Public Health England

Protecting and improving the nation's health

Screening Quality Assurance visit report

NHS Cervical Screening Programme
West Suffolk NHS Foundation Trust

7 February 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 West Suffolk NHS Foundation Trust cervical screening service held on 7 February 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 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 2013 commissioning of cervical screening for the West Suffolk population has been the responsibility of the NHS England (Midlands and East) Section 7a commissioning team. The Midlands and East (East) Screening and Immunisation Team is responsible for ensuring that local services meet the national cervical screening specification.

West Suffolk NHS Foundation Trust cervical screening programme (the programme) provides screening services for women served by NHS West Suffolk Clinical Commissioning Group. The eligible cervical screening population (25 to 64 year old women) for West Suffolk is around 61,000 women.

The trust provides colposcopy services as part of the NHS Cervical Screening Programme. Cambridge University Hospitals Cervical Cytology Network (CUH CCN) provides the cervical cytology and human papillomavirus (HPV) testing for the programme. The histology service is provided on the West Suffolk Hospital site by North East Essex and Suffolk Pathology Services (NEESPS) which is hosted by the newly formed East Suffolk and North Essex NHS Foundation Trust.

Findings

Since the last QA visit the service has successfully managed the implementation of HPV primary screening and the management of the additional colposcopy referrals that have resulted from this change of protocol.

The histology provision for the programme has been reorganised. Staff in histology are sustaining the service despite significant changes in management structure, loss of mandatory UK Accreditation Service (UKAS) accreditation and under-investment in accommodation, equipment and technical staffing. NEESPS and the trust should prioritise regaining UKAS accreditation and investment in histology on this site.

The trust's cervical screening provider lead (CSPL) is substantively employed by CUH CCN and there is no agreed trust job description, official appointment or contractual arrangement in place for the service provided to West Suffolk NHS Foundation Trust. CUH CCN will not provide a cytology service after the full implementation of HPV primary screening in 2019 and so the trust will need to make new arrangements for this vital role.

The trust should ensure that staff in lead roles are appropriately appointed and have suitable time to carry out their responsibilities within the cervical screening programme. This includes the need to have time for the oversight of individual and departmental performance data to ensure action is taken where standards are not met.

Despite the trust's screening service being part of a complex, geographically separate pathway involving multiple organisations, there is evidence of good communication and a collaborative multi-disciplinary team.

Immediate concerns

The QA visit team identified 1 immediate concern. A letter was sent to the chief executive on 8 February 2019 asking that the following item was addressed within 7 days:

- put in place alternative arrangements to make sure that all telephone calls to cervical screening patients take place in a suitable and confidential environment

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 6 high priority findings as summarised below:

- the trust does not have a Service Level Agreement (SLA) in place with Cambridge University Hospital for the provision of the CSPL role
- there is no agreed trust job description or official appointment for the CSPL role
- the laboratory is not UKAS accredited as required for all screening services
- neither the lead histopathologist or lead colposcopist has appropriate time designated to carry out all their lead role responsibilities
- the consultant histopathologists share office space with each other, registrars and biomedical scientists which is outside Royal College of Pathologists guidance and could cause distraction leading to the potential for errors when reporting specimens
- colposcopy clinical outcome standards relating to the proportion of women who are diagnosed with recurrent cervical disease after treatment and the outcome of treatments carried out at a patient's first visit are not met

Shared learning

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

- clear, comprehensive and easy to understand training on HPV primary screening
- the commissioners are taking part in a multi-agency project to increase attendance for cervical screening. This has included a recent visit to an outreach programme working with the homeless, migrants, refugees, asylum seekers and traveller communities
- a clear, user friendly and well-illustrated pathology manual
- an audit of the care pathway to check that all women have an outcome and have the correct next test due date following discharge to the community
- nursing staff in colposcopy have the opportunity to attend colposcopy multi-disciplinary team (MDT) meetings to support continuing professional development
- MDT records include a "what is the question?" column ensuring a clear rationale for discussion

Recommendations

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

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority	Evidence required
1	Put in place a service level agreement (SLA), or similar, for the provision of the cervical screening provider lead (CSPL) role	1 & 2	3 months	High	SLA or equivalent documentation
2	Appoint a CSPL with an agreed job description that includes accountability to the chief executive office, dedicated time and administrative support	1 & 2	3 months	High	Confirmation of appointment, trust job description, job plan and time allocation.
3	Update terms of reference for cervical screening business meeting to show that risks and individual performance data are discussed and minuted	2	3 months	Standard	Revised terms of reference
4	Put in place an overarching invasive cancer audit protocol	3	3 months	Standard	Invasive cancer audit protocol
5	Ensure the national invasive cancer audit data collection is up to date	3 & 4	3 months	Standard	Completion of all registered cases with a diagnosis date before 7 February 2019
6	Implement a ratified trust policy for the offer of disclosure of invasive cervical cancer audit	3, 4 & 5	3 months	Standard	Disclosure policy
7	Complete an audit to demonstrate offer of disclosure of cervical cancer audit	3, 4 & 5	6 months	Standard	Audit report and evidence of any actions taken as a result

No.	Recommendation	Reference	Timescale	Priority	Evidence required
8	Develop and implement a whole trust annual audit schedule for cervical screening services	1 & 4	3 months	Standard	The annual audit schedule covering colposcopy and histopathology and minutes of the meeting where it was agreed
9	Manage all screening patient safety incidents and serious incidents in accordance with 'Managing Safety Incidents in NHS Screening Programmes'	6	3 months	Standard	Ratified trust policy and evidence of all staff being trained in incident reporting
10	Put in place a detailed plan for achieving UK Accreditation Service (UKAS) accreditation, including business continuity arrangements	1	3 months	High	Detailed action plan
11	Demonstrate successful UKAS accreditation	1	12 months	High	Confirmation of accreditation
12	Ensure the lead pathologist has appropriate time for the role	1	3 months	High	Job plan with dedicated professional activity allocation
13	Ensure the lead colposcopist has appropriate time for the role	1	3 months	High	Job plan with dedicated professional activity allocation
14	Discuss all departmental issues and include all members of the colposcopy team in the quarterly colposcopy operational meetings	4	6 months	Standard	Terms of reference and minutes

Diagnosis - histology

No.	Recommendation	Reference	Timescale	Priority	Evidence required
15	All consultants must participate in an appropriate external quality assessment (EQA) scheme	1	6 months	Standard	Confirmation of EQA scheme participation
16	Develop standard operating procedure (SOP) for the provision of regular performance data for histopathologists	7	6 months	Standard	Copy of SOP
17	Develop an action plan to achieve key performance indicators for specimen turnaround times	7	3 months	Standard	Action plan
18	Demonstrate sustained achievement of key performance indicators for specimen turnaround times	7	12 months	Standard	Data submission and evidence of achievement
19	Develop and implement an operational continuity plan with respect to the cervical histology equipment	1	3 months	Standard	Operational continuity plan and evidence of implementation
20	Undertake a risk assessment of consultant pathologist accommodation to assess the risk of distraction whilst reporting	8	3 months	High	Risk assessment and action plan

Intervention and outcome - colposcopy

No.	Recommendation	Reference	Timescale	Priority	Evidence required
21	Implement changes to the IT system so that annual reporting on all national standards to the screening quality assurance service (SQAS) is in place	1 & 4	6 months	Standard	Confirmation of changes made Submission of complete annual data returns to SQAS Updated data collection and validation SOP
22	Ratify the department guidelines for the conservative management of cervical intraepithelial neoplasia grade 2	1	3 months	Standard	Updated and ratified clinical guidelines
23	Develop SOP for colposcopy clinic set up arrangements and infection control	1 & 4	3 months	Standard	SOP
24	Put in place a clinical check of the colposcopy discharge summary before submitting to the call and recall service and update SOP	1 & 4	3 months	Standard	Revised SOP
25	Implement and monitor a plan to achieve the standard for colposcopy waiting times	1 & 4	3 months	Standard	Agreed action plan with evidence of regular monitoring
26	Implement and monitor a plan to reduce colposcopy ‘did not attend’ rates	1 & 4	3 months	Standard	Agreed action plan with evidence of regular monitoring
27	Audit the colposcopy positive predictive value and implement an action plan	4	3 months	Standard	Copy of the audit for the period 1/4/2018 to 31/3/2019 and action taken
28	Complete a retrospective and prospective audit on the outcome of	4	3 months	High	Copy of the audits for the period 1/4/2018 to

No.	Recommendation	Reference	Timescale	Priority	Evidence required
	treatments carried out at first visit				31/3/2019 and 1/4/2018 to 31/3/2019 and action taken
29	Complete a retrospective and prospective audit on treatment failures within12 months	4	3 months	High	Copy of the audits for the period 1/4/2018 to 31/3/2019 and 1/4/2018 to 31/3/2019 and action taken
30	Update trust patient letters and leaflets	9	3 months	Standard	Revised patient letters and leaflets
31	Implement a comprehensive annual patient survey	1	6 months	Standard	Outcome of survey and evidence of review of results and action taken on findings
32	Put in place alternative arrangements to make sure that all telephone calls to patients take place in a suitably confidential environment	1	7 days	Immediate	Details of arrangements put in place

Multidisciplinary team (MDT)

No.	Recommendation	Reference	Timescale	Priority	Evidence required
33	Document the reviewer details with the histology and cytology review opinions on the MDT records	4	3 months	Standard	Copy of SOP

Next steps

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

SQAS will work with the 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.