Public Health England

Protecting and improving the nation's health

# Screening Quality Assurance visit report

## NHS Cervical Screening Programme
## Mid Cheshire Hospitals NHS Foundation Trust

3 July 2019

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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 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. PHE advises the government and the NHS so England has safe, high quality screening programmes that reflect the best available evidence and the UK NSC recommendations. PHE also develops standards and provides specific services that help the local NHS implement and run screening services consistently across the country.

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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 Mid Cheshire Hospitals NHS Foundation Trust (MCHT) screening service held on 3 July 2019.

## 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:

- 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 trust serves a local population of approximately 300,000. There is a eligible cervical screening population of 73,938 women. NHS England and NHS Improvement, Cheshire and Merseyside, has the lead commissioning responsibility for the cervical screening programme at MCHT. Vale Royal Clinical Commissioning Group (CCG) and South Cheshire CCG are the contract holders for colposcopy.

## Findings

SQAS last visited MCHT in 2014. Since this visit, they have been proactive in reducing their biopsy rate and auditing their colposcopy service. There are long turnaround times and a significant backlog of cytology samples at the University Hospital of North Midlands cytology service that is impacting upon service delivery at MCHT. Histopathology services provided to MCHT and East Cheshire Hospital Trust are failing to meet the expected turnaround times due to the lack of cervical histopathology reporting staff.

## Immediate concerns

The QA visit team identified 4 immediate concerns. A letter was sent to the interim chief executive on 5 July 2019 asking that the trust addresses the following items within 7 days:

- ensure that there is individual patient tray set up within colposcopy clinic and an infection control assessment of the storage of used equipment within the clinical area
- audit the use of provisional pathology reports in liaison with colposcopy (MCHT and East Cheshire NHS Trust) to assess their suitability to support the patient management pathway
- audit the results of histopathology samples that are recorded as not reported by a histopathologist that meets NHSCSP criteria
- ensure that MDT meeting arrangements meet national guidance

A response was received, and actions have been taken to partially mitigate the immediate risks within the programme.

## High priority

The QA visit team identified 18 high priority findings. These related to 6 main themes: commissioner oversight, leadership roles, staffing, capacity and recovery planning, colposcopy IT systems, policies and protocols, and multi-disciplinary team (MDT) meetings. Further detail is provided below:

- it is not clear how the Cheshire and Merseyside commissioners will maintain formal oversight of their NHSCSP services if there is any reconfiguration of the strategic programme boards following the laboratory reconfiguration
- the lead histopathologist is not formally appointed to their role with an appropriate job description, sufficient time, and administrative support to carry out the requirements of the role
- not all disciplines are aware to notify the CSPL if an NHSCSP incident occurs
- histology staffing is at a critical level and impacting on their turnaround times (TATs)
- there is no policy to check the suitability of locums to work within the NHSCSP
- colposcopy clinics led by nurse colposcopists are not supported by the required staff
- there is no plan in place to manage the potential increase in colposcopy work following the reduction of the cytology backlog, implementation of HPV Primary Screening and recovery of the histology TATs
- manual intervention is required to produce the mandated colposcopy data returns
- the colposcopy IT system is not available in theatre
- there is no protocol for the use of diathermy equipment
- women who have ablative treatment are followed up in colposcopy whereas women who have excisions are followed up in primary care

- it is not clear that the actual next test due date is being entered on the discharge forms
- not all colposcopists follow national guidance and appropriately discharge women for their test of cure test back into the community
- colposcopy and histopathology attendance at MDT meetings is not in line with national guidance requirements
- the case selection criteria for MDT meetings does not contain all cases required for discussion by national guidance
- the evidence submitted for the visit showed a small number of patient management plans, decided at MDT meetings, which do not follow national guidance

## Shared learning

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

- engaged CSPL, who is up-to-date with the invasive cancer audit (ICA)
- responsive colposcopy audit schedule following previous visits
- high quality colposcopy guidelines
- consistent completion of patient satisfaction survey with positive patient feedback and action taken on patient suggestions and negative comments
- double clinic slots allocated for women identified with additional needs
- histology department is proactive in training BMSs to complete cut-up

# Recommendations

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

## Governance and leadership

| No. | Recommendation | Reference | Timescale | Priority | Evidence required |
|---|---|---|---|---|---|
| 1 | The commissioners should ensure that they maintain formal oversight of their NHSCSP service providers following any reconfiguration of the strategic programme board, aligned with laboratory mobilisation | Public Health Section 7A – Commissioning Intentions 2018 and 2019<br><br>NHS Public Health Functions Agreement 2018 to 2019 | 12 months | High | Terms of reference for programme boards following laboratory's mobilisation |
| 2 | The commissioners should develop an action plan to reduce screening inequalities in underserved and protected population groups | NHS Public Health Functions Agreement 2018 to 2019<br><br>Guidance for NHS commissioners on equality and health inequalities legal duties 2015<br><br>Service Specification 25 | 6 months | Standard | Action plan presented to programme board |
| 3 | The commissioner should clarify formal links with Styal prison for NHSCSP | Service Specification 25 | 3 months | Standard | Governance structure and SOP |

| No. | Recommendation | Reference | Timescale | Priority | Evidence required |
|---|---|---|---|---|---|
| 4 | Ensure that the CSPL has an agreed job description that includes accountability to the CEO and dedicated time in their job plan | NHS Cervical Screening Programme: the role of the cervical screening provider lead | 6 months | Standard | CSPL's job description and agreed job plan |
| 5 | Produce an annual performance report and 6-monthly update to cover all NHSCSP services provided for the organisation's main clinical governance committee | NHS Cervical Screening Programme: the role of the cervical screening provider lead | 12 months | Standard | CSPL report and evidence of presentation at the organisation's main clinical governance committee |
| 6 | Develop and implement a whole trust annual audit schedule for cervical screening services | Service Specification 25 | 3 months | Standard | Annual audit schedule covering colposcopy and histopathology |
| 7 | Update the protocol for the completion of the invasive cervical cancer audit (ICA) | NHSCSP 28 | 6 months | Standard | Updated ratified protocol |
| 8 | Update the protocol for failsafe procedures in line with national guidance | Cervical screening: cytology reporting failsafe | 6 months | Standard | SOP |
| 9 | Ensure sign up to NHSCSP confidentiality and disclosure policy | Service Specification 25 | 3 months | Standard | Confirmation from the CSPL |
| 10 | Update relevant local policies to include reference to managing screening incidents in accordance with "Managing Safety Incidents in NHS Screening Programmes", the current SIAF, and up to date terminology | Managing Safety Incidents in NHS Screening Programmes | 3 months | Standard | Updated policies |

| No. | Recommendation | Reference | Timescale | Priority | Evidence required |
|---|---|---|---|---|---|
| 11 | Ensure CSPL is notified of all NHSCSP incidents | Managing Safety Incidents in NHS Screening Programmes<br><br>NHS Cervical Screening Programme: the role of the cervical screening provider lead | 3 months | High | Incident management flowchart and confirmation of implementation from CSPL |
| 12 | Ensure that a lead histopathologist for the NHSCSP is formally appointed with responsibilities included within their job description, dedicated time in their job plan and administrative support | Service Specification 25 | 3 months | High | Job description, job plan with dedicated professional activity allocation |
| 13 | Ensure that there is a mechanism for histopathology to inform the CSPL of all new Invasive Cancer Audit (ICA) cases | NHSCSP 28 | 3 months | Standard | ICA case management flowchart and confirmation of implementation from CSPL |
| 14 | Ensure that the lead nurse colposcopist for the NHSCSP is formally appointed with responsibilities included within their job description, dedicated time in their job plan and administrative support | Service Specification 25 | 6 months | Standard | Job description, job plan with dedicated professional activity allocation |

## Diagnosis - histology

| No. | Recommendation | Reference | Timescale | Priority | Evidence required |
|---|---|---|---|---|---|
| 15 | Seek support from the pathology network to manage the critical level of pathology staffing | Service Specification 25 | 3 months | High | Confirmation by lead histopathologist |
| 16 | Audit the results of histopathology samples that are recorded as not reported by a histopathologist that meets NHSCSP criteria | RCPath<br><br>Service Specification 25 | 3 months | Immediate | Audit |
| 17 | Ensure that local policy is followed for all NHSCSP samples stating that all NHSCSP samples are to be reported by a histopathologist that meets the requirements of the NHSCSP or sent to the outsourcing agency | RCPath<br><br>Service Specification 25 | 3 months | Standard | Workload data for individuals reporting NHSCSP specimens |
| 18 | Ensure that there is a policy in place to check the suitability of locums, including non-consultant staff, to work within the NHSCSP | RCPath<br><br>NHS employers guidance on the appointment and employment of doctors | 6 months | High | Ratified policy with evidence of implementation |
| 19 | Ensure that histopathologists have access to cervical screening results | RCPath | 6 months | Standard | Arrangements for accessing cervical screening results in place |

| No. | Recommendation | Reference | Timescale | Priority | Evidence required |
|---|---|---|---|---|---|
| 20 | Audit the use of provisional reports in liaison with colposcopy (MCHT and ECHT) to assess if they support the patient management pathway | RCPath | 3 months | Immediate | Audit |
| 21 | Implement a sustainable plan for the delivery of NHSCSP turnaround times (TATs) for histopathology samples | RCPath<br><br>Service Specification 25 | 6 months | High | Plan and update on histology TATs |

## Intervention and outcome - colposcopy

| No. | Recommendation | Reference | Timescale | Priority | Evidence required |
|---|---|---|---|---|---|
| 22 | Ensure that the nurse colposcopists have nursing support in line with NHSCSP 20 | NHSCSP 20 | 3 months | High | Confirmation from lead nurse colposcopist |
| 23 | Develop a sustainable plan to manage colposcopy and administration capacity | NHSCSP 20 | 6 months | High | Plan and update from lead colposcopist |
| 24 | Update the induction protocol to be specific to colposcopy | NHSCSP 20 | 3 months | Standard | Updated protocol |
| 25 | Ensure the colposcopy IT system can produce reliable data for KC65 submission and key performance indicators outlined in National Service Specification 25 that is not dependent on manual intervention | Service Specification 25 | 6 months | High | Audit of KC65 and KPIs |

| No. | Recommendation | Reference | Timescale | Priority | Evidence required |
|---|---|---|---|---|---|
| 26 | Ensure that there is access to the colposcopy database in theatre | Service Specification 25 | 6 months | High | Confirmation from lead colposcopist |
| 27 | Update the local Trust colposcopy clinical guidelines to ensure terminology is up to date | NHSCSP 20 | 6 months | Standard | Ratified guidelines |
| 28 | Update the colposcopy administration protocols to ensure that they are in line with current practice and contain sufficient information to support cross-cover arrangements | Service Specification 25 | 6 months | Standard | Administrative protocols |
| 29 | Implement SOPs to ensure that colposcopy nurse support staff can manage clinic set up without additional support | NHSCSP 20 | 6 months | Standard | SOPs |
| 30 | Document the protocol for the use of diathermy equipment | NHSCSP 20 | 3 months | High | Protocol |
| 31 | Standardise the management of women treated by ablation rather than excision and their eligibility for primary care follow up in line with NHSCSP 20 | NHSCSP 20 | 3 months | High | Updated colposcopy guidelines and update from lead colposcopist |
| 32 | Ensure that individual colposcopists manage their own results to support assessment of individual colposcopy practice and minimise administrative the burden on colposcopy nursing staff | NHSCSP 20 | 3 months | Standard | Confirmation from lead colposcopist |

| No. | Recommendation | Reference | Timescale | Priority | Evidence required |
|---|---|---|---|---|---|
| 33 | Complete a retrospective audit to check that the discharge notification process to call/recall has the 'next test due date' correctly completed | NHSCSP 20 | 6 months | High | Audit |
| 34 | Audit HPV triage and test of cure pathway to ensure individual colposcopist compliance and standardise protocols | NHSCSP 20 | 6 months | High | Audit |
| 35 | Audit the number of new appointments compared with the number of follow up appointments in line with NHSCSP 20 to identify actions to manage colposcopy capacity post implementation of HPV primary screening | NHSCSP 20 | 6 months | Standard | Audit |
| 36 | Review all letters and information leaflets to update terminology and to ensure that they are in line with NHSCSP 20 | NHSCSP 27<br><br>NHSCSP 20 | 6 months | Standard | Updated letters and leaflets |
| 37 | The trust's infection control team should risk assess the current process for non-specific tray set up, which is used for multiple patients within the colposcopy clinics and the of storage of used equipment within the clinical area | NHSCSP 20 | 3 months | Immediate | Risk assessment with action taken |

| No. | Recommendation | Reference | Timescale | Priority | Evidence required |
|---|---|---|---|---|---|
| 38 | Review the accessibility of equipment for the completion of cervical screening sampling for women with physical disabilities | Service Specification 25 | 6 months | Standard | Update from lead colposcopist |

## Multidisciplinary team

| No. | Recommendation | Reference | Timescale | Priority | Evidence required |
|---|---|---|---|---|---|
| 39 | Ensure all colposcopists attend a minimum of 50% of MDT meetings | NHSCSP 20 | 12 months | High | Attendance record for the 12-month period |
| 40 | Ensure histopathology representation at 100% of MDT meetings at both MCHT and East Cheshire NHS Trust | NHSCSP 20 | 12 months | High | Attendance record for the 12-month period |
| 41 | Ensure that MDT meeting arrangements meet national guidance, in terms of slide review by a competent histopathologist, the consistent decision making, and monitoring of the progress of actions | NHSCSP 20<br><br>National Service specification 25 | 6 months | Immediate | SOP |
| 42 | Update the case selection criteria for the MDT meetings in line with NHSCSP 20 | NHSCSP 20<br><br>National Service specification 25 | 3 months | High | SOP |
| 43 | Audit the MDT outcomes to demonstrate consistency in decision making | NHSCSP 20 | 6 months | High | Audit |

## 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.

The SQAS will make an unannounced visit to the MDT meetings within the next 12 months.

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.