Public Health England

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Screening Quality Assurance visit report

NHS Cervical Screening Programme Cambridge University Hospitals NHS Foundation Trust

22 and 23 May 2018

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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 Cambridge University Hospitals NHS Foundation Trust (CUHFT) screening service held on 22 and 23 May 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 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 Midlands and East regional SQAS as part of the visit process

Local screening service

The cervical screening service is commissioned by NHS England Midlands and East (East) Screening and Immunisation Team (SIT).

CUHFT provides cervical screening services (cytology and human papillomavirus (HPV) testing, colposcopy and histology) for women served by Cambridge and Peterborough Clinical Commissioning Group (CCG).

The Trust also provides cytology screening and HPV testing laboratory services to West Suffolk CCG, Ipswich and East Suffolk CCG, North East Essex CCG, Mid Essex CCG and East and North Hertfordshire CCG and the cervical histopathology service for West Norfolk CCG on behalf of the King’s Lynn Cervical Screening Programme.

The eligible cervical screening population (25 to 64-year-old women) for Cambridge and Peterborough CCG is around 240,000.

This figure includes the Peterborough population served by North West Anglia NHS Foundation Trust, most of which is not covered by this programme.

Cambridge University Hospitals NHS Foundation Trust provides cervical cytology, (HPV) testing, histopathology and colposcopy services as part of the NHS Cervical Screening Programme.

The cytology and HPV service is provided by CUHFT cytology network based at a laboratory hub in Newmarket and a satellite screening and reporting site at the Colchester General Hospital. Colposcopy and histopathology services are provided at Addenbrooke's Hospital, Cambridge.

The cytology screening service makes direct colposcopy referrals to Addenbrooke's Hospital as well as to 6 other local Trusts; North West Anglia NHS Foundation Trust (Hinchingbrooke Hospital only), West Suffolk Hospital NHS Foundation Trust, Ipswich Hospital NHS Trust, Colchester Hospital University NHS Foundation Trust, Mid Essex Hospital Services NHS Trust and East and North Hertfordshire NHS Trust.

Findings

Overall, there are clear arrangements in place for the commissioning and oversight of this cervical screening programme. The cervical screening staff are engaged and demonstrate enthusiasm and commitment to providing a high-quality service.

As is the national trend, staff shortages in the cytology workforce has presented a challenge for the service to report cervical screening samples in a timely fashion. The service has worked hard to mitigate delays in these difficult circumstances and has recently been approved to undertake a partial conversion to HPV primary screening to address this.

The main cervical cytology laboratory is based in Newmarket and the pathologists are based in Cambridge. As a result, the service does not meet national guidance for the routine daily presence of a pathologist on site at the cervical screening laboratory in Newmarket. This needs to be addressed.

The Trust has experienced difficulties in using its electronic patient record system 'Epic' to produce accurate and reliable colposcopy activity and performance monitoring data. This was a recommendation at the last QA visit in February 2015.

Whilst it is encouraging that action is now underway and progress is being made quickly, it is disappointing that it has taken such a long time to be addressed, which raises questions about governance and escalation processes within the Trust. At the time of this QA visit, accurate data for 2017/18 is unavailable.

Patients diagnosed with cervical cancer at the Trust have not routinely been offered the results of the review of their screening history. This needs to be implemented as a matter of urgency alongside a policy for the process and establishing a routine audit to demonstrate compliance.

Immediate concerns

The QA visit team identified 1 immediate concern. A letter was sent to the chief executive on 24 May 2018 asking that the following concern was addressed within 7 days: confirm that all women diagnosed with cervical cancer are openly offered the results of an audit of their screening history.

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 12 high priority findings as summarised below:

- there is a backlog for the completion of invasive cervical cancer audit
- there is no ratified Trust protocol for the audit and disclosure of the invasive cervical cancer audit and women are not being offered their results
- the Trust has not completed an audit to demonstrate that all women diagnosed with cervical cancer have been offered the results of the review of their screening history
- information governance training is not undertaken on an annual basis
- a lead cervical screening histopathologist has not been appointed. There is no job description and no time allocated for this role
- the lead colposcopist has not been officially appointed to their role
- there is only a consultant cytopathologist on site at the Newmarket laboratory on 1 day of the week when national guidance indicates there should be pathologist presence on site all the time
- there is not a documented process for the assessment and acceptance of locum staff prior to appointment within the cytology laboratory
- the cytology service is not achieving the 14 day turnaround times for cervical screening results
- histopathologists do not have direct access to cervical screening results
- the Trust has been unable to produce reliable and accurate data for colposcopy
- the colposcopy department does not have a standard operating procedure for the production, validation and discussion of internal performance monitoring data

Shared learning

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

- the cytology department has developed a computer programme which checks that screening results sent to Primary Care Support England have been correctly received and removes most of the manual checking of the report sent back to the laboratory which provides details of any rejected results
- the cytology department proactively analyses and discusses sub-contracted provider performance figures and uses this to inform decisions on selecting which screening providers to send work to
- lists of all cytology results which generate a colposcopy referral are manually audited against the original request forms as a failsafe to ensure cases are not missed
- The laboratory information management system is configured to accept valid cytology result code combinations

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 and stakeholders should work together to undertake a cervical screening health equity audit	1 & 2	12 months	Standard	The audit results and action plan

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority	Evidence required
2	Implement the new national guidance on the cervical screening provider lead role	3	3 months	Standard	Gap analysis and action plan
3	Confirm the governance arrangements for the cervical screening programme including accountability and escalation route for areas of concern and escalation of risks	1 & 3	3 months	Standard	Documents outlining the accountability arrangements

No.	Recommendation	Reference	Timescale	Priority	Evidence required
4	Ensure the national invasive cancer audit data collection is up to date	4 & 5	3 months	High	Completion of all registered cases with a diagnosis date before 22 May 2018
5	Implement a ratified policy for the offer of disclosure of the invasive cancer audit	4, 5 & 6	3 months	High	Disclosure policy
6	Confirm that all women diagnosed with cervical cancer are openly offered the results of an audit of their screening history	4, 5 & 6	7 days	Immediate	Confirmation that a process is in place
7	Complete an audit to demonstrate offer of disclosure of invasive cervical cancer audit	4, 5 & 6	3 months	High	The audit report and evidence of any actions taken as a result
8	Confirm all staff are up to date with annual information governance requirements	7	3 months	High	Confirmation of training received
9	Establish a process for ensuring that all risks are captured on relevant Trust risk registers	1 & 3	3 months	Standard	Details of the process
10	Nominate a deputy for the lead cytopathologist	1	3 months	Standard	Details of the deputy
11	Appoint a lead histopathologist for cervical screening with responsibility for ensuring good practice, compliance with protocols and that NHS Cervical Screening Programme (NHSCSP) standards are met and nominate a deputy	1	3 months	High	Job description, job plan with dedicated professional activity allocation and details of the deputy

No.	Recommendation	Reference	Timescale	Priority	Evidence required
12	Document the process for the invasive cancer audit histology reviews	6	3 months	Standard	Copy of the standard operating procedure (SOP)
13	Formally appoint the lead colposcopist for cervical screening with responsibility for ensuring good practice, compliance with protocols and that NHSCSP standards are met	1 & 5	3 months	High	Job description, job plan with dedicated professional activity allocation

Cytology

No.	Recommendation	Reference	Timescale	Priority	Evidence required
14	Put in place a system to ensure that a medical consultant reporting cervical cytology is on site every day	8	3 months	High	Job plans, sessional rota and staffing arrangements
15	Establish a service level agreement or similar for the provision of, support and maintenance for the laboratory computer system	1	3 months	Standard	Signed service level agreement, or equivalent
16	Document the procedure for the assessment and acceptance of locum staff prior to appointment	8	3 months	High	Copy of SOP
17	Update local procedures in relation to the national sample acceptance policy	9	3 months	Standard	SOP for sample acceptance to include check of sample taker codes against sample taker register and arrangements for vault cytology

No.	Recommendation	Reference	Timescale	Priority	Evidence required
18	Establish service level agreements (SLA) with external provider Trusts that contain clear quality requirements for cervical cytology	1	3 months	Standard	Signed SLAs with external providers
19	Update the poor performance SOP to also include pathologists	8 & 10	3 months	Standard	Copy of SOP
20	Establish a SOP for the collation, validation and provision of cervical screening data for Screening QA Service (SQAS) and commissioners	1 & 5	6 months	Standard	Copy of SOP
21	Implement and monitor a plan to achieve 14 day turnaround times for cervical screening results once human papillomavirus (HPV) primary mitigation has been implemented	1	6 months	High	Recovery plan supported by data submission and evidence of achievement
22	Audit screener inadequate rates and take action to ensure consistency of reporting	10	3 months	Standard	Copy of audit and actions taken

Human Papillomavirus Testing

No.	Recommendation	Reference	Timescale	Priority	Evidence required
23	Establish service level agreements to provide firm links with virology and any laboratories which may provide advice	1	3 months	Standard	Signed SLAs with virology/microbiology support providers

Sample taker register

No.	Recommendation	Reference	Timescale	Priority	Evidence required
24	Commissioners to document arrangements for the oversight of sample taker performance, including the sample taker register arrangements	1	3 months	Standard	Copy of overarching sample taker register document
25	Implement the sample taker register and provide comprehensive feedback both by individual sample taker, general practice/clinic relating to reporting profiles, workload, and error rates	1	3 months	Standard	Confirmation register is in place and example of reports issued

Diagnosis - histology

No.	Recommendation	Reference	Timescale	Priority	Evidence required
26	Ensure histopathologists have access to cervical cytology reports to correlate with histology findings	11	3 months	High	Details of the arrangements for accessing and correlating cervical screening results and the associated SOP
27	Document the process for obtaining second opinions, difficult cases and first diagnosis of malignancy	11	3 months	Standard	Copy of SOP

No.	Recommendation	Reference	Timescale	Priority	Evidence required
28	Audit the use of levels for cervical treatment specimens	11	3 months	Standard	Audit report including actions taken
29	Document the process for defining adequacy of biopsies	11	3 months	Standard	Copy of SOP
30	Include the Royal College of Pathologists dataset in all reports	11 & 12	3 months	Standard	Audit report including actions taken
31	Implement provision of regular performance data for histopathologists	11	6 months	Standard	Details of the arrangements and SOP

Intervention and outcome - colposcopy

No.	Recommendation	Reference	Timescale	Priority	Evidence required
32	Provide enough colposcopy administrative staff to meet the requirements of the NHSCSP	1 & 5	3 months	Standard	Colposcopy staff structure, defined responsibilities and absence cover arrangements protocols
33	Provide reliable, accurate and validated KC65 data for 2017/18	1 & 5	3 months	High	Fully validated 2017/18 colposcopy dataset (annual and individual 4 quarters)
34	Implement changes to the IT system so that annual reporting on all national standards to the SQAS is in place	1 & 5	6 months	Standard	Submission of complete annual data returns to SQAS
35	Capture data about women treated under general anesthesia in theatre	1 & 5	3 months	Standard	Copy of SOP
36	Revise the colposcopy administration	1 & 5	3 months	Standard	Revised SOP

No.	Recommendation	Reference	Timescale	Priority	Evidence required
	failsafe policy to include the process for women being treated under general anesthesia in theatre				
37	Document the process for the receipt of GP referrals outside the direct referral process	1 & 5	3 months	Standard	Copy of SOP
38	Document the process for the production, validation and discussion of internal performance monitoring data	1 & 5	3 months	High	Copy of SOP
39	Document the process for checking and validating the colposcopy discharge summary	1	3 months	Standard	Copy of SOP
40	Demonstrate compliance with HPV triage and test of cure protocol	5	3 months	Standard	Audit to demonstrate compliance data
41	Demonstrate compliance with the national standard for excisional treatment depth	5	3 months	Standard	Audit to demonstrate compliance data
42	Audit the treated women with cervical intraepithelial neoplasia or cancer within 12 months of procedure and implement an action plan	5	3 months	Standard	Copy of the audit for the period 1/4/2017 to 31/3/2018 and action taken
43	Implement a rolling, annual audit schedule for colposcopy as part of the Trust cervical screening audit schedule	1 & 5	6 months	Standard	Annual audit schedule
44	Revise the invitation letter to include the cervical screening result	13	3 months	Standard	Revised letter

Multidisciplinary team (MDT)

No.	Recommendation	Reference	Timescale	Priority	Evidence required
45	Document the process for identifying histology cases for the MDT meeting and the review process and attendance at the meetings	1 & 5	3 months	Standard	Ratified SOP
46	Document the histology and cytology review opinions on the MDT records	5	3 months	Standard	Copy of SOP

Next steps

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