Screening programmes across Cheshire and Merseyside primary care trusts

David Neary and Mary Lyons
Centre for Public Health, Liverpool John Moores University
SCREENING PROGRAMMES ACROSS CHESHIRE AND MERSEYSIDE PRIMARY CARE TRUSTS

NOVEMBER 2009

DAVID NEARY
MARY LYONS

CENTRE FOR PUBLIC HEALTH,

LIVERPOOL JOHN MOORES UNIVERSITY
Acknowledgements

We would like to thank all the PCT screening leads and commissioners and other staff who generously gave their time to talk with us and provided valuable guidance and direction.

We would also like to thank all the many programme leads, mainly based in the community or in hospital trusts who also provided considerable time to assist with our enquiries.

Thanks also go to Marie Coughlin from ChaMPs, Helen Lowey from NHS Wirral, Keith Osborn, Conan Leavey and other staff at the Centre for Public Health, Liverpool John Moores University for guidance and support.
EXECUTIVE SUMMARY

INTRODUCTION

The burden of ill health experienced by the population of Cheshire and Merseyside continues to shift towards chronic conditions such as heart disease and cancers that cause considerable disability as well as death. Many of these lifestyle related diseases have a long latency period, during which time the disease is developing, but there are as yet no clinical signs or symptoms.

Screening for a disease involves applying a test to the population at risk, in an attempt to detect those at increased risk of developing the disease. Screening is not diagnostic, and people who receive a positive result on a screening test are offered further evaluation or diagnostic investigations.

An implicit assumption associated with screening is that early detection before the development of symptoms will lead to better health outcomes, with reduced disability or lowered mortality; but the risks and costs associated with screening and the further diagnostic tests involved must be carefully weighed against the benefits. For example, a recent review of cervical cancer screening has determined that the age for initial cervical screening will remain at 25 years, and that to screen at an earlier age does more harm than good (DH 2009).

The number of screening programmes implemented across the North West is high and growing. Many of the national programmes that have been running for decades have quality assurance guidelines and continuous monitoring in place. However, similar guidelines and monitoring are not in place for other programmes.

For screening to be successful, programmes need to achieve high standards in relation to coverage and processes. Quality assurance systems offer guidance on how standards can best be monitored, and what data need to be collected to provide evidence of good practice. Ideally quality assurance systems should be developed before any screening is launched, so that the data needed to monitor and evaluate the programme are collected from the start. Monitoring systems are only effective if they are well managed and pick up any issues so that following intervention they can provide evidence to demonstrate improvement. Standards will only improve if appropriate resources are provided to tackle any problems uncovered.
SCREENING SAVES LIVES AND IMPROVES QUALITY OF LIFE

- Since the introduction of the NHS breast screening programme in 1988 some five million women have been screened, more than 100,000 breast cancers detected and an estimated 1,400 lives per year saved due to screening (NHS cancer screening programmes, 2008a).
- Since the introduction of the NHS cervical screening programme in 1988 there have been 64 million screenings, with 400,000 significant abnormalities detected and an estimated 4,500 lives per year saved due to screening (NHS cancer screening programmes 2008a).
- For every 400 women regularly screened by the NHS breast screening programme over a ten year period, one woman fewer will die from breast cancer than would have died without screening. Among women who are routinely screened and diagnosed with breast cancer, one in eight women would not have had their breast cancer diagnosed if they had not gone for screening. Since screening detects breast cancer earlier than it otherwise would have been found, one in eight women with breast cancer is spared the need for a mastectomy; and one in eight fewer women will die from breast cancer than would have died had they not been screened (NHS cancer screening programmes 2006).
- About one in 20 people in the UK will develop bowel cancer during their lifetime making it the third most common cancer in the UK. It is the second leading cause of cancer deaths with over 16,000 people dying from it each year. Regular bowel cancer screening has been shown to reduce the risk of dying from bowel cancer by 16 percent (NHS cancer screening programmes 2009).
- Diabetic retinopathy is the leading cause of blindness for people of working age in the UK. People with diabetes are up to 20 times more likely to go blind than people without diabetes. There are at least 2.3 million people with diabetes in the UK (Diabetes UK 2008).
- The NHS Health Check for cardiovascular risk will identify people in the 40-74 age group at heightened risk of a range of conditions including heart disease, the leading cause of death in the UK, as well as stroke, diabetes and kidney disease. It is estimated that the Health Checks could potentially save up to 2,000 lives per year and prevent 9,500 heart attacks and strokes. It should also detect at least 25,000 cases of diabetes or kidney disease earlier and thus allow individuals to better manage their condition and improve their quality of life (DH 2008).
SCREENING

The eight primary care trusts (PCTs) in Cheshire and Merseyside commission screening programmes that save lives and improve the quality of life for thousands of people every year. These programmes target people across the whole lifespan and range from antenatal and newborn programmes at the start of life to breast cancer screening for middle aged women and Health Checks for cardiovascular risk for those in their seventies. Given the range of screening programmes on offer, the diversity of the sub-region stretching from relatively rural eastern Cheshire through to urban Merseyside and the heterogeneous nature of the PCTs involved, it is not surprising to find that there is a complex web of activities and responsibilities that this report seeks to capture and summarise. Interviews with public health screening leads, commissioners and providers have provided a wealth of information about screening programmes across the sub-region and the associated database of contacts that accompanies this report provides contact details for people involved with screening across Cheshire and Merseyside.

The roles and responsibilities of public health staff with responsibility for screening programmes vary across the PCTs but the established screening programmes for breast and cervical cancer are always at the core of their work. The breast screening programme is currently undergoing an age extension and a transition to digital mammography that is providing a series of challenges across the sub-region. The cervical screening programme has had several years of declining coverage rates but with the death of Jade Goody in March 2009 there has been an increase in demand that has put some strain on the laboratory system. Both programmes have established quality assurance processes that operate well but there are longstanding concerns about inequalities in uptake that have been addressed through a variety of awareness and social marketing approaches.

The bowel cancer screening programme, the most recently introduced, has also experienced marked inequalities in uptake between and within PCTs. The process of calling people by age rather than by area has made it difficult to geographically target initiatives to address these inequalities. The quality of data from the hub at Rugby was poor but has improved recently making it more feasible to actively manage the programme in the future when it is decentralised to the PCTs; although the financial ramifications of this transfer are uncertain. The quality assurance process for this programme is under development but at the moment is not as well structured as the breast or cervical screening programmes.

PCT based public health staff have very little input into the range of antenatal and newborn screening programmes. These programmes tend to be grouped together and viewed by public health professionals as routine elements of maternity care, and primarily the responsibility of obstetricians. Consequently while there are some concerns about the availability of the most suitable screening test for Down’s syndrome, the general view is that these programmes operate satisfactorily and can largely, be left to look after themselves.
unless there is a change in their routine operation. The support and opportunities for net-
working that used to be provided by regional co-ordinators in the specialist commissioning
team was highly valued and most practitioners would like to see this service restored in
some way or other.

The organisational responsibility and operational effectiveness of the diabetic retinopathy
programme is somewhat variable and there are serious concerns about the developing
quality assurance process being repetitious and too bureaucratic. Staff in some PCTs feel
that it has required an unreasonable level of operational involvement from the public health
consultant. To promote efficiency, PCTs are advised to work together and offer the service
across a sufficiently large population. Where this has happened, joint working with other
PCTs is generally considered satisfactory; although the programme that is run across a
three PCT footprint is currently undergoing a turnaround programme after a quality
assurance visit.

The NHS Health Checks programme for determining cardiovascular disease risk is a major
initiative covering 40-74 year olds. It has the potential to save many lives and improve the
quality of life for even more. The programme assesses each individual’s risk of developing a
cardiovascular condition and provides advice and support to undertake lifestyle changes that
could significantly improve that person’s health and life chances.

There are many lessons to be learned from organisations that have already implemented
Health Checks around the country. Their experience highlights the importance of clinical
engagement from general practitioners and having the capacity to deliver stop smoking,
weight management and physical activity services on a sufficiently large scale, as well as the
absolute necessity of setting up appropriate IT systems. There is considerable variation in
the implementation of Health Checks across the sub-region with some PCTs having
established and well funded programmes whereas others have yet to roll out the programme
and are facing considerable resource constraints. The usual method of implementation is to
have a locally enhanced service with general practitioners, supplemented by the provision of
screening in the community, although there is an alternative system operating in Warrington
that has opted for using the out of hours polyclinic to systematically call people from across
the whole PCT. It is clear that all PCTs will need to make a step change in the scale of
provision in order to screen all of the people in the target age range over the next five years.

**ChaMPs**

Most screening programmes appear to be working well across Cheshire and Merseyside but
more lives could be saved and the quality of life improved if more people could be
persuaded to participate. Championing screening and supporting PCTs in their
commissioning through facilitating the sharing good practice and the experiences of
collaborative working should be at the core of the work for the ChaMPs screening lead.
Whenever there are changes in screening practices, such as the age extension for breast
screening, or the introduction of abdominal aortic aneurysm screening, there are challenges
that need to be met and the ChaMPs screening lead can play an important role in assisting
and supporting PCTs. Identifying and focusing on a number of key issues such as health
promotion and social marketing for screening or assisting in making the case for the
introduction of the most appropriate Down’s syndrome test while working with public health
screening leads and commissioners would seem to be the most productive role.
The NHS in England offers a wide variety of screening programmes ranging from antenatal screening through to programmes for newborn infants as well as Health Checks and breast screening for people in their seventies. The full range of screening and early detection programmes referred to in this review includes the following:

**ANTENATAL SCREENING PROGRAMMES**
- NHS fetal anomaly screening programme
- NHS infectious and non infectious diseases in pregnancy screening programme
- NHS sickle cell and thalassaemia screening programme

**NEWBORN SCREENING PROGRAMMES**
- NHS newborn and infant physical examination screening programme
- NHS newborn blood spot screening programme
- NHS newborn hearing screening programme

**YOUNG PERSON/ADULT**
- National screening programme for diabetic retinopathy
- National chlamydia screening programme
- NHS cervical screening programme
- NHS Health Check for vascular risk
- NHS breast screening programme
- NHS bowel cancer screening programme
- NHS abdominal aortic aneurysm (AAA) screening programme

Some of these programmes, such as chlamydia screening and the NHS Health Check (for vascular risk) are not UK National Screening Committee approved systematic population screening programmes, but are included here because of their clear links to these schemes.
BACKGROUND

Disease screening is regarded as ill health prevention and accountability for programmes falls under the director of public health who delegates responsibility to a nominated screening lead, usually a public health specialist in each primary care trust (PCT). Longstanding cancer screening programmes undoubtedly receive most attention, whilst the newer programmes as well as the antenatal and newborn screening programmes are largely overlooked by busy public health staff.

The regional director of public health asked for an analysis of the current situation to inform future strategic development of the screening programmes and of their quality assurance systems. In addition, the Cheshire and Merseyside directors of public health asked for a more specific situation analysis in the sub-region. A new post was created in the Cheshire and Merseyside public health network to support screening across the area. This study was commissioned to assist with the sub-regional analysis, and to provide recommendations to guide the work of the new post holder.

The Centre for Public Health at Liverpool John Moores University was commissioned to undertake the work, and a service level agreement was drawn up to guide the review.

METHODOLOGY

A team of experienced researchers interviewed the screening leads and commissioners of public health screening programmes in each PCT. Those responsible for antenatal and newborn screening programmes who sit outside the PCT in hospitals and the community were also surveyed. Staff with responsibility for the governance of the various groups that support screening programmes such as the cancer networks were also interviewed to gain a full picture of the situation. Throughout, the emphasis has been on exploring and analysing the responsibility of the PCT. Laboratory services have their own clear quality assurance procedures in place, but these are outside the scope of this study and have not been considered here. This review has concentrated on those programmes that are actively managed by the PCT.

The information gathered from all these various sources was synthesised to produce this report and the recommendations.

It may be worth mentioning that responsibility for screening across the Cheshire and Merseyside PCTs is complex and resembles a web rather than a series of linear relationships. There are undoubted benefits to developing services to meet local needs, but the corollary of this is that the diversity of systems that ensues makes it difficult to understand the web of responsibilities, and subsequently to share and learn from good practice.
GENERAL OVERVIEW

There is wide variation in responsibilities, structures and processes in relation to screening programmes across the eight PCTs in Cheshire and Merseyside. This is to be expected given the differences in organisational history, priorities, capacities and personnel in a group of PCTs that covers a diverse population of more than two million people ranging from rural eastern Cheshire to urban Merseyside. There are similarities and differences in how responsibilities for screening programmes operate at both a strategic and operational level and produce a complex and variable picture that reflects this diversity across the sub-region.

It is commonplace for the three major screening programmes covering breast, cervical and bowel cancer to be grouped together and to be regarded as a core part of the responsibility of the public health team. Within these three cancer detection programmes, the most recently introduced programme of bowel screening is viewed in a different light compared to the well-established breast and cervical screening programmes that are commissioned by the PCTs and involve cyclical quality assurance processes. The particular issues relating to each of the three major cancer screening programmes will be discussed in more detail later in the report.

Similarly, it is usual for the variety of antenatal and newborn screening programmes to be bundled together and viewed by public health professionals as something over which they have limited input and influence because they are an integral part of the maternity care pathway. The extent to which a public health professional could provide strategic oversight and be involved in actively managing these programmes is generally considered to be much more limited compared to the cancer screening programmes.

There are important differences in the range of screening programmes covered by public health screening leads and the amount of time they are able to spend on this area of their work. Some public health screening leads are responsible for all screening programmes and spend more than a day per week on average on this area of their work. In other PCTs, different patterns of responsibility are apparent and staff are able to spend far less time working on monitoring and advising on screening programmes. The director of public health (DPH) has responsibility for screening and the work associated with the various services is delegated to public health staff who work in partnership with colleagues in the commissioning arm of the PCT. The most notable exception to this general rule is Liverpool PCT where the aim is to move beyond this traditional approach by making screening a corporate responsibility that belongs with the appropriate care pathway. The potential tensions and challenges in local implementation through the traditional channel of the director of public health, who lacks the mechanisms to exercise accountability even though they are formally responsible for screening programmes, rather than through the developing world class commissioning route are acknowledged by other public health professionals.
There are also differences in the level of involvement with the launch of vascular Health Checks and also in relation to the operation of the diabetic retinopathy programme with some public health professionals being (too) heavily involved with operational issues while others have only peripheral involvement. Widely differing views on the importance of screening; the role of quality assurance processes; the value of collaborative support networks and the need for additional support in relation to this area of work are apparent among those working in this area.

There is a complex picture in relation to screening programmes across the eight PCTs in Cheshire and Merseyside that reflects a complicated pattern of responsibilities, structures and processes.
BREAST SCREENING

The breast screening programmes across the PCTs in Cheshire and Merseyside face a number of issues, both general and specific, that will need to be addressed in the next few years;

- the implementation of the age extension announced in the Cancer Reform Strategy in December 2007 to cover women from 47 to 73 years of age
- the roll out of digital mammography that will improve the work of the breast screening programmes
- the inequalities in screening coverage between women living in the more affluent and deprived areas within PCTs

The capacity of the individual PCT’s to cope with these challenges will vary and their ability to maintain coverage levels above the national target of 70 percent is a cause for concern.

TABLE 1: NHS BREAST SCREENING PROGRAMME COVERAGE OF WOMEN AGED 53-70 BY PRIMARY CARE ORGANISATION AT 31 MARCH 2007 AND 2008

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of women (aged 53 to 70) screened, March 2007</td>
<td>Coverage (less than 3 years since last test) (%)</td>
<td>Number of women (aged 53 to 70) screened, March 2008</td>
</tr>
<tr>
<td>England</td>
<td>3,738,149</td>
<td>73.8</td>
</tr>
<tr>
<td>North West SHA</td>
<td>208,904</td>
<td>78.3</td>
</tr>
<tr>
<td>Central and Eastern Cheshire</td>
<td>40,858</td>
<td>82.3</td>
</tr>
<tr>
<td>Halton &amp; St Helens</td>
<td>23,945</td>
<td>73.3</td>
</tr>
<tr>
<td>Knowsley</td>
<td>9,373</td>
<td>66.1</td>
</tr>
<tr>
<td>Liverpool</td>
<td>27,939</td>
<td>67.8</td>
</tr>
<tr>
<td>Sefton</td>
<td>22,068</td>
<td>72.7</td>
</tr>
<tr>
<td>Warrington</td>
<td>15,407</td>
<td>77.7</td>
</tr>
<tr>
<td>Western Cheshire</td>
<td>21,090</td>
<td>78.8</td>
</tr>
<tr>
<td>Wirral</td>
<td>26,913</td>
<td>77.8</td>
</tr>
</tbody>
</table>

The breast screening coverage rate is highest in Central and Eastern Cheshire at 82 percent and lowest in Knowsley at 69 percent although according to the most recent data (March 2008) coverage has increased across all the PCTs compared to the previous year. It is interesting to note that both the coverage rate and the absolute number of women in the target population who are screened are highest in relatively affluent and rural Central and Eastern Cheshire. In contrast, the coverage rate and the total number of women screened in relatively deprived and urban Knowsley are both the lowest in the sub-region. Both PCTs have somewhat complex patterns of service delivery from local providers with breast screening for Knowsley’s population being largely provided (about 80 percent of the breast screening commissioned by Knowsley PCT) at the Liverpool breast screening unit where Liverpool PCT is the major commissioner; with the remaining 20 percent of breast screening services provided at Whiston hospital, where Warrington PCT is the major commissioner of the service. This configuration of service provision gives Knowsley PCT less scope to influence the direction of the breast screening service than other commissioners with whom they have ‘interesting conversations’ from time to time. Consequently it is felt that Knowsley’s ability to influence service provision and coverage is comparatively low, despite the positive work that the PCT has undertaken with general practitioners, women in and near to the target population and with the breast screening unit. In contrast, Central and Eastern Cheshire PCT’s breast screening service is provided by the East Cheshire NHS Trust at Macclesfield District General Hospital who also provide mobile breast screening services to women who live in areas covered by neighbouring Stockport PCT. The capacity for breast screening provision in eastern Cheshire is encouraging but even in a PCT where coverage rates are high there are concerns about how the costs of age-range expansion, estimated to be £11,000 per 1,000 eligible women, will be met when there is already a sizeable deficit projected for the PCT.

In addition to providing services to Knowsley, Liverpool’s breast screening unit also provides services to Liverpool and Sefton. Digital mammography is provided at the breast screening unit’s base at the Liverpool Women’s hospital but not by mobile units that serve this patch. The willingness of people to travel to Liverpool Women’s hospital from outlying parts of Knowsley and Sefton makes the equitable provision of accessible services particularly challenging for these PCTs. A potential solution to this problem that is under consideration in Sefton is to move from mobile units to multiple static sites, although this will be difficult to achieve because of capacity and cost issues. Similarly, there are difficult decisions to be made about introducing mobile digital mammography which will be expensive and may not be cost-effective. These are issues that the public health screening lead in Sefton will have an important advisory input into, but are ultimately a matter for commissioners in the PCT to decide.

Breast screening programmes work relatively well across the Cheshire and Merseyside PCTs. Women are invited by practice on a three yearly cycle using a system that has been in operation for more than two decades. The work of public health professionals in monitoring performance, working to improve overall coverage rates and tackling inequalities between areas is universal and continues to develop.
EXAMPLES OF WORK IN CHESHIRE AND MERSEYSIDE FOR BREAST SCREENING

- Knowsley developed a report covering the three yearly cycle of breast screening for a cluster of general practices in order to better understand patterns of participation. Although developing interventions to increase uptake is difficult given the arms-length provision of the service from primary care.
- In Halton & St. Helens women who had not attended were contacted with a questionnaire asking why they had not gone for breast screening and what could be done to encourage them to participate. There were a variety of reasons given but interestingly, when they were asked if they would now like an appointment, about half of the women who returned the questionnaire said that they would and then went on to actually follow this through and attend for screening. The simple nudge provided by the questionnaire elicited an improvement in coverage. This work was done with some 'soft money' from the PCT’s budget so a repeat of this exercise is dependent on other commitments, although it would be preferable for this sort of local activity to be part of the main contract so that it becomes a routine part of screening practice.
- Breast screening services for Wirral are provided at Clatterbridge Hospital. There were concerns about falling coverage rates caused by women having difficulty attending appointments. In response to these issues, a more flexible service that includes an easy facility to change appointments and more after working hours provision has been developed which has helped to improve coverage rates and women’s experience of the service.

Most PCTs do not have a screening co-ordinator although this role is highly valued by those public health consultants and others who work with one. Both Sefton and Knowsley have such a post that provides the link between the public health department’s strategic oversight and the day-to-day operational activities of service providers. The screening co-ordinators focus on cancer screening programmes and contribute to relieving some of the pressures on the public health consultants who have a wide range of other responsibilities. The absence of such a linking co-ordinator is particularly acknowledged in Halton & St Helens where information analysts produced excellent performance reports on cancer screening programmes, highlighting areas for improvement, but there was insufficient capacity to work with general practitioners across the patch to ‘win hearts and minds’ and ensure that best practice was implemented as widely as might have been possible otherwise.

There are interesting differences in collaborative working across PCT boundaries that highlight the diversity across Cheshire and Merseyside. Knowsley, Warrington and Halton & St. Helens from the eastern sector of the Merseyside and Cheshire cancer network have a cancer oversight group that meets about three times a year (or when it is needed) to provide a strategic public health overview of these programmes across this sizeable footprint. This arrangement arose due to historical organisational factors and the good relationships between public health professionals in the three PCTs and is considered to be a useful
forum for developing and improving the screening programmes and should continue. The other PCTs do not participate in such collaborative arrangements. Central and Eastern Cheshire belongs to both the Merseyside & Cheshire and the Greater Manchester & Cheshire cancer networks but feels it is on the geographical periphery of both for public health.

The regional quality assurance (QA) processes directed by Ellis Friedman are regarded as robust and the quality assurance visits are welcomed as part of the necessary processes needed to maintain the good performance of the breast screening programme in each PCT. However, there were occasional concerns expressed about the role of the regional quality assurance group. Sometimes the quality assurance assessors act as if they are commissioners responsible for directing operations rather than providing advice and support for good practice. At times the directions given by the regional quality assurance group were at odds with those from the commissioners who had based their decisions on a better understanding of local operational and financial constraints and do have the ultimate responsibility for monitoring services. There are obvious sensitivities around these various roles and responsibilities and therefore it is important that the ChaMPs screening lead is aware of these and works with care and understanding to support PCTs.

WHAT’S HAPPENING?
The breast screening programmes are running smoothly across Cheshire and Merseyside, and quality assurance activity is undertaken regularly. There are significant differences in coverage rates between and within PCTs.

GOOD POINTS
There are some innovative interventions being employed to increase coverage rates and reduce inequalities in uptake. Collaborative cross-PCT work around breast cancer and screening between Knowsley, Warrington and Halton & St Helens seems to be mutually beneficial.

MAJOR ISSUES
The presence of a screening co-ordinator at the PCT level is important for providing the linkage between public health professionals and commissioners, and the operational activities of service providers. Whilst it is eminently feasible for PCTs to provide screening programmes for their populations without this, there appears to be a clear advantage in having someone in this intermediate role.

There is a lack of clarity and some tension between those with responsibility for undertaking quality assurance and commissioners of services.
CERVICAL SCREENING

The cervical screening programme is well-established and generally works satisfactorily across the PCTs and the transition to liquid based cytology has been successfully completed. There are two main issues in relation to this programme:

- the decline in coverage rates over the last few years, particularly among younger women, is a long-standing concern. However, the ‘Jade effect’ has led to an increase in demand for cervical screening and has put some strain on the ability of the laboratories to process tests
- the persistent inequalities in cervical screening coverage, which along with declining coverage, have provided the impetus for considerable work including social marketing initiatives and developments to enhance local services

| TABLE 2: NHS CERVICAL SCREENING PROGRAMME COVERAGE AT 31 MARCH EACH YEAR |
|-------------------------------------------------|------------------|------------------|------------------|------------------|------------------|
| England                                         | North West SHA   | Central and Eastern Cheshire | Halton & St Helens | Knowsley         | Liverpool         |
| Eligible population (000s) 2006-07               | Coverage (<3.5 years since last adequate test) 2006-07 | Coverage (<3.5 years since last adequate test) 2006-07 | Eligible population (000s) 2007-08 | Coverage (<3.5 years since last adequate test) 2007-08 | Coverage (<5 years since last adequate test) 2007-08 |
| 13,192.9                                        | 69.4             | 79.2             | 13,305.2          | 69.0             | 78.6             |
| 1,739.5                                         | 70.4             | 79.0             | 1,751.2           | 69.4             | 78.2             |
| 114.9                                           | 77.5             | 83.2             | 114.8             | 76.0             | 82.3             |
| 77.5                                            | 73.0             | 79.4             | 77.8             | 71.5             | 78.8             |
| 38.3                                            | 66.2             | 74.5             | 38.4              | 65.4             | 74.0             |
| 115.4                                           | 60.0             | 72.3             | 116.3             | 60.7             | 71.6             |
| 66.8                                            | 66.9             | 74.4             | 67.0              | 65.5             | 73.9             |
| 50.0                                            | 77.1             | 82.9             | 50.4              | 75.4             | 82.0             |
| 60.2                                            | 75.7             | 81.6             | 61.3              | 74.5             | 80.9             |
| 79.4                                            | 70.7             | 77.9             | 79.8              | 68.9             | 77.2             |

The coverage rates for cervical screening are highest in Central and Eastern Cheshire and lowest in Liverpool reflecting the differences between relatively affluent and deprived communities in England. Interestingly, Central and Eastern Cheshire despite having the highest level of coverage also reported some information technology (IT) difficulties with the administration of the calling system which was moved to Preston following the introduction of remote management of the system during the last year. Public health leads are particularly concerned about the gradual decline in coverage that has affected all PCTs over recent years and they have seen coverage fall below the 80 percent level in most areas. The differences in coverage rates between younger women living in deprived areas compared to older women from more affluent districts are of particular concern since initial entry or non-participation into the screening programme at a young age influences a woman’s behaviour in the longer term and therefore coverage rates both now and in the future. However, the death of Jade Goody from cervical cancer has greatly increased the demand for cervical screening, particularly among younger women, and there are some concerns about the ability of the system to cope with such a significant increase in the number of women participating in the programme. So far this challenge had been met but it is acknowledged that although parts of the system, notably the laboratory service, have been put under pressure they have performed admirably. Uncertainty about the recent decision to reorganise laboratory services into larger units is causing a great deal of anxiety, particularly for staff working in smaller laboratories, some of whom now face the prospect of relocating or leaving.

Commissioners, service providers from primary care, laboratory services and other staff involved in cervical screening programmes usually meet regularly three or four times per year. These meetings are used to monitor performance and to develop ways of improving the operation of the system particularly in relation to increasing coverage levels. In addition to regular meetings, there is a system of quarterly performance management reports that go through the director of public health to the PCT’s Board. For example, in Knowsley a four page fixed format system of reports using national data and local real time data from central operations Mersey has been running for more than two years and is distributed through the screening co-ordinator to every general practice to give information on performance and on ways to improve coverage. Knowsley also worked with the third sector organisation ‘Jo’s Trust’ to develop post card sized leaflets that raise awareness of cervical screening among young women who are approaching the age for entry into the programme. By arrangement with central operations Mersey, Knowsley sends all young women a ‘soft’ post card in the month before they receive an invitation letter for cervical screening and this process seems to be having a positive impact. Knowsley has also recently targeted the 2,000 women who have missed two calls for screening with a similar one-off mail shot that has prompted at least a further 100 women to attend for screening.

Another example of work in this area is in Sefton, where the PCT is working with the Improvement Foundation by focusing on five general practices with particularly low levels of uptake. This has involved a considerable amount of work for the public health consultant and the screening co-ordinator, for example in developing screening cards so that any health professional can discuss screening issues with a patient and point them in the right direction, and again appears to be having a positive effect. This work also involves training issues for staff working with people who have learning disabilities to improve the uptake of screening in
this group. Halton and St Helens is keen to improve their cervical screening coverage in light of the fact that their local laboratory reported that 12 of the 19 women who were diagnosed with established cervical cancer in the last year had never previously attended for screening. In contrast, cervical screening appears to be a lower priority for Liverpool PCT which acknowledges that the area has low coverage rates, but staff have taken the position that there are other more pressing priorities in Liverpool and the costs of increasing participation are relatively high compared with the potential benefit in terms of years of life lost due to premature death.

The quality assurance process for cervical screening is regarded as being very good for focusing attention on areas where the programme could be improved. As part of the process, several public health consultants have worked with the regional quality assurance team visiting other PCTs. This provides consultants with an opportunity to observe good practice and later apply any new ideas to their own situation. The quality assurance process for cervical screening has both a core as well as a section that is more flexible allowing the process to accurately reflect the local situation. The cancer screening implementation group (part of the Merseyside and Cheshire cancer network) meets regularly and their work is highly commended, in particular for providing a forum for bringing people together and providing an opportunity for learning from both positive and negative experiences, across the Cheshire and Merseyside area.

**WHAT'S HAPPENING?**
The cervical screening programmes are running relatively smoothly across Cheshire and Merseyside although there are significant differences in coverage rates between and within PCTs. The decline in coverage over recent years has been arrested due to the ‘Jade effect’ and the system is coping well with the increased demand.

**GOOD POINTS**
Some novel interventions to increase coverage rates and reduce inequalities in uptake are being implemented across the area. Social marketing initiatives in Knowsley and Sefton appear to be going well, although it will be difficult to determine how effective they are and whether they should continue in the long term because of the interference caused by the Jade effect.

**MAJOR ISSUE**
The inequalities in screening coverage have proven to be persistent despite concerted efforts to reduce them. This is an area in which more work will be needed although the Jade effect has ‘turned the tide’ for cervical screening after several years of declining coverage.
BOWEL CANCER SCREENING

The most recently introduced cancer screening initiative is viewed much less sanguinely by public health professionals than the breast and cervical screening programmes. The early implementation of bowel cancer screening across Cheshire and Merseyside is causing quite a few difficulties for public health professionals in PCTs. The main challenge in relation to bowel cancer screening are:

- the decision to call people by age rather than by practice area created a ‘scattergun approach’ that produced anomalies that hindered the initial stages of the implementation of the programme
- the regional hub in Rugby did not provide full postcode data that would allow PCTs and general practitioners to actively manage initiatives to increase uptake according to population group in small geographic areas. Following encouragement by National Office, data from Rugby have improved in recent months, so that targeted social marketing campaigns are now feasible
- the acceptability of the faecal occult blood (FOB) test process to people in their sixties coupled with limited public awareness of the risks and symptoms of bowel cancer appears to contribute to the lower levels of uptake compared to other cancer screening programmes
- the considerable distances involved in travelling across Cheshire to a hospital with an accredited unit for further screening or treatment is problematic, although this situation will be relieved when the Countess of Chester is able to offer appropriate care services
- the transition of the programme to the PCTs at some point in the future is going to present a range of organisational and financial challenges that will require active collaboration across commissioning organisations

The bowel cancer screening programme produced particularly strong views from public health professionals, possibly because it has proven to be extremely frustrating for them to actively manage it in any meaningful way. Initial implementation of the programme was described as having been ‘a nightmare’ and ‘a bit semi-detached’. The quality assurance for the screening programme is still developing and is not well understood, but once fully implemented should serve to improve the performance of the whole programme. The major issues that public health professionals have with the bowel screening programme relate to the decision made centrally to call people by age rather than practice area and the lack of adequate uptake data within PCTs. Although it was accepted that a decision had to be made to call people for screening by some method, most professionals thought that calling people by age was not the best decision that could have been taken because it produced anomalies such as husbands and wives or next door neighbours being called to participate in the programme at different times.

The gradual implementation of the programme across the PCTs in Cheshire and Merseyside could have allowed a more traditional practice area based approach to be adopted that would have engaged PCTs and general practitioners more directly with the operation of the programme. Although a primary care health inequalities group was established to guide the implementation process, it is acknowledged that some of the PCTs in the initial wave of
implementation undoubtedly benefited much more from the publicity and social marketing activity that boosted their participation rates than those PCTs who began later. The PCTs that joined later could not ride this initial wave of activity and consequently are more likely to have lower coverage rates. There are social marketing activities in Knowsley, Liverpool, Sefton and Wirral that have been designed to increase uptake in the programme but it is very difficult to target these initiatives where they are needed most, because of the system of calling people by age from across the PCT.

In addition to this difficulty the lack of adequate uptake data from the hub in Rugby has greatly hampered the input that public health professionals could have made to the programme. The general view is that data from Rugby is of poor quality, although it is acknowledged that there are always difficulties setting up any new service and in recruiting appropriate personnel. Another complaint was that progress reports are not sent out often enough. Their release was even compared to the frequency of the sitting of the Preston Guild, although it was acknowledged that data from Rugby had improved in the last six months. There is undoubtedly still scope for improvement with better information needed on trends and comparisons across areas.

It was also acknowledged that the bowel screening programme is always going to be a more difficult system to operate because of the self-administered nature of the faecal occult blood test. The effort required and barriers to be overcome to produce a sample and then to send it in the post for analysis is always going to prevent a sizeable proportion of people from participating in the programme. The variation in coverage between and within areas is of concern to public health professionals because it can serve to increase health inequalities. Data issues also make it difficult to obtain an accurate picture of the patterns of uptake etc. Coverage rates range markedly from about 25 percent in some wards to nearly 60 percent in others, indicating the large variations in uptake for bowel screening that present a challenge and will be extremely difficult to change even when the PCTs take over the commissioning role in the future. A related but slightly different concern is the limited provision of accredited hospital units in Cheshire. The prospect of a cohort of older people being called to a distant hospital for a colonoscopy is fraught with difficulties as a proportion may well have to travel long distances and undoubtedly as a result may decline the offer. Any delay in diagnosis leads to more invasive and less successful treatment regimes for those individuals, and could reduce the apparent effectiveness of the programme.

The developing system of quality assurance for the programme is poorly thought out with those involved suggesting that there is too much attention on clinical performance indicators and too little on public health considerations. A quality assurance process can have clear benefits in focusing attention on processes and systems within the programmes that should as a consequence then evolve and improve more rapidly. The existing system of feeding views through the Merseyside and Cheshire group to the national level is not thought to be a particularly effective way of working by some public health practitioners, especially when compared to the manner in which other good quality assurance systems could and should work.

The decentralisation of bowel screening to the PCTs in the future is also going to provide a major challenge to the operation of the programme. The original Cheshire and Merseyside screening centre covering a population of about 2.3 million people was considered too large to be managed as a single unit by the NHS Cancer Screening Programmes. Consequently,
a division along county lines has been introduced producing a larger population footprint for urban and densely populated Merseyside and a smaller population for the more rural and sparsely populated county of Cheshire. This division required the speedy establishment of services at Leighton which is problematic given the distances involved in travelling there from outlying parts of the county, although these problems should be reduced when the Countess of Chester Hospital is accredited to provide appropriate services. The lack of consultation about the decision and the speed of the division of the service was not appreciated by public health professionals in Cheshire.

The decentralisation of commissioning to the PCTs is in the planning phase, but what that will involve, particularly in relation to resources, is not yet clear. The position of public health practitioners who took a view was that given the system appears to be operating reasonably well, it would probably be wise to try and make Rugby work more effectively rather than ‘reinvent the wheel’ with a hub that is geographically located within one or other of the local counties.

**WHAT'S HAPPENING?**
The bowel cancer screening programme is operating generally satisfactorily from the perspective of public health screening leads although there are large inequalities in coverage rates between and within PCTs that need to be addressed.

**GOOD POINTS**
The programme is contributing to saving lives by identifying cancers earlier than they would otherwise have been diagnosed. The performance of the hub in Rugby in providing data to the PCTs has improved in the last six to twelve months although it is still not performing optimally.

**MAJOR ISSUES**
The decentralisation of commissioning to the PCTs will pose major challenges for the organisation and operation of the programme. There are inequalities in screening coverage between and within PCTs that are already established and are likely to present a major challenge to tackle in the future.
ANTENATAL AND NEWBORN SCREENING

This section relates to the following programmes:

ANTENATAL SCREENING PROGRAMMES
- NHS fetal anomaly screening programme, including screening for Down's syndrome, and spina bifida
- NHS infectious and non-infectious diseases in pregnancy screening programme. These programmes are primarily designed to pick up health issues in the mother that might affect the developing fetus and include screening for anaemia as well as a range of infectious diseases such as syphilis, HIV, hepatitis B, and rubella susceptibility
- NHS sickle cell and thalassaemia screening programme

NEWBORN SCREENING PROGRAMMES
- NHS newborn and infant physical examination screening programme
- NHS newborn blood spot screening programme for several serious but rare conditions such as phenylketonuria, hypothyroidism, cystic fibrosis, sickle cell disease
- NHS newborn hearing screening programme. Although this can be considered part of the newborn physical exam, it is often managed differently and regarded as a separate programme.

ORGANISATION

There are some organisational differences in responsibility for antenatal and newborn screening programmes across the PCTs. In most PCTs the consultant or specialist nominated as screening lead also has responsibility for providing public health input into this set of screening programmes, but in Knowsley and Liverpool they are dealt with separately from cancer and other screening programmes. The main issues in relation to antenatal and newborn screening programmes are:

- there is much less active public health involvement with these programmes because they tend to be grouped together, rather than being seen as separate entities, and they are regarded as being part of routine maternity care
- public health professionals are largely content to leave these programmes to 'look after themselves' because they are perceived to be operating satisfactorily. The public health role is to influence and inform commissioners, to help them to improve their relationships with service providers and to react to any incidents that affect the operation of the programme
- the advisory and supportive role previously provided through the specialist commissioning unit at the regional level is missed
Figure 1. Antenatal and Newborn Screening Opportunities

- **Pre-conception**: Commence folic acid
- **Antenatal**
  - Blood for haemoglobin, group, rhesus & antibodies, as early as possible, or as soon as a woman arrives for care, including labour
  - Blood for Sickle Cell & Thalassaemia
  - Blood for early Down’s syndrome test
  - Blood for later Down’s syndrome test
  - Repeat haemoglobin & antibodies
  - Blood for syphilis, Hepatitis B, HIV & Rubella immunity as early as possible, or as soon as a woman arrives for care, including labour

- **Newborn**
  - Physical Examination by 72 hours
  - Physical Examination by 6 weeks
  - Newborn Blood spot
  - Newborn Hearing Screen

Source: Screening tests for you and your baby, UK National Screening Committee, 2008
THE COMPLEXITY OF ANTENATAL AND NEWBORN SCREENING PROGRAMMES

The screening tests conducted or offered during the antenatal and newborn period take place during a time when women are, or should be, experiencing intensive contact with health service providers. This makes antenatal and newborn screening programmes somewhat different in nature to cancer screening programmes that are based on intermittent contact with people. Figure 1 shows the optimal time for screening tests during the course of pregnancy and after the birth of a child indicating the range of services involved in the provision of screening in maternity care pathways. That PCTs are likely to have contracts with several acute trusts, which may well then sub-contract with other service providers serves to increase the level of complexity in the commissioning and provision of antenatal and newborn screening services. Such complexity makes the active management of such programmes particularly challenging for public health professionals and commissioners.

Public health professionals generally have far less input into antenatal and newborn screening than they do with other programmes. This is partly because they are viewed as being a routine part of maternity care and come under the auspices of obstetricians and other clinicians working in practice. There is also a general reluctance to commit too much time to programmes that are deemed to be operating satisfactorily. As one public health professional said: “You can’t have a meeting every week or be looking over people’s shoulders. Once you’ve set up a programme and agreed that this is how it’s going to be monitored then you expect people to behave like responsible adults.”

In contrast to cancer screening programmes where there are invariably established and detailed processes for monitoring performance and quality including concerns about equitable coverage, there are relatively few instances when public health professionals reported being pro-actively involved with these programmes. As one public health screening lead commented: “If we knew in depth for each of these screening programmes what we know about the three cancer programmes then I’d feel much more confident about talking to people about them but we lump them together because they’re too big and it overwhelms you.” Consequently, public health input into antenatal and newborn screening programmes is often reactive and occasional. To overcome these barriers, in this case, would require a considerable organisational shift in public health attention and probably additional resources at the PCT level which is unlikely to happen given the financial and other pressures faced by many public health departments. Although there will always be concerns about the relative performance of some maternity units compared to others, there is a very strong sense that these programmes are working well. This may be a correct perception or a misapprehension coming from the lack of any thorough quality assurance process that might highlight shortcomings.

The major role that public health practitioners assume is to inform and influence commissioners by keeping them up to date with the periodic changes in testing procedures or the requirements of the laboratory service to process results. For example, developments in Down’s syndrome testing were mentioned as an issue that was of concern because of an inability of acute trusts to provide the best available test and the requirement for laboratories to process larger numbers of tests. The rationalisation of the laboratory service in pursuit of economies of scale was acknowledged as causing some local disruption to the operation of some services. For example, Warrington was well served by a laboratory that processed a smaller number of tests than was deemed likely to lead to good performance and so now
have Down’s syndrome blood test samples sent to Liverpool for processing at a greater financial cost and involving a process which is more difficult to monitor. There are minor concerns about the performance of some service providers and around data collection needed to ensure that outcomes and transitions through a care pathway can be easily quantified and measured but these are more than balanced by positive views of the good work of the maternity care staff in relation to screening provision and confidence that systems are working well. Since pregnant women tend to be in regular contact with services, issues about follow up are perceived to be easier than for programmes where an individual comes in for a specific test and is not likely to return unless a positive result ensues and this is followed up.

Nationally there has been a trend in recent years towards actively managing screening programmes and this has led to the extension of slightly more formal quality assurance processes into antenatal and newborn screening programmes. However, none are fully developed nor as well-established as those for breast and cervical cancer screening programmes. The leads responsible for each programme area feel strongly that their screening services are working well, but few can provide evidence to support this.

Information about audit type assessments can be found on the newly formed UK national screening portal web hub, where there is a section dedicated to these programmes. The process for auditing Down’s syndrome screening is the best developed, and could easily be used to create a good quality assurance programme. There are also clear standards for the thalassaemia and haemophilia screening programmes that with very little effort could be developed into proper quality assurance systems. However, there is considerable variation in the way audits and evaluations are being implemented and although some programme leads are using them to monitor, assess and improve their own services; there are no clear expectations, nor performance management systems in place to ensure consistency. There is no compulsion to use these tools and nobody is called to task if they do not.

Public health professionals take a positive view of risk management and quality assurance processes in the newborn hearing screening programme and suggest that where visits have taken place, they have really helped to focus practitioners minds on the operation of the system and have positively demonstrated that it is working well. This positive affirmation of the quality of provision stands in contrast to the view that these programmes must be operating satisfactorily because there are no children reaching school age who are unable to hear, speak or interact, which is acknowledged as a somewhat unsatisfactory default indicator that developmental problems are being picked up by screening. There are also some steps towards more active management of these programmes, with Central and Eastern Cheshire PCT having a commitment to change commissioned health visitor work in a way that will lead to the development of capacity to implement and actively manage developing quality assurance programmes across newborn screening programmes.

The current staffing problems have resulted in a lack of leadership, and inadequate provision of advice and support for these programmes and are a major concern mentioned by several respondents. This role used to be provided by regional co-ordinators in the specialist commissioning team at the Strategic Health Authority. There is currently a temporary administrator holding the fort. Although this individual is doing well and forwards information on to programme leads and even organised a successful regional forum to explore programme issues, it is not adequate. Given that there is a slight reluctance for public health
departments to become involved with the operation of these programmes, the absence of advice and support from the regional co-ordinators is something that both public health staff and practitioners themselves feel needs to be addressed. For example, support on Down's syndrome screening from the Strategic Health Authority is being actively sought across the North Merseyside footprint of Sefton, Liverpool, Knowsley and St. Helens because staff realise that there are deficiencies with the current arrangements. Similarly, plans to establish a North Mersey maternity commissioning group potentially provide a forum for antenatal and newborn screening issues to be part of the agenda when they need to be discussed.

**WHAT'S HAPPENING?**
Ante-natal and newborn screening programmes are generally perceived by public health screening leads and commissioners to be operating satisfactorily across Cheshire and Merseyside although there are some minor concerns. There is no hard evidence to support this view. There is very little and highly inconsistent active management of these screening programmes because many are seen as being a routine part of maternity care.

**GOOD POINTS**
There have been very few problems with the routine operation of these screening programmes and there are well-established maternity care pathways across Cheshire and Merseyside. This robust performance has continued despite the re-organisation of the laboratory service across the region that has required some changes to practice.

**MAJOR ISSUES**
The complexity and diversity of screening programmes makes active involvement by public health screening leads, who have a range of other responsibilities, problematic. The advice and support from the specialist commissioning team was highly valued but changes in personnel and uncertainty over continuing funding for these posts is an issue of concern among staff in provider units as well as PCTs.
DIABETIC RETINOPATHY

The diabetic retinopathy screening programme in England is offered to more than two million people over the age of 11 who have diabetes in order to reduce their risk of sight loss caused by damage to the blood vessels in the retina. In 2007-08, nearly 1.7 million people with diabetes were offered screening that would detect diabetic retinopathy at an early and treatable stage (Gloucestershire Hospitals NHS Trust and Department of Health 2008). The structures of responsibility for diabetic retinopathy vary across the PCTs in Cheshire and Merseyside and there are important challenges facing this screening programme.

- a quality assurance visit identified shortcomings in the programme covering Halton & St Helens, Knowsley and Warrington that necessitated the introduction of a turnaround programme and makes forthcoming visits to other PCTs a cause for concern
- the quality assurance process, although recognised as necessary for the operation of the programme, is considered to be somewhat repetitious and onerous

The diabetic retinopathy programme is a particularly significant issue in Halton & St Helens which acts as the lead commissioner for Knowsley and Warrington PCTs; and Sefton, which shares the operation of this screening programme with West Lancashire. The programme led by Halton & St Helens has experienced operational difficulties with diabetic retinopathy due to a number of factors. The screening programme and associated care pathway is moving towards being an integrated system but problems have arisen because of the lack of a programme lead until recently. There are continuing difficulties with incompatible IT systems. South Sefton and Ormskirk both operate the nationally used IT system whereas Southport does not, and this makes it impossible to extract meaningful data to actively manage the programme. With a quality assurance visit for the programme on the horizon, the PCT has recently recruited a part-time programme lead working two days a week to provide operational leadership and establish a programme board to provide strategic guidance. These developments should take some of the pressure off the responsible public health consultant who has been committing too much time to this programme. The changes that have now been put in place will eventually lead to rationalisation of the IT system and enable the production of performance monitoring reports that will go some way to satisfying the requirements of quality assurance inspections.

Halton & St Helens is the lead commissioner for both Knowsley and Warrington PCTs as well as itself. The combined population of about 700,000 people makes it a suitable size for an integrated screening and treatment programme. Along with other PCT’s around the country that have undergone a quality assurance visit, the programme was found wanting although the shortcomings were not sufficiently serious to warrant closure. The main failing of the screening programme is the lack of an ability to demonstrate the accurate and consistent grading of retinal photographs and this has prompted the introduction of a turnaround programme chaired by Dr. Daniel Seddon. This has begun to make changes to the operation of the programme including a focus on developing activity dashboards to provide an early warning system of any potential problems. There is confidence across the
three PCTs that the turnaround programme is bringing about changes that will lead to an improved service.

The diabetic retinopathy programme appears to be somewhat more peripheral to the public health concerns of screening programmes and it was noticeably more difficult to identify who was responsible for this programme within each PCT. It was common for the public health screening lead to either not be responsible for the diabetic retinopathy programme or to have only a perception of it functioning satisfactorily and therefore for it not to require their attention.
THE NHS HEALTH CHECK FOR VASCULAR RISK

The introduction of the NHS Health Check to assess the risk of people developing heart disease, stroke, diabetes, and kidney disease is an important step in preventing premature deaths, disability associated with these long-term conditions and the resulting health inequalities. These circulatory conditions claim the lives of more than 170,000 people each year; are responsible for a fifth of all hospital admissions and affect the health and wellbeing of more than four million people in England. The Health Checks cover people in the 40 to 74 years of age range and have been estimated to have the potential to save up to 2,000 lives each year, prevent 9,500 heart attacks and strokes and 4,000 people a year from developing diabetes by detecting at least 25,000 cases of diabetes or kidney disease early enough to take preventative action (DH 2008). The prevention and management of these chronic health conditions is a major public health challenge that is forecast to increase as the population ages and levels of obesity increase. It is estimated that by 2025 some 18 million people in England will be suffering from at least one such long-term condition¹, an increase of more than 3 million people from the current situation (The Cabinet Office 2009).

The Health Check takes approximately 20 to 30 minutes to conduct and involves a questionnaire covering age, gender, smoking status, physical activity, family history and ethnicity. It also involves a body mass index calculation, a cholesterol test and a blood pressure measurement leading to a filter for diabetes and an individual cardiovascular disease risk assessment calculation using the Framingham or QRISK2 algorithm. People are given advice about healthy living with those at high risk of developing cardiovascular disease in the next 10 years referred to their general practitioner for further assessment and treatment as well as to appropriate NHS services to stop smoking, manage their weight or increase their level of physical activity.

¹ Chronic long-term conditions defined as heart disease, diabetes and asthma.
**FIGURE 2. DIAGRAMMATIC OVERVIEW OF THE VASCULAR RISK ASSESSMENT AND MANAGEMENT PROGRAMME**

(Source: Putting prevention first. NHS Health Check vascular risk assessment and management best practice guidance, Department of Health, 2009b)
The Health Check programme has been launched in a number of pilot areas in a variety of ways since 2008 and is being extended to cover all people in the 40 to 74 age range in England over the next five years with implementation scheduled for completion by 2012-13 (NHS Choices 2009a). There are a number of important issues that need to be considered in the light of the experiences of pilot areas which have developed a number of models to deliver Health Checks.

The balance between Health Checks offered systematically through general practitioner practices and opportunistically in community settings

The NHS Health Check can be delivered in a variety of settings ranging from general practice, pharmacies, and community settings to mobile practices by nurses or health care assistants following a defined protocol. Basing the service in general practices, and using a team of dedicated nurses as in Sandwell (Sandwell PCT 2009) or by health care assistants as in Tower Hamlets (Tower Hamlets PCT 2009), provides a link to the existing structure of primary care and the potential for continuity of care if an individual is at high or even moderate risk of cardiovascular disease. However, in the view of commissioners from PCTs at an NHS improvement workshop event, provision through general practices runs the risk of Health Checks being 'medicalised' and therefore problematic in the eyes of the general public who are thought to be reluctant to go to their general practitioner when they are not ill (DH and NHS Improvement 2009). In order to reach groups who are reluctant to go to their general practitioner, the provision of Health Checks in the community can be considered either as an alternative or a complementary means of delivery.

Community Health Checks have been extensively provided in pharmacies in areas such as Hull and Blackburn (DH and NHS Improvement 2009); in Birmingham initially in partnership with Lloyds pharmacy and now with other pharmacies (Birmingham health and wellbeing partnership 2009); and in Manchester in ten pharmacies in the most deprived areas of the city (NHS Manchester 2009). The provision of the NHS Health Check by suitably trained pharmacists is an attractive option given the type of environment and the levels of trust and accessibility that a pharmacy provides, particularly in areas of deprivation where it is likely that there will be a large number of people at high risk of cardiovascular disease who may be reluctant to go to their general practitioner. Another variation is to deliver Health Checks in community venues where there is potential for large numbers of people to pass by and to be opportunistically risk assessed. This approach has been widely used in Bolton where supermarkets, betting shops and places of worship have all been used to provide a service delivered largely by health trainers to supplement the systematic provision of Health Checks running from 8am to 8pm through general practices via a local enhanced service (NHS Bolton 2009). In contrast, community Health Checks provided in association with the blood pressure association by nurses in a mobile practice unit are the mainstay of provision that began in March 2009 in Barking and Dagenham. This service provides Health Checks in shopping and community centres across the area, places of worship including mosques and Pentecostal churches as well as public events that draw large crowds such as the East London Mela. However, this service is only scheduled to deliver Health Checks for 36 days over a 12 month period for an area with a total population of 173,000 people with one of the highest levels of cardiovascular disease in the country (NHS Barking and Dagenham 2009). This is some way from the "industrial scale" of provision being provided in Bolton where take-up of the scheme is on track having reached almost two thirds of the initial target population for the first year by September 2008 (NHS Bolton 2009).
The provision of Health Checks through general practices allows a more systematic approach to be adopted assisted by various forms of software. Packages such as Oberoi used in Leeds (NHS Leeds 2009) and Stoke on Trent (NHS Stoke on Trent 2009) or bespoke systems that were developed for Manchester (NHS Manchester 2009) and Nottingham (Happy Hearts Nottingham 2009) have been used to identify patients on general practitioner’s lists who are likely to be at an elevated risk of cardiovascular disease and to write to them inviting them for a Health Check. This approach offers a systematic approach for calling patients who are potentially at high risk of cardiovascular disease and involves sending a pro-forma letter to patients. Opportunistic Health Checks, which are usually offered in the community, can attract groups who are reluctant or find it difficult to go to their general practitioner as well as people who are concerned about their health and want to be ‘fully engaged’ in it.

However, there are major challenges in transferring the results of opportunistic Health Checks conducted in the community on to the patient records held at the general practice. There has been a lack of compatibility between IT systems commonly used in general practice, EMIS, and those used during community Health Checks in a number of PCTs. This is because EMIS is not compatible with third party software systems and so this has required the use of paper copies or the double entry of results into two IT systems at the point of delivering the Health Check. For example, Doncaster PCT’s ‘Test Your Heart’ scheme aimed at people living in the most deprived communities has a stand-alone IT system that does not link with any other NHS organisation. Results then need to be sent to other organisation via hard copy pro-forma (Doncaster PCT, 2009). In Manchester, the results of Health Checks conducted in pharmacies are faxed through to the appropriate general practice which has a standard template in the bespoke software that allows for the simple translation of the information from the fax to the patient record (NHS Manchester, 2009). This process is acknowledged as a challenge to the operation of the programme and it is difficult to comment on the suitability of this model of data transfer without observing it in operation but it seems unlikely to be a viable, secure long-term solution. Both of these systems appear to be preferable to the situation in pharmacies in Birmingham where results are recorded on a secure IT programme developed by a private company called ‘North 51’ with two copies of the results printed by the pharmacy. One copy is for the patient to keep and the other is for the patient to give to their general practitioner, although it is unlikely that every patient or even a high proportion of them will comply with this instruction (DH and NHS Improvement 2009). Even a programme such as Nottingham’s ‘happy hearts’ that provides Health Checks in general practices using dedicated clinical health care assistants and a bespoke cardiovascular disease risk assessor software requires the double entry of results into two IT systems, and although this takes a little extra time, it does ensure that the general practitioner’s patient record is up to date (Happy Hearts Nottingham 2009).

The Importance of Social Marketing to the Provision of Health Checks

Providing Health Checks is not simply a matter of providing a service and then expecting people to use the service because they should benefit from it. People can be very reluctant to engage with issues of health and lifestyle because of fears about the results of a Health Check along with a sense of fatalism and uncertainty about their ability to do anything about their risk of cardiovascular disease. There are also issues of denial about the impact of lifestyle on a person’s health and a sense that they may be asked to give up all the things that they enjoy doing. There may also be a lack of knowledge about the impact of lifestyle
choices on a person’s long-term health and issues about the (in)accessibility of the Health Check and other NHS services. Therefore, it is widely regarded as important for local commissioners to use social marketing techniques first to gain a better understand of the needs and values of their populations when making decisions about the design of Health Check services.

For example, NHS Leeds decided to plan the whole programme of Health Checks as a social marketing intervention to reduce health inequalities related to cardiovascular disease. This involved generating insights about the significance of cardiovascular disease to the lives of the local people. Given that cardiovascular disease is the biggest killer but cancer is considered to be a much more feared disease this work helped the NHS staff understand people’s attitudes a lot better and design a programme tailored to their needs. It also included the likely responses to invitations to attend for a Health Check, factors that would motivate attendance and expectations of the service. These social marketing insights informed the large-scale pilot involving a local enhanced service (LES) with 42 general practices that each had at least 30 percent of their patients coming from the most deprived areas. The LES included training in motivational interviewing to encourage people to have a Health Check (NHS Leeds 2009). A similar process of social marketing and training in motivational interviewing for staff delivering the Health Checks took place in Nottingham based on qualitative research designed to develop the service and improve on the initial 65 percent response rate to the invitation for assessment (Happy Hearts Nottingham 2009). In Barking and Dagenham, social marketing processes informed the development of targeted health promotion material. This work was carried out in partnership with the blood pressure association who have considerable experience in providing services to disparate groups such as Somali Muslims and Nigerian Pentecostalists who are often incorrectly grouped together as part of the African and Caribbean community as if this was a homogeneous group. Social marketing can really make a difference to the effectiveness of services by helping practitioners understand what factors motivate people and how to reach them. An example of a social marketing insight that is worthwhile noting is that there was a considerable increase in take-up of Health Checks in Birmingham when patients were contacted by telephone instead of receiving an invitation letter; with participation increased to 80 percent having typically been 20 percent (Birmingham health and wellbeing partnership 2009).

THE IMPORTANCE OF CLINICAL ENGAGEMENT

Clinical engagement from general practitioners is a key factor in successfully introducing Health Checks although there has been considerable controversy in the pages of Pulse (one of the UK’s leading medical weekly publications, counting more than 70% of general practitioners among regular readers) over many months about the implementation of the £332 million programme. The implementation of the programme has been criticised as ‘chaotic’ with vast differences in how PCTs are planning to introduce Health Checks representing a ‘recipe for postcode medicine’ across the country and as ‘localism gone mad’. There are fears that this approach will undermine the notion that this is a clinically driven intervention that can be assessed for cost effectiveness like other NHS initiatives (Pulse, 2009a). The concerns of general practitioners were also shared, to an extent, by the House of Commons Select Committee on Health in their report on health inequalities. The report urged the Government to take great care in implementing Health Checks suggesting that there was a risk they would not contribute to reducing health inequalities because of
differences in take-up between relatively affluent and deprived groups (House of Commons Health Select Committee 2009). There are also continuing concerns about the choices made by PCTs about whether to use the modified Framingham or the QRISK2 method of assessing cardiovascular disease risk that may have implications for the work of general practitioners (Pulse, 2009b). While concerns among general practitioners about the impact of the implementation of the programme are entirely understandable, it could be argued that PCTs are in the invidious position of commissioning additional services from general practices leading to concerns from the medical profession about the associated increase in workload or adopting alternative community based provision that prompts complaints from general practitioners about the quality of the results and cost in terms of time and subsequent treatment of referrals (Pulse, 2009c).

Clinical engagement from general practitioners is needed to move beyond Health Checks into the provision of continuing care, particularly for those people at high risk of cardiovascular disease. A positive example of this was the appointment in Stoke on Trent of a general practitioner as a clinical champion for the scheme to work with other clinicians, including the deputy director of public health and two project nurses who led on the identification of high risk patients. This group visits practice nurse forums and practice based commissioning groups as well as the Professional Executive Committee (NHS Stoke on Trent 2009). Clinical engagement was considered central to the success of the ‘Big Bolton’ Health Check, where the chair of the Professional Executive Committee and the project manager visited every practice to discuss and engage with the whole practice team thereby building up good channels of communication (NHS Bolton 2009). This type of commitment should encourage practices to level up to the best and will minimise the risk of large scale variation between general practitioners in their commitment to primary prevention and reducing health inequalities. The provision of financial incentives through a locally enhanced service is another means of ensuring clinical engagement with the Health Checks programme although not every general practice may choose to participate in such arrangements.

**Locally Enhanced Services and Workload Issues**

It is commonplace for PCTs to introduce a locally enhanced service (LES) to provide incentives that will encourage general practitioners to participate in the Health Checks programme. The structure of a LES can be as varied as the provision of Health Checks but there are some clear examples of how a PCT can seek to influence the behaviour of general practitioners. NHS Bolton’s LES includes a logarithmic incentivisation scheme for each practice so that more complete testing results in a disproportionately increased payment (NHS Bolton 2009). The aim of this provision is to reward excellence rather than average performance or reaching a minimum target that could act as a ceiling rather than a floor in terms of conducting Health Checks. The LES in Leeds provides three tiers of incentives starting with an initial lump sum for compiling the list of patients and having a member of staff attend a two-day training course on vascular risk assessment and motivational interviewing skills. This is followed by a flat rate payment of £10 for each patient they assess and a further sum for managing the patient effectively based on the quality and outcomes framework (QOF) model that has been locally adapted (NHS Leeds 2009). The locally enhanced services in Manchester (NHS Manchester 2009) and Doncaster (Doncaster PCT 2009) also incentivise the establishment of a cardiovascular disease register and the
continuing provision of appropriate treatment with an annual review for people identified as being at high risk.

There is a potential risk that a PCT that develops a LES for Health Checks will be paying for services that are already rewarded under the quality and outcomes framework (QOF) or under an existing LES for long-term conditions. This is because although the Health Check as a whole are not part of the structure of the QOF there are parts of it, such as the recording of blood pressure in patients aged 45 and over in the last five years, or those with a Body Mass Index greater than 30 in the last 15 months, that are included. Therefore, PCTs could be paying twice for services provided by general practitioners. They have been advised of this risk by the Department of Health and “…may wish to be aware of this in order to factor it into their arrangements and avoid double payments (DH, 2009b).” It is interesting and pertinent to note that when this issue was raised at a vascular checks workshop event in July 2008, Bolton PCT took the stance that they were not prepared to pay for follow-up activity required after a check as this should be done by general practitioners anyway as part of their core work and contract. In contrast, Knowsley PCT’s LES with general practitioners offered additional payments for this follow-up activity because it was viewed as the pragmatic way to get the programme moving forward (DH and NHS Improvement 2009). There are pros and cons to both stances and it is a matter for local commissioners in PCTs to decide upon the most appropriate course of action for their locality as the Health Checks programme develops. However, it would seem unlikely to be sustainable in the longer-term for PCTs to commission services that are covered by both QOF points and a LES when there are likely to be greater budget constraints for PCTs in the future.

There is no doubt that the full implementation of Health Checks is going to increase the workload in primary care because it covers a large group of the population, typically about 40 percent of the total population depending on the age structure of the locality although only perhaps a fifth of this group will be at high risk of cardiovascular disease. Even in areas such as Bolton, Leeds, Birmingham (who have invited 36,000 men since December 2007 and tested more than 9,500 by June 2008) and Ashton, Leigh and Wigan that have had relatively large pilot programmes running for some time, there are acknowledgements of the ‘industrial scale’ of the challenges ahead due to the number of people to be seen. There is going to be a step-change in the level of activity associated with Health Checks if the commitment to offer it to all people in the 40 to 74 age range is to be achieved in the next five years. In addition to the number of people entitled to have a Health Check, there are also issues associated with ‘hard to reach’ patients who are likely to need this service the most. It will require considerable resources to entice these people in for a Health Check and then support them through a change in lifestyle programme.

There is a substantial risk with regard to workload issues both in conducting the Health Checks and the capacity of lifestyle services related to stopping smoking, weight management and being more physically active to cope with the increased demands that will be placed upon them. Manchester is determined to have referral pathways, services and a system for monitoring high risk patients in place before launching Health Checks (NHS Manchester 2009) and this sentiment is apparent in other pilot areas where workload and capacity issues are often mentioned. For example, Ashton, Leigh and Wigan’s ‘find and treat’ initiative began with assessments in general practices with practice nurses managing the process, but it very quickly became apparent that this additional work was limiting the number of Health Checks that could be conducted. Consequently, the PCT trained 37 health
care assistants at Bolton University to undertake the Health Checks following a very clear protocol. In the first 18 months of the programme from October 2007 to March 2009, nearly 9,400 patients were invited to attend one of the 31 nominated general practices for a ‘find and treat’ Health Check and just over 5,400 attended. Even the earliest practice to join the programme has still only screened about one third of eligible patients due to a number of factors. These include patients not responding to the invitation, the provision of Health Checks being limited to normal practice hours which restricts access for those in paid employment and the limited amount of space available for a consultation (Ashton, Leigh and Wigan PCT 2009). There was a national assumption that 47 percent of patients identified as being at high risk of cardiovascular disease would already be known to general practitioners but analysis of initial results in Leeds shows that only 21 percent of the high risk patients in first tranche of participants were already in the system. This suggests a much higher level of undiagnosed cardiovascular disease in the locality than was expected and indicates that more resources will need to be allocated if patients are to receive the optimal level of treatment. These capacity and workload issues have been commonly reported issues in pilot areas and are certain to intensify as Health Checks are implemented in all PCTs.

KEY ISSUES FROM A REVIEW OF THE IMPLEMENTATION OF HEALTH CHECKS

- most programme will probably revolve around a mixture of primary care and community based Health Checks although the form and balance between these two elements will vary with each PCT and over time
- transferring the results of Health Checks in the community into primary care is a potential weak point in the system. General practitioners need to have confidence in the results from community Health Checks and their serious concerns about the implementation of the programme need to be addressed
- workload issues: providing Health Checks to all 40-74 year olds over a five year period is going to require provision on an industrial scale that is only getting up to speed in some of the early implementing PCTs. There will have to be a step-change in activity levels that is going to place a strain on primary care and lifestyle services.
- capacity issues: there is likely to be uncertainty about the capacity of lifestyle services such as stop smoking, weight management and physical activity to cope with the increased demands that will result from improved identification of those at high risk of cardiovascular disease
- there is a risk of double payments to general practitioners through a locally enhanced service for Health Checks and the quality and outcomes framework. While this position may be acceptable during the initial implementation stage it is unlikely to be sustainable given the financial pressures that PCTs face.
HEALTH CHECKS ACROSS CHESHIRE AND MERSEYSIDE

There are considerable variations in the stage of development that PCTs have reached in implementing Health Checks, although this is hardly surprising given the host of differences between areas. It is also important to emphasise that the process of implementation is rather fluid, and is a time when elements of the programme will develop and change in the light of experience so the contents of this section are a mixture of the general principles informing the approach to Health Checks along with specific examples to highlight salient points.

Most PCTs have opted to commission a locally enhanced service with general practitioners to provide the bulk of the Health Checks that will be needed over the next five years although there are considerable variations in this process. For example, Wirral developed a LES that most of the general practices signed up to when it began in April 2008 that rewarded the development of a cardiovascular disease risk register with a focus on the 55 to 74 age group. A second version of the LES was introduced in June 2009 to run for a year and focused on coverage of those with a high risk score. This version of the LES made an initial payment to practices followed by coverage-related payments above a 50 percent floor with incremental increases up to 90 percent coverage. This incentive structure weighted rewards to those practices that achieved the highest levels of coverage although it is too soon to say how the LES is influencing performance. To supplement this provision, Health Works (a private contractor) was commissioned to provide 5000 community Health Checks aimed at the difficult to reach and most deprived communities over a two year period ending in March 2010. This branch of the service works in conjunction with the PCT’s health trainers who provide the most intensive support in health action areas, the five areas with the greatest levels of deprivation. Newly recruited health trainers will increase the capacity of ‘health challenge’, Wirral’s community programme by providing healthy lifestyle advice and case finding outreach work to the difficult to reach groups. Awareness will be raised by social marketing and health awareness campaigns in forthcoming months as the programme continues to expand and momentum needs to be gained. As a site that was chosen for early implementation, Wirral is well advanced in terms of provision of Health Checks but a step-change in activity level is still likely to be required if adequate coverage of the 40 to 74 year old population is to be achieved over the next few years.

In Liverpool, the implementation of Health Checks is set in the context of existing initiatives to improve the standard of primary care and seeks to reward practices that reach and exceed certain measures from the quality and outcomes framework. This ‘gold standard’ in primary care provides a focus and a foundation for commissioners of Health Checks that will be built upon. However, the details of the implementation process for Health Checks have yet to be completed by the multi-disciplinary steering group. There is an acknowledgement that if existing primary care arrangements cannot provide a satisfactory level of service then the programme will need to be extensively supplemented by alternative community based screening such as the Kensington pharmacy project that provides Health Checks in one of the most deprived regeneration areas of the City. Implementation will also include strengthening links to existing cardiovascular disease priority areas and with practice based commissioning consortia to build upon existing vascular risk registries as well as engaging in social marketing activity to provide a suitable service for a diverse population. However,
financial constraints and the huge scale of the task to identify and provide appropriate services to those at risk of cardiovascular disease is a particularly formidable challenge.

Sefton PCT had also established a LES with general practitioners as the main strand in a four-pronged approach to Health Checks that became fully functional in July 2009. Rather than waiting until people reached the age of 40, Sefton has decided to extend the coverage of the Health Checks programme to people in the 35 to 74 age range, giving a target of approximately 144,000 out of a total population of 280,000. The age range was extended in Sefton because of an above average incidence and mortality from cardiovascular disease. In addition to provision through general practices, Sefton PCT has also commissioned Health Checks in the community at 10 pharmacies in the most deprived areas to provide increased capacity for opportunistic checks for those groups or individuals who may be reluctant to go to their general practitioner. Sefton PCT and Sefton Metropolitan Borough Council has also been offering a ‘lift your lifestyle’ programme since 2006 that targeted middle aged men in the workplace and is being developed further so that it is fully compatible with the Health Checks guidance. This strand of cardiovascular disease prevention and healthy lifestyle promotion also provides scope and capacity to offer opportunistic Health Checks in the community at venues such as shopping centres with a high footfall or larger local events. The final strand, the healthy Sefton telephone line, provides advice and access to a range of services such as stop smoking, community weight management programmes, alcohol and mental health services. The overall approach in Sefton is to support general practitioners by giving them freedom within boundaries to work on Health Checks with their own populations with the PCT providing further advice and support to practices with lower levels of coverage. Sefton has established multiple and flexible strands to provide Health Checks to its population and has made the decision to widen the population covered to start at the age of 35 producing an additional tranche of people to be screened. Therefore, it is poised to deliver Health Checks in a variety of ways and on the scale that will be required, although it is too soon to assess how well the system is currently operating or will stand up over time.

Western Cheshire PCT is in the process of planning and implementing the Western Cheshire Health Check for a launch in 2010. This will feature a LES that is weighted with performance incentives for general practitioners, who were considered to offer a particularly good standard of primary care to the local population, supplemented by Health Checks in the community although the balance between these two elements is yet to be finally determined. As Western Cheshire is not a spearhead PCT and has not developed a large scale proactive cardiovascular disease prevention programme there is an acknowledgement that there is still a considerable amount of work to be done in this area. However, there is a strong commitment to support lifestyle changes and reaching people in the most deprived areas through community-based Health Checks and the provision of services, both from the PCT and in partnership with other organisations such as the newly formed Cheshire West and Chester Council as well as with third sector organisations. The redesign of existing services to meet the demands of an expanded client base will be easier said than done. Western Cheshire faces a number of challenges that are typical for a PCT when implementing Health Checks, such as service development and engagement of both clinicians and the target population, all of which will need to be addressed in the forthcoming months and years.

The Health Checks programme in Knowsley has been running since October 2008 after nearly 18 months of planning as part of a wider programme, ‘Knowsley at heart’, which aims
to reduce the above national average level of cardiovascular disease and the contribution it makes to health inequalities. The PCT has had a LES to develop cardiovascular disease risk registers and has a LES for long-term conditions with general practitioners that incentivises an annual health check. It could be argued that this sort of locally enhanced service provides additional financial rewards to general practitioners who receive payments for some of the work involved with Health Checks under the quality and outcomes framework but most PCT’s have taken the pragmatic decision that such potential double payment is acceptable.

In addition to provision in general practices, an extensive programme of community Health Check provision has been developed in the light of experience of an earlier campaign, ‘pit stop’, which provided a health ‘MOT’ for older men and a range of social marketing research that informed the development of the service. Community Health Checks are provided by a third sector provider, Optimal renal care, at scheduled venues and times across the PCT. The service has provided nearly 3000 Health Checks although about two thirds have been provided to females when public health intelligence indicates that men constitute three quarters of the group who are likely to be at high risk of cardiovascular disease. This gender imbalance in Health Checks is likely to be a function of the 9am to 5pm provision of the Health Checks in the community although there is scope for opportunistic provision at large scale community events that have proven to be successful in attracting men. Optimal renal care, who were commissioned to provide the service ahead of the in-house Knowsley integrated provider services, now work in conjunction with lifestyle advisers (health trainers) who provide on the spot advice and support to people who have just had a Health Check. The aim of the service is to improve the health and wellbeing of the individual through the provision of a quality holistic service rather than simply reaching quantitative targets and ticking boxes. There are also a variety of community engagement strategies, such as the recruitment of community health champions and local taxi drivers, to spread by word of mouth the value and benefit of having a Health Check. Although this programme is advanced and operating smoothly there are still areas that could be improved such as a fully functional electronic call and recall system and there is a need to track what happens to people’s engagement with services such as ‘stop smoking’ and ‘activity for life’ services after a Health Check. Knowsley’s programme of Health Checks has benefited from considerable resources, commitment and imagination over a period of time and has learned many valuable lessons about implementation. These lessons include the importance of social marketing to service design and of communication by a variety of methods with both clinicians and the target population as well as the provision of a high quality holistic service that meets people’s needs and expectations. Even in Knowsley there are still some shortcomings but there is a strong commitment to learning lessons and improving the provision of Health Checks.

In Halton and St. Helens there is a strong emphasis on prevention and early detection with a significant commitment of £40 million over a five year period in the strategic plan for commissioning. As part of this commitment, there are a range of activities and initiatives that have been developed, often using social marketing techniques to inform them and contain elements associated with the Health Checks programme. For example, in Widnes and Runcorn there are advanced weighing machines in general practices that give weight, body mass index, pulse and blood pressure as well as asking about smoking status. Results are given to the patient and recorded on the patient record at the practice with patients with a body mass index greater than 30 being called for a diabetes test. There are locally enhanced services for diabetes and for cancer screening reflecting the commitment to early detection
and treatment of diseases responsible for premature deaths and health inequalities. Practice based commissioning in Widnes and Runcorn will provide a ‘health bus’ staffed by a range of health care professionals who will offer Health Checks in the community. The ‘go’ men’s health campaign offers free Health Checks, a personal health MOT, to any man over 40 but with a particular emphasis on those living in more deprived neighbourhoods. A workplace health programme that offers screening and healthy lifestyle advice is being piloted and will also be rolled out with the intention of targeting those groups who are likely to be at high risk of cardiovascular disease and poor health and who may be reluctant to go to their general practitioner for a Health Check. The more comprehensive programme of Health Checks will be extended to all in 2010 broadly following the Bolton model with patients being called to their general practice but with this service complemented by an array of alternative community based measures. Halton and St. Helens has an array of Health Check provision available and is in the process of fully extending the programme in the context of a strong commitment to prevention and early detection.

Only Warrington PCT is taking an alternative approach with the whole Health Check programme commissioned through the equitable access centre, a Lord Darzi-style polyclinic that opened in July 2009 to provide out of hours general practitioner cover for the local population. The programme is due to commence in October 2009 and will systematically call every person in the 40 to 74 age range for a Health Check. There will be an emphasis on calling those most likely to be at high risk first by using an appropriate risk stratification tool and because this is a pan-PCT initiative this should be more equitable because it will not have the inevitable variations in performance that occurs when general practices are used to deliver the programme. In addition to trying to secure greater equity, the rationale for this approach is that it will in the long-run reduce the workload burden on general practitioners who will receive the results and will provide continuing primary care to those patients who have been identified as high risk of cardiovascular disease. Although general practices have been ‘tetchy’ about this approach and there have been operational issues about the ownership and transfer of patient data, the programme will be piloted later this year although full implementation could be influenced by the swine flu pandemic. In addition to this central hub approach, health and wellbeing trainers working alongside volunteers will provide opportunistic community Health Checks in the more deprived and difficult to reach areas. This is a different approach to that adopted by most PCTs and has the appeal of offering an equitable service across the whole PCT rather than the inevitable variations by general practice that are the result of locally enhanced services. As with any new programme and system, there are bound to be operational difficulties and issues that will need to be addressed as they arise. There is understandable uncertainty about how this system will function and how many more people will be identified as being at risk of cardiovascular disease and referred to healthy lifestyle services. With regard to the capacity of these services to cope with increased demands, Warrington as with all other PCTs, while not quite commissioning in the dark, certainly has to plan in the gloom when the prospects for NHS funding are looking somewhat bleaker than they have done in recent years.
KEY ISSUES IN THE IMPLEMENTATION OF HEALTH CHECKS ACROSS CHESHIRE & MERSEYSIDE

- there are considerable differences in the implementation of Health Checks across Cheshire and Merseyside. This is due to some PCTs having been selected as sites for early implementation as well as longer-standing differences in emphasis on the development of programmes to prevent and detect cardiovascular disease.

- it is commonplace to provide Health Checks in primary care and community based settings although the detail and scale of this provision is complex and will change over time. While most PCTs have opted to use the existing system of primary care as the mainstay for Health Check provision with the use of a locally enhanced service, there are variations in the focus and structure of all of these LES protocols. Warrington has chosen to adopt an alternative model for Health Checks that should provide an interesting case study.

- social marketing has played an important role in service design in those areas that are more advanced in the process of implementation and will need to play a role in areas that are developing services. Building and maintaining the momentum of each Health Checks programme will require some social marketing input, health promotion/awareness activity and a continuing flow of spending. With these elements in place, achieving the desired result of lowering the overall level of cardiovascular disease and reducing the health inequalities associated with it.

- all of the Health Checks programmes will have to increase the level of activity if all people in the target age range (which begins at 35 in Sefton) are to be covered in the next five years. In some cases this level of increase will be relatively modest, although it should not be under-estimated, while in those PCTs that are starting implementation it will be considerable as Health Checks will need to be provided on an ‘industrial scale’ and reach the most reluctant populations if they are to achieve their aims and objectives.

- quality assurance procedures for the Health Checks have not been developed, but will be needed if the programmes are to mainstreamed successfully in the future.
CHLAMYDIA SCREENING

Chlamydia is the most commonly diagnosed sexually transmitted infection in England and rates have been increasing since the mid-1990s. Between 2007 and 2008, the number of confirmed cases of chlamydia in England rose from 121,791 to 123,018 (NHS Choices 2009b). Chlamydia often has no symptoms but it can have serious long term health implications, including infertility if it is not treated. The Health Protection Agency recommends that anyone who is sexually active and under 25 years of age be tested for chlamydia annually or on changing a sexual partner. Chlamydia tests are free and confidential as part of the national chlamydia screening programme and involve giving a urine sample or taking a swab and are self-administered (Health Protection Agency 2009).

Chlamydia screening is the responsibility of the sexual health services team in each PCT and is supported by the Cheshire and Merseyside sexual health network, with data collated by the Health Protection Agency (HPA). There is no recognised quality assurance programme and it is rarely mentioned by public health screening leads because it invariably falls outside their remit of responsibilities. The coverage of chlamydia screening is essentially opportunistic and is usually relatively low in relation to the population of sexually active 15 to 24 year olds. Warrington has run a local enhanced service with general practices and they commissioned the Terence Higgins Trust to provide training and undertake outreach work in the community. The resources and work committed to this area of work has borne results and Warrington’s coverage and national ranking are both high. The table below shows the ‘vital signs’ indicators for chlamydia across the eight PCTs in Cheshire and Merseyside.

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<th>TABLE 3: CHLAMYDIA TESTS, COVERAGE RATE AND NATIONAL RANKING BY PCT</th>
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ABDOMINAL AORTIC ANEURYSM (AAA) SCREENING

Most abdominal aortic aneurysms (AAA) are asymptomatic but mortality after rupture is high with nearly a third of people dying before they reach a hospital. Even for those who undergo emergency hospital treatment, the post operative mortality rate is around 50 percent giving a case fatality rate after rupture of 82 percent. Ruptured AAA account for 2.1 percent of all deaths in men aged 65 and over compared to 0.8 percent in women of the same age group. The estimated period prevalence of AAA in men aged 65 to 80 is 7.6 percent compared to 1.3 percent for women and at the age 65 is around 3 percent in men and 0.8 percent in women (National Screening Committee UK 2009).

Consequently, a national screening programme for abdominal aortic aneurysms in men aged 65 was announced for England at the start of 2008 and is to be implemented by 2012/13. It will consist of ultrasound screening in the community; will call men for screening when they reach the age of 65 and will be available on request for men over this age. Local screening programmes will be developed to cover populations in the 800,000 to 2,500,000 range and a suitable network of vascular specialists and practitioners will be put in place to treat patients with detected AAA. Quality assurance between and within units will be an integral part of the programme to reduce the probability of error and to help professionals and organisations improve year on year (National Screening Committee UK 2009).

Given these population size recommendations, groups of Cheshire and Merseyside PCTs will have to work in partnership with each other to form clusters to commission the AAA screening programme, but it is possible that responsibility for this will be given to an alternative organisation when the programme is implemented. Although public health professionals acknowledge that this will fall on their plate, there is very little evidence of public health screening leads preparing or planning for the introduction of AAA screening at this point in time.

There is no early implementation site for AAA screening in Cheshire and Merseyside but when the UK National Screening Committee invited the submission of proposals for early implementation Greater Manchester was one of six successful sites identified as suitable by their Strategic Health Authority and the national office. The five other early implementation sites in the initial wave of pilot programmes covered West Sussex, Leicester, Gloucester, South Devon and Exeter, and South West London.

A plan for the development of AAA screening in the south sector of the Greater Manchester area based on service provision from the University Hospital of South Manchester NHS Foundation Trust (Wythenshawe Hospital and Withington Community Hospital) has been in operation since August 2008, with Bury PCT as the lead commissioner and screening office host on behalf of the association for Greater Manchester PCTs. Bury PCT’s director of public health, Dr Peter Elton, along with Dr Soraya Meah of the Greater Manchester Public Health Practice Unit and Elaine Whitby, the Greater Manchester screening lead, provide the strategic leadership for the programme. The timetable was for implementation to commence in April 2009 to provide an overarching programme for Greater Manchester with shared management, clinical protocols, administrative processes, quality assurance and performance monitoring processes. The AAA screening programme is linked to a vascular
service in each of the four geographic sectors within Greater Manchester to provide appropriate care pathway services for patients picked up by screening.

There will undoubtedly be valuable lessons to be learned in relation to the operation and social marketing of such a service from the experiences of these early implementation sites around the country and Cheshire and Merseyside is fortunate to have a site so close at hand within the North West region. Given that AAA screening is scheduled to provide national coverage from April 2013, there is scope for evaluation research over the next couple of years so that the lessons from early implementers can be considered and problems averted when the programmes are put into operation across the region.
SUMMARY OF MAIN POINTS FOR CONSIDERATION

1. Screening programmes across Cheshire and Merseyside generally work well although there are differences between trusts and persistent inequalities in the uptake of invitations for screening. Early detection of disease saves lives but despite the best efforts of public health and clinical staff there are still deaths and disabilities occurring that would have been prevented if people could have been persuaded to come forward earlier and be screened. The key role for the ChaMPs screening lead is to champion the merits of screening across Cheshire and Merseyside, possibly through the production of a short annual report highlighting good practice and indicating lives saved as a result. This report could also be used to improve communication and increase awareness of the differences in the way programmes are developed and implemented and help staff to understand that if programmes are not taken up by those in most need, they can serve to increase rather than decrease health inequalities.

2. Directors of Public Health are responsible for screening programmes and PCTs commission these services, although there are occasional or temporary exceptions to this general rule. This organisational reality is unlikely to change and the role of a public health network such as ChaMPs is to support relevant staff across Cheshire and Merseyside by encouraging the sharing of good practice and learning from experience. This will involve facilitating strategic co-operation when and where this is appropriate and of mutual benefit to PCTs in their role as commissioners of health services for their population. There is likely to be scope for representing the views of Cheshire and Merseyside PCTs at a regional or national level and acting as a conduit for information flowing downwards from these levels. There may be issues, such as the reorganisation of laboratory services, which affect all Cheshire and Merseyside PCTs that they cannot individually shape but collectively can influence.

3. When there are changes to screening programmes, such as age extension and the introduction of digital technology in breast screening, there is likely to be an enhanced role for the public health network in assisting PCTs during periods of transition. There is likely to be a need for assistance and support for PCTs during the introduction of the NHS Health Check for vascular risk within the framework of responsibility for commissioning which resides with PCTs. The introduction of abdominal aortic aneurysm screening in the near future will also provide an opportunity for a strategic co-ordinating role that is appropriate for ChaMPs. There is also likely to be scope for assisting in the development of programmes such as diabetic retinopathy or chlamydia that appear to be less central to the concerns of public health screening leads. These programmes could be considered to be ‘Cinderella’ services in comparison to the long established cancer screening programmes and could benefit from championing across Cheshire and Merseyside.
4. Specific issues in antenatal and newborn screening, such as the capacity to offer the most appropriate Down's syndrome test, should be the focus of activity for the ChaMPs screening lead. The range of antenatal and newborn screening programmes offered as part of maternity care is multifaceted but appears to be operating smoothly. Working in conjunction with other NHS staff to help develop and ensure consistency in quality assurance processes and procedures so that all trusts can demonstrate that they provide the best available service choices to pregnant women would seem to represent a sensible way forward rather than trying to influence provision of all antenatal and newborn screening programmes.

5. There may be scope for enhanced social marketing and promotion of screening services across Cheshire and Merseyside to supplement the work of PCTs. This activity should not simply duplicate initiatives taken at the level of the PCT but should provide a unified message that adds value to the resources being committed at a local level. For example, recruiting and deploying individuals who have benefited from the early detection of disease through screening (ChaMPs screening champions) for social marketing campaigns in the local media could be a project that would help to increase uptake and reduce inequalities.

6. The quality assurance processes for the large national programmes, especially the cancer screening services are well developed, and although there are minor issues, all seem to be working well across Cheshire and Merseyside. However the same cannot be said for the other screening programmes. It is of concern that many of the newer screening programmes are being set up before quality assurance programmes have been developed. This means that the data required to quality assure these programmes are not being collected, which will make any rapid evaluation or quality assurance virtually impossible. As a result, any good practice will be difficult to pick up and share. One role that the ChaMPs screening lead could very usefully play would be to help trusts work towards ensuring a greater level of consistency in how quality assurance will be carried out across all the Cheshire and Merseyside PCTs for the newer screening programmes and those where quality assurance is less well developed, such as the antenatal and newborn programmes as well as the rapid sharing of any good practice. This could be a challenge and the ChaMPs screening lead will need to be seen to be supporting PCT commissioners as there could easily be potential for tension and conflict to arise.

7. Whilst it is important for services to be developed that meet the needs of the local population, a more strategic approach to issues such as IT and data collection would be helpful across all the Cheshire and Merseyside PCTs. The ChaMPs screening lead could assist in the development of a more consistent approach to issues such as monitoring of programmes, setting up IT systems and data collection.
APPENDIX 1: DIAGRAMS OF SCREENING PROGRAMME ACTIVITY ACROSS CHESHIRE AND MERSEYSIDE PRIMARY CARE TRUSTS

Please note that the primary aim of the following diagrams is to represent and highlight the similarities and differences in organisational structures for screening programmes rather than to provide a complete list of all of the organisations and people involved with these activities. There is a separate database of screening contacts associated with this report that provides a more comprehensive list of organisations and people working in screening programmes across Cheshire and Merseyside.
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