NHS England

Screening Commissioning Intentions 2014/15

London Region

THE NHS CONSTITUTION

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NHS England and cooperative partnerships

NHS England recognises the cooperative nature of relationships in order to deliver high quality services across London. The respective commissioning of screening and treatment need to have operational fluency, underpinned by formal agreements and practices to ensure the best possible patient outcomes. The current commissioning arrangements are reliant on strong partnership working; NHS England commissions the screening programmes, CCGs commission the services that manage or treat the conditions that are detected. All partner organisations must be committed to ensuring standards and timelines are met.

All programmes: Even where NHS England (London Region) is contracting directly, the contract/particulars are sitting within the overarching CCGs contract with a provider. Current contracting levers are not always appropriate for screening programme commissioning. If this continues to be the position for next year, NHS England screening commissioners would like to see more appropriate and effective commissioning levers included.

Nationally we said…	A. The full scope of NHS England screening programmes are shown in appendix 1. B. NHS England is responsible for the routine commissioning of national screening and immunisation programmes under the terms of the section 7a agreement and the national service specifications that support it. NHS England is also responsible for the collection of information on disease and seeking strategies to improve coverage. NHS England works in close partnership with Public Health England. C. Role of Public Health England (PHE) - is responsible for producing the service specifications for the Section 7A services, ensuring that there is professional public health advice for NHS England's public health commissioning teams. D. Service Specific Issues - S7A changes 1. *Tightening key areas of the agreement.* We have given further clarity to what NHS England is accountable for. More outcome measures are now set against numerical baselines, for example six screening programmes have baseline measures set for the first time. 2. *Beginning to deliver further ambitions* NHS England inherited historic variations in contractual arrangements and local levels of service performance. The S7A sets out steps for NHS England to align contractual arrangements with national service specifications and, through focusing on low performers, to start reducing historic variations in local performance.
Re-commissioning of national screening programmes	NHS England will commission nationally prescribed screening programmes as identified in appendix 1.

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Service review and developments	• Breast screening: Modernisation of the breast screening administration process. An options appraisal is underway with a view to implementing the desired option in 2014/15. • Cervical cytology: Full implementation of HPV triage and test of cure in conjunction with consolidation of cytology labs • Bowel Screening: introduction of the bowel scope project, "Improving Outcomes – a Strategy for Cancer" (published in January 2011) committed to pilots for flexible sigmoidoscopy for bowel cancer screening commencing in 2011/12. NHS England will support the roll out of Bowel Scope screening in 2014/15 and will work with PHE to agree future funding arrangements for 2015/16. • Bowel screening age extension under service developments • Cervical cytology: develop a single sample take database 2014/15. • Cervical cytology: reconfigure cytology labs to enable all labs to process the national figure of 35k samples per annum. 2014/15 • Cervical Screening Costs of London NHSCSP to be identified across entire pathway, budgets identified, sufficient funding to commission entire screening pathway in 2014/15 • Diabetic eye screening: Options review to rationalise the DES service for 2015/16
Service developments with co dependencies on CCGs, Public Health England, specialised commissioning , Primary care Commissioning, Local Authorities and other providers	• Formalise co-commissioning arrangement with CCGs and other commissioning partners such as local authorities • Breast screening: We will support CCG partners in implementing pan London vacuum assisted biopsy to eliminate inequalities • Breast screening: we will support PHE in the implementation of breast screening age extension, age trail and randomised age trail • Bowel Screening: we will support PHE is the implementation of bowel scope across London • Cervical cytology: we will support PHE into piloting into primary HPV testing • Cervical cytology: we will support the local authorities in commissioning cervical sample take training to ensure women have a choice of provider. • Cervical cytology: formalise agreement with CCG to identify budgets and funding of the patient pathway • Aortic Abdominal Aneurism: work with specialist commissioning to ensure timely and high quality treatment plans for men identified with AAA through screening • Antenatal and Newborn: More formalised arrangement with CCG and maternity trusts on the commissioning of antenatal and new-born • NHS England will work with CCGs to ensure Diabetic Eye Screening service is managed in the most effective way for, taking into account and complexities of the roles of different partner organisations. • NHS England will work with CCG to develop a joint commissioning of Patient transport: • Diabetic eye screening: CCGs should ensure that their HES services are commissioned to provide a failsafe functions that have dedicated DESP time. This function must link in with the DESP failsafe function • Diabetic eye screening, IT: a joint commissioning exercise between NHS

	England and CCG to ensure ophthalmologists have access to patient data and images for screening referred patients • Diabetic eye screening: GPs are especially important in identifying diabetic patients to the Diabetic eye screening Programme and provide the gateway into that programme. NHS England with work with GPs to ensure data accuracy and ensure contracts specify regular (agreed intervals) data flow between GPs and screening providers. • Work with CCGs to commission smooth pathways from screening into treatment, and ensure fail safes are in place. NHS England will support CCGs in identifying and sharing best practice around screening and immunisations. This may include benchmarking uptake of screening programmes by practice -scrutinising cervical screening QOF data by practice -participation in screening primary care serious incident management -supporting practise strengthen their role in improving uptake through coding of screening status on the patient records, opportunistic promotion of screening uptake during consultations, publicising screening programmes, active participation in primary care uptake improvement projects London-wide
National intentions around Contracts	**Contracts** 1. NHS England has been engaging with stakeholders to inform the development of a revised NHS Standard Contract for use in 2014/15 and this will be published during December 2013. It is likely that there will be considerable continuity with the current contract, in terms of both structure and content. There will also be some significant revisions, to reflect stakeholder feedback and other important developments, including implementation of recommendations from the Francis report and from NHS England's review of incentives, rewards and sanctions, which will be completed by the end of October 2013. 2. The 2014/15 Standard Contract will be used for all new contracts agreed for specialised services from 1 April 2014 onwards. Where existing contracts do not expire at 31 March 2014, these will be updated for 2014/15 using Deeds of Variation which will be produced by NHS England early in 2014. Forms of contract other than the NHS Standard Contract will not be used. 3. An online system for completing the NHS Standard Contract (the eContract) was made available for the first time in February 2013 and an improved, more robust system will be available for use for 2014/15. The eContract approach has significant benefits, for instance in enabling the tailoring of contract content to reflect the specific range of services being commissioned. We anticipate that use of the eContract approach will become the norm for specialised services contracts for 2014/15. **Single Provider Contract** 4. The intention for 2014/15 is that NHS England should normally only

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	hold (or be party to) one NHS Standard Contract with any provider, which includes the five areas of direct commissioning with contract schedules for each area team. **Consistent Contracting** 5. 2013/14 was a year of collaboration between NHS England, CCGs and providers to implement the NHS England single national operating model whilst seeking to maintain service and financial stability. Area teams will continue to work with providers to ensure local practice is transitioned to the single national operating model and transparency about the application of Section 75 rules and evidenced consideration of "most capable provider" in commissioning and funding decisions.
Local contracting	Local contracting will be consistent with the national contracting protocol
Supporting coverage	NHS England acknowledges that CCGs have an important role to play in supporting screening programmes by contracting for the treatment of the condition that has been detected through screening. NHS England will work cooperatively with CCGs around ensuring smooth transition from screening to treatment. Working collaboratively with LA and CCGs and others, NHS England will support the improvement of coverage and timely uptake of screening across London. This will include the direct commissioning of interventions as well their activity around improving coverage. • It is recognised that primary care has an important influence on the uptake and coverage of screening. • NHS England acknowledges that CCGs neither contract nor performance manages primary care. • CCGs do have a role in the improvement of quality in primary care and the provision of clinical education programmes. NHS England would like to see these used as a means to supporting local coverage initiatives and providing education and stimulating debate around the role of primary care in supporting screening coverage.
CCG Information technology and IT developments	NHS England and CCGs will need to work cooperatively around IT developments within primary care, where there are often multiple interfaces with screening programmes. Changes to IT have led to incidents within screening programmes. Joint consultation with will need to occur when changes are proposed so that any potential impact can be assessed. CCGs also need to commission their services to provide the data collection required to support screening programmes CCG commissioners should be aiming to achieve agreed standards in the services that they commission for the management of screen detected disease. To ensure that patients who are identified as having screen detected disease

	are not lost CCGs should commission their services to provide the failsafe systems identified in national and locally agreed specifications.
Antenatal and new-born screening	NHS England needs to work closely with CCGs who commission maternity services. These screening programmes are part of the maternity services and are funded from the maternity tariff. NHS England staff working in both screening and immunisations need to work closely with child health record departments to ensure fail safes are in place, including the national receipt of blood spot Failsafe system.
Clinically led and patient involvement	The policy for screening programmes is led by PHE. Patient experience of screening will influence participation in screening programmes. NHS England will have to develop a strategy that maximises patient and public involvement in the commissioning of programmes. NHS England will participate in such visits and monitor the implementation of recommendations. It will work cooperatively in the commissioning of their role.
Quality Assurance	NHS England needs to work with CCGs to ensure all screening programmes are subject to external Quality Assurance (managed by PHE). NHS England would like to see this specified as a requirement extended to all screening services that are contracted for by a CCG. In addition NHS England would also wish to see CCGs participating in such visits as commissioners of the service (or specific components of it)

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Appendix 1

Key deliverable and performance monitoring (shown in bold) and supporting indicators	*Baselines*

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Programme category or programme	Services
Screening programmes	Infectious Diseases in Pregnancy Screening Programme
	Down's Syndrome Screening (Trisomy 21) Programme
	Foetal Anomaly Screening Programme
	Sickle Cell and Thalassemia Screening Programme
	Newborn Blood Spot Screening Programme
	Newborn Hearing Screening Programme
	Newborn and Infant Physical Examination Screening Programme
	Diabetic Eye Screening Programme
	Abdominal Aortic Aneurysm Screening Programme
Cancer screening programmes	Breast Screening Programme
	Cervical Screening
	Bowel Cancer Screening Programme

Screening programmes Access to non-cancer screening programmes (as defined in Public Health Outcomes Framework indicator 2.21) http://www.screening.nhs.uk/kpi/data-collection	
Antenatal and newborn screening programmes	
2.21i: HIV coverage: percentage of pregnant women eligible for infectious disease screening who are tested for HIV, leading to a conclusive result	98.5%
2.21ii :Syphilis, hepatitis B and susceptibility to rubella uptake: The percentage of women booked for antenatal care, as reported by maternity services, who have a screening test for syphilis, hepatitis B and susceptibility to rubella leading to a conclusive result	To be confirmed
2.21iii: The percentage of pregnant women eligible for antenatal sickle cell and thalassemia screening for whom a conclusive screening result is available at the day of report	98.5%
2.21iv: The percentage of babies registered within the local authority area both at birth and at the time of report who are eligible for newborn blood spot screening and have a conclusive result recorded on the Child Health Information System within an effective timeframe	90.5%
2.21v: The percentage of babies eligible for newborn hearing screening for whom the screening process is complete within 4 weeks corrected age (hospital programmes - well babies, all programmes - NICU babies) or 5 weeks corrected age (community programmes – well babies)	97.4%
2.21vi The percentage of babies eligible for the newborn physical examination who were tested within 72 hours of birth	To be confirmed
2.21vii: The percentage of those offered screening for diabetic retinopathy who attend a digital screening event	79.6%
Abdominal Aortic Aneurysm Screening Programme	
Offer accepted. % of subjects that are offered the screen and accept. (Taken from AAA SMaRT – national screening system)	78.6%
Eligible Subject tested. % of eligible subjects with a complete initial screening test result with a measurement in both planes (conclusive screening test). (Taken from AAA SMaRT – national screening system)	78.4%

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Cancer screening programmes Cancer screening coverage (as defined in Public Health Outcomes Framework indicator 2.20)	
2.20i: The percentage of women in a population eligible for breast screening at a given point in time who were screened adequately within a specified period	76.9% coverage aged 53-70
2.20ii: The percentage of women in a population eligible for cervical screening at a given point in time who were screened adequately within a specified period	75.3% coverage aged 25 to 64
Bowel cancer screening programme FOBt (faecal occult blood testing) Screening Uptake (all rounds) Source: NHS Cancer Screening Programmes	55.8%
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