

**PERFORMANCE QUICK GUIDE**

**PUBLIC HEALTH PERFORMANCE IMPROVEMENT**

**Breast Cancer Screening**

<p>Vital Signs Indicator 2009/10</p>	<p>Percentage of women aged 53-70 screened for breast cancer in the last three years. NB The NHS Breast Cancer Screening Programme will be extended to all women aged 47–73 by 2012. The commitment is that all women will receive their first call by the age of 50.</p>
--	---

**Rationale**

Around 130,000 people die from cancer every year of whom 65,000 are aged under 75. In 2006/2007, over 1.6 million women were screened for breast cancer in England, and nearly 13,500 cancers were detected. In February 2006, a report from the Advisory Committee on Breast Cancer Screening (Screening for Breast Cancer in England: Past and Future, NHSBSP Publication No 61) estimated that the breast screening programme in England is saving 1,400 lives per year.

The International Agency for Research on Cancer (IARC) of the World Health Organisation (WHO) evaluated the evidence on breast cancer screening in March 2002. IARC concluded that trials have provided sufficient evidence for the efficacy of mammography screening of women between 50 and 70 years, and that the reduction in mortality from breast cancer among women who choose to participate in screening programmes was estimated to be about 35%.

At present, women are invited for screening seven times at three yearly intervals between 50 and 70 years. Over time, this will be extended to nine screening rounds between 47 and 73 years with a guarantee that women will have their first invitation for screening before the age of 50 – at present some women wait until nearly their 53rd birthday before they receive their first invitation. There is also increasing evidence of the clinical and cost-effectiveness of screening women up to age 73.

The Cancer Reform Strategy (December 2007) stated that the extension of the breast screening programme will start from April 2008 and will be managed by NHS Cancer Screening Programmes in partnership with local health services. The necessary phasing in of this expansion is being carefully considered to ensure that the most useful epidemiological data can be gathered to inform future decisions about the programme. Full implementation is expected by the end of 2012. The number of additional women to be screened in London as a consequence of the age extension is substantial and will need extra capacity.

The percentage of 50 year-old women with a breast screening test result and the percentage of 50-73 year-old women screened for breast cancer in the last three years should increase with time.

For screening to be most effective in reducing the morbidity and mortality associated with cancer it is vital to ensure that as many of the relevant population as possible is both being invited to screening and is taking up that invitation and being screened.

## Metrics

### Indicator

For 2009/10: Percentage of women aged 53-70 screened for breast cancer in the last three years. The national target has been increased from at least 70% of women to at least 75%.

NB. The NHS Breast Cancer Screening programme will be extended to all women aged 47-73 by 2012. The commitment is that all women will receive their first call by the age of 50.

The age group of women invited for routine screening was extended to 50-70 from 50-64 in April 2001, and all PCTs began inviting women of the extended age group for screening by March 31st 2006. The three year screening cycle for the 50-70 age range was completed by all PCTs by March 31st 2009. The data covering women aged 50-52 will not be used in the indicator as not all women will be invited due to the three year screening cycle. However, PCTs should be inviting women of this age group for screening to ensure satisfactory coverage by the age of 53. Similarly, the new extension programme to include women between 47-49 years and 71-73 years will be taken into account following the completion of a three year cycle.

### **Numerator**

The number of women aged 53-70 screened for breast cancer in the last three years.

### **Denominator**

The number of women aged 53-70 eligible for screening (on 31<sup>st</sup> March 2009).

### **Indicator**

The indicator is the numerator divided by the denominator, expressed as a percentage.

Source: CQC website September 2009

Organisations' Delivery Setup and Commissioning

1. Breast Screening Programmes Role:
  - Deliver and maintain minimum standards, improving the performance of all aspects of cancer screening to ensure access to a consistent, high quality screening service. <http://www.londonqarc.nhs.uk/section.php?id=1>
2. PCT Network Role (Networks should align with the areas covered by the London Breast Cancer Screening Programmes):
  - Each group of PCTs should have a nominated lead commissioner arrangement for Cancer, to ensure commissioning strategy plans and commissioning intentions include the requirements of the Cancer Reform Strategy working with the Cancer Networks. Screening should be considered as part of the cancer care pathway and commissioning plans should aim to widen the access to both breast cancer screening services in terms of time and location and to appropriate diagnostic and follow up pathways.
  - Have a programme management infrastructure comprising an Acute Commissioning Programme Manager, input from Public Health and Practice Based Commissioning to identify problems with particular practices and escalate strategic issues.
  - Have clear and regular arrangements for performance managing and reporting progress on the plan to partners; Directors of Public health

need to be included at all levels in the commissioning process.

- Have a policy on GP list validation that is common across the lead /associate PCTs to achieve and maintain data accuracy; the policy should be regularly reviewed in the light of changes to how GP data is collected.
- Have a health promotion resource to spread good practice and learning across the network that actively involves GPs in supporting screening, raising awareness and promoting the breast screening service in a planned and managed way; GPs should have an active role in improving coverage and encouraging attendance particularly among hard to reach groups.
- Have a service specification that is in accordance with the National Strategy and includes: quality measures, operational standards, metrics to review the acute screening service (activity monitoring should be at least quarterly, moving where possible to monthly, to allow the most timely action to be taken).
- Have a Collaborative Commissioning co-ordinating group or similar mechanism that provides an arena for performance management, quality review and planning of shared Breast Screening Programme offices and Call and Recall services against the National Strategy.
- The contract for Acute Trusts that host breast screening services should include a separate schedule for the screening service that includes failsafe and audit mechanisms linked to outcomes of the London QA programme. This must be signed by the lead commissioner, associate commissioners and the acute trust.

### 3. Individual PCT Role:

- Each PCT should have a lead Board Executive with responsibility to deliver a plan (with milestones) to achieve the breast screening target to improve coverage and take up; PCT plans should be linked to the PCT network plan.
- Have input from Public Health and Practice Based Commissioning to identify problems with particular practices and escalate strategic issues.
- Have clear and regular arrangements for reporting progress on the plan internally and performance managing progress. Reporting should be integral part of Periodic review monitoring. Clear escalation routes should be set up should programme milestones be missed.
- Have undertaken a health equity audit of the local population in relation to breast screening and radiotherapy.
- Have mapped capacity to ensure it is sufficient to meet the assessed need.
- Develop health promotion initiatives that specifically target the needs of their local population.
- Ensure GPs play an active role in supporting the screening programme and promoting the importance of taking up screening especially among hard to reach groups.
- Implement the evidence based actions to improve performance as set out in the service specification or in the PCT project plan. For example, pre-invitation letters from GPs, timed appointments, second timed appointments, easy access to change appointment, extended opening hours.

	<ul style="list-style-type: none"> <li>• Have a robust GP list validation process. This may be achieved through a List Validation Group comprising the Primary Care Head of Performance and IT (or deputy), Head of the Call/recall service, an agreed LMC representative, a practice manager and the relevant GP commissioning representative to review the information available (as outlined below) and make recommendations about the list validation exercise that needs to be undertaken.</li> </ul>
<p>Improving Data Flows and Quality</p>	<ol style="list-style-type: none"> <li>1. Adopt an active patient management approach to identify for Commissioners the areas in their commissioned provision that need strengthening and suggest methods to rectify the deficiencies. Steps include : <ul style="list-style-type: none"> <li>• An intensive validation/data cleaning exercise (with a particular focus on poorly performing practices) to create an accurate list of who should be invited to be screened, who has taken up the invitation and who has not attended; this will inform how to work with hard to reach groups. Access to GP databases and a nominated person whose role is data cleansing will be required.</li> <li>• A regular schedule of GP list validation/cleaning to remove patients who have left the practice</li> <li>• Regular Exeter system validation/cleaning to identify and remove duplicates accurately and quickly.</li> <li>• Develop a Performance Management metric[s] on practice performance to manage those with low uptake.</li> <li>• Active searching for and targeting of defaulters. Ensure that fail safe mechanisms are in place in GP practices so that the screening status of every eligible patient is known (including “refused”).</li> <li>• Ongoing support and training for GP practice staff and health visitors.</li> </ul> </li> <li>2. Involve GP practices in regular discussions on quality and accuracy of data via a designated person in commissioning/primary care.</li> <li>3. Communicate information back to GPs e.g. via monthly generated reports.</li> <li>4. Use IT front end reports and templates to track cohorts. Screening units to report to PCTs quarterly as required, including: <ul style="list-style-type: none"> <li>• ‘Round length’ performance,</li> <li>• Uptake and non attender reports</li> <li>• Technical recall rates</li> <li>• delays (in results, offered and actual assessment, referral to treatment)</li> <li>• Call/recall offices to report to PCTs KC63</li> <li>• Other national reports.</li> </ul> </li> </ol>
<p>Evidence of Effective NHS Intervention</p>	<p>“European Guidelines for Quality Assurance in Breast Screening and Diagnosis” N. Perry et al. Annals of Oncology Feb. 2008</p>
<p>Top Tip</p>	<p>Call and Recall or registration offices should report on FP69 levels as a total and for women within the eligible age range by GP practice, to PCTs. These figures along with the routine performance management information should be used as a proxy indicator of list inaccuracies to target list cleaning exercises.</p>