unit. As from October 2016, NHS South West London Newborn hearing screening programme will be contracted by the Portland Hospital to screen their babies, and national data collection will reflect this as of March 2017 (so will show from the Q3 2016/17 data, with full implementation showing from Q4). The figure below shows the coverage by provider unit, and shows how performance has become more consistent in the past year.

Since establishing a hub and spoke model of service across South East London, coverage across the area covered by that service has improved, and for the past four quarters has been above the acceptable threshold. This has had an appreciable impact on coverage across London as a whole.

KPI NH2 measures the timely assessment for screen referrals, with a requirement that babies receive audiological assessment either within 4 weeks of the decision that referral for assessment is required or by 44 weeks gestational age. This is reported quarterly by region but only annually by provider unit because of small numbers.


NH1: Newborn hearing screening – coverage:
102.0%
100.0%
98.0%
96.0%
94.0%
92.0%
90.0%
88.0%
86.0%
84.0%
82.0%
Axis Title
2014/15 Q1
2014/15 Q2
2014/15 Q3
2014/15 Q4
2015/16 Q1
2015/16 Q2
2015/16 Q3
2015/16 Q4
2016/17 Q1
2016/17 Q2
2016/17 Q3
Barking and Havering
Bexley and Greenwich
Bromley
Ealing and Hounslow
Hackney
Hammersmith
Harrow and Brent
Harrow Ealing and Brent
Hillingdon
Hounslow
Kensington, Chelsea and Wesminster
Lambeth, Southwark, Lewisham
Newham
North Central London
Redbridge
South West London
Tower Hamlets
Waltham Forest
Whipps Cross and Redbridge
South East London


KPI NH2: Newborn hearing – timely assessment for screen referral
96.00%
94.00%
92.00%
90.00%
88.00%
86.00%
84.00%
82.00%
80.00%
78.00%
76.00%
Axis Title
Q3 1415
Q4 1415
Q1 1516
Q2 1516
Q3 1516
Q4 1516
Q1 1617
Q2 1617
Q3 16/17
England
North
South
Midlands and East
London

3.6 Newborn Infant Physical Examination

The national NIPE screening programme covers the 72 hour examination of hips, heart, eyes and testes. Many maternity units also include other clinical examinations, but these are not a formal part of the NIPE screen. The NIPE handbook includes guidance on the 6-8 week NIPE examination, which GPs can work to, but this is not yet part of the screening programme. The handbook is available at https://www.gov.uk/government/publications/newborn-and-infant-physical-examination-programme-handbook

Reporting the NIPE KPIs is now mandatory, and overall for England there is now 93.8% completeness of reporting. Within London this is 96%, with only one trust in London which is not able to report the KPI. NHSE is now beginning to focus on the performance of those units able to report as well as on whether or not units are able to report, since many of the units reporting are not meeting acceptable standard for timely coverage of NIPE. The main difficulties for most unites are completeness of data capture rather than underlying performance, and action plans are in place.

KPI NP1 Newborn and infant physical examination – coverage Q3 2016/17

Area	Performance %
England	93.2
London	91.0
Highest in London	99.2%
Lowest in London	40.8%

Source: https://www.gov.uk/government/publications/nhs-screening-programmes-kpi-reports-2016-to-2017

KPI NP2, timely assessment of developmental dysplasia of the hip, measures the proportion of babies who have a positive screening test on newborn physical examination and undergo assessment by specialist hip ultrasound within 2 weeks of age. Due to small numbers this KPI will be publically reported annually by provider. For Q3 2016/17 three maternity units in London were not able to return data, so overall data completeness for London was 88%, compared to 84.8% for England as a whole. Quality of data collected is improving but is not yet sufficiently robust to allow interpretation.

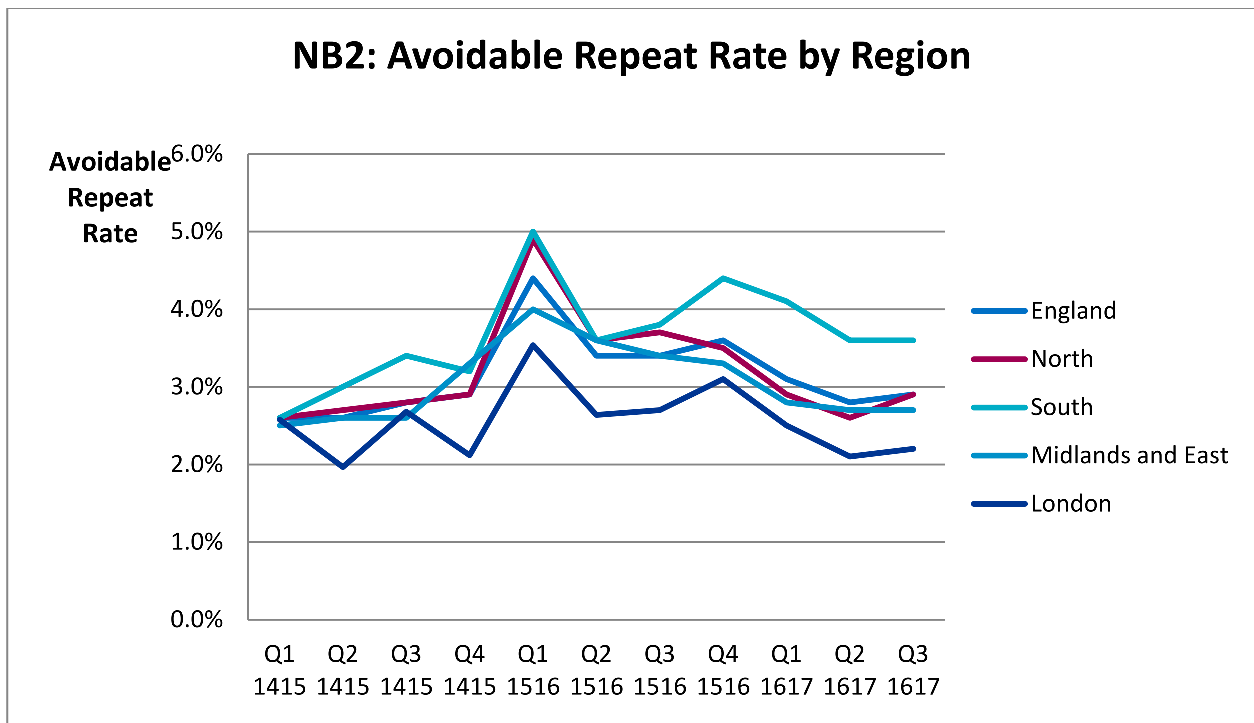
KPI NP2 Timely assessment of developmental dysplasia of the hip Q2 2016/17

Area	Performance %
England	50.4
North	57.2
South	33.7
Midlands and East	64.9
London	35.2

Source: https://www.gov.uk/government/publications/nhs-screening-programmes-kpi-reports-2016-to-2017

3.7 Newborn bloodspot screening

NHSEL has focused strongly on reducing the proportion of babies having an avoidable repeat bloodspot sample taken. Information on the reasons behind the avoidable repeats has been fed back to each provider, and revised trajectories will be agreed for 2017/18 with each to continue progress towards the acceptable standard of 2.0% for London as a whole, and towards the achievable standard of 1.0% for those trusts which already meet the acceptable standard.



In Q3 2016-17 there were 753 babies in London who had an avoidable blood sample, causing distress to the baby and family and cost to maternity services. The proportion of avoidable repeat samples by maternity unit varied from 0.5% in one maternity unit to 4.5%.

3.8 Incidents and Serious Incidents

The recent cyber attack has had an impact on antenatal and newborn screening programmes. The national programme leads considered risks following the attacks, in particular issues around generating NHS numbers for new babies. A decision was taken to temporarily allow newborn bloodspot cards to be processed without the babies NHS number. Some individual maternity units were also badly affected by the cyber attack, and are now reviewing lessons learned.

4 Cancer Screening

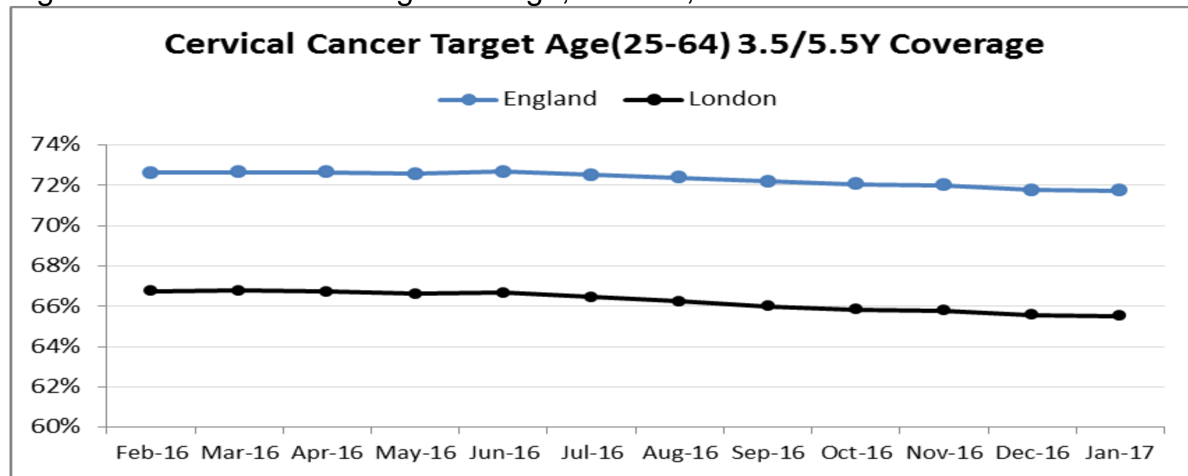
4.1 Cervical screening

4.1.1 Coverage

Cervical screening coverage declined by 1.3% between February 2016 and January 2017 (66.8 to 65.5%- Figure 1). This decline is seen in all age groups and all parts of the country. London continues to have the lowest coverage in England (65.5 vs 71.7%).

All boroughs in London fall below the 80% coverage target but rates vary from 74.8% in Bexley to 53.6% in Central London.

Figure 1: Cervical Screening Coverage, London, women 25-64



Source: Open Exeter NHSE OIC

4.1.2 Improving coverage

Texting

NHSE will be working with Primary Care Support England and a text provider to send GP Endorsed text reminders to all women invited for cervical screening in London. NHSE has taken advice from the NHS Information Commissioners Office on data protection and information governance requirements. It is anticipated that this intervention will improve uptake by up to 4%.

Survey

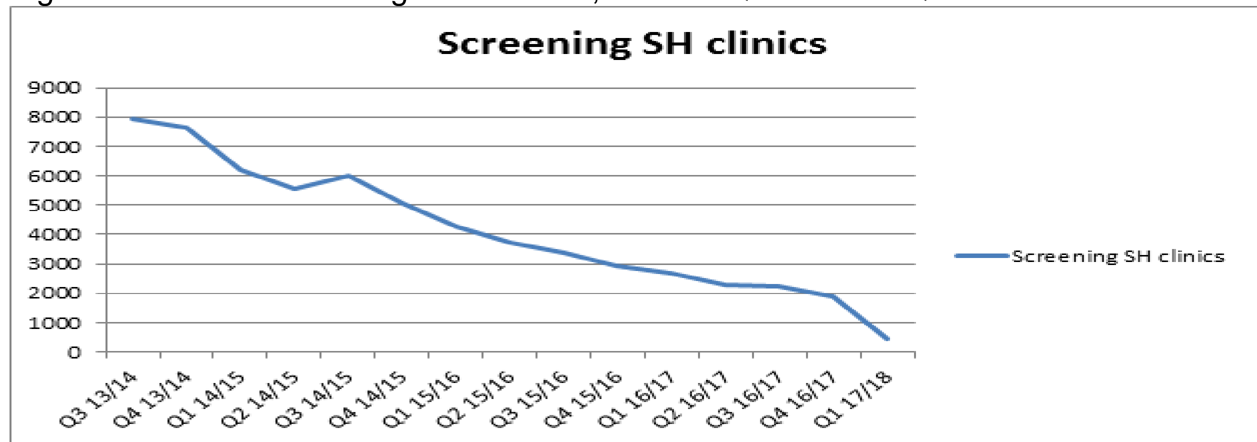
NHSE has funded Imperial University to undertake a survey to identify the barriers to attendance of cervical screening in London. It is hoped that the findings of the survey will inform future uptake improvement initiatives

Funding screening in SH clinics

To improve uptake, NHSE funded opportunistic cervical screening in sexual health clinics for women who were overdue screening[1]. Between October 2016 and June 2017, 4500 women were screened across London within sexual health clinics. This is less than the 7500 screens contracted for. This lower activity could be partly explained by the reconfiguration of SH services in London which limited provider engagement with this project. This also partly explains the continued decline in the volumes of women screened in SH services in London. (Figure 2)
NHSE is currently seeking additional funding to invest further funding for screening with new sexual health providers across London.

[1] Overdue screening- women aged 25-49 who have not been adequately screened in more than 3.5 years / women aged 50-64 who have not been adequately screened in more than 5.5 years

Figure 2: Cervical screening in SH clinics, London Q3 2013/14-Q1 2017/18



Source: Primary Care Support England

Learning Disability

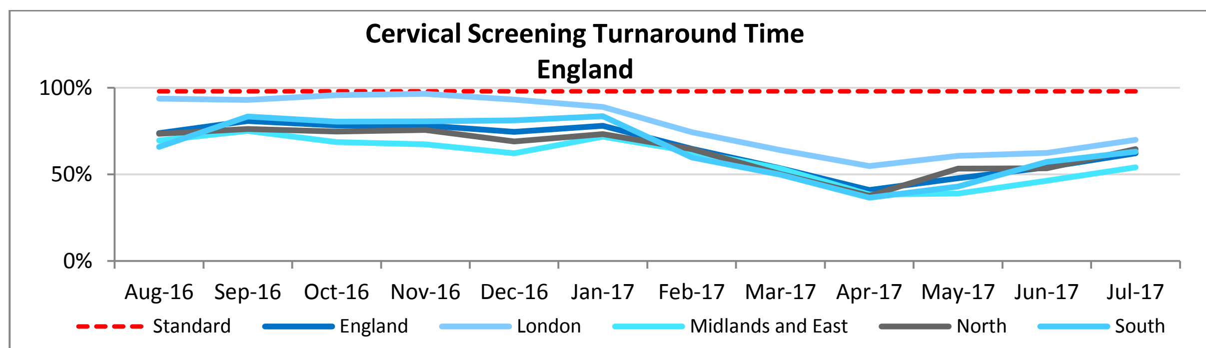
NHSEL is working with Learning Disability (LD) nurses and GP practices across Barnet CCG on access issues for people with LD to improve coverage/uptake. The intention is to establish best practice and extend this work to all CCGs in London.

4.1.3 Provider Performance

Cytology performance- 14 day turnaround time vital signs

Ninety-eight percent (98%) of women should receive their results letter within 14 days of screening. Due to national shortage of cyto-screeners, cytology laboratories are struggling to process cervical samples in a timely manner resulting in large backlogs of samples. London has the best turnaround times in the country, but these fell to 55% in April but improved to 70% in July 2017. Barts (Royal London) and Barking, Havering Redbridge University Trust and Inner and Outer NE London CCGs have been most significantly affected. Both trusts have improvement plans in place so it is anticipated that the upward trajectory will continue. (Figure 3)

Figure 3: Cervical Screening Turnaround Times England



Source: Open Exeter NHSE OIC

4.1.4 Cervical screening in primary care

Sample Handling Guidelines

Implementation of the London Sample Handling Guidelines has resulted in a significant reduction in sample handling errors in primary care.

Between July 2015 and March 2017,

- Sample handling errors in London *reduced by 57%;* from 2.1% (1788) to 0.9% (516) of all samples.
- The number of out of programmes samples (women being screened too young, too early or inappropriately) *declined by 47%;* from 1.17% (663) to 0.62% (236)
- The number of women requiring a repeat screen *declined by 36%,* from 1.45% (824) to 356 (0.93%)

The effectiveness of the London Sample Handling Guidelines can be attributed to the following factors:

- the collaborative nature of the development process,
- localisation of the guidelines to London
- joint ownership by NHSE, laboratories and samples takers,
- extensive engagement with laboratories, primary care and cervical screening training providers,
- monitoring and reporting
- feedback to sample takers by laboratories
- NHSE screening team engagement with primary care staff across London

Cervical Sample Takers Database

The London Sample Takers Database was fully rolled out across London in August 2016, with 6,166 registered sample takers and 5,973 (97%) issued with unique sample taker codes.

4.1.5 Cervical screening Quality Assurance Visit themes

Cytology

- Ensure that screening safety incidents are reported in accordance with national guidance
- Annual staff screening numbers to reach minimum national standards

Colposcopy

- All colposcopists should attend at least 50% of MDT meetings to ensure the timely management of difficult cases and discordant results
- All colposcopists must see 50 new cases with ‘abnormal cytology’ (this may include normal cytology/HPV positive cases) each year in accordance with national standards
- Review clinical capacity to improve treatment of women with high grade CIN within 4 weeks, following receipt of diagnostic biopsy report
- To develop an SOP for the direct referral policy
- Ensure that screening safety incidents are reported in accordance with national guidance

4.1.6 HPV Primary Screening

The screening test

From April 2018, testing of high risk HPV (genotypes 16 and 18) will replace liquid based cytology as the screening test within the cervical screening programme. All

women will have a 'smear' taken as usual, which will be tested for HPV (HR HPV 16/18).

Evidence
High risk HPV is found in 99.7% of cervical cancers. Over three quarters of sexually active women will acquire the infection. It is most common in women under 35 years and most infections are transient
HPV testing is more sensitive than LBC. The test has a very high negative predictive value and therefore will be a more effective way to let women know whether they have any risk of developing cervical cancer. This will allow the screening interval to be extended.
HPV as a primary test will be cost effective, as it will save more lives, and reduce costs largely through extension of screening intervals, when confirmatory NHS Cervical Screening. HPV vaccination further strengthens the rationale for primary HPV screening as this will most accurately identify the falling proportion of HPV positive women who will remain at risk of cervical cancer

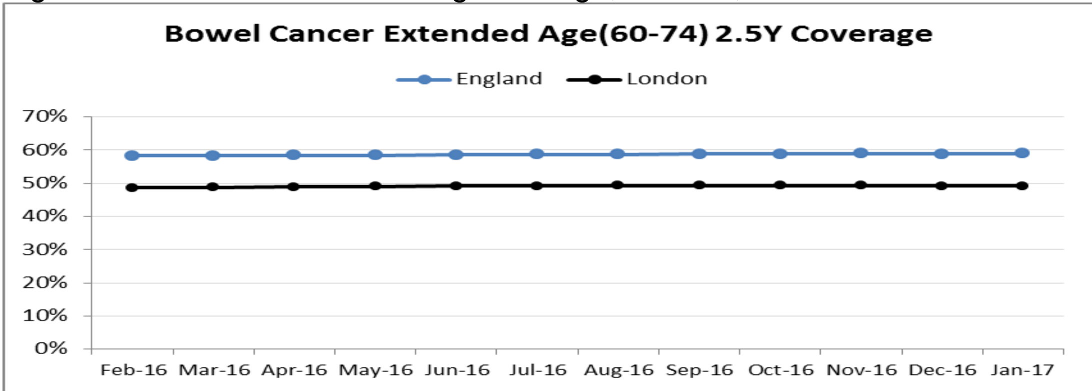
Implementation
HPV Primary Screening will be implemented across England from 2018. An 80% reduction in cytology activity is anticipated. This will require a reduction in cytology labs in London from ten (currently) to one or two. This will also require procurement of HPV/cytology labs across England.

4.2 Bowel screening

4.2.1 Uptake and coverage

Between February 2016 and January 2017, uptake increased by 2.2% (46.2% to 48.4%) and coverage increased from 48.5% to 49.2%. (Figure 4) Monthly fluctuations in uptake of +/- 2% are common in London and across the country. The higher the proportion of 60 year olds invited each month the lower the uptake. Coverage ranged from 39% in Barking and Dagenham to 58% in Bromley.

Figure 4 Bowel cancer screening coverage, London, 60-74



Source: Open Exeter NHSE OIC

4.2.2 Improving Uptake

Subject to PHE Approval, NHSEL will implement text reminders within the bowel screening programme in London in 2017/18.
In 2018/19, faecal immunochemical testing will replace faecal occult blood testing within the bowel screening programme across England. Pilot studies have shown that uptake will increase by up to 7% (see section 2.4).

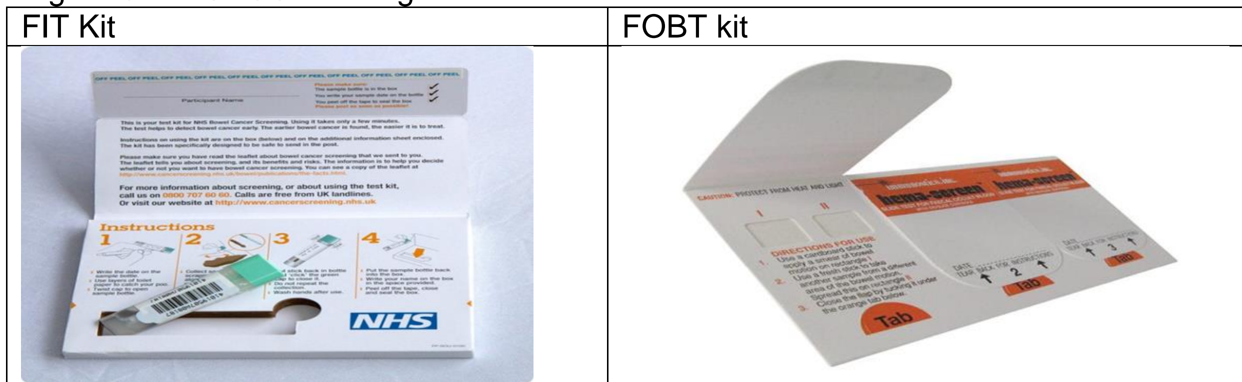
4.2.3 FIT

The test

From April 2018, faecal immunochemical testing will replace the faecal occult blood test within the bowel screening programme. Only one faecal sample is required for FIT as opposed to FOBt where three samples are taken on three different days.

Figure 5: NHSBCSP testing kits

FIT Kit	FOBT kit



Evidence
FIT is easier to use and can be measured more reliably using a machine rather than the human eye. FIT is sensitive to much smaller amount of blood than FOBt and therefore can detect cancers more reliably and at an earlier stage. The increased sensitivity enables FIT to detect more pre-cancer lesions (advanced adenomas). FIT requires a single faecal sample and is more acceptable to invited subjects which markedly increases participation rates. FIT is a cost effective alternative to FOBt.

Implementation
There is work underway across the country to determine the FIT threshold (the cut off for a positive test). This will be dependent on endoscopy capacity.

4.2.4. Bowel scope screening

Bowel scope screening (BSS) is rolling out across London. It is currently being offered in 53% of CCGs. Thirty four percent (34%) of practices and 33% of eligible men and women have been invited for screening.

4.3 Breast Screening

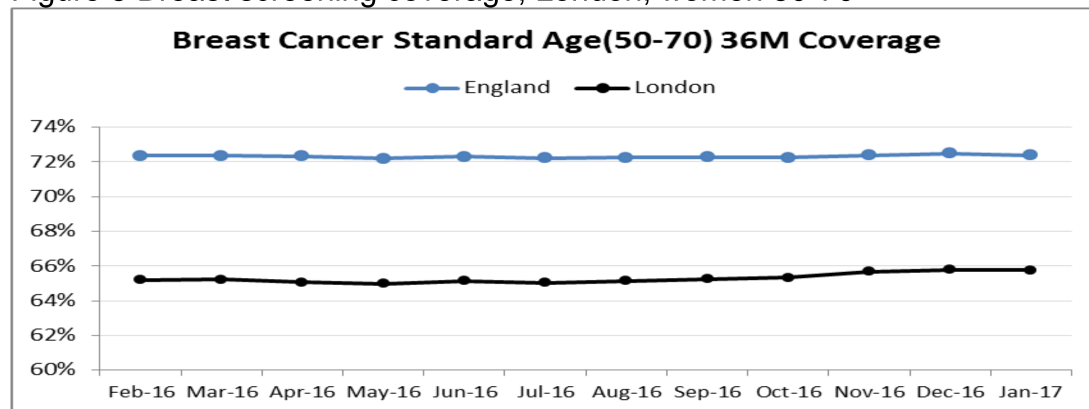
4.3.1 Uptake and coverage

Between February 2016 and January 2017 breast screening coverage in London increased by 0.6%. Coverage ranged from 57% in West London CCG to 76% in Bromley. (Figure 5)

4.3.2 Improving uptake and coverage

Expansion of text reminders using GP-held mobile phone numbers in Q4 2017/18

Figure 5 Breast screening coverage, London, women 50-70



Source: Open Exeter NHSE OIC

4.3.3 Provider performance and procurement update

The breast screening administrative functions has transferred from all units to the London Administration Hub (Royal Free). This will facilitate standardised processes and practices including but not limited to Round-Planning and Quality Management Systems.
Royal Free (NLBSS) awarded contract for delivering breast screening clinical services for Central and East London
There are concerns regarding performance and service delivery at South West London BSS (clinical); the service is currently under close observation and discussions are ongoing with PHE on the process to secure safe service delivery.
Mobilisation of clinical services from Bart's to Royal Free is challenging. Service delivery at Barts is compromised as a result of the loss of archive files. The Trust is currently working through a recovery and retrieval process. Outcome of recovery is currently unknown

5 Adult Screening

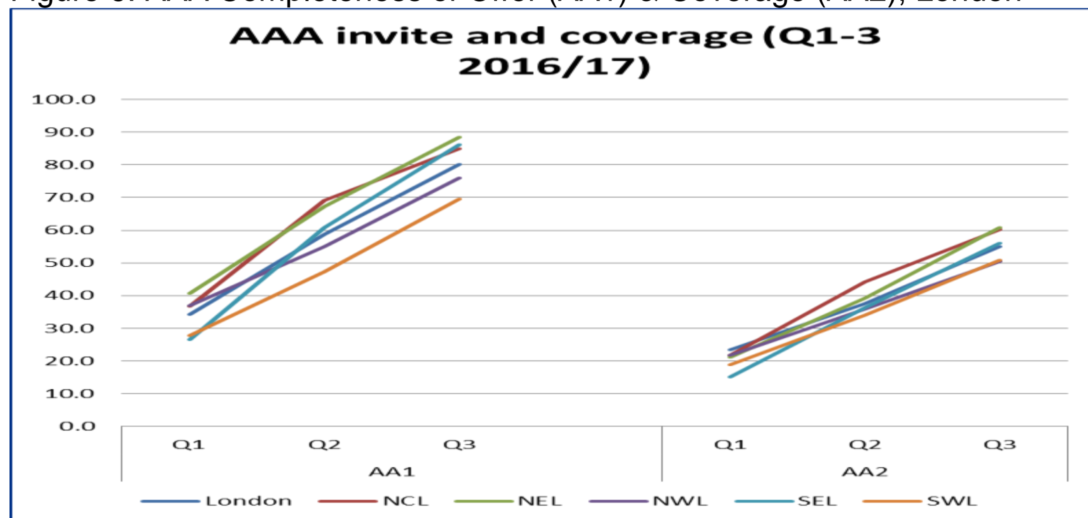
5.1 Abdominal Aortic Aneurysm Screening

5.1.1 Uptake and coverage

AAA is a one off screen for the majority of the population, as such uptake and coverage is measured cumulatively, throughout the year (Figure 6). Programmes

have different strategies and rates for inviting their cohort, making in year comparisons of uptake difficult.
Quarter 4 show uptake and coverage is comparable to 2015/16 with the exception of NWL. Uptake in NWL is anticipated to fall by approximately 10% for 2017/18. In 2016/17, significant gains were made due to a programme of promotional work that was deemed excessive and outside of the scope of the NAAASP, by the national team. Consequently a return to 2015/16 performance is anticipated. Confirmed full year uptake data will be available in September 2017

Figure 6: AAA Completeness of Offer (AA1) & Coverage (AA2), London



Source: PHE

5.1.2 Procurement

The five AAA services across London are aligned to STP borders (see Figure 7). NHSEL is currently procuring a single London-wide AAA service. Providers will be mobilised in December 2017 and the new service will commence in April 2018.

Figure 7: AAA Services in London

5.2 Diabetic Eye Screening Programme

5.2.1 The programme

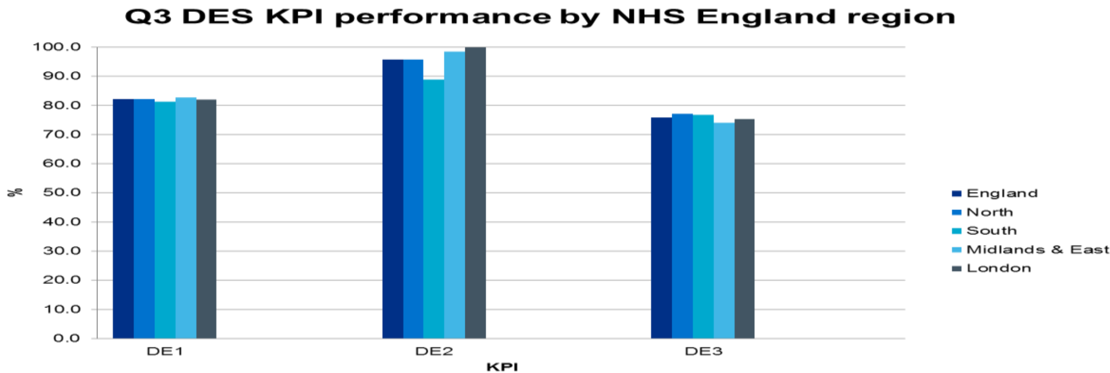
There are five DESP providers across London (Figure 8). Q3 reporting showed 425,000 individuals were eligible to receive an invitation to screening in the previous 12 months with 350,000 attending.

Figure 8: DESP Providers London

5.1.2 Provider performance

Performance of London providers compares well with the rest of country. (Figure 9) In 2015/16, a national project ran to standardise the delivery of the screening pathway and the methodology for reporting. As such accurate, validated performance data is only available from Q1 2016/17.

Figure 9: Provider performance



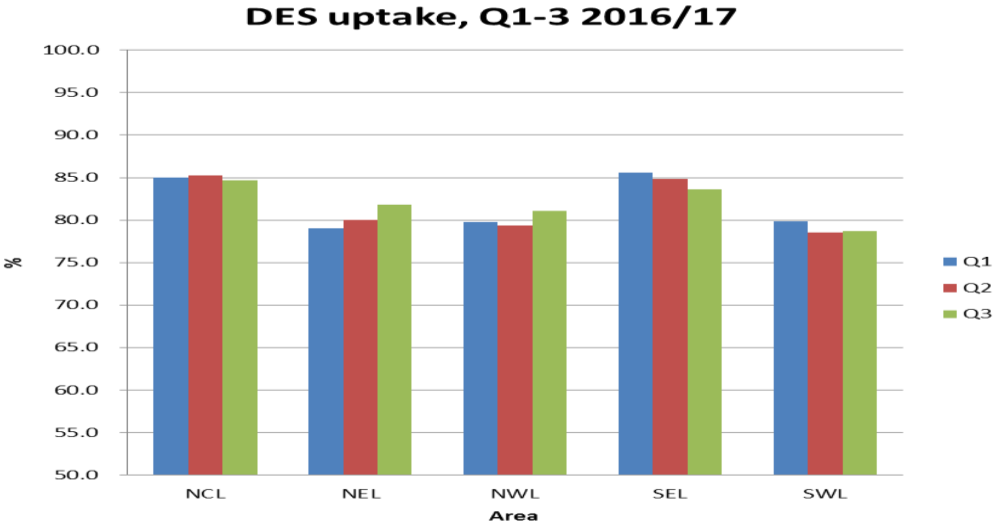
KPI	Description	Minimum Standard (%)	Achievable Standard (%)
DE1	Uptake of routine digital screening event	≥ 70.0%	≥ 80.0%
DE2	Results issued within 3 weeks of screening	≥ 70.0%	≥ 95.0%
DE3	Timely assessment for R3A screen positive		≥ 80.0%

Source: PHE

5.2.3 Uptake

Uptake across all London programmes is above acceptable standard and in most cases, equal to or greater than achievable standard. (Figure 8) Some services – i.e. SEL – have overseen a planned fall in uptake whilst the programme establishes its preferred infrastructure, to support ongoing service improvement and the capability to increase uptake further.

Figure 8: DESP Uptake London



Source: Open Exeter NHSE OIC

5.2.4 Improving Uptake

Looking forward, the implementation of the pregnancy pathway, the monitoring of performance in secure settings and the delivery of the 2017/18 CQUIN (enhanced surveillance in DESP) are the priority areas on which we will report to this Board. Services are currently undertaking HEA to understand where the area of focus is required to continue uptake and performance improvement

5.2.5 Improving quality

- Pan-London oversight and risk management group has been established with agreed ToR. The Group HAS identified work streams to support project delivery.
- EMIS - Some progress achieved with organisational restructure and key new appointments. Monthly full performance review meetings planned

6 Useful links

2017/18 NHSE Service Specifications are available at
https://www.england.nhs.uk/commissioning/pub-hlth-res/

PHE Screening professional briefing with high level national commentary on KPIs.
https://www.gov.uk/government/publications/nhs-screening-programmes-kpi-reports-and-briefings-2016-to-2017

The KPI data for each programme is published online at
https://www.gov.uk/government/collections/nhs-screening-programmes-national-data-reporting

Background information on cervical screening coverage and its relationship with other health data is available as well as top tips for actions that increase attendance. Data is available on the PHE Screening website and through a new interactive dashboard

Breast screening programme annual statistics 2015-16
http://content.digital.nhs.uk/article/2021/Website-Search?productid=24457&q=breast+screening+&sort=Relevance&size=10&page=1&area=both#top