Audit of the inclusion of screening inequalities identified at quality assurance visits during 2019 to 2020

Screening quality assurance service

November 2020

Background

The Public Health England (PHE) screening inequalities strategy was published in March 2018. https://phescreening.blog.gov.uk/wp-content/uploads/sites/152/2018/03/Supporting-the-health-system-to-reduce-inequalities-in-screening.pdf

The strategy has been developed to support PHE screening in discharging its professional and legal commitment to reduce inequalities, ensure equitable access to screening and to support its partners involved in the delivery of screening. This strategy is consistent with the PHE equality objectives: 2017 to 2020 and PHE's strategic plan.

All national screening programmes participate in regular quality assurance activities as led by the PHE screening quality assurance service (SQAS). Quality assurance (QA) aims to maintain national standards and promote continuous improvement in screening. This is to ensure that all eligible people have access to a consistent high-quality service wherever they live. The operating model for SQAS 2018/19 to 2020/21 has identified a goal to contribute to the reduction of health inequalities across screening programmes.

A way of measuring the contribution in reduction of health inequalities across screening programmes is to look for recommendations or considerations to address inequalities identified from QA visit reports. This will provide a baseline audit to show improvement trends and demonstrate how PHE SQAS is contributing to reducing screening inequalities.

The PHE Screening division included an objective to produce an annual audit of inequalities coverage in QA reports in the 2019 to 2020 PHE corporate scorecard.

Aims and objectives

The aim of this baseline audit is to ascertain the current impact of QA visits in identifying and addressing health inequalities and to demonstrate that screening QA is delivering on the requirements of the inequalities strategy.

The impact will be identified by noting the QA visit recommendations made around inequalities, and noting the work already undertaken by providers and commissioners in addressing screening inequalities. The audit can be repeated in the future to establish improvement trends and demonstrate change.

Method

A simple quantitative, retrospective audit of all quality assurance reports produced across England between 1 April 2019 and 31 March 2020 (n=94). The national audit builds on work undertaken in the Midlands and East region in 2019.

To fully audit the reports, it is necessary to perform a search within the entire report and not just look at recommendations. This is because if a service has demonstrated work towards addressing inequalities a recommendation may not be made.

Key words have been identified using words within the Equality Act 2010 and the 2017 to 2018 national service specifications relating to inequalities.

The following key words around inequalities have been searched using the Microsoft search function;

- Equity audit
- Needs assessment
- Inequalities action plan
- Programme board
- Health inequalities (with reference to programme boards or trust screening steering group for antenatal and newborn (ANNB))
- Vulnerable groups
- Protected characteristics
- Learning disability
- Serious mental illness
- Prisons
- Homelessness
- Accessible information standard
- Underserved or under-served

Key words contained within the generic report template are excluded.

To minimise the possibility of unconscious bias and to make sure the audit activity did not have a disproportionate impact on specific teams or programmes the audit was undertaken by the national QA team.

QA visit reports uploaded to the IT system known as Marvin were identified and searched for the key terms identified in the table. A simple red/amber/green rating was applied to each question and a summary RAG rating was applied. Most questions were simple yes/no answers and easily rated although the question relating to service specifications required a judgment to be made, and comments added if required.

The questions relating to the search terms were:

1. Has a health equity audit (HEA) been performed?
2. Has an action plan been developed in response to the HEA?
3. Is the plan monitored at the programme board (or equivalent)?
4. Are there standard operating procedures or equivalent in place for vulnerable groups?

The audit findings were recorded in an excel spreadsheet and an overall rating for the provider was applied as follows:

Score Yes	RAG
0 out of 4	Red
1 to 3 out of 4	Amber
4 out of 4	Green

Limitations

This is a simple quantitative audit. Limitations include;

The presence of a ‘key word’ in the report does not necessarily mean that there is significant context around the word – for instance, the report may just state that there are two prisons in the programmes geography and not that any work around prisons has been undertaken.

The omission of a ‘key word’ in the report does not necessarily mean that this element has not been identified or considered. It may mean that the service has already undertaken work, and text on this element hasn’t been included in the report as it isn’t significant in the context of the current QA visit.

Subjectivity of the individual(s) undertaking the audit in determining if an inequality has been identified or addressed.

Report author(s), for example the author(s) may decide not to include information in the report on a particular inequality due to other priorities within the service at the time of the QA visit and the requirement to keep reports concise.

Professional clinical advisors (PCAs) used for the visit for example a PCA may have a significant interest in a particular type of inequality.

For cancer screening programmes historically there hasn’t been a commissioning review included in QA visits.

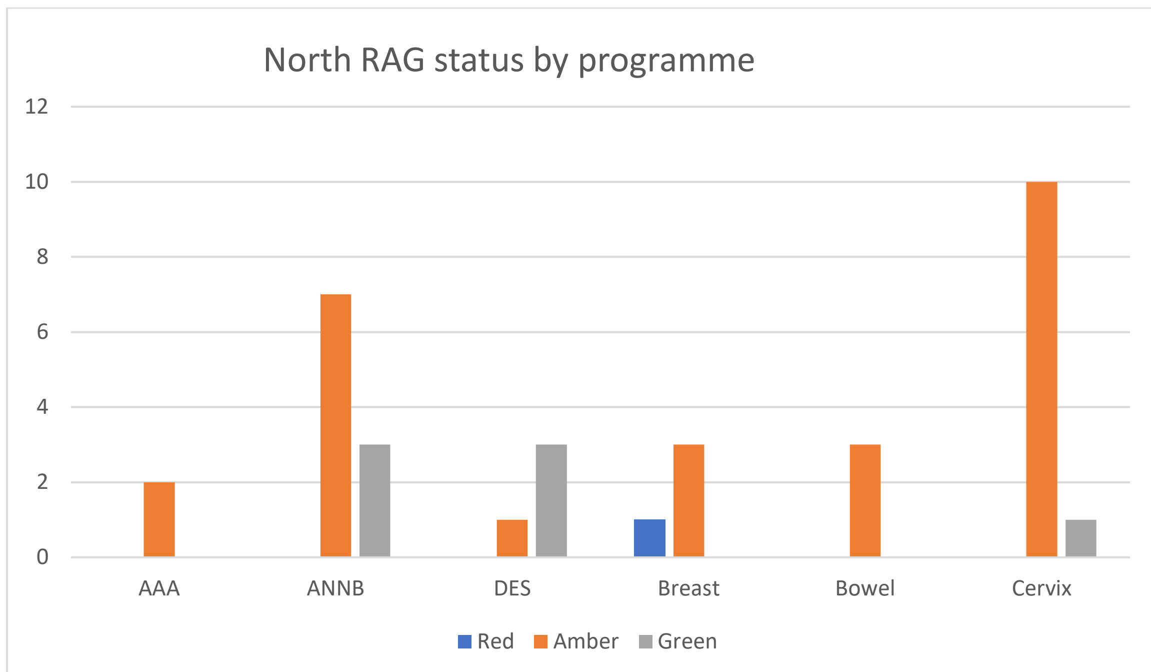
Findings and discussion

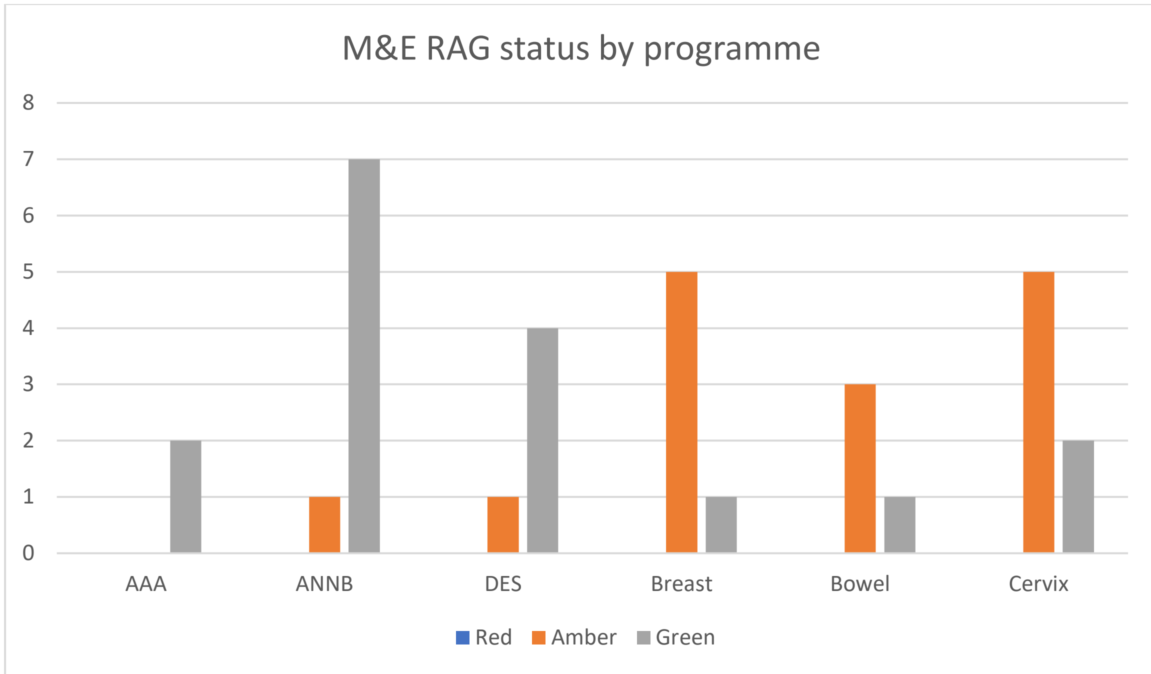
A total of 94 QA visit reports were audited and of these 1 was rated red, 56 were rated amber and 37 were rated green.

The findings were broken down by region and programme are summarised in the table and graphs below.

RAG status	Region				Total
	North	Midlands & East	London	South	
Red	1	0	0	0	1
Amber	26	15	5	10	56
Green	7	17	1	12	37
Total					94

Table 1: Total by region




M&E RAG status by programme
8
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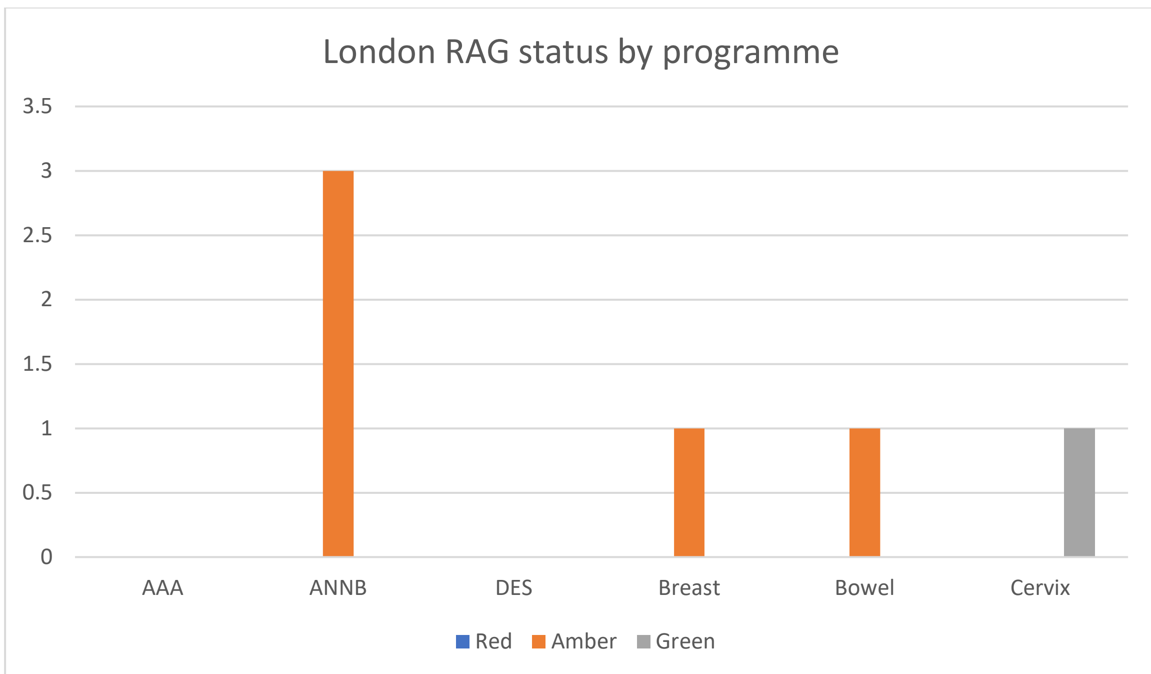
AAA
ANNB
DES
Breast
Bowel
Cervix
Red
Amber
Green


London RAG status by programme
3.5
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1.5
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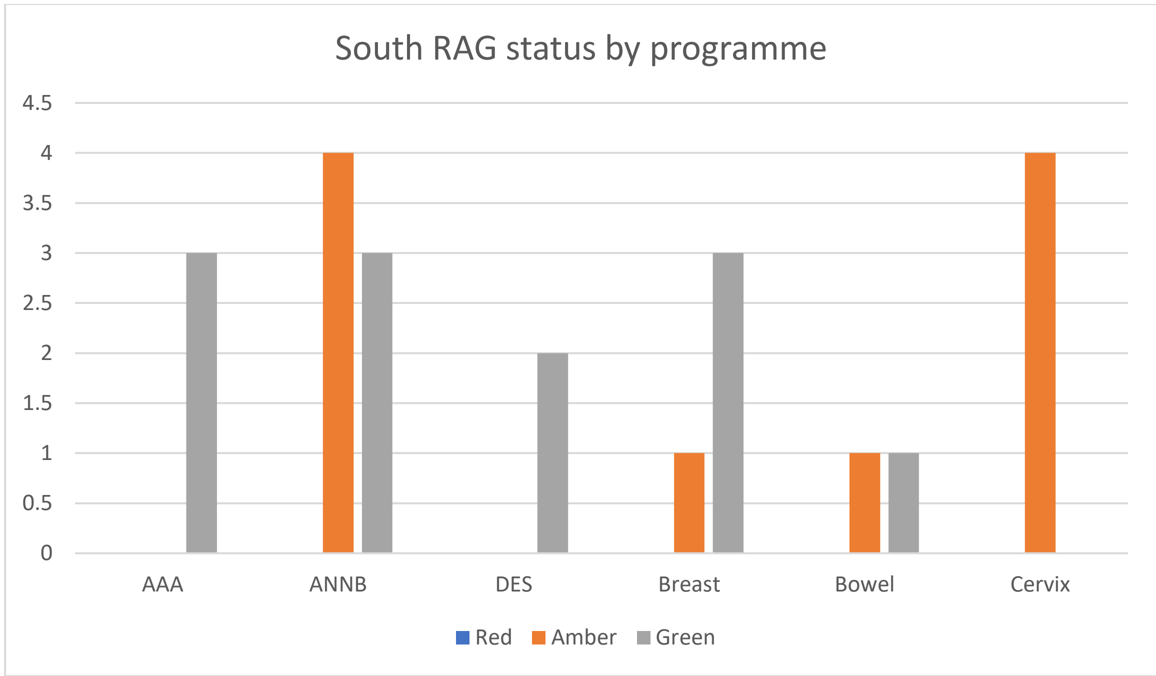
AAA
ANNB
DES
Breast
Bowel
Cervix
Red
Amber
Green


South RAG status by programme
4.5
4
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AAA
ANNB
DES
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Bowel
Cervix
Red
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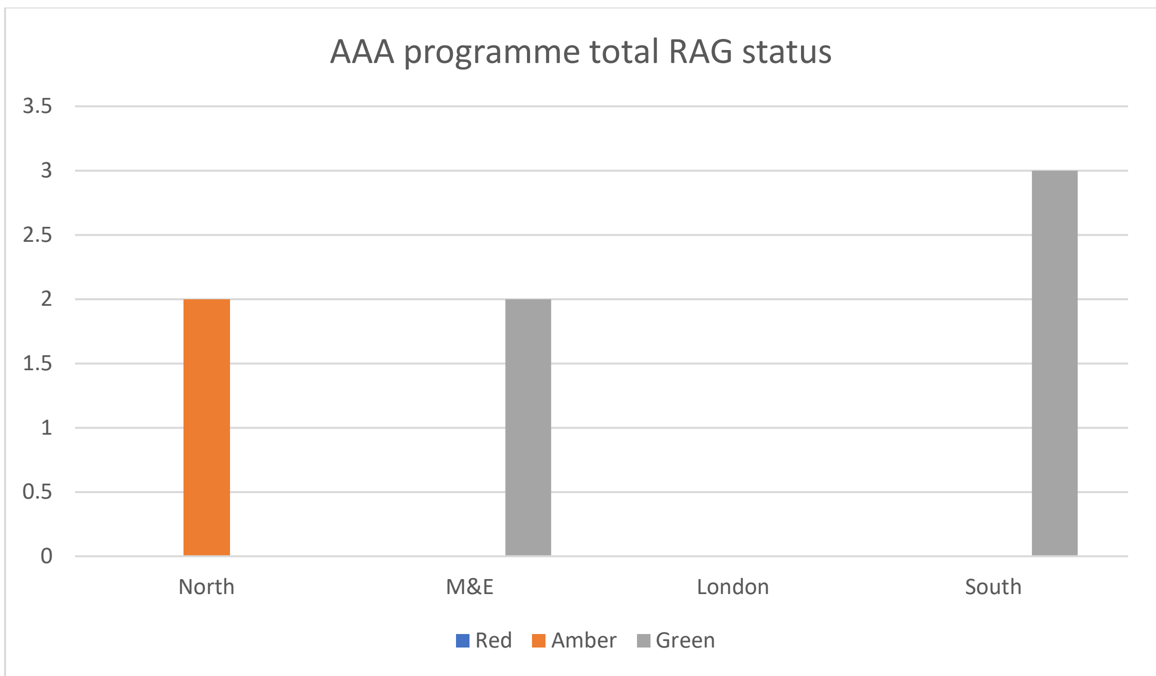
Green


AAA programme total RAG status
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North
M&E
London
South
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Amber
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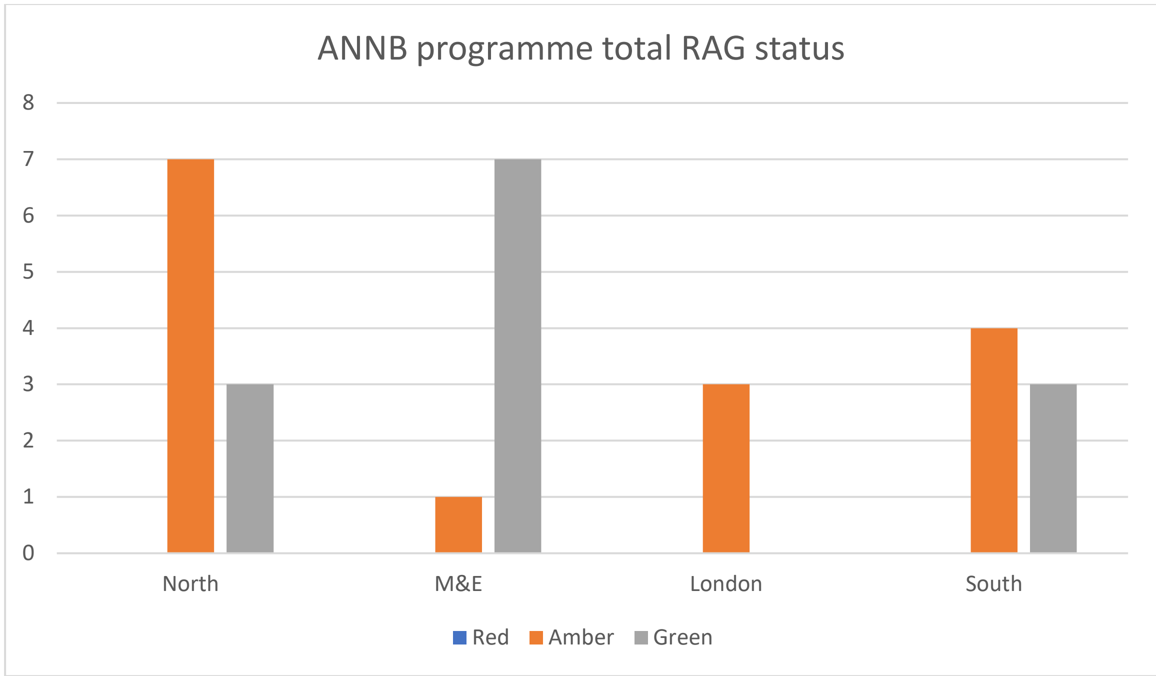
ANNB programme total RAG status
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Red
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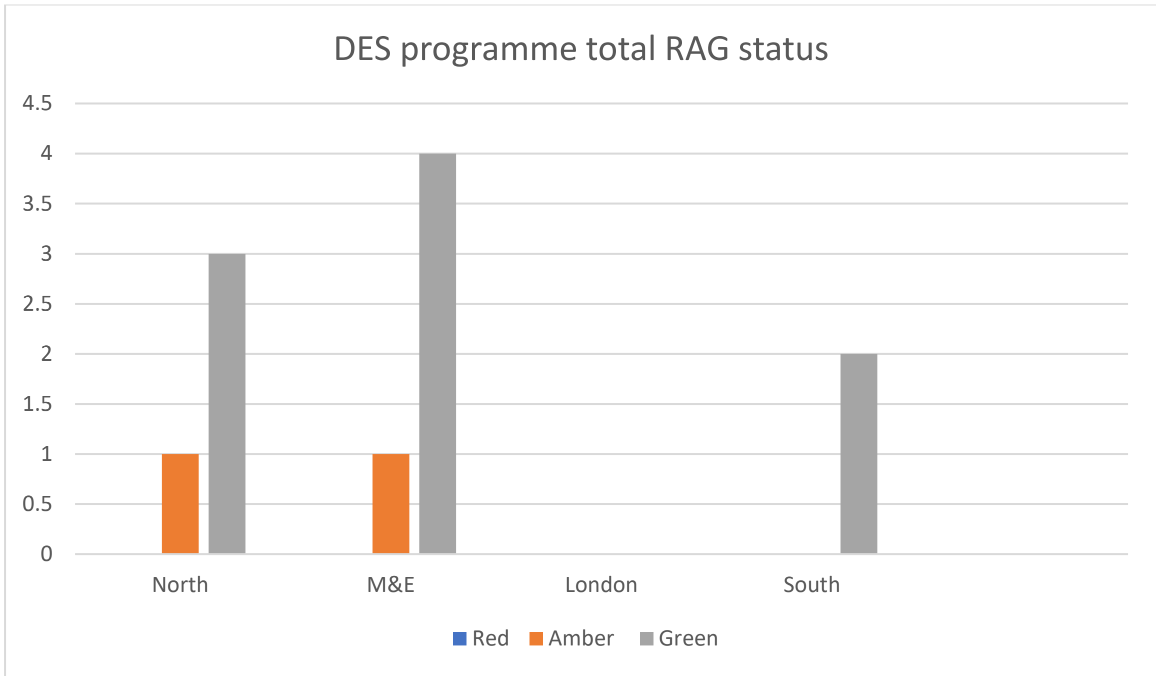
DES programme total RAG status
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North
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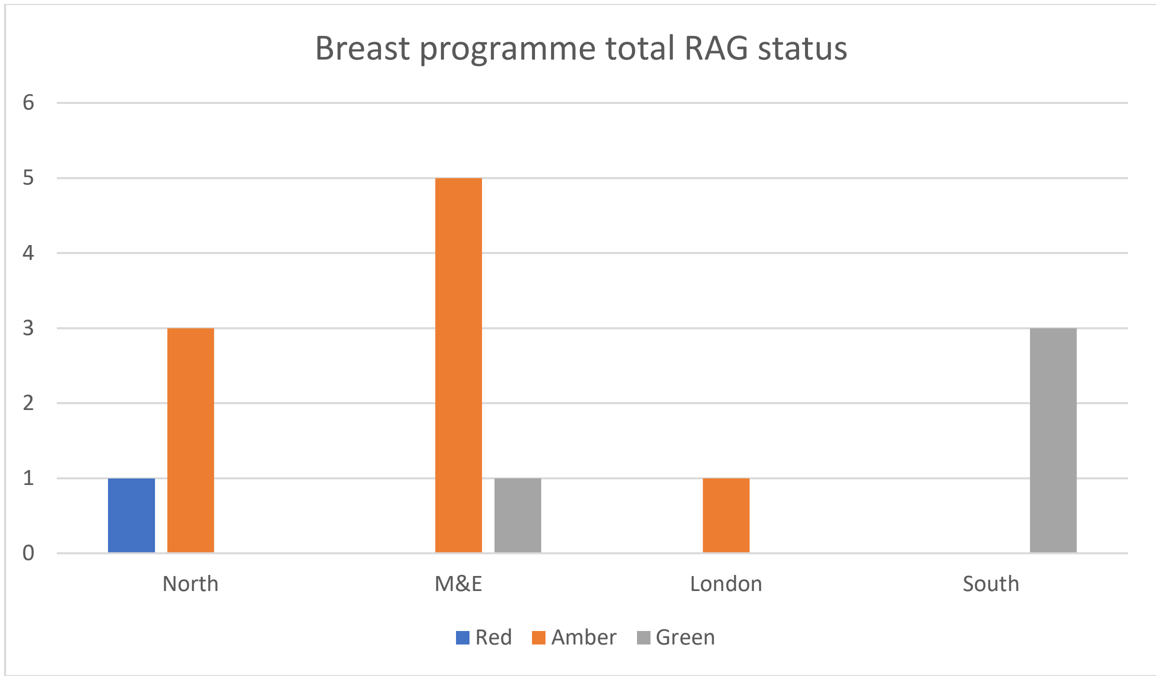
South
Red
Amber
Green


Breast programme total RAG status
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North
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South
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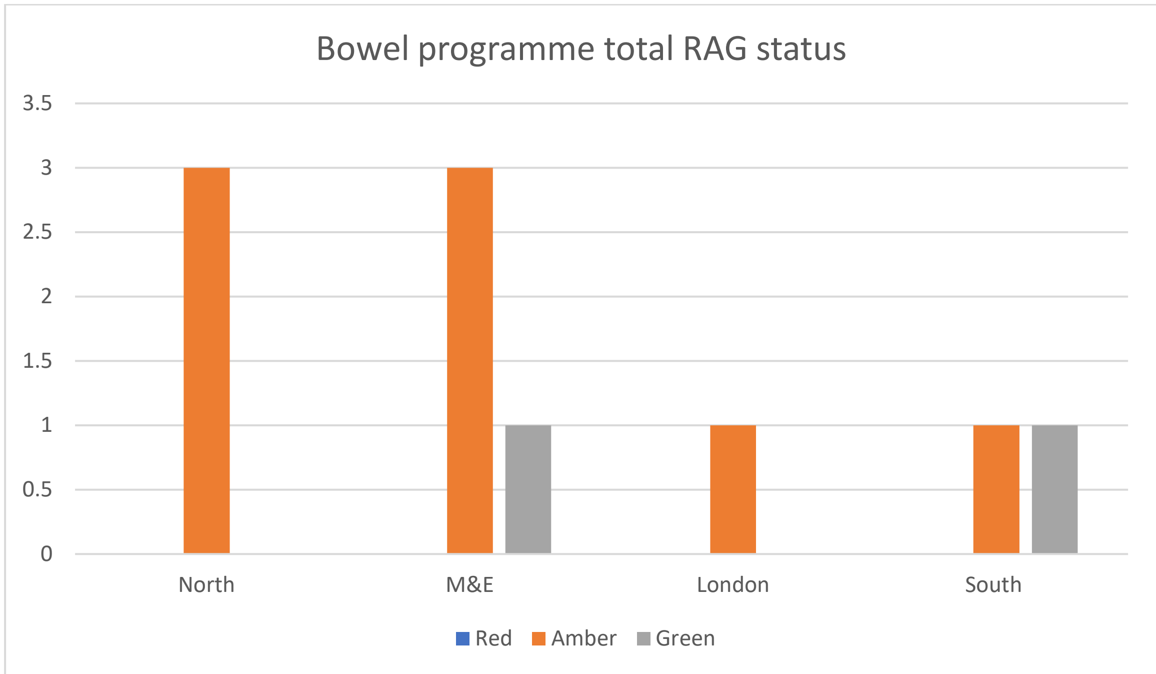
Amber
Green


Bowel programme total RAG status
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0.5
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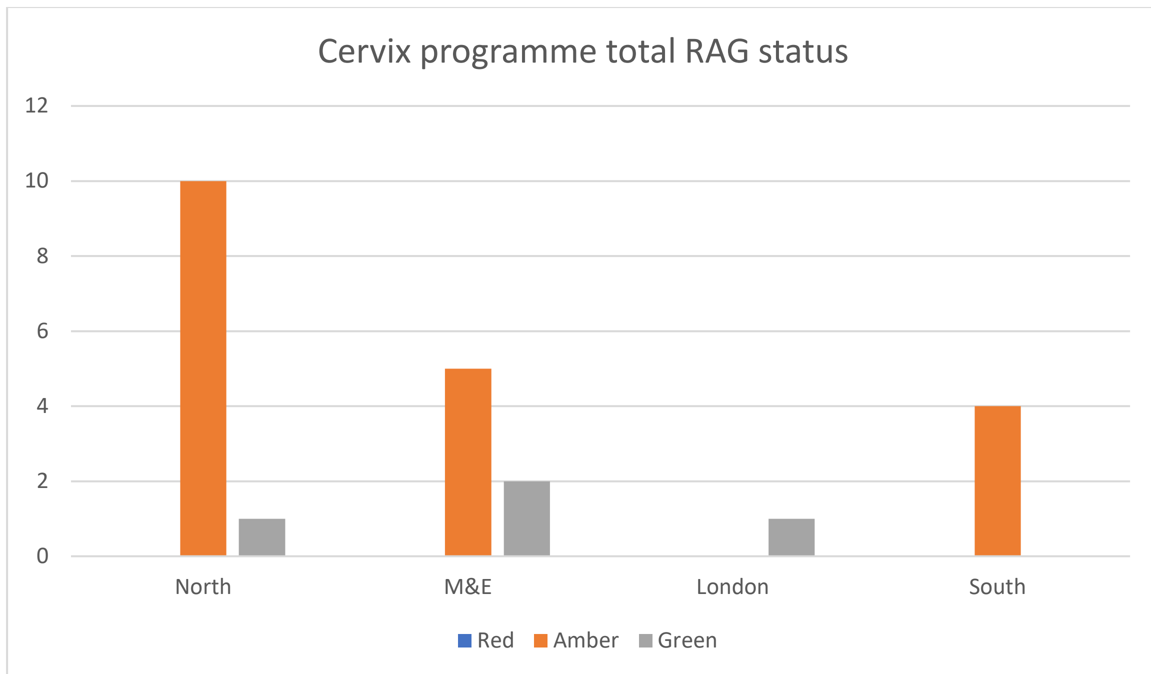
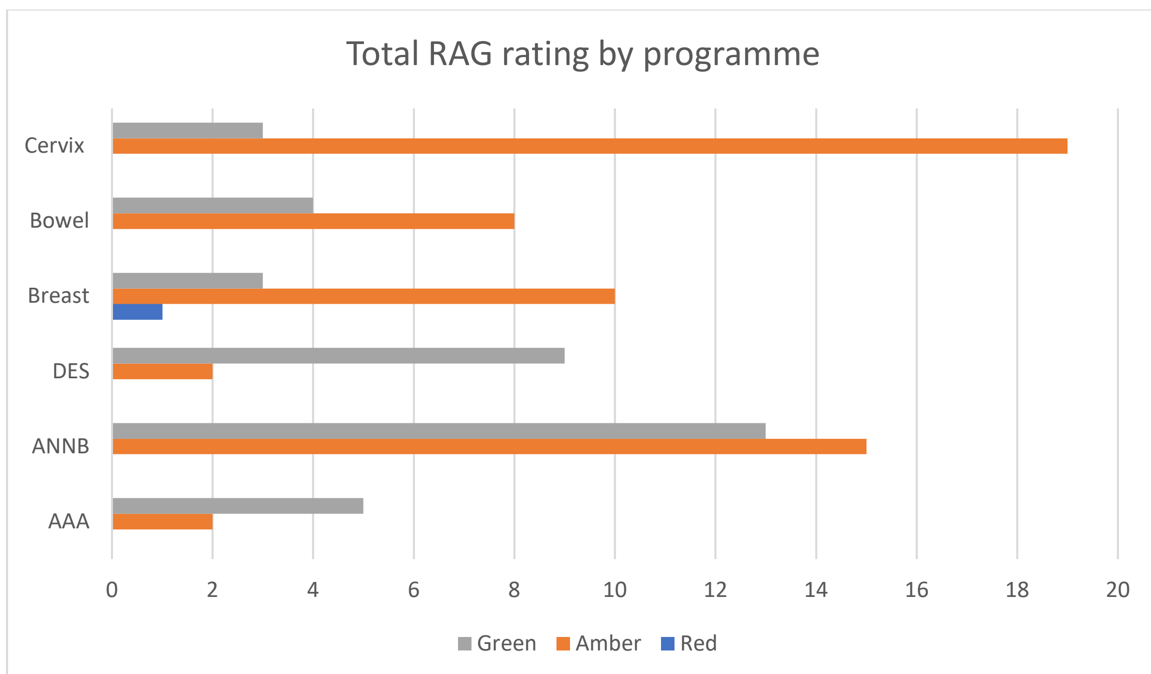
North
M&E
London
South
Red
Amber
Green





The key word search showed variation across programmes and regions in the number of search terms included in the reports.

Only 1 report did not contain any reference to inequalities however as pointed out in the limitations section this does not necessarily mean that inequalities were not assessed at the visit.

It was important to search the whole report as inclusion of inequalities were made in different sections of the report depending on the author.

Specific recommendations in relation to inequalities were made in 46 (49%) of the 94 reports. These were broken down in the table below:

Programme	Region				Total
	North	Midlands and East	London	South	
AAA	1	1	0	2	4
ANNB	1	8	0	3	12
Breast	2	6	1	4	13
Bowel	1	0	1	2	4
Cervix	2	2	1	0	5
DES	2	4	0	2	8
Total	9	21	3	13	46

The findings suggest that SQAS teams are more consistently addressing inequalities in QA visits across all screening programmes. This is likely to be linked to the Screening division focus on inequalities over the past 2 years and the introduction of specific inequalities toolkits for each programme.

Whilst the findings are encouraging the audit did not look in detail at the specific content within each report or at the themes of the recommendations made.

Within the body of some reports there was also evidence of regional inequalities initiatives as demonstrated by the following quotes (note: this is not an exhaustive list just a selection of some of the initiatives reported):

> *"There is a quarterly ANNB screening and immunisation programme board chaired by the SIT for all trusts in NW London which provides a strategic overview and monitoring of the 6 programmes and includes plans for service developments and addressing inequalities within the screening pathways. There is senior representation from each organisation at head or director of midwifery level. The programme board's standing agenda includes the review of screening data and key performance indicators. Local Authority (LA) representatives are invited to attend together with Health Visiting leads. London-wide activity around service improvements and inequalities is ongoing and has included SCT pathway mapping, work with local authorities on health visitor training and an audit of fetal anomaly screening programme (FASP) quadruple test rates." (NB whilst this report related to trusts in NW London there are boards for all London areas which work to a common agenda)*

“A London wide screening inequalities strategy has been produced, and a new London Screening Improvement Board has been recently established. Initiatives are also being developed via the Cancer Alliances, working closely with the Transforming Cancer team; these include - looking at developing a social marketing campaign; improving uptake in people with learning difficulties; text messaging using the NHSE Spine.”

“The Cheshire and Merseyside Health Inequalities Strategy Group was established in March 2019 to lead work to reduce health inequalities in all Section 7a commissioned services. This group meets quarterly and is chaired by the SIL. A list of priorities is in development, with the intention of production of specific recommendations to reduce local screening inequalities.” (Cheshire and Merseyside SIT, North region).

“Lancashire and South Cumbria have an overarching draft screening inequalities action plan. Inequalities is a standing item at the programme board.” (North region)

“The SIT has a strategic approach to health inequalities work and leads a multiagency locality group (Barnsley Prevention and Early Diagnosis Steering Group). This group has a comprehensive action plan and mechanisms in place to monitor the effectiveness of engagement work which is an example of good practice.” (North region).

“There is evidence of the service undertaking good initiatives to increase uptake of bowel cancer screening such as visiting prisons and community venues. The service had a 2 year Commissioning for Quality and Innovation (CQIN) plan for health inequalities work which was used to develop a health equity audit. Health promotion activities are ad hoc and the service needs to be supported to develop a prioritised health promotion action plan, based on links with CCGs and other stakeholders.” (South region).

“The SIT plan to develop a screening inequalities strategy which will include interventions to improve uptake of breast screening however funding is to be confirmed.” (Milton Keynes Midlands and East region).

“The SIT is planning a strategic prioritisation approach to health inequalities work. This will include a learning disabilities audit for providers and joint work with the county council to identify women with learning disabilities.” (Colchester and Chelmsford, Midlands and East region).

Recommendations

This was a simple baseline audit and regions may wish to look in more detail at their results in total and by programme to better understand the breadth and depth of work undertaken to date and to propose further actions.

Consider repeating the England wide audit when the QA visit process is re-established (interrupted in 2020 by the COVID-19 pandemic).

Use the report findings in conjunction with the work undertaken previously in the North and Midlands and East regions to look at ways of improving quality. Learn from the work undertaken on inequalities in the AAA programme.

Amend the report template to include a specific section on inequalities to enable consistency in the way inequalities are identified and recorded in QA visit reports.

Identify the core set of information relating to inequalities which is to be included in each QA visit and report (for example inclusion of a short paragraph on the service demographic profile (geography, ethnicity and deprivation). Define where in the report the information should be contained.

Develop a set of core recommendations for use when addressing inequalities.

Make sure all QA visits include the use of a public health commissioning PCA to review the evidence related to commissioning, governance and inequalities.

QA visit cycles are such that providers are visited at most every 4 years. SQAS should develop a means of addressing and monitoring the response to inequalities regularly with providers and commissioners outside of the visit process.

Share report findings at relevant conferences.