Public Health England

NHS

Screening Quality Assurance visit report

NHS Cervical Screening Programme
The Princess Alexandra Hospital NHS Trust

28 March 2017

Public Health England leads the NHS Screening Programmes

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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 four UK countries. The Screening Quality Assurance Service ensures programmes are safe and effective by checking that national standards are met. PHE leads the NHS Screening Programmes and hosts the UK NSC secretariat.

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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 (QA) review of the Princess Alexandra Hospital NHS Trust screening service held on 28 March 2017.

Quality assurance purpose and approach

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 of 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 South regional SQAS as part of the visit process

Local screening service

Since April 2013, commissioning of cervical screening for the West Essex population has been undertaken by the Midlands and East Screening and Immunisation Team (SIT).

The Princess Alexandra Hospital NHS Trust cervical screening programme (the programme) provides screening services for women served by West Essex clinical commissioning group (CCG) and a small number of women from East and North Hertfordshire CCG. The eligible cervical screening population (25 to 64 year old women) for Harlow is approximately 79,000.

The Princess Alexandra Hospital NHS Trust provides histopathology and colposcopy services as part of the NHS Cervical Screening Programme. The cytology and human papillomavirus (HPV) testing service is provided by Sheffield Teaching Hospitals NHS Foundation Trust.

Findings

Since the last QA visit the service has successfully managed the transfer of the cervical cytology service to Sheffield and established quarterly cervical screening business meetings. However, several of the recommendations from the previous QA visit in 2014 remain outstanding. The Trust and service leads need to take ownership of the actions required to make service improvements in a timely fashion.

There is a need to formalise the internal governance arrangements, including arrangements for lead roles, incident reporting, and escalation and reporting within the Trust.

The service should ensure that comprehensive guidelines, covering all aspects of the service provided, are agreed and documented. There is a need to establish processes to routinely audit and review service and individual colposcopist performance.

Immediate concerns

The QA visit team identified two immediate concerns. A letter was sent to the chief executive on 31 March 2017 asking that the following items were addressed within seven days:

- establish a documented system to check that all locum histopathology staff have the appropriate qualifications and are appropriately inducted
- all cervical histology cases must be formally reviewed prior to presentation at the multi-disciplinary team (MDT) meeting and this process documented in a standard operating procedure (SOP)

A response was received within seven days that assured the QA visit team the identified risks had been mitigated and no longer pose an immediate concern.

High priority

The QA visit team identified 11 high priority findings as summarised below:

- there are no contract management arrangements for the Sheffield cervical cytology service that link with internal Trust cervical screening governance systems in place
- there is no job description for the hospital based programme co-ordinator (HBPC) role which needs to detail all responsibilities, time, accountability and allocation of administrative support
- annual and six monthly reporting to a high-level Trust governance committee has not been established

- the invasive cervical cancer audit and disclosure policy has not been finalised
- not all staff involved in cervical screening activities have undertaken the mandatory NHS Information and Governance training
- not all cervical screening staff are aware of how to identify incidents or potential incidents and that they need to bring them to the attention of the HBPC
- there is no process to ensure cervical screening risks are placed on the relevant risk registers
- national standards for turnaround of cervical histology specimens are not met
- not all colposcopists meet the NHS CSP requirement to see 50 new abnormal cytology referrals per year
- cytology presence and participation in multi-disciplinary team (MDT) meetings does not always meet the national standard
- MDT documentation needs improving and formalising to include all case details, findings and outcomes

Shared learning

The review team identified two areas of practice that are worth sharing:

- development of proforma to request review of cervical cytology tests at the laboratory in Sheffield
- dedicated telephone service for colposcopy patients to ring for advice

Recommendations

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

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
R3.1	Establish contract management arrangements for the Sheffield cervical cytology service that link with internal Trust cervical screening governance systems	1	3 months	High	Document detailing the process agreed
R3.2	Establish Trust hospital based programme co-ordinator (HBPC) job description to encompass time allocation, all responsibilities, clear accountability to the chief executive and confirm allocation of administrative support	1	3 months	High	Copy of the established job description encompassing time allocation, clear accountability and confirm allocation of administrative support
R3.3	Establish annual and 6 monthly reporting to a senior Trust governance committee	1	3 months	High	Documents detailing the arrangement agreed. A copy of the first report given and minutes of the meeting where it was presented
R3.4	Finalise the Trust policy on the audit and disclosure of invasive cervical cancer audit results to women	2	3 months	High	Copy of the Trust ratified audit and disclosure policy

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
R12.1	Demonstrate that the disclosure of invasive cervical cancer audit data to women is in place	2	12 months	High	A copy of the report from the first annual disclosure audit undertaken. The findings and any actions taken as a result
R3.5	All staff involved in cervical screening activities to undertake the mandatory NHS Information and Governance training	1	3 months	High	Documentation demonstrating annual NHS Information and Governance training for all cervical screening staff
R3.6	Document a reference to national screening incident guidance in the Trust policy on managing serious incidents	1	3 months	Standard	Copy of the revised Trust policy on managing serious incidents
R3.7	Ensure that all cervical screening staff are aware of the mechanism for identifying and reporting incidents or potential incidents related to cervical screening activities and bringing them to the attention of the HBPC	1	3 months	High	Documentation such as standard operating procedures (SOPs), demonstrating the agreed process and meeting minutes at which staff have been made aware
R3.8	Establish a process for ensuring that all risks are recorded on relevant Trust risk registers	1	3 months	High	Documents detailing the process agreed
R3.9	Identify a suitable time allocation to undertake the lead pathologist role and establish the process for governance reporting	1	3 months	Standard	Job plan with dedicated professional activity allocation

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
R3.10	Formally appoint the lead colposcopist	3	3 months	Standard	Copy of formal appointment and Trust job/role description
R3.11	Update organisational chart showing colposcopy accountability within the Trust	1	3 months	Standard	Copy of the revised chart
R6.1	Nominate a deputy for the lead colposcopy nurse role	3	6 months	Standard	Details of nominated deputy
R3.12	Establish quarterly colposcopy operational meetings with clear terms of reference and reporting line within the Trust	3	3 months	Standard	A copy of the terms of reference along with the minutes of the meetings occurring since the QA visit and dates of meetings for the next 12 months
R3.13	Update and ratify clinical colposcopy guidelines	3	3 months	Standard	Copy of revised ratified colposcopy guidelines and evidence of dissemination to all relevant staff

Diagnosis – histology

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
R1.1	Establish a documented system to check all histopathology locum staff have the appropriate qualifications and are appropriately inducted	4	7 days	Immediate	Copy of the standard operating procedure (SOP) agreed and actions taken in relation to existing locum staff
R3.14	All locum histopathologists reporting cervical screening specimens must comply with national guidance on external quality assessment (EQA), education/training and appraisal requirements	4	3 months	Standard	Copy of the SOP and actions taken in relation to existing locum staff

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
R3.15	Develop and implement procedures for tracking cervical screening specimens when they are sent outside the Trust	4	3 months	Standard	Copy of the SOP and details of the tracking system established
R3.16	Update the SOP and reporting template for the reporting of cervical histology specimens	4	3 months	Standard	Copies of the updated SOP and reporting template to include when samples need a second opinion and what qualifies as an inadequate specimen
R6.2	Audit compliance with minimum data set reporting and the reporting of inadequate specimens	4	6 months	Standard	Copy of the audit and actions taken in response to the findings
R3.17	Cutting of levels in cervical histology specimens in line with national guidance	5	3 months	Standard	Data showing use of levels in line with national guidance
R3.18	Establish a cervical histology audit plan	4	3 months	Standard	Copy of the audit plan
R6.3	Establish regular feedback of individual performance data to all pathologists	4	6 months	Standard	Document detailing the process agreed
R6.4	Demonstrate that turnaround times for cervical histology specimens meet national standards	5	6 months	High	Data showing that cervical histology specimens are being reported in line with national standards and this is being maintained
R3.19	Develop and implement procedures for the assessment of consultant competency	4	3 months	Standard	Copy of the SOP and details of the process established

Intervention and outcome – colposcopy

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
R3.20	Ensure cover for absence is in place for all colposcopy nursing and administrative activities	3	3 months	Standard	Evidence of cover arrangements and relevant training
R3.21	Document all colposcopy administrative and nursing activities	3	3 months	Standard	Copies of the SOPs
R3.22	Ensure that all colposcopists are projected to meet the NHS CSP workload criteria of 50 abnormal screening referrals per year	3	3 months	High	Data showing that all colposcopists will meet the NHS CSP annual workload criteria
R6.5	Demonstrate that all colposcopists meet the NHS CSP requirement to see 50 new abnormal screening referrals per year	3	6 months	High	Data showing that all colposcopists meet the NHS CSP requirement to see 50 new abnormal screening referrals per year and this is being maintained
R3.23	Undertake an audit of compliance with the HPV triage and test of cure protocol	3	3 months	Standard	Copy of the audit report and details of the action taken as a result
R3.24	Establish a colposcopy audit plan and document the mechanism for regular review of the data by the lead colposcopist and presentation of the findings	3	3 months	Standard	A copy of the audit plan and document detailing the regular data review and presentation process
R12.2	All national clinical colposcopy standards met	3	12 months	Standard	Colposcopy dataset for the period 1.4.17 to 31.3.18
R3.25	Ensure that all colposcopy invitation and result letters include the patient's screening result	6 and 7	3 months	Standard	Copies of the revised letters
R3.26	Establish an annual patient survey	3	3 months	Standard	Copy of survey, report and actions taken

Multidisciplinary team

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
R3.27	Ensure cover arrangements are in place so there is always appropriate cytology presence at the MDT meetings	3	3 months	High	Copy of the attendance register
R3.28	Establish video conferencing arrangements for the cytology service to participate in MDT meetings	3	3 months	Standard	Details of the arrangements in place
R1.2	All cervical histology cases must be reviewed prior to presentation at the multi-disciplinary team (MDT) meeting and this process documented in a SOP	3	7 days	Immediate	Copy of the SOP and confirmation that all cases will be reviewed in advance of all MDT meetings
R3.29	Record all elements of the MDT (including details of the cases, review outcomes and management plan)	3	3 months	High	Minutes of the meetings
R6.5	Audit the selection of cases for the MDT and that the outcomes agreed have been carried out	3	6 months	Standard	Copy of the audit report and details of the action taken as a result

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/progress in response to the recommendations made for a period of 12 months following the issuing of the final report. 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.