The Screening for the Future Review

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**Version:** 1  
**Sponsoring Executive Director:** Dr Quentin Sandifer, Executive Director of Public Health Services/Medical Director

**Who will present:** Dr Quentin Sandifer, Executive Director of Public Health Services/Medical Director and Dr Sharon Hillier, Acting Director of Screening Division

**Date of Board / Committee meeting:** 16 May 2017

**Committee/Groups that have received or considered this paper:**

The Committee are asked to:
- **Approve** the recommendation(s) proposed in the paper
- **Discuss** and scrutinise the paper and provide feedback and comments
- **Receive** the paper for information only

**Link to Public Health Wales commitment and priorities for action:**
(please tick which commitment(s) is/are relevant)

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**Priorities for action 6D**

By the end of 2019-20 we will have ensured that all our programmes are using the best available technology to maximise clinical outcomes with embedded service user engagement, and continue to meet or exceed national clinical and timeliness standards.
1 Introduction

This briefing relates to the External Review of the Screening Division and is being submitted to provide assurance on the process of considering and implementing the recommendations therein.

2 Background

The Trust Executive Team commissioned an external review of the Screening Division in early 2016. Andrew Rostron, National Programmes Lead (Antenatal and Newborn Screening Programmes) Public Health England undertook the review, looking specifically at the structure and organisation of the Screening Division, with particular focus on:

- How the Division can grow efficiently as additional programmes are added to the portfolio.
- Potential for developing common core business processes between programmes.

The clinical quality or effectiveness of the services provided was not within the scope of the review.

The Division's Senior Management Team has considered, taking advice from the People and Communications teams, how best to develop an appropriate action plan. This paper summarises the report and how this will be taken forward.

3 Timing

Not applicable, decision not required.

4 Description

The report contains twenty far reaching recommendations with timescales for implementation extending beyond three years in some instances.

Benefits accruing from the changes are generally not quantified. In some cases it is not clear how they would help the Division to grow more efficiently.

The report encompasses most aspects of the Division and its position within the Trust, with major implications for some individual teams, services and professional groups such as nurses.

Some recommendations concentrate on individual teams within the Division, which has led to concerns about role changes, job security and the value placed on individual roles and teams by the Trust. The report
advises that changes should be carried out sensitively and with the involvement of those affected. It acknowledges that implementation will be challenging and require significant capacity, skill and leadership if it is not to distract from the continued provision of high quality screening programmes, which is the purpose of the Division.

The reviewer carried out the task conscientiously and sensitively and undertook mixed methods with review of documentation and stakeholder interview with personnel and key stakeholders. The report reflects fairly the information gathered from the various sources during the review.

4.1 Sharing the report

The report was received by Public Health Wales in December 2016 with an initial discussion by the Executive Team on 14 December.

The report was then shared with the Screening Division Senior Management Team, staff and Trades Unions in January 2017. It has also been shared with stakeholders including Welsh Government and Health Board Executives who had contributed to the review.

Members of staff have been encouraged to feedback their queries, questions and concerns to the review, and feedback has been received which will be used to inform work going forward.

4.2 Considering the recommendations

The Screening Division Senior Management Team carried out a SWOT (strengths, weaknesses, opportunities, threats) analysis on 11 January. Of the twenty recommendations, there was broad agreement with many, although some recommendations were identified as requiring further consideration. It was appreciated that the recommendations had wide implications and that this needed to be supported as an organisation and could not be addressed solely within the division. Recommendations fall into 3 categories;

4.2.1 Recommendations already being addressed:

Actions to meet some of the recommendations made were already underway by the time the report was received, including five of the thirteen identified as short term:

- Business planning to be a fully integrated part of Public Health Wales business planning process (recommendation 3).
- Three year forward planning should be maintained with reviews each year (recommendation 4).
- Improve flexibility within financial management to include phasing of budgets and enable where possible virement across budget lines (recommendation 6).
- Manage the core Public Health Wales functions of HR, IT, Communications and Finance as part of the core Public health Wales functions (recommendation 7).
- Review HPV primary screen pilot plan and ensure source of funding is agreed and manage transition (recommendation 20).

4.2.2 Recommendations with broad agreement:

- The Screening Division should ensure an All-Wales approach for all programmes, based on standard operating procedures (1st part of recommendation 1)
- A review of screening pathways and programme standards to ensure they clearly identify the screening end point and hand over points (recommendation 2)
- Re-baseline screening budgets following implementation of any agreed recommendations (recommendation 5)
- Recruitment of new Director of Screening with clear strategic leadership and managerial focus and public health / population screening expertise (Recommendation 8)
- Screening documentation, web content and facilities to be dual branded with Public Health Wales and develop common styling and format of screening products (recommendation 9)
- All nursing and midwifery posts to be operationally managed by their respective Head of Programme (recommendation 12)
- Management of programme specific administration functions to be within programme teams, including newborn hearing/newborn bloodspot screeners/co-ordinators (Recommendation 15)
- Management of screening division core administration functions to remain with the Head of Administration (Operations) (recommendation 16)
- Review specifically Diabetic Eye Screening Wales management structure (recommendation 18)
- Abdominal Aortic Aneurysm Screening line manager should be under the same structure as other programmes (recommendation 19)

4.2.3 Recommendations requiring further detailed consideration:

- Development of regional teams and Regional Screening Centres (part of recommendation 1)
- Integration of the Screening Engagement Team as part of Public Health Wales core functions (part of recommendation 7)
- Review of senior leadership structure
- Director of Screening –strategic lead with fewer direct reports
The Division is establishing the “Screening for the Future Project” to take the work forward. This approach has been agreed with the Executive Director of Public Health Services and aims to develop the Division into what we would like it to be in the future. The project scope will include actions arising from the staff survey, and include other drivers such as the Public Health Wales strategic plan (IMTP), workforce planning, quality and impact framework, Public Health Wales’ values and behaviours and the larger policy framework of the Wellbeing of Future Generations Act.

A project structure is being developed and will include staff and Trades Union representation as well as other key stakeholders from across the organisation. The project will develop a detailed plan and will comprehensively consider all risks, issues, financial implications and the benefits of implementation. A project manager will be recruited on a fixed term basis, funded from an existing vacancy within the Division. The Executive Director of Public Health Services, Dr Quentin Sandifer, will chair the project board and is the Executive Lead for the project which will ensure there is clear and consistent high level leadership.

The first action will be to hold three regional events, facilitated by the 1000 lives team, during May 2017 with the aim of engaging and listening to staff and to identify themes to inform the project.

The ultimate aim is a Screening Division that provides equitable, safe, effective and cost effective services and is a great place to work.

5 Financial Implications

Although the reviewer states that implementation should be cost neutral, more detailed examination of the recommendations suggest that this is unlikely to be the case. A detailed appraisal of the financial implications will be undertaken during the implementation project outlined below.

6 Recommendation

The Committee is asked to note the report.
Public Health Wales
Review of Screening Division

Final Report

Andrew Rostron
Version 1, 08.12.16
About Screening and Public Health Wales

Welsh Government sets screening policy and the model for screening in Wales, as advised by the Wales and UK National Screening Committees. Screening programmes are funded, planned and delivered separately from acute services, although the model cannot work without significant Health Board input.

Public Health Wales is responsible through its Screening Division for the management and delivery of seven national population based screening programmes:

Breast Test Wales (BTW)
Cervical Screening Wales (CSW)
Bowel Screening Wales (BSW)
Wales Abdominal Aortic Aneurysm Screening Programme (WAAASP)
Diabetic Eye Screening Wales (DESW)
Newborn Hearing Screening Wales (NBHSW)
Newborn Bloodspot Screening Wales (NBSW)

The Division also hosts the Managed Clinical Network for antenatal Screening in Wales, Antenatal Screening Wales (ASW)

Screening programmes reduce mortality, morbidity and demand on health services arising from late presentation of disease, by a process of identifying apparently healthy people who may be at increased risk of a condition. They are offered information, further diagnostic tests or treatment to reduce their risk and/or any complications arising from the condition.
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## Glossary

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Executive Summary

This review has been commissioned by the Executive Team of Public Health Wales. The Senior Responsible Officer is Dr Quentin Sandifer, Executive Director of Public Health Services. The review has been chaired by Mr John Spence, previously a non-Executive Director of Public Health Wales. The scope was to review the structure of the Screening Division and its functionality as a divisional unit and within the Public Health Wales overall structure. The review has not included enquiry, nor subsequent commentary with regard to the effectiveness or performance of the screening programmes.

The report is presented to the Public Health Wales Executive Board to provide key information and recommendations following the review of the screening division. The focus of the report was to identify changes to the management and structure of the division and the screening programmes, to enable the division to accept and implement new screening programmes and changes to screening pathways in a more efficient manner and within a more challenging fiscal environment.

The findings of the review present many challenges that the screening programmes face. The structure has been built from a historical basis thus rendering the current arrangement overly complicated with much variation across programmes. Many individual posts have developed over time leading to job descriptions not reflecting current roles. Lines of management are convoluted with key programme personnel being managed by non programme managers. Although relationships across managers are very good there remains difficulty when managing core programme functions.

There is a general feeling amongst interviewees that staff grading across the Division is high when compared to comparable roles in the NHS and there is a great variance and inconsistency across the Division for similar roles. There are a number of historical positions that are occupied by very senior medical staff (traditionally Associate Specialist level) where in reality these roles could be undertaken by more junior or non-medical staff with appropriate skills. Consideration should be given to merging some of the roles and accessing clinical expertise on a sessional fixed term basis rather than direct employment.
The senior structure of the Division requires clarity between strategic and operational roles to ensure robust management of the programmes. The senior team may require some restructure and recommendations are made in the report. As above many roles, even senior positions have developed over time and a role review should consider the posts required and who has the most appropriate skills and experience for these.

Programme structures are varied with a shift to a stated All-Wales approach. This is to be recommended and replicated across all programmes. The All-Wales model should be supported by a regional structure with the regional leads having fundamentally the same roles (subject to some programme specific requirements). To support the regional delivery Public Health Wales should consider the strategic direction of moving to a structure based on regional screening centres, where core services, for all programmes, can be co-located, this will include all general administration, call/recall, failsafe and medical secretarial support. In many cases these centres might offer screening for multiple programmes, subject to clinical requirements being satisfied. Clearly not all services can be delivered from these centres and local services must still be supported.

Core Public Health Wales services and core Screening Division services must work closer together. Screening has approximately one third of the staffing resources and one third of the funding of Public Health Wales. Merging these functions together will have great benefits to all but there is a risk of reduction in support to the Screening Division. Such merging of function requires that the Screening Division receives adequate support in all areas. This is most likely to be achieved by robust business and forward planning.

Financial planning was an area discussed at great length during the review. Public Health Wales should work closely with the Screening Division, being clear around financial management and control. Large annual underspends should not be tolerated without clear mitigating circumstances. Phasing of budgets may help and early indications and transparency of predicted spends throughout the year. It may be necessary to re-baseline the screening budget to support new initiatives or other cost pressure areas with Public Health Wales.

An overwhelming finding identified that all team members interviewed are happy in their roles, screening is a good place to work and the Division and Divisional Director are well
respected across the healthcare arena. Changes will be required and these should be carried out sensitively and with the involvement of those affected by change.

Recommendations are presented throughout the report, and for ease of reference these are detailed as a separate section on page 42.
Background

Public Health Wales (PHW) was established on 1 October 2009. The Screening Division is part of the Public Health Services Directorate of Public Health Wales, along with microbiology and health protection.

Screening Division

The Screening Division delivers seven population screening programmes for NHS Wales, and delivers the all-Wales Managed Clinical Network for Antenatal Screening. It has a budget of circa £37m and directly employs around 500 staff, with many others providing services via honorary contracts or Service Level Agreements with Health Boards. It has grown from a single programme, Breast Test Wales, which first started screening in 1989, to present day. Additional programmes have been added to the portfolio, either as a result of Welsh Government policy decisions to transfer existing programmes into the Division (Cervical Screening Wales 1999, Newborn Bloodspot Screening Wales 2014 and Diabetic Eye Screening Wales 2016), or the development of new programmes, again at the request of Welsh Government (Newborn Hearing Screening Wales 2003, Antenatal Screening Wales 2003, Bowel Screening Wales 2008, and the Wales Abdominal Aortic Aneurysm Screening Programme 2013).

The Screening Model in Wales

The model of population screening in Wales is for a single organisation (currently Public Health Wales) to be commissioned by Welsh Government to provide, evaluate and quality assure population screening programmes in Wales. Elements of each programme (generally relating to diagnostic testing of participants with abnormal initial screening results) are commissioned from Health Boards, who are responsible for the health of their resident populations, but have no obligation to participate in screening programme delivery and are not performance managed to do so by the Welsh Government. Public Health Wales is responsible for the whole pathway from identification of the eligible population to diagnosis with the disease in question. Health Boards are responsible for treatment of the diagnosed population.
Individual programmes have been added to the Division’s portfolio over the last 27 years, and more are likely to be added over time. The design of each programme varies depending on the condition and the test involved but in general each programme has a managerial lead (Head of Programme) with a dedicated administration (pathway management, including failsafe function and call/recall), an appropriate workforce to deliver the initial screening test and referral arrangements with Health Boards for subsequent assessment procedures. To reduce the number of business units, the Division combined the three Maternal and Child (MAC) screening programmes into one unit with a single Head of Programme in 2014.

Wales Audit Office Review 2012

A Wales Audit Office review of Directorate Management arrangements was carried out in 2012, when the Division was providing five programmes. It made several recommendations to improve and streamline lines of accountability within the Division, and to improve governance.

Following the 2012 review, further examination of the screening division has been requested with a focus on:

- the structure and organisation of the Division itself:
- consideration of how the Division can grow efficiently as additional programmes are added to the portfolio
- potential for the development of common core business processes between programmes.
Methodology

The review has been undertaken employing a number of mixed methods. These include:

- review of screening and corporate documentation
- stakeholder interviews with personnel and key stakeholders
  - screening division staff
  - Health Board stakeholders
  - executive board members (Public Health Wales)

Review of Documentation

A range of documentation relevant to the screening division has been provided directly, or accessed via the screening division website. The documentation has provided a range of information such as; historical relevance, performance reports, programme specific information, screening pathways, programme standards, Senior Management Team (SMT) reports and organisational structures.

Review of documentation has provided a good insight into the management and delivery of the screening programmes and has provided good evidence of improvements, particularly around data reporting over the last few years. Additionally it has provided the opportunity to view, from an external perspective, the public facing information.

Stakeholder Interviews

Interviews have been undertaken with key screening division staff, some members of the Public Health Wales executive board and external stakeholders. Interviews were held either face to face or via telephone (25 in all). All screening programmes were represented as were key members of the screening division’s management team and senior stakeholders from the Health Boards.

The interviews were open format with guide questions in order to discuss specific areas of enquiry. Generally the conversations flowed easily with the respondents talking freely and openly about the challenges and successes of the screening programmes and the wider division. This has provided a wide range of information for analysis with a very good insight
into the screening division at all levels and both operationally and strategically. There are a number of common themes identified from the interviews and these will be discussed fully in the findings section.

Staff Survey

A number of staff from the screening division indicated their desire to participate in the review. Geographical and time restraints prevented face to face discussions with all therefore an online survey was produced and circulated to 40 additional staff members.

Of the 40 staff invited to take part in the online survey a total of 24 responded. The response rate of 55% is a good response rate for this type of survey and demonstrates a keenness of staff members to be involved in the review and the future of the screening division.

The responses were varied but again fit into the same common themes identified throughout the individual interviews. Again these are discussed further in the findings section of the report. A copy of the questionnaire is shown in Appendix 1.
Findings

Following completion of the interviews and on-line survey common themes emerged. These are listed below. Additionally qualitative data in the form of comments, observed from the review, have been used to give insight in to some issues disclosed within the review.

Themes mainly focused on:

- structure
  - screening division structure
  - programme structures

- delivery model (geography and management)

- screening pathways

- resourcing and corporate links
  - business planning
  - finance
  - human resources
  - IT
  - communications and engagement
  - governance

- identity
  - programme
  - corporate

Structure

The structure of the screening division has attracted most comments and of course is a very complex area for discussion. The main themes with regard to the structure are centred on variability across teams, variability in support roles to Heads of Programmes, nursing and administration management, working together and geographical challenges.

Findings relevant to the physical structure of the Division will be presented at the end of this section.
Geographic Delivery Model

All programmes deliver their national screening programme to the population of Wales. How this is then organised varies from programme to programme. Several programmes organise their structure into regions, mostly three but some four. These regions roughly split into North, South East and South West but the geographies differ even where they may each have 3 regions.

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<tr>
<th>Programme</th>
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<td>Wales Abdominal Aortic Aneurysm Screening Programme (WAAASP)</td>
<td>National focus – 3 vascular networks</td>
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<td></td>
<td>• Llantrisant, embedded in BSW (SE)</td>
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<td>• Swansea/Carmarthen, embedded in CSW(SW)</td>
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<td>• Llandudno, embedded in BTW (N)</td>
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<td>Diabetic Eye Screening Wales (DESW)</td>
<td>National model</td>
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<td>• Multiple local centres</td>
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<td>Bowel Screening Wales (BSW)</td>
<td>All-Wales base in Llantrisant (provides pathway management for WAAASP SE Wales)</td>
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<td>Breast Test Wales (BTW)</td>
<td>4 centres</td>
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<td>• Cardiff</td>
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<td>• Wrexham</td>
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<td>• Llandudno (provides pathway management for WAAASP)</td>
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<td>Cervical Screening Wales (CSW)</td>
<td>National focus</td>
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<td>• 3 programme managers</td>
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<td>○ South East</td>
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<td>○ North</td>
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<td>Maternal and Child (MAC)</td>
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<td>• Hearing – 3 regions</td>
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<td>• Blood Spot – national focus – single lab</td>
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<td>• Antenatal – maternity led</td>
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<td>Newborn Hearing Screening Wales (NBHSW)</td>
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<td>Antenatal Screening Wales (ASW)</td>
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Table 1 – Geographical make up of screening programmes

As can be seen from the table above the regional geographies vary and even where there are similarities services are not often co-located in the same offices / clinics. This results in
multiple estate solutions and duplication of resources and in some cases isolation from work colleagues. Screening Division currently has 16 separate offices across Wales providing pathway management for the various programmes, although there are active plans to merge some offices.

“Feel isolated from the rest of team. Others not sure what my role is. Working alone a lot of the time”

“Communication at times with different departments, can be very difficult, many feel isolated and forgotten about if you don’t work in Cardiff”

Review of the geography of screening teams offers opportunities for grouping functions within and across programmes. This will lead to reduction in duplication and streamlining of pathway management and other office functions, for example, generic administration support can be more focussed and support multiple teams. It is important that any review of roles and function do not lead to loss of knowledge, skills, pathway expertise and IT system expertise.

A review of the above functions will need to tie in closely to the review of the team structures. Together they offer a great opportunity to improve efficiencies within and across programmes and to develop roles and functions possibly with an ability to build in some degree of succession planning. This is important as a reasonable number of staff (in some teams) are nearing the age of retirement.

Review of geographical bases does not need to necessarily affect clinics or treatment centres as these are important to ensure optimum access to screening. Non clinical services and potentially some clinical services can be co-located.

“Screeners have to work across the sites and therefore bases are needed in the hospitals. The Regional Admin teams vary in their structure and could be an area for review possibly look at sharing some admin resources with other Screening teams”
“Bring CSAD into the Capital Quarter to be seen as part of the wider Public Health Wales team. Bring West Wales into one office. Perhaps move towards a central CSW hub as the programme changes with HPV testing”

“There is significant scope for us to review the set-up and role of regional teams across the screening programmes, both in terms of degree of autonomy, responsibility and objectives”

Due to the current structure of programmes and the rurality of Wales there remains a need for home based workers and mobile working. The screening division offers a good infrastructure for mobile working which was frequently identified during the review. Home working does offer some challenges as interviewees reflected difficulties contacting home workers despite contact being at a time when they were expected to be available. Managers within Screening Division should ensure that home working policies are understood and that home workers are appropriately managed.

All programmes should offer an All-Wales approach to screening. This is different to being a national programme. For example BSW and WAAASP have a very strong All-Wales approach with each region or screening facility offering screening using national models, the same policy and procedures with good regional support to ensure that the service offered is the same wherever it is accessed. Other programmes, although delivering regional models deliver variability across the country with parts of the team undertaking work based on historical working practices that results in variation of service delivery. It is likely that all programmes do consider that they offer an All-Wales approach but in reality this is not so when compared to other programmes.

“when processes were set up, I would be met with in such n such programme we do it this way or we have always done it this way”

It is important that all programmes strengthen the All-Wales approach with clear regional structures and clear policies and procedures for all to adhere to, wherever located. Review of individual programme structures and delivery will enable this to be actioned. It is important
that this report does not question the quality of any of the screening tests and clinical service delivery.

**Recommendation 1:**

The Screening Division should ensure an All-Wales approach for all programmes, based on standard operating procedures, and work towards regional teams within regional offices – Regional Screening Centres

**Screening Pathways**

Screening pathways are the linchpin for all screening programmes. The pathways detail what is required of the programme from identification of the eligible cohort to, in most cases, a screening outcome which may or may not be a diagnostic test. Within each of the programmes the pathway is very clear with all personnel from the programme understanding the pathway and their role within it. Externally to the programmes the pathways are, in some cases, less understood.

The review has identified that some key stakeholders in the Health Boards are unclear where screening stops, and more importantly who is accountable for certain parts of the pathway especially around diagnosis. Typically, screening programmes screen to identify a positive screen outcome which is in most cases an indication that there might be a problem, it is usually not a diagnosis. For example, the blood spot screening programme identifies babies that are likely to be affected by one of the conditions screened for. A confirmatory test is then required to confirm diagnosis. A similar example exists in DESW. The majority of the programmes undertake initial diagnostics prior to referral to clinical services. For example, the cervical screening programme undertakes colposcopy with onward referral following a diagnosis of cancer.

Clear programme standards are essential in order that commissioning is clear and providers are in no doubt with regard to responsibilities and expectations. All programmes have standards, except for DESW (these are being developed), and have a cycle for review. Moving forwards the programme standards should all follow the same presentation style.
and be reviewed to ensure that they are measurable and target areas of most importance and areas of required improvement. It should be noted that DESW only moved in to the screening division approximately six months ago and, as such, is still in the process of full integration including the need to move to common structures, pathways and standards. Continuation of this process should be very much part of the recommendations of this review.

Whilst each respective programme is clear it is important to have robust mechanisms in place where care or diagnostics are handed over to another provider. Each time there is a hand over (e.g. referral) there is a risk of a break or failure of the pathway. Responsibilities for the screening cohort is important, some respondents were less clear with regard to responsibilities at intervals in the screening pathway, especially at points beyond the initial screening test. It is important that failsafe procedures are clear about referrals in to clinical services and acceptance of that referral to ensure, at all times, clarity with regard to clinical responsibility at any point in the pathway. For example, CSW has an electronic ‘colpsafe’ system which will identify when women referred for colposcopy have failed to attend their appointments.

When compared to England some of the screening pathways extend beyond the end point set in England. For example in the newborn hearing screening programme the English pathway stops when a child is referred from the screening programme to paediatric audiology following a no-clear response from the screen. The audiology services are then responsible for the diagnosis with habilitation being organised thereafter. Within Wales the newborn screening programme is responsible for the service up to the point of diagnosis and referral for habilitation. This is through agreements with Health Boards for diagnostics. Currently a benchmarking exercise is underway to ensure funding to Health Boards from Public Health Wales for these services are fair and equitable. The model sought is a cost per head (confirmed permanent childhood hearing impairment [PCHI]). It is important that the cost per head refers to the actual number of children referred to in to the paediatric audiology service rather than from the Health Board from which the baby resides in order that the services treating the baby receives adequate and fair funding.
Resources and Corporate Links

The Screening Division is well respected across Public Health Wales and within the Health Boards. Many respondents have identified that there are good levels of engagement with screening at all levels and especially at senior level.

The Screening Division, over recent years, has improved its position within Public Health Wales working more collaboratively and sharing excellence in service delivery. Similarly Public Health Wales has reviewed the senior management team as the organisation continues to mature. It is evident that the Screening Division needs to further integrate with Public Health Wales particularly around the wider public health agendas. Many of the attributes of the Screening Division are of a high standard and it is of mutual benefit to work closer with the other Public Health Wales teams and senior management where sharing of good practice and in some cases resources can benefit all parties. A recent successful example has been the merging of IT management where both parties have gained. Further examples where this may be of benefit are discussed below.

Business Planning

Business planning is key to the successful delivery of the screening division's objectives and annual commitments. Similarly this is the case for wider Public Health Wales where screening is allocated approximately one third of the overall budget. Business planning across Public Health Wales is important and including screening is core to ensure overall objectives can be resourced and met.

Historically the screening division has been allocated their funding at levels requested, including additional requests for alterations to screening pathways or new screening programmes. Over the last couple of years NHS funding has been more restrictive with

**Recommendation 2:**

A review of screening pathways and programme standards to ensure they clearly identify the screening end point and hand over points.
closer scrutiny of finance allocation and actual spend. Looking forward it is likely that business planning will need to be more robust and expectations of full funding requests being met should be considered unlikely. As such business planning may need to be undertaken more formally where the division may have to make uncomfortable decisions deciding between programme requests.

Across the wider Public Health Wales business planning processes the screening division should be an integrated part of corporate planning. The overall planning process should be a single process accepting it may be necessary to address some objectives that are unique to screening and others where merging or sharing of resources might address constraints in funding and uniform functions across Public Health Wales. Within the wider Public Health Wales planning difficult conversations may be required where priorities across the public health agenda conflict and are restrained due to under-resourcing.

**Recommendation 3:**

Business planning (including forward look) to be a fully integrated part of Public Health Wales business planning process

The expected changes to screening programmes will be a major challenge for the years ahead. There are a number of key changes expected to be integrated in to screening:

1. HPV as primary screen (major change in CSW pathway)
2. FIT (major change to BSW screening pathway)
3. NIPT (additional test in Downs screening pathway - ASW)
4. Age extension for BTW (subject to outcome of RCT In England)
5. Interval length for DESW

In addition, there are programmes agreed by the UK NSC that are not implemented in Wales but may be possible future programmes.
Finance

Financial management is another key area to the successful delivery of objectives within the allocated funding. The Screening Division has historically received funding commensurate with requirements and until recently these have usually been met with minimal challenge. Looking ahead NHS funding is under more scrutiny and demand constantly outweighs available funding. Indications recently have highlighted that the Screening Division is less likely to secure new funding for new programmes or altered pathways.

As detailed above robust business planning through Public Health Wales is likely to be viewed positively and within Public Health Wales more input into the Screening Division’s requirements can only help to further develop equitable use of resources.

The Screening Division is a large division within Public Health Wales and consumes approximately one third of the overall annual budget. Over the last few years the Screening Division has consistently presented annual underspends. It is important to understand why there is recurrent underspend as it is possible that factors outside the screening division delay or prevent the ability to spend to budgets e.g. protracted recruitment processes. However it is noted that these underspend has addressed financial challenges elsewhere in the organisation.

It is important that the Screening Division identify the rationale for recurrent requests at this level and justify underspends. From this point it should then be possible through negotiation to reallocate funding, ideally within screening for other areas where there may be shortfall or to fund the expected additional screening pathways / programmes. Another possibility is to divert this funding in to other areas within Public Health Wales. As per the recommendation above it is important to ensure a three year forward planning to be maintained to ensure

Recommendation 4:

Three year forward planning should be maintained to ensure funding levels are appropriate, with reviews each year to overcome the difficulty in projecting future costs accurately.
funding levels are appropriate, with reviews each year to overcome the difficulty in projecting future costs accurately.

With the impending changes to programmes, and new programmes (listed above), it is of great importance to fully review the financial structure of the Screening Division to enable more flexibility across the Screening Division and where necessary agree re-allocation of underspend to areas that may require additional funding. It is also opportune to consider re-baselining of budgets taking in to account any changes that may be made with regard to the roles and functions of staffing across programmes, review of grading structures, and rationalisation of call/recall functions.

**Recommendation 5:**

Re-baseline screening budgets following implementation of any agreed recommendations

There were a few comments regarding the lack of financial management or control within programmes. Some Head of Programme’s stated they knew of underspend in some areas whilst within their programme were experiencing difficulties in other areas. Furthermore they had experienced being challenged, in their view, unnecessarily about particular lines being overspent even though their overall budget was underspent. They stated it was very difficult to agree to virement across cost codes / centres.

**Recommendation 6:**

Improve flexibility within the financial management to include phasing of budgets and enable, where possible virement across budget lines
Human Resources

Many of the comments from the review were focussed around the resourcing of the teams. This is discussed in more detail later in this section.

It is important Public Health Wales to recognise that as the recommendations focus on the structure of the screening division, and staff roles within it there will be a significantly increased requirement for HR resources to the Division in order to undertake necessary changes.

With regard to support to the screening division there were a number of comments describing a reduced level of support from Public Health Wales HR partners.

“As a Manager I feel that HR support over recent years has deteriorated which can leave Managers feeling unsupported”

“…generally not much HR or finance support”

However it was recognised by some that HR support to the Division has improved recently. HR support is, and should continue to be, a core function for Public Health Wales with support to the Screening Division accessed and provided similarly to other sections of Public Health Wales. It should be recognised though that the Screening Division has approximately 34% of the total Public Health Wales staffing establishment. Within the Screening Division there seem to be areas that require a high level of HR input. It is important that sufficient recognition of the level of support required to the Screening Division will need to be consistently high.

IT and Informatics

IT support for the Screening Division has recently been merged with Public Health Wales. Despite reservations around the levels of support for the screening division, and access to IT system development it has been shown and acknowledged that this merger of IT has actually been a very positive change.
IT is a very large component to the Screening Division encompassing data management and reporting, call/recall, and management of failsafe. It is also a very high cost component of the Screening Division.

Merging functions should offer a high level of support and wider access to services supporting IT, such as legal and procurement specialists for contracting, contract management and re-procuring of new systems. An example of such work is already evident with the plans to move towards a single screening platform for the screening programmes. At present lack of interoperability between systems presents risks including poor access to data and the possibility of missed screens.

Screening Engagement

The Screening Engagement team is spoken very highly of from the majority of programmes with regard to output from the team. They are recognised as a very good resource to the programmes producing excellent materials and dealing well with public facing initiatives.

“The engagement team produce really good information for the public”

However there were also many comments stating that there was lack of clarity in how work is directed by and within the engagement team. There was mention of duplication at times and lack of a co-ordinated approach within Public Health Wales and the wider Health Board public health initiatives. There were also comments about the team being self-directed and not engaging directly with the screening programmes.

“The engagement team are not engaged, they represent the programme without any prior knowledge”

“…would be more useful if they had a named link per programme”

The work of the engagement team is often duplicated; this was supported by some Health Boards stating areas of the work undertaken by the engagement team had already been done similarly at local level by the Health Board.
The engagement team could work more effectively and offer greater benefit by providing similar functions for Public Health Wales. This will, however, present a big risk of reduced support to the Screening Division. In order to ensure adequate resources for public engagement is secured for the Screening Division the work of the engagement team should be forward planned, focussed on major forthcoming events for the screening programmes and to support issues around access and inequity of screening services.

The Screening Engagement Team is perceived by other areas of the organisation as a very well-resourced team which could withstand efficiencies / take on a wider focussed remit for Public Health Wales. More recently (2016) Public Health Wales have commissioned an external review of its engagement work. The outcome of this report is not known at this stage.

**Recommendation 7:**

To manage the core Public Health Wales functions of HR, IT, Communications, and Finance as part of the Public Health Wales core functions and consider integrating the Engagement Team

**Governance**

The governance of Public Health Wales is of crucial importance internally and externally. This extends within all divisions of Public Health Wales. Historically the Screening Division has developed independently of hosting organisations and to some extent is still somewhat insular. More recently there has been focus on further integration with the wider Public Health Wales structure and management processes with some good areas of success. It is fair to say that more can be done leading to mutual benefits.

The Screening Division is a well respected Division across the whole health arena in Wales and works well in clinical and managerial interfaces at many levels. Because of this success it is often difficult to identify changes that may be required and the benefits change could offer.
Increasing constraints in funding together with closer national scrutiny across the NHS means that efficiencies and the ability to absorb additional workstreams is increasingly required. Governance across Public Health Wales will enable cohesive management units to enable effective, supportive business functions.

The Screening Division has expanded (built up on early structures) as more programmes have been added. Whilst the Division is well respected it has been described as a collection of programmes with several mentions of silo working. Moving forwards the Screening Division needs to strengthen the team to ensure cohesiveness and to fit corporately.

Future structures of the Division should focus initially on the overall management of the division, including cross programme working where relevant. Programme delivery is not part of this review. The Division is managed well but with the impending retirement of the Director of Screening it is opportune to review the senior management team and reporting structure. Governance of the Division requires strong strategic management with knowledgeable and effective direct reports that are, in turn, able to manage their teams effectively. There should be clarity between strategic and operational roles and clarity regarding reporting structures.

Recruitment to the new Director of Screening is the most important change as the appointee will need to lead the team through a number of agreed changes. It is important to appoint someone with good leadership and managerial skills, with a strong focus on public health and track record in leading programmes and delivering change. The post holder does not necessarily need to be medically qualified but experience in population screening would be desirable together with a strong history of achievement.

Heads of programmes should be tasked with reviewing their teams and ensure roles are reviewed, new roles developed where necessary to support the programme, and to change roles and functions and reporting structures as required. It should be clear that any new roles should be from changes in structures and grades rather than additional funding overall, although there may need to be a balancing of funding between programmes. Some specific areas to consider are discussed fully later in this review.
**Divisional and Corporate Identity**

The identity of the Screening Division is very strong across Wales. Individually programmes are easily recognisable to the public. Across the Division there is clarity with regard to purpose and programme identity but as a whole the Screening Division, although well known, does not have a strong identity as a unit and less identity as part of Public Health Wales.

All programmes have very strong programme identity with some having more public awareness than others. For example WAAASP has less of an identity nationally than BTW. Public recognition is, as would be expected, relevant to the targeted screening cohort. As such men of 65 are less aware of BTW or newborn hearing than they are of WAAASP.

Cross Programme collaboration is required to ensure closer working together and acceptance that any given programme is part of the ‘family’ of screening programmes. This needs to be achieved in a number of ways. When liaising with stakeholders any member of a team should always be aware of other screening programmes and where appropriate take the opportunity to increase awareness of other programmes and at times promote screening in the wider context. For example conferences / events that may be programme centric can also have available information for all programmes. (This would be dependent on audience).

Another area that can help with wider divisional identity is to further improve the presentation of programme and divisional documentation including web content. All documentation should be presented as a suite of documents from the Screening Division with clear reference to screening and also Public Health Wales. It should contain the same format and style, clearly identify the Screening Division, the programme and contain dual branding (screening programme and Public Health Wales), including logos. Some of this has already been undertaken but this requires extending across all screening activities. Branding should also extend to facilities management.

**Recommendation 8:**

Recruitment of new Director of Screening with clear strategic leadership and managerial focus and public health / population screening expertise.
Presentation of products in this manner gives a very professional window to external stakeholders and service users. The wider NHS, Health Boards and the public can instantly recognise, at a glance, a screening product and engage with programmes more effectively. Within England this approach has been taken, with PHE taking the lead on branding and information styling based upon the national digital strategy and gov.uk requirements. The English screening programmes initially responded negatively to this approach and had to accept the decision. Nevertheless the resultant information branding is now seen internally as very successful and professional, and externally a recognised product from the screening family. This approach will require a Public Health Wales corporate approach and prove very beneficial with external stakeholders, especially clinical and Health Board colleagues, and will clearly identify that screening is part of Public Health Wales and that screening champions the wider public health agenda.

Figure 1 – example of branded screening documentation

**Recommendation 9:**

Screening documentation, web content and facilities to be dual branded with Public Health Wales and develop common styling and format of screening products
Screening Division Structure

The structure of the screening division has developed over many years. The model based around BTW has accommodated new programmes with the result being a rather complicated structure with very complex lines of management that are spread across many teams. A number of reviews have been undertaken over the years that have altered the structure in places, mainly within programmes, this, although making positive changes, has not addressed the Division as a whole and a diverse model across the Division remains.

With the ever expanding remit of the Screening Division the current structure has become overly complex with a number of inequities. Lines of management are often not clear and many are inconsistent with similar roles across the Division. There are also high percentages of senior grades across the Division and these are not comparable across programmes nor with similar levels of responsibility in NHS roles. Grades of individual staff were not available for the review but there is a clear perception that many posts are graded higher than would be necessary when assessed against role and function. Many roles have changed over time with the work now undertaken, by some, not reflective of their job description. There are many examples of various grades of staff undertaking similar roles.

At a senior level the Division is led by the Director of Screening with a Deputy Director. The number of direct reports appears similar with sharing of programmes. The programmes require commonality of leadership and management. The Director’s role has a huge remit necessitating interface and communication with a wide range of stakeholders from the public to Welsh government. It also includes leadership and oversight of programmes and activity but this may be better achieved by grouping the programmes under a single manager. In addition to the Director, there are two Public Health Consultants in the Division appointed at senior level (Consultant in Public Health, and Deputy Divisional Director). These two roles should look to undertake the formal management of all Heads of Programmes providing the interface between the operational deliveries and the strategic requirements of the Division. The programmes should be split, with consideration of workloads, as a simply splitting by number of programmes may not be optimal. Other areas of responsibility may also be delegated/retained. A suggested senior management structure is shown in Appendix 2.
There is widespread recognition that changes to the structure are required even though individuals may be apprehensive about such changes. It is important that any changes recommended for the improvement of effectiveness, efficiency, or to equip programmes with the resources to manage future challenges are set within a positive context and to embrace improvements to the Screening Division.

**Recommendation 10:**

Review of senior leadership structure

- Director of Screening – strategic lead with fewer direct reports
- New structure for the management of all Heads of Programmes

**Programme Structures and Management**

As introduced above the structures within each of the individual screening programmes vary. These variances are complex with some focussed around management of the programme, some around the geographical make up of service delivery and others around the screening pathway. Whilst all of these requirements for variance may be justifiable within some programmes there are unnecessary complexities and inequities.

Each programme is led by a Head of Programme with a general acceptance that the role and responsibilities are similar across all programmes. When discussing further it is evident that all Heads of Programmes see themselves as lead for their respective programmes yet each have differing views with regard to the support they require within the structure. Delivery of the programmes vary, they are generally set up to deliver screening on a regional basis under the umbrella of the national programme. This has necessitated regional roles and functions, many of which are historical and most of which are not consistent from programme to programme. Inconsistencies arise from acceptable specific roles but also with regards to span of work, grades of post holders and numbers of such roles.
“I feel current line management structures prohibit regional team development. Our three regional leadership roles report to different line management structures (regional programme manager reports to head of programme, lead nurse to head of nursing and CSAD manager to lead CSAD manager). This arrangement complicates local performance management from a regional programme manager perspective”

At a senior level within each programme there are a variety of structures, with roles such as programme managers, programme lead, regional co-ordinators and other specialist roles. It does seem apparent that the levels of support for some Heads of Programmes is very minimal compared to the support some of their peers have within their programme structure, this is not always reflective of the complexity of programmes.

Within the individual programmes there is inequity of structure. It is fair to say, however, that one size will not fit all. It may be worth considering the development of a minimal core team structure that provides a base resource within each team. Thereafter it is important to acknowledge that single programmes should be able to develop their workforce and structure to best meet the needs of the screening programme and those that access the programme. However, this approach will need careful oversight to ensure equity across the division and appropriate use of specialist roles and support roles.

‘…an inequity in the banding of individuals in similar posts across the programme’

Recommendation 11:

Review of programme structures
a)   
  • All HoPs should have the same job description
  • To include programme specific nursing and administration roles

b)   
  • All roles programmes to have core structure that formalises national and regional roles
Within some programmes there is a feeling of over management from senior members of the Division. The Heads of Programmes see their roles as more strategic than operational. There is a fine balance to addressing both operational and strategic requirements of the programmes and it is important to address the fact that the core role of the Heads of Programmes are predominantly as operational managers delivering the strategic plan. Exposure and contribution to the strategic objectives is important but this should be executed through the Divisional Director / Deputy Director with the Heads of Programmes being encouraged to input in to the strategic planning and direction for their programme and where necessary be able to present the detail of their programmes at relevant meetings/boards. Notwithstanding clarity of strategic leadership for the Division should be maintained.

The programmes, individually, require a clear programme lead. They assure the quality and governance of the programme and ensure all elements of the pathway are fit for purpose and are accessible to the eligible population. The Heads of Programmes (HoP) fulfil this requirement usually with support at regional level from Programme Managers or Regional leads. There is variation in structures across programmes that are not always attributable to size and complexity of programmes.

Within the structure there are examples of individuals managing small numbers, or in some cases no direct reports and others (e.g. DES) managing very large numbers of direct reports. Consideration of these structures is key to improving resilience for future changes and to afford efficiencies in service delivery.

With regard to the wider programme team most programmes have clinical posts (medical and nursing) and a range of administration staff. Unanimous comments observed are the lack of managerial responsibility for nursing and admin roles from within the programme teams.

“…need to review nursing team”

“…nurses do not see their line manager much”

“…admin roles not under my management remit”
Appendix 3 presents a suggested core team structure. This only represents the senior tiers within a programme but the same core structure should be considered for each team. This approach aims to provide a good level of support to the head of programme and offers a designated All-Wales lead, 3 regional managers, a structure for clinical advice/expertise and a structure for the integration of programme specific administration and nursing/midwifery roles. Beneath the senior tier will be the remainder of the programme team which should include the transfer of admin and nursing roles as detailed below.

**Nursing within Programmes**

A number of programmes have nursing roles within their structure, some of these are historical and many new with specific functions within the screening programme. At present all nursing roles within the screening division are managed and professionally led by the Head of Nursing. These management arrangements cause difficulties within programmes as there are occasions when a Head of Programme or other senior roles are unable to manage directly a nurse within their team. On the whole such arrangements do work well and are harmonious, however, to enable Heads of Programmes full autonomy to manage their programme team the line of management for all the team needs addressing. Management of nurses within a programme structure will add great benefit to the whole team. It will enable clarity of management and delivery of programme objectives and enable further development of a more cohesive team and collaboration across programmes.

Professional lines of accountability would not be affected by changes in line management. All nurses should remain professionally accountable to the Head of Nursing. Professional accountability, in some areas, is not well understood. It may be necessary for professional leads to ensure clarity in this area. This structure of split managerial and professional accountability is common place across the NHS and works very well. Consideration of how this role could be further developed to provide leadership around quality for service delivery and contribute to the wider nursing and quality corporate agenda.

**Recommendation 12:**

All nursing and midwifery posts to be operationally managed by their respective Head of Programme
Further review of nursing roles and responsibilities are required for some programmes. The roles nurses undertake vary and some do little clinical work. Many undertake audit and reporting functions that could be undertaken by non-clinical colleagues. There are, of course, nurses who undertake clear clinical roles. Again there is variance in grading of nurses with differing grades for those doing similar roles. A review of all roles in nursing within each team should be undertaken to ascertain the level of clinical expertise required, whether clinical qualifications are required for that role currently undertaken, whether the grade of the role is commensurate with responsibilities and equitable across the screening division. Changes to managerial lines of responsibility may offer the opportunity for the Head of Nursing to undertake other roles important to nursing and the Screening Division. These could include overseeing QA and governance functions for the Division.

**Recommendation 13:**

All nursing and midwifery roles and functions to be review to ascertain Divisional nursing grading structure. Some nursing roles are currently not very clinical.

The Division needs to be clear that the Public Health Wales vision for nursing is in line with the corporate nursing strategy. Reducing direct line management for the Head of Nursing will improve the ability to deliver a national vision for nursing within screening, including quality initiatives. Further thought should be given to a good system of peer support / clinical supervision for nurses as many work in near isolation professionally. It is recognised that the recent investment in the new appraisal process (My Contribution) has improved morale and identified areas of development from nursing within the division.

**Clinicians within Programmes**

Clinicians work in various roles within the Screening Division and play a crucial part in the success of service delivery and quality assurance. Many roles are clearly clinical and are required for programme delivery, such as, breast surgery, colposcopy, endoscopy, radiology, vascular surgery, and of course many more.
Some roles are less clear and many include a QA function for the programmes. In the structures reviewed it is not clear exactly what some of the roles undertake. There are opportunities to review these roles as there are a number that are vacant, or due to become vacant due to retirement. Additionally national staff shortages for some professions require a succession plan for recruitment or training of advanced roles such as advanced practitioner, consultant nurse, or consultant radiologist roles.

Clinicians in some programmes provide a programme wide role offering clinical expertise and advice, QA and act as a national lead. Each programme does need such support but consideration should be given as to how this is secured. This can be part of a role for a clinician undertaking clinical work. A good example in the BSW programme is demonstrated where a bowel surgeon also undertakes the national clinical advice role with agreed PA’s in the contract. In other programmes the focus may be on QA. The actual time required should be reviewed as, for example, in MAC there are three senior clinical posts (at 0.5, 0.5, and 0.4 wte) that offer programme support to NBHSW. An in depth review of MAC clinical requirements would most likely have a different structure.

Generally clinical expertise can be managed by fixed sessions per week or per month to provide clinical advice to programmes and input into standards and pathways and as required for other specific tasks. Consideration of other specialist roles should also be made to provide professional advice and support rather than a default to a senior doctor. The specialist roles mentioned above can provide a good level of support. In the example of MAC a reduction of the clinical support would facilitate the development of regional co-ordinators and the enhancement of midwifery support to the programme.

**Recommendation 14:**

Review of clinical input for each programme

- Are all posts required, should there be more concentrated expertise
- Identify single clinical advisor to each programme (?All-Wales lead) (this does introduce a single point of failure)
- Strengthen non-medical programme expertise to lead initiatives and address shortages of consultant roles
- Continually review to ensure consistency and sustainability
Administration within Programmes

The administration roles within the Division encompass a lot more than the title suggests. External views are that many roles are generic administration posts supporting programme functions or individuals. However, the remit of the administration team cover a magnitude of functions, including, but not limited to; basic admin duties, call/recall, pathway management, sharing of programme information, failsafe management, personal assistants and medical secretaries.

For the purpose of the review it is helpful to distinguish the pathway management essential for delivery of quality screening programmes to that of administration supporting staff (PA and secretaries) or specific administration tasks for defined programmes.

Like nursing the management of this staff group does not sit with specific programmes / teams. All ‘administration’ functions, and Newborn Hearing Screeners, are managed by the Head of Administration. The scope of the Head of Administration is enormous and would be more accurately described as a Heads of Operations. Although this role and the management of the administration teams are viewed very positively, it was a common theme, similar to nursing, that the general administration staff members should be managed within and by the respective programme teams.

The majority of the administration team work along the screening pathway whether this is the initial cohort identification or managing steps along the pathway and onto referral. Most programmes work within a three or four regional basis and as such there are fairly large numbers of the administration team undertaking similar roles, either within a programme regionally, or across programmes in the same region. There is an opportunity to better manage this across the division though careful analysis of role and function is required. It is important not to lose expertise in programme specific pathway management although it is fair that over time much of this expertise does not require a single programme or a geographical knowledge base. The teams undertaking these roles should continue to be managed by the head of Administration (Operations) to ensure a unified approach for failsafe/pathway management and equity across programmes.

For example there should be careful consideration of a move towards a national call/recall service, certainly for individual programmes but more effectively this could be national for all
programmes. BSW have used this model and also share resources for call/recall with the WAAASP in SE Wales. A national IT solution for call/recall is under consideration that could enable this direction of travel, although it will be several years before this becomes operational.

There are concerns that merging functions will lose local knowledge requirements for this service but most do not provide validity. For example, one comment referred to the administrator as

“…requiring local knowledge to be able to advice the public on a specific bus route”

This level of detail is not required, (it would be more appropriate to sign post to public transport information) but seems typical of very local practices that have developed over the years. More importantly, diligence around cohort identification and pathway management is required to be robust especially at hand over between services to ensure failsafe requirements.

General administration functions (eg secretarial support) within teams and specific administration support should be managed with the programme team. If the recommendation of a national (or regional) call/recall solution is accepted and implemented then this service should continue to be managed by the Head of Administration (Operations), as should administration functions for the core screening division team. Failsafe/pathway management roles would also continue to remain under the remit of the Head of Administration (Operations).

Newborn Hearing screeners should be managed directly within the NBHSW programme. This gives greater control and management to the programme and ensures the screeners are supported fully within their role and programme within which they work.

**Recommendation 15:**

Management of programme specific administration functions to be within programme teams, including newborn hearing/newborn bloodspot screeners/co-ordinators
**Recommendation 16:**

Management of screening division core administration functions to remain with the Head of Administration (Operations)

Management of regional or national call / recall, failsafe/pathway management

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**Structural Considerations within Specific Programmes**

**Maternal and Child**

Most programmes have a single Head of Programme, whereas the maternal and child (MAC) programmes have been grouped under a single Head of Programme. Whilst there is a clear logic in grouping MAC programmes, as the cohorts are the same (pregnant women and their newborn babies), this seems to have led to a large in-balance of responsibility and scope of management when compared with the adult programmes.

In England the antenatal and newborn screening programmes run as six individual programmes with a Head of Programme equivalent managing each. Within the Public Health Wales Screening Division the current structure encompasses several screening programmes under one Head of Programme.

Whilst grouping MAC as a business unit adds its own benefits and efficiencies there does not appear to be the recognition that the group is effectively five screening programmes. The Head of Programme has support from three Regional co-ordinators in NBHSW (0.5, 0.5, and 0.4 wte) but in general the requirements for the programmes are not met appropriately from the current structure. Of the three NBHSW regional posts two are community paediatricians (one post currently vacant) with the other being a teacher of the deaf. It is acknowledged that paediatric input in to the newborn programmes is essential, but this could be offered sufficiently within one of these posts (0.5 wte), acting as Newborn All-Wales lead. Specialist advice can still be sought on a fixed term arrangement or project specific arrangement if required. Habilitation is the responsibility of the Health Boards (Health) and Local Authorities (Education).
The ASW programme is delivered within the maternity services across the NHS with local screening co-ordinators and governance support within the Health Boards (7 x 0.1 wte). The ASW programme centre often finds implementing, auditing and improving local services a challenge and is usually overcome through good will and negotiation. The programme centre requires stronger midwifery support of a level that is able to forge closer relationships with heads of midwifery and to challenge local services where standards are not met.

Adherence to programme standards, ensuring effective failsafe and timely referral to clinical services is essential. In all programmes this is an area of potentially very large litigation claims should screening fail and harm is caused. Specifically within the ASW pathway litigation would be the responsibility of the Health Boards, therefore a structure within the programme centre that supports the ASW pathway is required, as is adherence to those pathways within the clinical setting.

A thorough review of MAC is required ensuring clinical safety of the antenatal screening delivered by Health Boards and comparable levels of support. Consideration should be given to either separating programmes, each with a Head of Programme or adding antenatal and newborn regional co-ordinators. Not reviewing this structure questions why the adult programmes cannot also be grouped as a single business unit.

Either of the changes will require funding. Savings should be available across the division dependent on the recommendations accepted and implemented.

Appendix 4 shows the two options for MAC.

**Recommendation 17:**

- Review specifically MAC group structure
  - Consideration that HoP is managing multiple programmes
  - Regional managers requires appropriate skills and grade for role
  - Strengthen maternity leadership/management in ASW
Diabetic Eye Screening Wales

The Diabetic Eye Screening programme has recently moved into the Screening Division from a health board. As a new programme to the screening division there has been a period of settling in. The DESW programme continues to be managed, and runs in a very similar way to how it functioned pre PU Public Health Wales BLIC HEALTH WALES. There are markedly different structures and standards were not evident (although this is being addressed currently). The screening division has given support for the integration and this continues.

The management structure may be clear to the programme and will be dependent on local services and mobile unit management. With regard to direct reports the organisation structure shows roles of the same grade having different levels of responsibility, with, for example some Health Science Practitioners having no direct reports, and others have up to fifteen. There appears to be a hierarchy of roles but no hierarchy of management with the majority leading to the Operations Manager having over 50 direct reports despite a hierarchy of grades beneath.

There is a real need to review the whole management structure of DESW. The current structure is very different to all other programmes. In line with the overall recommendations of the review a core structure for each programme is recommended. There should be a time scale set across programmes to ensure this work is undertaken and escalation where necessary where plans are unable to be met.

**Recommendation 18:**

Review specifically DESW management structure

- Consideration that line management needs to be implemented across all grades
- Consider the introduction of regional managers (one in North currently)
Wales Abdominal Aortic Aneurysm Screening Programme

WAAASP have a very good structure that generally follows many of the recommendations. This is likely to be attributable to this being the newest programme. There is keenness in WAAASP to work more collaboratively across programmes and specifically across Heads of Programmes.

The line management of the Head of Programme appears to be via a consultant in public health. This is not replicated for any other programme. Line management should be the same as all other programmes. A new senior management structure is recommended that will address this anomaly.

**Recommendation 19:**

WAAASP line manager should be the same as other programmes

Breast Test Wales

BTW is a well organised programme with an All-Wales focus supported by four regional centres with ten mobile units. The structure works well for the programme and it has good interface with other areas of the screening division. In common with all programmes it should consider moving to a common screening call/recall centre where this is possible.

There are many complexities within the nursing and administration roles and line management as previously discussed.

Cervical Screening Wales

CSW again fits very closely to the proposed recommendations. The programme has recently undergone review of its structure and has strengthened the programme with an All-Wales lead and three regional co-ordinators. Additional clinical expertise also forms part of the programme structure.
The programme has identified areas of improvement that include, inclusion in presentation of programme plans, require more financial management of programme, require more cross programme working and supports regional screening centre model.

The biggest challenges that face the programme are the retention of pathologist support and the forthcoming pilot of the HPV as Primary Screen. Whilst HPV is expected to be cost saving in the long run funding for the pilot needs to be agreed. It is expected that this can be sourced from within existing funding.

**Recommendation 20:**

Review HPV Primary screen pilot plan and ensure source of funding is agreed and manage transition

**Bowel Screening Wales**

BSW is currently reviewing its structure with an aim to follow the example of CSW. The programme offers an All-Wales approach with a single programme centre. It does have regional nurses and also a number of vacancies pending which offer a good opportunity to review roles. Within BSW there is the need to review job descriptions as a number of roles have been developed over time and do not reflect current roles delivered.

If the recommendation of managing staff that work specifically for the BSW programme is accepted then there will be greater scope to further improve the structure ready for the implementation, once approved, of the FIT screening test.

**Laboratory Services**

The laboratory services for the screening division are largely centred around a single lab with some outsourcing (three laboratories). Public Health Wales laboratory services are subject to a separate review looking to merge all lab services in to a single business unit. This will offer a number of efficiencies and in addition changes to screening programmes (FIT, HPV) will reduce capacity demands on the laboratory services. Owing to the separate review this report will make no recommendations to laboratory services.
Recommendations

The recommendations in this section have been grouped together for ease of reading them as a whole. They have been divided into three sections based on suggested timescales for implementation.

Short Term - within eighteen months
Medium Term - eighteen to thirty six months
Long Term - beyond 36 months

Short Term

Recommendation 2:
A review of screening pathways and programme standards to ensure they clearly identify the screening end point and hand over points

Recommendation 3:
Business planning (including forward look) to be a fully integrated part of Public Health Wales business planning process

Recommendation 4:
Three year forward planning should be maintained to ensure funding levels are appropriate, with reviews each year to overcome the difficulty in projecting future costs accurately

Recommendation 6:
Improve flexibility within the financial management to include phasing of budgets and enable, where possible, virement across budget lines

Recommendation 7:
To manage the core Public Health Wales functions of HR, IT, Communications, and Finance as part of the Public Health Wales core functions and consider integrating the Engagement Team
**Recommendation 8:**
Recruitment of new Director of Screening with clear strategic leadership and managerial focus and public health / population screening expertise

**Recommendation 10:**
Review of senior leadership structure
- Director of Screening – strategic lead with fewer direct reports
- New structure for the management of all Heads of Programmes

**Recommendation 11:**
Review of programme structures
a)  
- All HoPs should have the same job description
- To include programme specific nursing and administration roles

**Recommendation 12:**
All nursing and midwifery posts to be operationally managed by their respective Head of Programme

**Recommendation 17:**
Review specifically MAC group structure
- Consideration that HoP is managing 5 programmes (possibly 6 with NIPE)
- Regional managers requires appropriate skills and grade for role
- Strengthen maternity leadership/management in ASW

**Recommendation 18:**
Review specifically DESW management structure
- Consideration that line management needs to be implemented across all grades
- Consider the introduction of regional managers (one in North currently)

**Recommendation 19:**
WAAASP line manager should be under the same structure as other programmes
Recommendation 20:
Review HPV Primary screen pilot plan and ensure source of funding is agreed and manage transition

Medium Term

Recommendation 5:
Re-baseline screening budgets following implementation of any agreed recommendations

Recommendation 9:
Screening documentation, web content and facilities to be dual branded with Public Health Wales and develop common styling and format of screening products

Recommendation 11:
b)
- All roles programmes to have core structure that formalises national and regional roles

Recommendation 13:
All nursing and midwifery roles and functions to be review to ascertain divisional nursing grading structure. Some nursing roles are currently not very clinical

Recommendation 14:
Review of clinical input for each programme
- Are all posts required, should there be more concentrated expertise
- Identify single clinical advisor/director to each programme (?All-Wales lead)
- Strengthen non-medical programme expertise to lead initiatives and address shortages of consultant roles

Recommendation 15:
Management of programme specific administration functions to be within programme teams, including newborn hearing/newborn bloodspot screeners/co-ordinators
Recommendation 16:
Management of screening division core administration functions to remain with the Head of Administration (Operations)
Management of regional or national call / recall, failsafe/pathway management

Long Term

Recommendation 1:
The Screening Division should ensure an All-Wales approach for all programmes, based on standard operating procedures, and work towards regional teams within regional offices – Regional Screening Centres
## Glossary

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ASW</td>
<td>Antenatal Screening Wales</td>
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<tr>
<td>BSW</td>
<td>Bowel Screening Wales</td>
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<tr>
<td>BTW</td>
<td>Breast Test Wales</td>
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<tr>
<td>CSW</td>
<td>Cervical Screening Wales</td>
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<td>DESW</td>
<td>Diabetic Eye Screening Wales</td>
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<td>FIT</td>
<td>Faecal Immunochemical Test</td>
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<td>HPV</td>
<td>Human Papilloma Virus</td>
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<td>HR</td>
<td>Human Resources</td>
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<td>IT</td>
<td>Information Technology</td>
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<tr>
<td>MAC</td>
<td>Maternal and Child</td>
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<td>NBHSW</td>
<td>Newborn Hearing Screening Wales</td>
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<td>NIPT</td>
<td>Non Invasive Pre-natal Test</td>
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<td>NBSW</td>
<td>Newborn Blood Spot Screening Wales</td>
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<td>PCHI</td>
<td>Permanent Childhood Hearing Impairment</td>
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<td>PHE</td>
<td>Public Health England</td>
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<td>Public Health Wales</td>
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<td>QA</td>
<td>Quality Assurance</td>
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<td>UKNSC</td>
<td>United Kingdom National Screening Committee</td>
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<tr>
<td>WAAASP</td>
<td>Wales Abdominal Aortic Aneurysm Screening Programme</td>
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Appendix 1:
Public Health Wales Screening Review Questionnaire

Q1. What is your role / job title?

Q2. What screening programme / core service do you work for?

Q3. How long have you worked in your current role?

| 1 – 2 Years □ | 5 – 10 Years □ |
| 3 – 5 Years □ | Over 10 Years □ |

Q4. Is your role clear to you?

Yes □ No □

Q5. Briefly describe your role in screening.

Q6. Describe what you like about your role, what works well?

Q7. What are the challenges to your role? What doesn’t work well?
Q8. Are line management arrangements clear and do they work well?

Yes [ ] No [ ]

Q8b. If No, please give examples;


Q9. Are the roles of others that you work closely with clear?

Yes [ ] No [ ]

Q9b. If No, please give examples


Q10. Do you feel you get enough support from the wider screening divisional team in order to fulfil your role? For example, management team, finance, HR, engagement team

Yes [ ] No [ ]

Q11. Does your role cover a large geographical area?

Yes [ ] No [ ]

Q11b. If yes, what challenges does this present


Q12. Does the organisation of your screening programme make sense?

Yes [ ] No [ ]

Q12b. Please expand on your answer, examples could include - geographical structure of team, staffing of team, access to clinical expertise, comparisons to other teams, size of team, or anything you wish to present.


Q13. Do you feel you have professional support and development opportunities to your role and where relevant profession?

Yes □ No □

Q14. Is the identity of the programme within which you work clear to the public and NHS colleagues?

Yes □ No □

Q15. Do you feel the screening division has a single identity, or needs one?

Yes □ No □

Q16. On a scale of 1 - 10 how happy are you in your role?

1 not at all happy 2 3 4 5 6 7 8 9 10 very happy

Q17. Is there anything you would change?

Yes □ No □

Q17b. Please expand on your answer.

Q18. Are there any further comments you would like to make?
Appendix 2:
Screening Division: Senior Management Structure

One of the consultants in Public Health is designated the Deputy Director so there is a clear leadership when Director is on leave.
Appendix 3:
Screening Division: Core Programme Structure
Appendix 4: Maternity and Child: Programme Structure