



Public Health  
England

Protecting and improving the nation's health

# **Public Health England response to the external review of quality assurance services for NHS screening programmes**

January 2015

## About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

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## Foreword

Public Health England welcomes the external review of quality assurance services for NHS screening programmes and we would like to thank Professor Chris Bentley for his extensive work.

We agree with the key tenets of the report: that Public Health England should have a single quality assurance service, delivering a core set of functions, and operating consistently to a standard set of processes and procedures. We are already under way with the development of a quality assurance service operating model which will provide an important framework for the delivery of this approach.

We have looked in detail at each of the recommendations in the review and considered whether we can incorporate them into our new way of working. Our work to develop a quality assurance service model will address many of the recommendations contained within Professor Bentley's report. However, there are instances that require a more thorough consideration of value with respect to our financial environment. In these instances, we have chosen to recognise the rationale for the recommendation and work through the value-for-money options to move it forward. In addition, the recommendations in the report have been reviewed in the context of our wider Public Health England change programme 'securing our future', and will be implemented in accordance with this agenda.

This paper outlines Public Health England's response to the recommendations in the external review, highlighting how they will be translated into the design of the quality assurance services for NHS screening programmes as we move forward as an organisation to develop a quality assurance service fit for the future.

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## Background and context

From 1 April 2013, the cancer and non-cancer screening quality assurance (QA) teams became part of the newly incepted Public Health England (PHE). Historically, these teams have worked independently. The transition into PHE provides an opportunity to reshape QA teams into a single strong and effective service. The health and wellbeing directorate's initial 'striding forward' programme and the current, wider PHE programme 'securing our future' provide the context for this review. This work was deemed particularly important as there have been significant changes over time to the way screening services are commissioned. In the current landscape, new commissioners, public health leads and other NHS professionals have a keen interest in the work of the quality assurance teams, both as health professionals and on behalf of patients and the public.

At its inception, PHE inherited two groups of staff and associated professionals dedicated to assuring the quality of national screening programmes across England. Historically, the QA teams working with cancer services were managed by the ten regional directors of public health and have developed in different ways from each other. The QA teams for non-cancer screening services, by contrast, are relatively new and have been developed with a single operating model and are accountable through a national QA lead to the director of English screening programmes. The advent of PHE therefore offered an opportunity to further align the QA functions for greater public benefit, including the best value-for-money, and to ensure that the QA model for all screening programmes is fit for the future.

The review of QA services for NHS screening programmes (QA review) aims to support a QA function that can illustrate to patients and the public that all NHS screening programmes in England are of sufficient quality, working within agreed parameters, and delivering more benefit than harm to the population screened. This will be achieved by:

- building greater links between QA teams and aligning QA functions
- developing a common understanding of the contribution that a quality assurance approach makes
- sharing and building on best practice
- informing future work programmes and
- identifying options for ensuring financial sustainability

The QA review has been guided by several principles, that:

- current QA functions would continue to be supported to continue with business as usual during the time of the review

- we would, and will, continue to support the QA service to do the right thing in the most appropriate way for the public, providers and the service itself, recognising where differences in approach are appropriate and applicable
- the review would ensure that the interdependencies between the QA and other functions, such as standard setting or screening programme developments, are recognised when developing any options for QA service modelling

The QA review programme comprises of three phases:

- phase one – review of the current QA services
- phase two – define and design the future QA services
- phase three – start implementation of the new QA service

Phase one included assessments of the role of QA and its methodology:

- developing an understanding of what constitutes good practice for a QA process, learning from and building on current good practice
- understanding the cost-effectiveness of different approaches
- understanding the roles and responsibilities of all QA teams across cancer and non-cancer programmes

It was recognised that it was vital to build on the current strengths of the QA service and draw on the wealth of knowledge already within QA teams. To that end, Professor Chris Bentley worked as an independent consultant with QA staff, clinical professionals and QA stakeholders. These have been addressed through his external review of quality assurance services, along with work completed within PHE. The independent report from phase one has identified options and made recommendations for the QA service to meet future needs.

The output of this analysis was used to:

- identify options for and make recommendations on the structure of future QA services (“function”)
- advise on methodology and the operating model for QA services (‘form’)
- generate options for a model (establishment) for QA service, including the option of no change, if this is the most appropriate

Phase two translates the work of phase one into defining and designing the future QA model. Phase three of the project will start the work to deliver the future QA model. It will also include an assessment of the roles and responsibilities of screening QA versus other QA systems in the rest of the NHS.

# PHE response to external review recommendations

## Definition of common elements to screening QA programmes

### Recommendation 1

- Organisational development, seeking to optimise effectiveness, efficiency and manageability of screening QA, might initially build a common language and culture, based on factors such as:
  - common understanding of unique selling points
  - common (generic) operational framework
  - common elements of an organisational model
    - professional leadership and support
    - data and intelligence management
    - system engagement (local relationships)
    - QA core team
  - common basis of working methods
  - addressing common concerns about governance issues
  - common barriers to best population impact

Accepted and under way. These areas have been accepted as representing the requirements for the new single screening QA service and form the areas for consideration in the QA operating model.

## Shared understanding of QA

### Recommendation 2

- There is a fairly consistent idea of the nature and unique selling points of QA across a full range of staff working in cancer and non-cancer QA teams. This appears to be largely echoed by peers from NHS England working alongside them. This could be developed into a single statement of the role and purpose of QA, which would address one of the key concerns arising from respondents – the current perceived lack of clarity and direction about their role, responsibilities and interactions with other partners, such as area teams.
- This statement would need to emphasise the screening QA role in ‘facilitatory improvement’ as part of quality assurance, as opposed to a regulatory or performance management function.

Accepted. PHE agrees with this focus and will be developing an operating model that will set out the role and purpose of the screening QA services.

### **Recommendation 3**

- Screening QA, in recent reorganisations, appears to have lost its facility to directly 'assure' the population served about the uptake, access, safety, effectiveness and outcomes of population screening programmes, as it is required to do. Working with peer agencies, the mechanisms to restore these direct links, particularly to local authorities (and their public health) and CCGs, should be established and agreed on a national basis. These could be captured as part of a working framework document agreed with peer agencies. Local implementation of the necessary arrangements should then follow.

Accepted. This consideration will be reflected in the pathways work currently under way for the operating model and will be developed further in conjunction with the PHE centres.

### **Recommendation 4**

- PHE policies on sharing of data and reports, relevant to these processes, should be reviewed where possible to enable such moves, and the practical consequences clearly communicated with the field teams.

Accepted. Our working relationships with peer organisations, for the purpose of providing an effective QA service, will be addressed as part of discussions within PHE on ways of working with partner organisations. This will be subsequent to the establishment of a new PHE organisational structure.

## **A core operational framework**

### **Recommendation 5**

- That a single clear core operational framework is developed and agreed across screening QA, based on a generic structure for the screening programmes themselves, but allowing for justifiable agreed variations by programme.

Accepted and under way. A common standard operating model is currently being developed through the existing QA service leads, and will be subject to consultation in January 2015.



### **Recommendation 6**

- That such a framework be used to identify 'add-ons', eg, research projects; pilots; developmental work by team. This is not to suppress innovation/good practice, but to safeguard business capacity.

Accepted, in principle. It is agreed that the framework will be useful to identify add-on functions. However PHE's main priority is to develop a core QA service to ensure the quality of local screening programmes. 'Add-on' services therefore will be considered in light of the scope and capacity of the new QA service and on a case-by-case basis.

### **Recommendation 7**

- That the framework is used to develop a process to more objectively assess and benchmark the effectiveness of QA programmes as part of the management of their own quality.

Accepted.

### **Recommendation 8**

- That screening QA as a single service considers how it should strengthen its mechanisms of assurance on how programmes systematically capture and analyse user experience to drive improvements in service. Resulting advice and support should capitalise on developments and best practice within the NHS as it seeks to 'raise the bar' on expectations in this area (see also Recommendations 39-41).

Accepted, in principle. PHE will consider ways that QA can support local programmes to strengthen their response to user experience.

### **Recommendation 9**

- To date, the impact of the QA screening programmes has not been systematically measured or evaluated. This could be addressed by:
  - a) a retrospective assessment, with examples of the evidence of impact of the programmes
  - b) a prospective programme of evaluation based on routine data and audit

Accepted. PHE agrees that the QA service needs to systematically incorporate the evaluation of QA into its day-to-day work. This will be included in the operating model and will be used to inform how QA develops as a cost-effective service in the future.

### **Recommendation 10**

- It is critical that there are clear lines of escalation whereby concerns arising across programme teams in relation to 'interpretation' of specifications and other guidance are seen to be addressed within and beyond PHE, and guidance on how QA teams should consistently manage agreed and disseminated.

Accepted. This will form part of the operating procedures that are developed when the redesigned service is operational.

## **Professional leadership and support**

### **Recommendation 11**

- That the current models of provision of professional/technical expertise within screening QA provide a variety of solutions to a range of different problems. In the future these should be applied on the basis of need/appropriateness rather than culture (cancer/non-cancer). This will result in a 'mixed economy' of solutions across screening QA practice.

Accepted

### **Recommendation 12**

- There would appear to be a strong case for carrying on using a model where there is continuous engagement of lead professionals in teams, with infrastructures for on-going engagement of provider screening professionals, applied in particular circumstances. This would apply particularly where there are large numbers of local practitioners, relying particularly on professional/technical skills to make key judgements, and where there are complex arrays of developed standards to be assured.

Accepted

### **Recommendation 13**

- Currently, the professional lead arrangements in QARCs are fundamental parts of the 'fabric' of the multidisciplinary team model. They are also at the centre of local screening professional infrastructures providing day-to-day advice and support, valued networks for communication, education, debate, benchmarking and sharing good practice. Full consideration needs to be given to the value of these arrangements in any structural reorganisation.

Accepted. It is recognised that the professional/technical expertise is crucial in delivering an effective QA model and therefore an urgent piece of work is under way to develop a cost-effective and affordable model of working.

## Data and intelligence management

### Recommendation 14

- That a professional systems analysis approach is taken to map out the necessary data flows to properly support quality control, assurance and improvement in screening programmes. With a QA team focus, the flows to within PHE should be mapped, but also those to commissioners and the population served.

Accepted. The new proposed services structure will enable this process to be undertaken during 2015.

### Recommendation 15

- Drawing in this analysis, work within PHE to ensure that advice and support is provided to assist, rather than impede, the safe and effective use of data to protect user and population health. This should encompass data protection, data sharing and publication and information governance, but with a 'can do' approach.

Accepted. It is recognised that there are steps that can be taken to improve the safe and effective use of data within an overall framework which ensures PHE remains compliant with data protection and information governance requirements. The QA service will work with colleagues in the CKO directorate to develop this approach.

### Recommendation 16

- Principles of data asset ownership and data flows should be established and clearly stated and communicated to relevant stakeholders at national and local levels. They could also be captured within the generic operating framework, working framework documents, etc.

Accepted

### Recommendation 17

- The difference between data needs to serve distinct purposes should be acknowledged in solutions:
  - aggregated data to assure population and organisational level indicators and outcomes
  - linked person level data to assure safe and effective systems

Both will be necessary for effective QA programmes.

Accepted. The QA service will work closely with colleagues in national programmes and the CKO directorate as well as key stakeholders, such as professional groups, to develop a systematic and effective approach to the use of data for QA purposes.

### **Recommendation 18**

- Opportunities should be explored to automate menial tasks such as the linkage of datasets and matching of user data along pathways. This may be done efficiently at national level, freeing up skills of local teams to focus on focal analysis and interpretation.

Accepted. The QA service will explore new ways of using data that focuses on a 'do once' approach nationally. However, it is recognised that this may require the implementation of new IT solutions, which will need a longer-term approach for delivery.

## **System engagement**

### **Recommendation 19**

- It would be useful to establish structural maps for each of the PH screening programmes, based on the 7a specification, and augmented and agreed in consultation with representatives of the major players. Responsibility for this could be shared by topic across the regional QA teams.

Accepted. This will be achieved through the consultation process during the development of the QA service operating model.

### **Recommendation 20**

- Based on the generic QA operational framework, establish a generic working framework document to be agreed between QA teams and NHS England screening and immunisations teams, encompassing unique contributions of each; interdependencies; rights and responsibilities. This would emphasise the different roles of regulation, performance management and facilitatory improvement:
  - sections within a working framework document (WFD) would need to cover information and data sharing; risk assessment and mitigation; follow up of action plans from QA visits; management of incidents and communications
  - generic WFDs might be augmented to reflect needs of specific screening programmes (fixed and variable sections)
  - in due course, similar WFDs may be developed with other relevant commissioners (CCGs, local authorities)

Accepted, in principle. Initially, the operating model will describe how the QA service will work with key stakeholders across the system. And while accepting the need for clarity of roles

and responsibilities across the system, the approach to do this will need to reflect the new ways of working developed through 'securing our future'.

### **Recommendation 21**

- It would be useful to initiate some joint organisational development and learning on core practice across cancer and non-cancer teams. With much discussion about 'levers', refresh on the practical principles of change management might be a useful starting point.

Accepted. PHE will support the development of a new single service with an organisational development programme.

### **Recommendation 22**

- Screening QA, as it goes forward as a 'single service' should actively explore lessons from other parts of healthcare that might appropriately be adapted to QA practice, eg, total quality management, focus on care bundles.

Accepted. The new QA service will take this forward as part of the development arm of the national QA team.

## **QA core team**

### **Recommendation 23**

- It would be useful to agree and specify the key competencies of leadership in screening QA teams. These are essentially similar in cancer and non-cancer, but distributed differently across non-cancer regional QA leads and cancer QA directors; non-cancer external QA leads and cancer professional leads.

Accepted and under way. This has been considered through the development of the new team structures and new posts have been developed to reflect the leadership competencies required.

### **Recommendation 24**

- Business planning support and administration are critical in both systems, although demands are different and changed through transition. It will be important to tailor sufficient support to emerging team, operational frameworks based on best practice, and realistic workload assumptions.
- It will be important to model use of RQAL and QA lead time to ensure that adequate and effective ongoing input and support is possible across the geography.

Accepted and under way. This is reflected in the development of the new operating model and team structure.

## Risk management

### Recommendation 25

- Screening QA should have its own formalised risk assessment and management protocol(s):
  - a broadly standardised assessment process agreed across the programmes would link to a generic operational framework
  - this would be built on the triangulation of multiple inputs, including hard and soft intelligence
  - QA risk assessments would be shared with NHS England, and shared intelligence would form part of the triangulation
  - team work plans would demonstrably be connected to risk assessments

Accepted. This approach will be reflected in the new operating model.

## Multidisciplinary visits

### Recommendation 26

- Agree standard guidance on management of visits, with fixed and (programme) variable components:
    - model desk review for visit preparation
    - organisation, preparation and conduct
    - standards for content and quality of the report and recommendations
    - all recommendations to be based on statutory guidance and standards
    - quality of feedback, based on change management principles
    - formal follow up on action plan, agreed with local SIL and programme board (who and how)
- For each programme type, there is the potential for 'variable' sections to 'spec up' based on best practice.

Accepted. This will form part of the operating procedures to be developed once the new service is operational.

## Incident/risk management and failsafe

### Recommendation 27

- Standard guidelines for incident management are already in development, and consulted upon. While capturing useful commonality between guidance to QA and NHS England screening teams, the guidance should not discourage systematic recognition of potential/near miss incidents by QA teams.
- Guidance on upward reporting/escalation/sign-off and communications should be standardised, however, to allow oversight on a like-for-like basis.

Accepted. This will form part of the operating procedures once the new service is operational.

### Recommendation 28

- Attention to failsafe issues should extend consistently across the full pathway, starting with eligibility and inequality of uptake, and extending to verification of health outcomes, and user experience.

Further consideration required. This is currently being considered for future implementation but is reflected within the pathways work currently under way for the operating model.

### Recommendation 29

- More unanimity and sharing of experience on incident management across screening QA programmes could be used to improve the potential to identify ways of 'designing out' recurring problems.

Accepted. This approach will be supported by a single QA service. The national QA team will be responsible for ensuring there is a systematic process for sharing learning across QA.

## Networks and education

### Recommendation 30

- It is important that all QA programmes are funded appropriately to continue their professional networking and multidisciplinary educational programmes.

Further consideration required. The importance of professional networking and multidisciplinary education programmes is acknowledged. However, PHE will need to take account of value-for-money and consideration given to the frequency and method of delivery of these programmes.

### **Recommendation 31**

- In particular, the value and impact of regular joint meetings run by each of the professional leads in cancer screening QA teams seems clear. These aim to support consistency in safe and effective delivery by ensuring that everyone is kept informed of developments and learning at the same time, and that there is the opportunity for benchmarking and sharing concerns and experience. They also provide an iterative direct link with national structures. These appear to be a strength of the current system, and it is recommended that they are continued, accepting that there may be some resource efficiencies in their conduct in some areas.

**Further consideration required.** The importance of links into national structures is acknowledged alongside recognising the value of everyone being informed of developments, benchmarking and sharing concerns and experience. However, when reviewing the approach to doing this, PHE will need to take account of value-for-money and how similar functions are delivered in other disciplines.

### **Recommendation 32**

- Attempting to dismantle this system on the grounds of cost is likely to be damaging to the levels of engagement and performance of professional/technical groups, who have come to appreciate the level of support and professional leadership it provides. However, it may be possible to use experience across the regions to rationalise the frequency and organisation of meetings to best balance cost and effect.

**Accepted.** PHE agrees that it should be possible to rationalise the frequency and number of national meetings and that the funding of these should be put on to a similar footing to other expert groups where the members of the group are reimbursed for their time.



## QA and programme development

### Recommendation 33

- That the different national mechanisms whereby cancer and non-cancer screening works with programmes to generate new developments, and changes to standards, guidelines and KPIs, is clarified and made transparent.
  - that a final common decision making pathway for both systems is established whereby significant proposed changes, eg, to standards, KPIs, technology and techniques are approved through NSC/NO/PHE
  - that where necessary the process to negotiate changes and their resourcing with NHS England is also clarified
  - this may involve clarification of a negotiating annual cycle revolving around the 7a specification 'refresh', which teams may regard as helpful

Accepted. This area of work will form part of the ways of working once the single QA service is implemented.

### Recommendation 34

- That within this process (see Recommendation 33) there is a clear scheme of delegation, common to all screening programmes, indicating the level of proposed change not requiring the above level of sanction.

Accepted. This area of work will form part of the ways of working once the single QA service is implemented.

## Organisational governance

### Recommendation 35

- The bringing together of QADs and RQALs as an integration group with a national QA integration lead is perceived to be an excellent move, and already appears to be having psychological and practical benefits. There would be benefit in capitalising on this by producing a simple, conceptual organisational chart, emphasising more balance between cancer and non-cancer systems. Without too much detail, with a common style, branding and logo (within PHE guidelines), this could show:
  - balance under the umbrella of national screening committee and PHE leadership
  - through this, linkage with tripartite arrangements with DH and NHS England
  - team relationships with their relevant programme development
  - system linkage through QA executive group

Accepted. A new organisational structure will be developed as part of the translation of the QA operating model.

**Recommendation 36**

- The process towards achieving this would need to clarify some inter-relationships, particularly those involving national office (cancer screening and prevention) and the differential ongoing management of the operationalisation of non-cancer programmes by the national screening committee.

Accepted. This will be developed as part of the operating model and new team structure.

**Recommendation 37**

- There needs to be a unified strategy and system of internal and external communications to ensure that information is received evenly across the components of screening QA organisation.

Accepted. This will be achieved through the development of the single QA service and operating models supported by standing operating procedures.

**Recommendation 38**

- Stakeholder mapping is needed, to pinpoint internal teams with whom screening QA has important links, eg, KIT, communications, and raise awareness within QA teams.

Accepted. This area of work will form part of the ways of working once the single QA service is implemented.

## Population responsibilities

**Recommendation 39**

- There would appear to be a need to strengthen screening QA focus on uptake/coverage, equity of uptake and outcome and distribution of benefit/harm.

Accepted. This will be reflected in the new operating model.

**Recommendation 40**

- PHE 'owns' screening operationalisation, as a population health measure. It should be well placed to provide a focus for evidence collation, appraisal and guidance on addressing uptake. This could then provide the basis of practical constructive support and advice for QA teams (and SITs) as well as to other, relevant population health programmes.

Accepted. This recommendation will be discussed as a separate piece of work with the national programme teams.

#### **Recommendation 41**

- In conjunction with Recommendation 40, there would then be benefit in creating, as an outlet for the collated expertise, a professional co-ordinating group for improving uptake and pathway completion, alongside other professional lead/programme advisory groups developed for different components of the pathways. In similar ways, this would provide a strong link between national leadership/policy and local implementation.

Further consideration required. This proposal is being reviewed alongside the overall review of national advisory and expert groups that support screening programme development.

#### **Recommendation 42**

- The possible roles and responsibilities of key players for screening programme elements that are not directly commissioned as NHS (eg, LA/PH; HWB; HPC), and so not covered by the 7a specifications, need to be clarified in principle. This might be issued as complementary guidance to the 7a specification enabling screening. Among other benefits, this would help clarify the role of screening QA outside the parameters of the current specification.
- PHE could facilitate 'internal' discussions involving its employed screening QA, PHE-Cs and public health staff in (NHS England embedded) screening and immunisation teams to:
  - identify and strengthen appropriate roles and relationships. (See also Recommendation )
  - provide equal access to appropriate evidential and guidance materials
- This would enable more coherent joint-working, and a greater consistency of communications in support of local inputs, to increase local benefits from screening programmes.

Accepted, in principle. This recommendation will need to be considered by the national screening programme board and the national tripartite group, as it would require the interpretation of section 7a specifications. PHE will however consult on the operating model to capture roles and responsibilities and ensure that these are covered within the final document.