Screening Quality Assurance visit report

NHS Cervical Screening Programme
Airedale NHS Foundation Trust

18 October 2018

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Public Health England, Wellington House, 133-155 Waterloo Road, London SE1 8UG
Tel: 020 7654 8000 www.gov.uk/phe
Twitter: @PHE_uk Facebook: www.facebook.com/PublicHealthEngland

About PHE Screening

Screening identifies apparently healthy people who may be at increased risk of a disease or condition, enabling earlier treatment or better informed decisions. National population screening programmes are implemented in the NHS on the advice of the UK National Screening Committee (UK NSC), which makes independent, evidence-based recommendations to ministers in the 4 UK countries.

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Prepared by: Screening QA Service (North)
For queries relating to this document, please contact: phe.screeninghelpdesk@nhs.net

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Executive summary

The NHS Cervical Screening Programme invites women between the ages of 25 and 64 for regular cervical screening. This aims to detect abnormalities within the cervix that could, if undetected and untreated, develop into cervical cancer.

The findings in this report relate to the quality assurance visit of the Airedale NHS Foundation Trust cervical screening service held on 18 October 2018.

Quality assurance purpose and approach

Quality assurance (QA) aims to maintain national standards and promote continuous improvement in cervical screening. This is to ensure that all eligible people have access to a consistent high quality service wherever they live.

QA visits are carried out by the PHE screening quality assurance service (SQAS).

The evidence for this report comes from the following sources:

- routine monitoring data collected by the NHS screening programmes
- data and reports from external organisations
- evidence submitted by the provider(s), commissioner and external organisations
- information shared with the North regional SQAS as part of the visit process

Local screening service

The area served by Airedale NHS Foundation Trust has an eligible population for cervical screening of approximately 37,500 women. The trust serves the Craven and Wharfedale area. This is largely a rural area at the south-western edge of North Yorkshire and the north east of the City of Bradford metropolitan borough.

NHS England North (Yorkshire and the Humber) West Yorkshire Locality Team has the commissioning responsibility for the NHS cervical screening programme at Airedale NHS Foundation Trust. NHS Airedale, Wharfedale and Craven Clinical Commissioning Group (CCG) is the contract holder for colposcopy services.

Colposcopy and histology services are provided at Airedale Hospital.

Cytology screening and human papillomavirus (HPV) testing are provided by Leeds Teaching Hospitals NHS Trust at St James's University Hospital.

Findings

This is the fifth QA visit to this service. The cervical screening provider lead is very experienced and there is evidence of collaborative working across the service. The service is committed to delivering a high quality service with good patient feedback. All but one recommendation from the previous visit is addressed. The outstanding recommendation is in relation to the data entry into the colposcopy database. Senior trust management have recently approved the replacement of the database and the service are in the early stages of planning the implementation of the new database.

Immediate concerns

The QA visit team identified 2 immediate concerns. A letter was sent to the chief executive on 19 October 2018, asking that the following items were addressed within 7 days:

- multi-disciplinary meetings (MDT) should be held at a maximum 2 month interval
- revision of patient standard template letters

A response was received within 7 days which assured the QA visit team the identified risk has been mitigated and no longer poses an immediate concern.

High priority

The QA visit team identified 10 high priority findings which relate to 4 main themes: staffing, IT, performance and patient information within the service. These are summarised below:

- patients not discharged to community for NHSCSP test of cure cervical sampling
- no sustainable workforce plan for colposcopy and histopathology
- inadequate colposcopy database for data capture of key performance indicators
- inadequate system support for pathology IT system
- infrequent multi-disciplinary meetings and the impact on the patient pathway
- unsuitable content in patient information leaflets and letters
- backlog of invasive cervical cancer audit cases

Shared learning

The QA visit team identified several areas of practice for sharing, including:

- Screening and Immunisation Team have locality based health inequality plans working with NHS and local authority partners
- high quality histopathology tracking system for cervical specimens

Recommendations

The following recommendations are for the provider to action unless otherwise stated

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority	Evidence required
01	NHS England commissioners should support the service to re-implement community based provision of HPV test of cure cervical sampling	5,8	6 months	High	Confirmation the pathway has been re-instated
02	Ensure that the cervical screening provider lead (CSPL) reporting arrangements are in line with national guidance	11	3 months	Standard	Accountability structure
03	Complete process for formal appointment of CSPL deputy	11	6 months	Standard	Confirmation of appointment
04	Ensure that the national invasive cervical cancer audit data collection is up to date	7	6 months	High	Completion of cases for time period January 2016 to April 2018
05	Improve the annual audit schedule documentation to ensure there is a process to demonstrate actions taken to drive improvement	11	6 months	Standard	Annual audit schedule with outcomes for improvement within the service

No.	Recommendation	Reference	Timescale	Priority	Evidence required
06	Ensure that all histopathology staff working within the NHS Cervical Screening Programme (NHSCSP) are aware of and have signed up to the NHS Cancer Screening Programmes Confidentiality and Disclosure Policy	5	3 months	Standard	Evidence of sign up
07	Ensure that the CSPL annual performance report includes all elements of the screening pathway delivered by the service	11	3 months	Standard	Annual performance report 2017/18
08	Update the local trust policy to reference 'Managing Safety Incidents in National Screening Programmes guidance' for all screening programmes within the trust and remove references to QARC	6	6 months	Standard	Policy
09	Make sure the lead colposcopist has designated sessions to fulfil the role	5,8	6 months	Standard	Job plan with dedicated professional activity allocation

Diagnosis - histology

No.	Recommendation	Reference	Timescale	Priority	Evidence required
10	Ensure that there is a sustainable workforce plan for histopathology including lead roles for the NHS Cervical Screening Programme (NHSCSP)	5	6 months	Standard	Workforce plan

No.	Recommendation	Reference	Timescale	Priority	Evidence required
11	Update the pathology IT system to reduce the risk associated with a single point of system failure	5	12 months	High	Project plan and projected timeline for implementation of IT system
12	Ensure that histopathology staff working in NHSCSP have access to NHAIS Open Exeter	5	3 months	Standard	Confirmation of access
13	Ensure that any use of digital pathology is in line with NHSCSP guidance parameters	5	6 months	Standard	Confirmation plan for NHSCSP specimens

Intervention and outcome - colposcopy

No.	Recommendation	Reference	Timescale	Priority	Evidence required
14	Make sure that there is a sustainable colposcopy workforce for cover for periods of absence and to manage future demand from implementation of HPV primary screening	5,8	6 months	High	Workforce plan
15	Make sure that there is a process for the colposcopy lead to verify the accuracy of KC65 data, including type of procedure	8	6 months	Standard	Protocol
16	Make sure that the service can consistently provide the offer of treatment at first visit for high grade referrals	5,8	6 months	High	Service review and confirmation of actions taken
17	Make sure that the national screening pathway for test of cure within the community is re-implemented	8	12 months	High	Completed action plan

No.	Recommendation	Reference	Timescale	Priority	Evidence required
18	Make sure that there is cross-cover for the timely input of KC65 data	5	6 months	Standard	Confirmation of administration staff cover arrangements
19	Update the colposcopy IT system to ensure that validated and accurate data can be produced for the mandated national data set	5,8	12 months	High	Updates on progress and implementation date
20	Ensure that colposcopy staff have access to Open Exeter	5	3 months	Standard	Confirmation of access
21	Update the local colposcopy clinical guidelines to reflect current NHSCSP guidance	8	6 months	Standard	Ratified updated guidelines
22	Develop standard operating procedures for all colposcopy administration duties, including production of KC65 performance returns	8	3 months	Standard	Standard operating procedure
23	Review colposcopy data to provide assurance that all colposcopists have seen a minimum of 50 new cases	8	6 months	Standard	Data submission showing number of new NHSCSP referrals for each colposcopist in the period April 2018 to March 2019
24	Update patient pre-appointment information	8,10	3 months	High	Copy of revised patient information leaflets
25	Update written consent form for LLETZ procedure with information on evidenced based known complications	8	3 months	High	Copy of revised consent form

No.	Recommendation	Reference	Timescale	Priority	Evidence required
26	Update patient result and non-attender letters	8,10	7 days	Immediate	Updated patient letters
27	Complete a colposcopy user survey annually	5	6 months	Standard	Outcome of survey and evidence of review of results

Multidisciplinary team

No.	Recommendation	Reference	Timescale	Priority	Evidence required
28	Ensure that the frequency of the multidisciplinary team (MDT) meetings meets the minimum frequency recommended in national guidance	8	7 days	Immediate	Confirmation schedule and MDT business continuity plan
29	Audit the impact of the infrequent MDT meetings on the patient care pathway	8	6 months	High	Audit from September 2017 to September 2018
30	Ensure that all members of MDT are aware of current NHSCSP selection criteria as outlined within the local colposcopy guidelines	8	3 months	Standard	Updated standard operating procedure

Next steps

The screening service provider is responsible for developing an action plan in collaboration with the commissioners to complete the recommendations contained within this report.

SQAS will work with commissioners to monitor activity and progress in response to the recommendations made for a period of 12 months after the report is published. After this point SQAS will send a letter to the provider and the commissioners summarising the progress made and will outline any further action(s) needed.