Public Health England

NHS

Screening Quality Assurance visit report

NHS Cervical Screening Programme
Luton and Dunstable University Hospital NHS Foundation Trust

28 February 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 Luton and Dunstable University Hospital NHS Foundation Trust screening service held on 28 February 2017.

Quality assurance (QA) purpose and approach

The aim of QA is to maintain minimum 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 is derived from the following sources:

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

Local screening service

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

Luton and Dunstable University Hospital NHS Foundation Trust cervical screening programme (the programme) provides screening services for women served by NHS Luton clinical commissioning group (CCG). The eligible cervical screening population (25 to 64 year old women) for Luton is approximately 58,000.

Luton and Dunstable University Hospital NHS Foundation Trust provides histopathology and colposcopy services as part of the NHS Cervical Screening Programme. The Bedford Hospital NHS Trust, via a contract with a private company called Viapath, provides the cervical cytology and human papillomavirus (HPV) testing for the programme.

The Trust is taking part in the government's Sustainability and Transformation Plan (STP) process. This is a five-year plan, which sets out steps through which local organisations should deliver sustainable, transformed health services. Luton and Dunstable University Hospital NHS Foundation Trust is working with Bedford Hospital NHS Trust and Milton Keynes University Hospital NHS Foundation Trust to develop the STP for the area. It is currently unclear what impact this re-structuring may have on the cervical screening programme at Luton and Dunstable Hospital.

Findings

This is a well-led cervical screening service with a team of proactive, engaged and audit-focussed staff working collaboratively across all disciplines to provide a good quality and reliable service. There is evidence of sustained achievement against the majority of national cervical screening standards. However, some lead staff have very high personal workloads. This raises concerns for service resilience and sustainability.

Patients are benefiting from the major project to re-build and upgrade the colposcopy accommodation and equipment since the last QA visit.

There is a need for a new IT system in pathology to make sure the service is able to meet future cervical screening programme requirements.

Immediate concerns

The QA visit team identified no immediate concerns.

High priority

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

- annual and six monthly reporting to a high-level Trust governance committee has not been established
- an invasive cervical cancer audit and disclosure policy has not been established
- there is no process to ensure cervical screening risks are placed on the relevant risk registers
- national standards for prompt reporting of cervical histology specimens are not met
- not all colposcopists meet the NHS CSP requirement to see at least 50 women each year referred as a result of an abnormal screening test
- the national standard for colposcopist positive predictive value (PPV) is not met
- colposcopy attendance at multi-disciplinary team (MDT) meetings does not meet the national standard

Shared learning

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

- the Trust has incorporated the national screening incident management policy into its local serious incident policy
- a nurse-led evening colposcopy clinic is in place which has improved patient attendance rates
- there is an active clinical colposcopy audit programme and presentation of audits at national conferences
- annual colposcopy patient surveys are embedded and action is taken on the results
- the 'Goldstar' alerting system in place in histology ensures critical results are acted upon promptly
- cervical histology specimens are prioritised within the laboratory
- the national cervical histology minimum data set has been introduced and an audit completed which showed achievement of the requirements

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	Document administrative support arrangements in the hospital-based programme co-ordinator's (HBPCs) job description	1	3 months	Standard	Copy of the revised job description describing administrative support arrangements
R6.1	Establish quarterly cervical screening business meetings separately to the colposcopy operational meetings	1	6 months	Standard	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
R3.2	Establish annual and 6 monthly reporting to a senior Trust governance committee	1	3 months	High	Documents detailing the arrangements agreed, a copy of the first report given and minutes of the meeting where it was presented
R3.3	Establish a 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 findings 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
R3.4	Establish a process for ensuring that all risks are captured on relevant Trust risk registers	1	3 months	High	Documents detailing the process agreed
R3.5	Ensure lead histopathologist has adequate time to carry out the role	1	3 months	Standard	Job plan with dedicated professional activity allocation

Diagnosis – histology

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
R3.6	Update standard operating procedures (SOPs) for specimen reception and the dissection of cervical treatment biopsies	3	3 months	Standard	Copies of the updated SOPs
R3.7	Use of levels in line with national guidance	4	3 months	Standard	Data showing use of levels in line with national guidance
R6.2	Demonstrate that turnaround times for cervical histology specimens meet national standards	4	6 months	High	Data showing that cervical histology specimens are being reported in line with national standards and this is being maintained

Intervention and outcome – colposcopy

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
R3.8	Ratify clinical colposcopy guidelines	5	3 months	Standard	Copy of ratified colposcopy guidelines
R3.9	Finalise and ratify non-clinical colposcopy guidelines and archive old versions	5	3 months	Standard	Copy of ratified non-clinical colposcopy guidelines
R12.2	Ensure all colposcopists meet the NHS CSP requirement to see 50 new abnormal screening referrals per year	5	12 months	High	Data showing that all colposcopists meet the NHS CSP workload criteria
R3.10	Audit positive predictive value (PPV) of individual colposcopists and demonstrate achievement of national standard and equal split of referral cytology amongst colposcopists	5	3 months	High	Copy of audit report and details of the action taken as a result
R6.3	Audit the standard that a biopsy should have taken place within 2 years for all low grade referrals	5	6 months	Standard	Copy of the audit report and details of the action taken as a result
R6.4	Demonstrate achievement of the national standards for treatment taking place within 4 and 8 weeks of a biopsy indicating treatment is needed	5	6 months	Standard	Data demonstrating sustained achievement of the standards for treatment after a biopsy
R3.11	Colposcopy invitation letters should include the patient's screening result	6 and 7	3 months	Standard	Copies of the letters

Multidisciplinary team

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
R6.5	Ensure all colposcopists attend a minimum of 50% of MDT meetings	5	6 months	High	Copies of MDT attendance registers for 6 months
R3.12	Develop a SOP for the identification of cases for inclusion in the MDT by the histology department	3 and 5	3 months	Standard	Copy of the SOP

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.