Public Health England

Protecting and improving the nation's health

Screening Quality Assurance visit report

NHS Cervical Screening Programme East and North Hertfordshire NHS Trust

27 February 2018

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-leading science, research, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services.
We are an executive agency of the Department of Health and Social Care, and a distinct delivery organisation with operational autonomy. We provide government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific and delivery expertise and support.
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 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.

www.gov.uk/phe/screening Twitter: @PHE_Screening Blog: phescreening.blog.gov.uk
For queries relating to this document, please contact: phe.screeninghelpdesk@nhs.net

© Crown copyright 2020
You may re-use this information (excluding logos) free of charge in any format or medium, under the terms of the Open Government Licence v3.0. To view this licence, visit OGL. Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

Published: July 2020
PHE publications
gateway number: GW-1387

PHE supports the UN
Sustainable Development Goals

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.

This report show the findings of the quality assurance visit of the East and North Hertfordshire NHS Trust screening service held on 27 February 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 Midlands and East regional SQAS as part of the visit process

Local screening service

The cervical screening service is provided by the East and North Hertfordshire NHS Trust. It is commissioned by NHS England Midlands and East (Central Midlands) Screening and Immunisation Team (SIT).

The East and North Hertfordshire NHS Trust provides screening services for women served by East and North Hertfordshire clinical commissioning group. The eligible cervical screening population (25 to 64 year old women) is around 150,000.

Colposcopy and histopathology services are at the Lister Hospital, Stevenage. There is also a colposcopy service at Hertford County Hospital.

The cytology and human papillomavirus service is provided by Cambridge University Hospitals Cytology Network based in Newmarket and is not included in the scope of this QA visit.

Findings

There have been improvements in operational team working since the interim QA visit in February 2016. However, there is further work to do to be able to demonstrate a fully integrated Trust cervical screening programme with clear governance arrangements where histology as well as colposcopy plays a full part and there are collaborative links with the external cytology service in Newmarket. The role of hospital-based programme co-ordinator (HBPC) is critical to making this happen. There is a need for greater formality and documentation of lead job roles so that post holders are clear what is expected of them and they have the time to carry out their responsibilities.

The Trust needs to follow national guidance on incident reporting and management. Whilst there has been an improvement recently, there is still a need to be more open and transparent as and when issues arise. It is important that incidents are reported to commissioners and SQAS promptly so that appropriate advice can be given and incorporated into investigations.

The service's colposcopy administration team has been severely disrupted due to team members leaving or having long term absence. Designated, trained cover for the full range of colposcopy administration functions should be in place.

Immediate concerns

The QA visit team identified 1 immediate concern. A letter was sent to the chief executive on 1 March 2018 asking that the following item was addressed within 7 days:

- all patient result letters and colposcopy discharge lists must be reviewed by a colposcopist prior to sending

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 11 high priority findings as summarised below:

- there is no job description which details all responsibilities, time, accountability and allocation of administrative support for the HBPC role
- quarterly cervical screening business meetings chaired by the HBPC with representation from all service leads (including cytology) are not in place
- annual and 6 monthly reporting to a high-level Trust governance committee has not been established
- there is a backlog for the completion of invasive cervical cancer audits

- there is no process in place by which the service can confirm that all staff are up to date with information governance requirements
- screening incidents have not been managed in accordance with national guidance and not all staff were aware of the procedures for reporting incidents that occur within the cervical screening programme
- there is no process to ensure cervical screening risks are placed on the relevant risk registers
- the lead cervical screening histopathologist has not been officially appointed, does not have a job description and does not have time allocated in a job plan
- the lead colposcopist and lead nurse have not been officially appointed to their respective roles
- there is an insufficient trained colposcopy administrative staff and the colposcopy failsafe is dependent on a single staff member

Shared learning

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

- the SIT has provided cervical screening coverage data using the PHE Screening coverage tool to each general practice and is involved in training sessions with practices to increase cervical screening awareness
- the colposcopy administration department has an extensive set of “how to” step-by-step guidelines for all administrative tasks
- the histopathology consultants have 1 hour multi-headed microscope sessions every day to discuss difficult cases
- the histology department uses a multi-disciplinary team (MDT) alert system to identify cases that need to be discussed at an MDT meeting

Recommendations

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

Commissioning and Accountability

No.	Recommendation	Reference	Timescale	Priority	Evidence required
1	The commissioners should document a process for escalation of issues from the programme board	1	3 months	Standard	Confirmation of the escalation process
2	The commissioners should put a process in place for the identification and escalation of primary care performance issues and concerns	1	3 months	Standard	Confirmation at the programme board of primary care contract management and escalation arrangements
3	The commissioner and stakeholders should work together to undertake a cervical screening health equity audit	1 & 2	12 months	Standard	The audit results and action plan
4	The commissioners should put in place a process so that incidents are managed effectively and closed promptly	3	3 months	Standard	Documented process and confirmation that the process has been implemented

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority	Evidence required
5	Document the appointment of the hospital-based programme co-ordinator (HBPC) with an appropriate job description and lines of accountability that do not generate a conflict of interest	1 & 4	3 months	High	Job description including accountability and job plan
6	Establish quarterly cervical screening business meetings chaired by the HBPC with representation of all professional leads and reporting from the colposcopy operational meeting	1 & 4	3 months	High	Terms of reference, reporting lines, meeting schedule and minutes of meetings occurring since the QA visit
7	Complete a 6 monthly HBPC report and present to an appropriate Trust governance meeting	1 & 4	6 months	High	The report and the minutes of the meeting at which it was presented
8	Ensure the national invasive cancer audit is up to date	4 & 5	3 months	High	Completion of all registered cases
9	Implement a ratified policy for the offer of disclosure of the invasive cancer audit	4 & 5	3 months	Standard	A copy of the disclosure policy
10	Complete an audit to demonstrate offer of disclosure of invasive cervical cancer audit	4 & 5	12 months	Standard	A copy of the report from the first annual disclosure audit undertaken, the findings and any actions taken as a result
11	Put in place a process to confirm that all staff are up to date with information governance requirements	1 & 4	3 months	High	Confirmation of process agreed and confirmation of training received

No.	Recommendation	Reference	Timescale	Priority	Evidence required
12	Manage and document all screening patient safety and serious incidents in accordance with national guidance and ensure all staff are aware	3 & 4	3 months	High	Copy of updated Trust policy, local histology and colposcopy protocols including reporting to the HBPC and evidence of staff training in incident reporting and compliance with national guidance
13	Put in place a risk management process	1 & 4	3 months	High	Details of process
14	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
15	Document the appointment of the lead cervical screening histopathologist	1	3 months	High	Job description including accountability, job plan and time allocation and name of nominated deputy
16	Document the appointment of the lead colposcopist including appropriate contractual and revalidation arrangements	1	3 months	High	Job description including accountability, job plan, time allocation and contractual and revalidation arrangements
17	Document the appointment of the lead colposcopy nurse	1 & 6	3 months	High	Job description including accountability, job plan, time allocation

Referral

No.	Recommendation	Reference	Timescale	Priority	Evidence required
18	The commissioners should ensure that all general practices are covered by a direct colposcopy referral process	1	3 months	Standard	Confirmation that all general practices are covered by direct referral

Sample taker register

No.	Recommendation	Reference	Timescale	Priority	Evidence required
19	The commissioners should ensure that a document detailing the roles and responsibilities for the sample taker register is put in place	7	3 months	Standard	Document detailing the roles and responsibilities

Diagnosis - histology

No.	Recommendation	Reference	Timescale	Priority	Evidence required
20	Ensure that histopathologists have access to cervical screening results	8	3 months	Standard	Arrangements for access to cervical screening results in place and copy of standard operating procedure (SOP)
21	Document the process by which the laboratory will determine the grade of cervical intraepithelial neoplasia in cases which are uncertain for high grade	8	3 months	Standard	Copy of SOP
22	Audit the use of levels for biopsies and	8	3 months	Standard	Audit report including

No.	Recommendation	Reference	Timescale	Priority	Evidence required
	cervical treatment specimens to ensure compliance with national guidance				actions taken
23	Include the Royal College of Pathologists dataset in all reports	9 & 10	6 months	Standard	Audit of results and action taken
24	Implement provision of regular performance data for histopathologists	8	6 months	Standard	Copy of SOP

Intervention and outcome - colposcopy

No.	Recommendation	Reference	Timescale	Priority	Evidence required
25	Provide sufficient, colposcopy trained administrative support to meet the requirements of the NHS Cervical Screening Programme at all times, including periods of leave	1 & 6	3 months	High	Colposcopy staffing structure, defined responsibilities and absence cover arrangements protocols
26	Implement changes to the IT system to ensure that a separate KC65 return is produced for each clinic and that the new fields required for annual reporting on national standards to SQAS are in place.	1 & 6	6 months	Standard	Submission of discrete clinic KC65 returns and complete annual data returns to SQAS
27	Revise documents so that women are aware that they are able to have a friend or relative present during their procedure if they wish	6	3 months	Standard	Copy of revised SOP
28	Implement a failsafe process so that the cytology laboratory is informed of the outcome of all colposcopy appointments	6	3 months	Standard	Copy of SOP
29	Audit the colposcopy positive predictive value and implement an	6	6 months	Standard	Copy of the audit for the period 1/4/2017 to

No.	Recommendation	Reference	Timescale	Priority	Evidence required
	action plan				31/3/2018 and action taken
30	Implement an annual audit schedule for colposcopy as part of the Trust cervical screening audit schedule	1	3 months	Standard	Copy of the schedule
31	All patient letters and colposcopy discharge lists must be reviewed by a colposcopist prior to sending	1 & 6	7 days	Immediate	Confirmation of the process put in place
32	Revise the local non-clinical colposcopy guidelines to include the process of letters and discharge lists being reviewed by colposcopists	1 & 6	3 months	Standard	Copy of revised SOP
33	Audit the process of letters and discharge lists being reviewed by colposcopists	1 & 6	6 months	Standard	Audit of results and action taken
34	Complete an annual user survey of colposcopy services	1 & 6	3 months	Standard	Outcome of survey, evidence of review of results and SOP showing incorporation of survey into annual activities
35	Provide adequate and sufficient sterile instruments for use in both colposcopy clinics at all times	6	3 months	Standard	Confirmation from lead nurse that supplies are sufficient and no delays have occurred

Multidisciplinary team (MDT)

No.	Recommendation	Reference	Timescale	Priority	Evidence required
36	Implement a SOP for case selection for multi-disciplinary team (MDT) meetings that covers the involvement of cytology, histology and colposcopy	1 & 6	3 months	Standard	Copy of SOP
37	Implement a SOP for the selection and review of histology cases before MDT and for changes to reports before or at the MDT	6	3 months	Standard	Copy of SOP
38	Complete an audit to check that all cytology, histology and colposcopy cases indicated in national guidelines have been identified	1 & 6	12 months	Standard	Completed audit and actions taken

Next steps

The screening service provider is responsible for developing an action plan 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.