



Work Stream 2 – tracer short report: Screening Programmes (Understanding the new commissioning system in England: contexts, mechanisms and outcomes)

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Understanding the new commissioning system in England: contexts, mechanisms and outcomes

Work Stream 2 – tracer short report: *Screening Programmes*

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Introduction

The aim of this project is to understand the development of the commissioning system in England following implementation of the Health and Social Care Act 2012 (hereafter 'HSCA12'). An initial phase of data collection (March – December 2015) used interviews and observation to develop an overview of the functioning of the new commissioning system. The second phase of the project (November 2015 – March 2017) built upon these findings, focusing upon five different service areas ('tracers') in order to explore in more depth the issues arising in different contexts. This report summarises the findings of our exploration of the commissioning of screening programmes. This 'tracer' was chosen because of its potential to illuminate the commissioning and delivery of public health services, including the role of NHS England (NHSE) and its relationship with other national institutions such as Public Health England (PHE) and the National Screening Committee (NSC).

Understanding screening

Screening programmes are a public health strategy focusing on specific diseases within large-scale, clearly defined populations, with the intention of reducing risk of the disease within that population. For example, there is a screening test for bowel cancer (the specific disease) offered every two years to all adults aged 60-74 (the defined population) (Public Health England, 2015a).

Though screening provides the opportunity to detect risk of diseases and allows for early intervention to save lives, it can be **complex, emotive, and often misunderstood**. Public understanding tends to be centred upon the opportunity to save lives through earlier detection of ill health, and in recent years there have been increased calls to widen the scope of existing screening programmes or to develop programmes for diseases not currently screened for. However, understanding screening requires appreciation of two fundamental concepts, **sensitivity** and **specificity**, and their related outcomes of **false negatives** and **false positives** (Public Health England, 2013):

- Sensitivity refers to the ability of a screening test to detect people who have the disease
- Specificity refers to the ability of a screening test to avoid erroneous detection of people who do not have the disease
- Imperfect sensitivity leads to false negatives, i.e. where a screening test fails to identify people who have signs of the disease. This may lead people to believe that they have been given the all-clear and to ignore future symptoms

- Imperfect specificity leads to false positives, i.e. where a screening test falsely identifies people as showing signs of the disease when they do not have it. This may lead to people unnecessarily undergoing further tests or treatment.

In a perfect world, any screening test offered to the public would be 100% sensitive and 100% specific, but in reality **no test is entirely accurate**.

It is important to **differentiate screening from diagnosis**: screening is applied to apparently healthy people who are at risk of developing a specific disease, whereas diagnostic tests are applied to people already showing symptoms of the disease (Sense About Science, 2015). Screening poses **numerous ethical complications**, such as the anxiety for people upon discovering that they may have a health problem. There are also more specific complications regarding particular types of screening; for example, reproductive screening raises the need to make decisions about pregnancy termination and issues relating to societal perceptions of disability (Delatycki, 2012).

There are **internationally-recognised criteria** for appraising screening programmes (Public Health England, 2015b), which include considerations of whether:

- the disease presents a significant population-level health problem and its rate of progression is slow enough to allow time to intervene after detection;
- the screening test is simple, valid, and acceptable to patients;
- there is an effective intervention to treat people positively identified through screening;
- there is robust evidence for the clinical effectiveness of the screening programme, for its social and ethical acceptability, that its benefits outweigh harms, and that it is cost-effective;
- there is a clear implementation plan.

Since its inception in 1996, the **UK National Screening Committee (NSC)** has been responsible for recommendations on all aspects of screening policy. The NSC was developed to improve quality in the development and appraisal of screening programmes, guided by the principle that any screening must do more good than harm (UK Screening Portal, 2015). At the time of writing, the NSC database provides appraisal information for screening for over 100 conditions, recommending systematic population screening programmes for 30 (Public Health England, 2017b).

Screening programmes: public health commissioning pre- and post-HSCA 12

In order to understand the commissioning of screening programmes in the post-HSCA12 system, it is useful to consider changes in the broader field of public health services commissioning. Prior to the 2010 general election, public health responsibilities lay with NHS Primary Care Trusts (PCTs). Following the election, the Coalition Government set out a new strategy for public health in its 'Healthy Lives, Healthy People' White Paper (HM Government, 2010). This proposed a shift in public health responsibilities from PCTs to local authorities (LAs), arguing that LAs were better placed than PCTs to oversee public health improvement for local populations because of their existing functions relevant to addressing the wider determinants of health. It also announced the creation of a new *"dedicated and professional public health service"* (p.52) called Public Health England (PHE), an executive agency of the Department of Health, which would be a *"uniting force for the wider family of professionals who also spend time on improving people's lives and tackling inequalities"* (p.27), with a mandate to allocate ring-fenced public health budgets to LAs. The HSCA12 saw the majority of

duties to improve the public's health transferred to LAs, and amended Section 7A of the NHS Act 2006 to allow the Secretary of State for Health to delegate responsibility for public health functions to NHSE, which now has responsibility for commissioning national screening programmes as a consequence. The Act also saw the Secretary of State's duty to protect health and address inequalities delegated to PHE.

NHSE's regional teams are responsible for commissioning national screening programmes but PHE employees are 'embedded' within their Screening and Immunisation teams "*...to provide accountability and leadership for the commissioning of the programmes and to provide system leadership*" (NHS England and Public Health England 2013, p.7). PHE produces national service specifications to direct NHSE in the commissioning of national public health services via an annual 'public health functions agreement' between the Secretary of State for Health and NHSE (Department of Health, 2015). These agreements contain a list of 'Section 7A services' to be commissioned by NHSE, including screening programmes. The Immunisation and Screening National Delivery Framework and Local Operating Model (NHS England and Public Health England 2013), published in 2013, set out the roles and responsibilities of NHSE, PHE, the Department of Health, and LAs in relation to screening. At the national level, PHE houses the secretariat of the UK National Screening Committee. One national level interviewee described the dynamic between PHE and 'the NHS' thus: "Public Health England writes the knitting pattern and the NHS finishes it" [16350, National level, Oct 2016]. CCGs do not commission national screening programmes, the services that they do commission, or pay for, can however form part of some screening pathways. For instance, in sickle cell and thalassaemia screening, prenatal laboratory genetic testing costs are paid by NHSE from the screening and immunisation budget, whereas the costs for specialist counselling are to be split between CCGs and NHSE according to a local agreement, and any terminations are commissioned by CCGs. In the new system, LA public health teams have a responsibility to ensure that adequate screening and immunisation plans are put in place within their area and to challenge NHSE if this is not the case. Diagram 1, below, provides a simplified representation of the key organisations in the post-HSCA12 screening programme system.

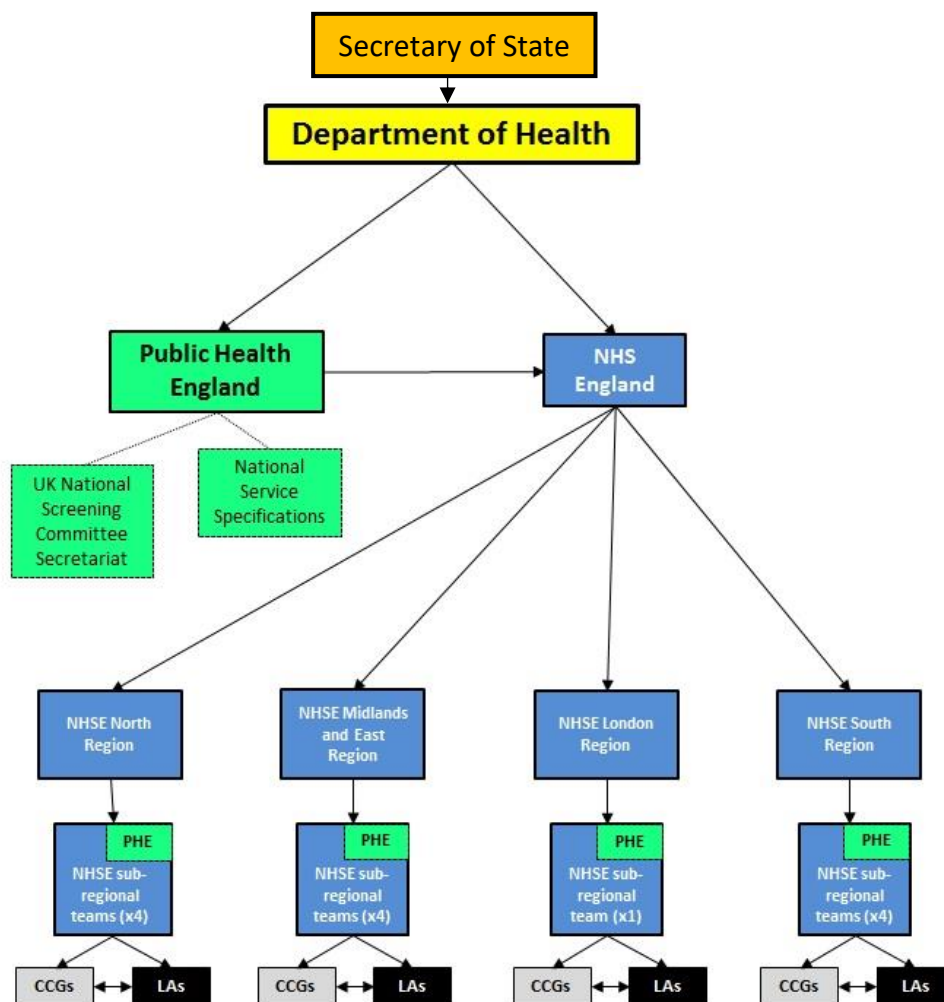


Diagram 1: The key organisations in the post-HSCA12 screening programme system.

The main implication for screening arising from the HSCA12 was the creation of PHE, to bring together a range of public health professionals and specialists from more than 70 organisations into a single public health service (Public Health England, 2017a) and oversee protection and improvement of national health and wellbeing, and the allocation of commissioning responsibility over national programmes to NHSE. **There is no identifiable programme theory (Weiss, 1998) for these changes to screening programme commissioning,** however, it is notable that in contrast to the valorisation of localism associated with the creation of CCGs, screening commissioning (like specialised services commissioning) became more centralised as a consequence of the HSCA12.

To explore the impact of HSCA12 upon the commissioning of screening programmes, we conducted interviews with a range of commissioners and service providers. This comprised the 78 interviews in Work Stream 1 (involving individuals from CCGs, NHSE, and LAs), and subsequent, more detailed, Work Stream 2 interviews with 6 individuals from PHE, and NHSE. Due to the relevance of the national scale to screening programme commissioning, we extended our focus for this tracer beyond the two English Areas (corresponding to NHSE Area Team footprints, as originally conceived) that we have primarily explored in our study. Some interviewees’ work related primarily to the national level whereas others worked in geographical patches that included, or matched closely with, one of our two Areas. There was little difference between Areas in terms of the issues reported. Data analysis was iterative, with the findings from the emerging analysis informing later interviews.

- **Area 1** is a socio-economically diverse metropolitan county with a population of over 2.5 million and a large city at its core

- **Area 2** is a highly ethnically and socio-economically diverse metropolitan county with a population of over 1.25 million and a large central city.

In this section we present data according to three emerging themes: 1) Perspectives on screening; 2) Advantages and challenges of the new national screening programme commissioning architecture; 3) Fragmentation of responsibility and ambiguity in accountability.

Theme 1: Perspectives on screening

Most CCG interviewees from the first phase of the project (March – December 2015) were positive about the value of screening in general but some had particular reservations. Contrast the two following examples from CCG interviewees:

“I think screening is really important, to me, that’s in the preventative and proactive end of care. I’m a great one for all the screening things that go on, because it makes a difference and it saves money.” [4246, CCG, Area 1, Jun 2015]

“Well there are very few things that have I think clinical and financial utility in screening. I think it causes more upset than it often saves and unless you’ve got a very specific and a very sensitive test I think it is a flawed process and also, as I said to you, financially it’s difficult for us to do because if we do screen people and do pick up stuff and manage them early so they don’t get the complications and so on, that’s a costly process which won’t produce any financial benefit to the organisation until five, ten years or further down the line.” [2627, CCG, Area 1, Apr 2015]

There was considerable **variation in the degree to which different CCGs considered a focus on screening to be a priority**. For example, some CCGs were financially incentivising their member GP practices to increase uptake of bowel cancer screening and breast screening [4785, CCG, Area 1, Jul 2015], whereas others did not see screening as a feature of their day to day work [6323, CCG, Area 2, Sep 2015].

When asked to comment on screening in general, CCG interviewees frequently mentioned the NHS Health Check programme but some were unsure whether it technically constituted a screening programme. NHS Health Checks are offered to all UK adults aged 40-74, every five years, to ascertain risk of heart disease, diabetes, kidney disease and stroke. National level interviewees, and those from NHSE and PHE, noted that the Health Check programme had not been through the assessment process the NSC used to define a screening programme and was unlikely to fulfil the requisite criteria if it did. The creation of the programme, much like the National Chlamydia Screening Programme and the National Childhood Measurement Programme, was “*politically inspired*”, i.e. it was created as a result of the preferences of politicians [16350, National level, Oct 2016].

In summary, interviews with CCG members early in the project revealed variety in terms of perceptions about the value of screening, and relatedly the degree to which screening was considered a focus of CCG activity. There was also some uncertainty from interviewees about what was technically a screening programme. Interviews at the national level revealed that the introduction of a small number of national programmes, including NHS Health Checks, had occurred as a result of the efforts of politicians and had not been subjected to the NSC’s process to designate screening programmes.

Theme 2: Advantages and challenges of the new national screening programme commissioning architecture

A national level interviewee felt strongly that the HSCA12 had conferred a number of advantages to screening. Previously, each of the 152 PCTs had a screening lead with considerable variability between them in terms of their levels of enthusiasm for the role and engagement with the national level, which provided some challenges for the NSC in co-ordinating screening activities. Post-HSCA12, the NSC deals directly with a significantly smaller number of individuals, each of whom sits within an NHSE regional team, which has facilitated **more effective communication and programme organisation between national and local levels:**

“So this reorganised system has had its advantages in the sense that in terms of, kind of, orchestrating screening programmes nationally, it’s more straight forward having these, kind of, 10 Public Health England embedded teams within the current NHS England structure.” [16350, National level, Oct 2016]

An NHSE interviewee believed that these changes had resulted in more dedicated commissioning attention being paid to screening than PCTs (as a group) had been able to provide and that commissioning across larger geographic areas was likely to be beneficial in terms of improving screening quality [20012, NHSE, Area 2, Mar 2017]. Additionally, the creation of PHE has meant that a concentration of expertise has taken place at the national level, and having a single employer (with one set of HR policies) has provided a “mechanism” to, for example, unify what were previously organisationally disparate cancer screening teams and their quality assurance teams [16350, National level, Oct 2016; 19974, National level, Mar 2017]. The reforms have also meant that **identifying good local practice in screening programme implementation and incorporating this into national guidance has become more straightforward** [16350, National level, Oct 2016].

However, the **embedding of PHE employees into screening and immunisation teams within NHSE was recognised by both PHE and NHSE interviewees as problematic**. The allocation of staff from PCTs to LAs, NHSE, or PHE in the post-HSCA12 system occurred on the basis of an insensitive formula relating to time spent working on particular tasks. This was highlighted as an issue contributing to a loss of professional expertise and institutional memory:

“It meant when it came to transition the rules which have to be there were if 50 per cent of your job was in one thing, you go to local authorities or you go to NHS England, PHE, wherever you went, which meant that a lot of capacity at the time in 2013 with the screening expertise was actually going into Local Authority and not very much was coming in the transitional process here, and so a lot of expertise and organisational memory stuff was getting lost and is lost, and has been lost within the processes.” [18352, PHE, Area 1, Jan 2017]

One PHE interviewee, embedded in NHSE, noted that members of her screening and immunisations team had left their jobs because they found it too difficult attempting to cover the size of geographical area that corresponded to their NHSE sub-regional ‘patch,’ which was significantly larger than they were used to. There were **logistical issues, such as travel times, associated with covering larger patches but also other practical difficulties** associated with attempting to influence screening practices at a more local level:

“...say we wanted to sort out cervical screening coverage in GP practices, in [Town G] PCT you’ve got 64 GP practices, [...] bottom 20 per cent you could talk to the 12

practices. In my new patch we've got 600 practices. So you have to think in a completely different way. So you never have that thing of oh, we'll just take the bottom ten per cent and [...] because that's just not possible. Couldn't do that to 70 practices. You don't have the time..." [17685, PHE, Area 2, Dec 2016]

Challenges associated with working at a broader scale without an increase in resources, also arose from the fact that Directors of Public Health (DPH) and their LAs have a statutory health protection role which involves seeking assurance from NHSE on the suitability and quality of local screening programmes. For an NHSE screening commissioning team, the sheer number of LAs in its patch provided difficulties in terms of meeting requests for data and evidence:

"So we get a lot of pressure, because now there's so many local authorities and DPHs all asking for reports, asking for all kinds of things because they think they have...well, they do have an assurance role and they want to implement that role. So there's a balance to strike between providing assurance of what we're doing and actually doing things." [17685, PHE, Area 2, Dec 2016]

Information governance processes were reported as another difficulty. Issues stemmed from the fact that PHE, as an executive agency of the Department of Health, is part of the Civil Service and has different information governance policies and 'gateways' than NHSE, an executive non-departmental body of the Department of Health whose staff are not part of the Civil Service. This has **necessitated local strategies and workarounds** as well as attempts between PHE and NHSE at the national level to address the problems this gives rise to:

"So PHE holds some data, it can't let NHS England look at it. Because of our embedded nature in the service, we get to see both the PHE data and the NHS England data, and we have to have internal conversations about who you can then let see it and manage it and do it, instead of it all being in one place, and, as I say, that's been there since April 2013 and it is still not resolved. There are fixes in different places that are being done, and recently there have been some formal MoUs that have been put in place between NHSE and PHE to kind of sort the organisational thing which is then feeding through to us." [18352, PHE, Area 1, Jan 2017]

This formal distinction between PHE and NHSE was thrown into relief by the day to day realities of those working within these NHSE regional teams with embedded PHE staff. One screening and immunisation lead, employed by PHE, talked about the pragmatic practices that she and her team members adopted when dealing with those from outside the team:

"So if people talk to us and think that we're PHE then we'll respond, we'll say that's who we are, because otherwise you end up in a confusing conversation about the difference in responsibilities...If people talk to us as if we're part of NHSE then we'll talk to them back as part of NHSE. We'll kind of go either side, which actually gets the right conversation happening with people around the process." [18352, PHE, Area 1, Jan 2017]

This speaks to a **blurring of identities for public health professionals in PHE**. A PHE interviewee in Area 2 discussed this issue in relation to the variety of opinions that her team members had about their identities within NHSE and whether they thought of themselves as commissioners:

“...If you ask people in my team are they commissioners or are they PHE or are they both you’d get a variety of answers. I’m reasonably comfortable about being a PHE person, but I would also consider myself a commissioner. I don’t know if everyone else would. So there are various models. Some people think the SIL [Screening and Immunisation Lead, PHE employee] around quality and is there to make sure that quality’s implemented by NHS England. Some people think that we’re pure commissioners, others think we’re a mixture, and the people within the team have different views about that as well.” [17685, PHE, Area 2, Dec 2016]

One positive aspect of the reforms identified by PHE staff embedded in NHSE was **improvement in access to training opportunities** when compared to those available to screening commissioners within Primary Care Trusts [17685, PHE, Area 2, Dec 2016].

In summary, this theme illustrates how the post-HSCA12 national screening programme commissioning architecture was perceived as having some advantages, particularly for those working at the national level, in terms of national-regional co-ordination, disseminating best practice, and increasing access to training opportunities. However, at the NHSE sub-regional level of screening and immunisation teams, which include PHE staff embedded in NHSE, the new architecture was problematic in a number of respects including: a loss and re-allocation of professional and local expertise, practical challenges of working in large geographical ‘patches’ containing numerous organisations, information governance incompatibilities, and identity dissonance and confusion.

Theme 3: Fragmentation of responsibility and ambiguity in accountability

A PHE interviewee described her perceptions of the post-HSCA12 screening system as it was taking shape and the resultant distribution of responsibilities between organisations, which made little sense to her:

“...by the time we got through to December ’12 and beginning of ’13, the system that it was clear we were going to be having of a weird process of having public health specialist advice in one organisation called Public Health England, the commissioning responsibility for most but not all of the screening programmes resting in a new body called NHS England, with support coming from different places, it felt to me, and to many of my colleagues, to be very strange at different times, and utter madness.” [18352, PHE, Area 1, Jan 2017]

For CCG and LA commissioners, approximately two years after the implementation, there was ongoing uncertainty about where the boundaries of responsibility for screening lay between organisations, and between national and local programmes:

“... I don't know the technical answer to who the commissioner is for some of the screening services... literally I don't know whether it's Public Health England [or] public health local [authority] who are the Commissioner.” [3271, CCG, Area 1, Apr 2015]

One CCG interviewee in Area 2 was uncertain as to exactly what NHSE’s role in screening was. She described screening as an area that existed in the “fault lines between organisations”:

“And screening is another one that resonates with me because it’s an area of high confusion between Public Health England, CCGs and NHS England in so much as they commission primary care. So those two areas exist in the fault lines between

organisations, so they are issues we've had quite a lot of work dealing with like whose job is this anyway?" [6010, CCG, Area 2, Aug 2015]

The **uncertainty around divisions of responsibility as a consequence of a "fragmented commissioning framework"** [17685, PHE, Area 2, Dec 2016] were also associated with **ambiguity over accountability in the system**: "...some of those screening things are a bit of a muddle in terms of who's actually accountable" [7033, LA, Area 1, Sep 2015]. One PHE interviewee noted that this does not present a significant issue when screening programmes are operating as they should but could become problematic if there was an "incident."

"...there are some issues around accountability, responsibility, leadership. If something went wrong, if [...] if there was an incident in a screening programme who's ultimately accountable, responsible, is it shared, is it PHE, is it the SIL [Screening and Immunisation Lead, PHE employee] is it the head of public health commissioning [NHSE employee]. Those are the scenarios where I'm not sure it's going to be totally clear." [17685, PHE, Area 2, Dec 2016]

An NHSE interviewee noted that although the **National Delivery Framework and Local Operating Model** (NHS England and Public Health England 2013) sketched out the roles and responsibilities of NHSE and PHE in terms of screening, this was **not sufficiently detailed to be of practical value locally** and was now out-dated (the document refers to NHS England Local Area Teams and other organisational entities which no longer exist) [20012, NHSE, Area 2, Mar 2017]. As a consequence, **considerable variation has developed locally** in terms of the relative roles and relationships between NHSE and PHE employees within the sub-regional screening and immunisation teams in NHSE. When asked whether this dynamic had become clearer over time a PHE interviewee stated:

"It's become less clear really. What happened was we started with the national framework of how we work together and then local teams basically didn't follow the framework and there was complete variation across the country, and then the result of the second review was that they said we'll tolerate the variation, so there is a kind of fudge and there's variation and there's various things going on across the country. I don't think it's any clearer now than it was two years ago." [17685, PHE, Area 2, Dec 2016]

Cervical screening provides an illuminating example of the difficulties associated with fragmented responsibilities within the post-HSCA12 system. Primary Care Trusts previously commissioned screening and sexual health services. Officially, cervical screening was provided by GP practices, which received additional funding, linked to levels of activity. In practice, some GPs were less interested in providing these services and patients would be told that they could get their smears done at the local sexual health clinic (even though the latter received no additional funding for this) [8384, LA, Area 1, Nov 2015]. Post-HSCA12, LAs commission sexual health services and NHSE commissions cervical screening. However, due to funding constraints and a recognition that it is not their responsibility, LAs are not including smears as a funded activity in new sexual health service contracts. NHSE and PHE would prefer it if patients could choose to go to a GP or sexual health clinic for their smears, whereas some LAs insist that they will only provide opportunistic smears and that NHSE should commission clinics to provide smears. One NHSE interviewee argued that the public health budget of each LA reflects the levels of cervical screening activity previously taking place in their sexual health clinics but that this is not clear because the funding was not "disaggregated" [4058, NHSE, Area 1, Jun 2015], in other words it is not possible to discern what the sexual health component of the public

health budget consisted of previously. A PHE interviewee suggested that NHSE is reluctant to commission for logistical reasons:

“So cervical screening we could go to every sexual health provider and have a separate contract. The difficulty again becomes around commission capacity. So I think we’ve got 14 local authorities, so we have 14 separate contracts all very low value, it’s about 1,000 screens in each, so you’re talking maybe 14 £20,000 contracts or something. So it’s a very bitty way of doing stuff. So we could still do it and we could pay for it, but in terms of the amount of paperwork or the amount of outcomes it becomes potentially unmanageable.” [17685, PHE, Area 2, Dec 2016]

She also noted that national guidance was too vague to help resolve the issues, stating things like: “...‘local authorities and NHS England should work together for a local solution,’ which means nothing” [17685, PHE, Area 2, Dec 2016]. A national level interviewee suggested that the consequences of this ambiguity of responsibility, and the resulting gaps in provision, were likely to be highly variable across the country, reflecting the different trends in GP cervical screening provision, and result in reductions in the number of patients receiving smears [18352, PHE, Area 1, Jan 2017]. Adding to the complexity of the picture is the fact that CCGs are assessed on whether certain levels of patients are receiving smears and, in some local contexts, there is not sufficient capacity to meet these targets without sexual health clinics taking a share of the activity [8384, LA, Area 1, Nov 2015].

Numerous interviewees talked about the **importance of inter-personal relationships in overcoming fragmentation and ambiguity** within the screening commissioning system in order to get things done:

“How does it work now? It works now on the basis of people and relationships. There are still organisational issues which are unclear around responsibilities and such...” [18352, PHE, Area 1, Jan 2017]

A national level interviewee, interviewed in March 2017, reported that in the new system **an effective system leader with the power to compel organisations to follow a particular course of action is lacking**. In order to overcome this, it was sometimes necessary to call on established relationships with individuals working in other organisations in order to negotiate responses to issues, allocate responsibility, and present a coherent message to the public:

“...we do use all those personal relationships shamelessly in order to get round the system where you don’t have any...you don’t really have any power to make anybody do anything.” [19974, National level, Mar 2017]

The key messages from Area 1 and Area 2 interviewees regarding screening were largely consistent but a PHE interviewee from Area 1 highlighted how certain characteristics of Area 1, such as pre-existing inter-organisational arrangements and operational forums, were advantageous in facilitating collaborative work that helped to mitigate some of the fragmentation within the system [18352, PHE, Area 1, Jan 2017].

For those operating **at the national level there was a perception of a lack of ‘levers’ to employ to engender change at more local levels** despite the increased centralisation in screening commissioning as a consequence of the HSCA12. For instance, an attempt to codify the responsibilities of (now LA employed) Directors of Public Health in regard to screening programme responsibility has been derailed by the lack of a mechanism to get such a proposal

agreed nationally [16350, National level, Oct 2016]. A more specific concern related to the Chlamydia Screening Programme, which is now a LA sexual health commissioning responsibility. A national level interviewee was concerned that LAs were disinvesting heavily in the programme. This was a particular concern for the NSC because the effectiveness of the programme is predicated on a sufficient level of funding and provision. However, due to the post-HSCA12 division of commissioning responsibilities, the NSC could not identify a means of influencing the level of financial resource LAs allocated to the programme. This problem stems from the fact that, as noted earlier, the Chlamydia Screening Programme is one of four national programmes not subject to the NSC appraisal process for what constitutes a screening programme. The fact that LAs have taken on responsibility for it, as part of their broader sexual health remit, reflects its position as outside the usual commissioning mechanisms for national screening programmes. The significant cuts to LA budgets, and an annually shrinking ring fenced public health budget, are also important contextual factors.

Clear mechanisms for exerting influence over providers were apparently lacking between NHSE, PHE, and CCGs at the local level. In the following example, a CCG commissioner explained that PHE had approached the CCG and requested that it monitor the performance of a local hospital Trust in relation to outcomes of screening services which the CCG was not commissioning:

“...Public Health England have some concerns about how our hospital has been running one of the screening services... but it is very odd, because they’ve then said, well can you include that in your contract meeting with the Trust and we’re like yeah, but our contract meeting is about our contract with them, what are you doing with them. So we have said in the end, you know what, we’ll bloody performance manage it for you through our contract meeting, but it just seems very odd, you know, that they come in and do visits and they do quality assurance and then they send letters having concerns and they copy me in but what real influence do I have because it’s not what I do, you know.” [3262, Area 1, CCG, Apr 2015]

Another comparable incident was raised by a different CCG [7412, Area 1, CCG, Oct 2015].

A PHE interviewee provided a clear example of how a lack of influence over providers was related to the post-HSCA12 fragmentation of responsibilities and funding:

“...one part of the screening programme is the antenatal newborn screening programme. So these are screens done by midwives, and they are paid something called a maternity tariff. So every birth the maternity service is paid a set amount to do all the maternity checks for that birth, and part of that care includes some of the screening antenatally and of the newborn baby. Now, technically NHS England are the commissioners of that, because under 7A we’re the commission of antenatal newborn screening. But all the payment is part of the tariff, and that tariff is paid by CCGs who are the commissioner of maternity services.” [17685, PHE, Area 2, Dec 2016]

Finally, two interviewees highlighted what they perceived as a governance deficiency in the new system in terms of accountability. Both expressed **concerns that NHSE was effectively assuring itself for its performance as a commissioner of national screening programmes** [16350, National level, Oct 2016; 19974, National level, Mar 2017]. However, an NHSE interviewee did not share this opinion and believed that current assurance mechanisms were sufficient [20012, NHSE, Area 2, Mar 2017].

In summary, the HSCA12 resulted in a system of screening commissioning, and a distribution of responsibilities between organisations, that some public health professionals found confused. Two years after implementation of the Act, local CCG and LA commissioners were still uncertain as to which organisation was responsible and accountable for screening. The relative accountabilities of PHE, embedded in Screening and Immunisation Teams, and NHSE were particularly fuzzy to PHE interviewees, and this was considered an issue that would be tested should a significant 'incident' occur. The National Delivery Framework and Local Operating Model (NHS England and Public Health England 2013) was sufficiently vague to allow considerable local variation to develop nationwide in the dynamics between PHE and NHSE, and despite some faltered attempts to impose standardisation from national level discussions, this has only increased over time. Inter-personal relationships have been important in 'working round' the consequences of these issues, as well as the lack of an effective organisational arbiter for screening. The fragmentation of commissioning responsibilities, within and beyond screening, had implications for the ability of commissioners to exercise influence over providers due to the distribution of organisational 'levers.'

Summary

- Opinions of CCG commissioners about the value of screening, and the extent to which it was considered a CCG priority, were variable
- Uncertainty among CCG commissioners about whether NHS Health Checks was technically a screening programme reflected the fact that it was created outside of the usual NSC designation process with governmental impetus and commissioned, post-Act, by LAs
- A number of advantages of the new screening commissioning system were highlighted: enhanced national-regional co-ordination (between NSC and NHSE/PHE), more straightforward dissemination of best practice, increased access to training opportunities for PHE employees, and potential improvements in screening quality
- A number of disadvantages were also identified: loss and re-location of professional and local expertise; practical challenges of working in large geographical 'patches', without an increase in resources, containing numerous organisations; information governance incompatibilities
- The division of responsibility within the new system was a source of confusion for local commissioners in CCGs and LAs, even two years after the Act's implementation
- NHSE's regional teams are responsible for commissioning national screening programmes but PHE employees, 'embedded' in NHSE Screening and Immunisation Teams, have a role providing expert advice and leadership. The relative responsibilities and accountabilities of these organisations, in practice, were not clear to interviewees, and a range of varied inter-organisational dynamics have evolved in local contexts
- Inter-personal relationships were identified as crucial in 'working round' the ambiguities of the system and the lack of an effective organisational arbiter
- Fragmented commissioning responsibilities, within and beyond screening, had implications for the ability of commissioners to exercise influence over providers due to the distribution of organisational 'levers'
- Cervical screening illustrates how the fragmentation of screening commissioning responsibilities has disrupted an established but largely tacit arrangement for provision leading to local variation and potential gaps in provision.

Actionable messages

- Respondents highlighted difficulties associated with the fragmentation of responsibility for commissioning and monitoring screening programmes. The NHS in England is currently engaged in creating geographically focused Sustainability and Transformation Plans. There may be utility in creating a designated 'screening lead' with statutory oversight of screening programmes in each STP area
- The role, accountabilities and responsibilities of PHE staff embedded in NHSE could usefully be clarified
- The lack of clarity over how the delivery and performance of screening programmes should be locally monitored suggests that consideration could be given to the development of some kind of co-commissioning arrangement, whereby CCGs have a formal role in contract monitoring. This would, however, require the transfer of additional management resource to CCGs
- The status of some screening programmes as outside the scope of the NSC is a source of confusion. Consideration could be given to a process whereby screening programmes outside the purview of the NSC could be brought within its remit

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