Public Health England

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Screening Quality Assurance visit report

NHS Cervical Screening Programme
West Hertfordshire Hospitals NHS Trust

15 and 16 January 2020

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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 (CSP) 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 Hertfordshire Hospitals NHS Trust screening service held on 15 and 16 January 2020.

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

West Hertfordshire Hospitals NHS Trust (WHH) provides NHS cervical screening services to an eligible population of approximately 171,000 women, covered by the Herts Valley Clinical Commissioning Group. The service is commissioned by NHS England and NHS Improvement supported by the East of England Screening and Immunisation Team.

WHH provides colposcopy from the Watford General Hospital (WGH) and St Albans City Hospital. Cervical histology is provided from the Hemel Hempstead General Hospital.

The cytology and human papillomavirus (HPV) testing service transferred from WGH to the Norfolk and Norwich University Hospitals NHS Foundation Trust on 10 November 2019 as part of the national roll out of HPV primary screening across England.

Findings

The trust has a team of dedicated and hardworking staff throughout the whole cervical screening service. A cervical screening provider lead (CSPL) has been appointed recently and is working hard to establish the internal governance arrangements, including incident reporting, cervical screening business meetings, escalation of risks and issues and governance reporting within the trust.

There is an unclear demarcation of roles and responsibilities within the colposcopy department and also between the lead colposcopist and the CSPL which is leading to confusion and individuals undertaking work that is not their responsibility. The QA team identified several discrepancies between the visit evidence and discussions on the day compared with information being reported within the trust and to commissioners. This raised concerns that such reporting may be inappropriately reassuring.

A disorganised and chaotic multidisciplinary team (MDT) meeting was observed by the SQAS professional clinical advisor, where discussion was ineffective and clinical decision making was not always appropriate to the circumstances. Not all colposcopists attend at least 50% of the meetings, despite it being a high priority recommendation at the previous QA visit. Future meetings need to be significantly improved as a matter of urgency.

The service has recently implemented HPV primary screening. Local colposcopy guidelines have not been updated to fully comply with the new pathway and there is evidence that not all colposcopists are following the new clinical management protocols.

Immediate concerns

The QA visit team identified 3 immediate concerns. A letter was sent to the chief executive on 20 January 2020 asking that the following items were addressed within 7 days:

- sample requests must be completed at the time of the sample being taken by the person taking the test
- colposcopy MDT meeting standard operating procedures (SOPs) and associated documentation should be updated to support the effective discussion and clinical management of patients
- a retrospective 12-month audit of suspected and confirmed glandular cases and their review at MDT meeting

A response was received within 7 days which assured the QA visit team that appropriate actions were being taken to mitigate the identified risks.

High priority

The QA visit team identified 9 high priority findings as summarised below:

- quarterly cervical screening business meetings chaired by the CSPL with representation from all service leads are not fully established
- annual and 6 monthly reporting to an overall trust governance committee has not been established
- disclosure of invasive cancer audit findings has not been undertaken in accordance with the local protocols
- not all staff are aware of how to identify potential screening incidents and who they should be escalated to
- there is no risk management process in place for the cervical screening service
- there is no induction or assessment process for locum histopathologists reporting in the NHS CSP
- colposcopists are not following the national HPV primary screening protocol
- there is no SOP in place to regularly assess trust, clinic and individual clinician performance
- national standards for performance and MDT meeting attendance have not been met by all of the colposcopists

Shared learning

The QA visit team identified 2 areas of practice for sharing, including:

- a post coital bleeding clinic which maximises colposcopy clinic capacity for screening appointments
- cervical histology reports indicate correlation with cytology and whether MDT meeting discussion is needed

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 and stakeholders should develop an action plan to improve coverage in underserved and protected population groups	1 & 2	3 months	Standard	Action plan presented to the programme board
2	Commissioners should ensure patient feedback from the colposcopy service is routinely discussed at programme boards	2	12 months	Standard	Patient satisfaction survey report presented to the programme board
3	Confirm the arrangements for the nominated deputy to the cervical screening provider lead (CSPL) who can undertake all aspects of the role in the CSPL's absence and document the CSPL administrative support	3	3 months	Standard	Confirmation of deputy and the revised CSPL job description which encompasses the administrative support provided
4	Develop an organisational accountability structure for the cervical screening service including detail of escalation routes for governance and performance issues	2 & 3	3 months	Standard	Details of the structure and escalation routes

No.	Recommendation	Reference	Timescale	Priority	Evidence required
5	Update the terms of reference for the quarterly cervical business meetings to clarify reporting and escalation lines into and from the meeting and ensure representation from all cervical screening service leads	2 & 3	3 months	High	Copy of the terms of reference along with the minutes of the most recent meeting
6	Establish annual and 6 monthly reporting to the trust's main clinical governance committee	2 & 3	3 months	High	A copy of the first report given and minutes of the meeting where it was presented
7	Put in place an overarching invasive cancer audit protocol	4	3 months	Standard	The updated protocol
8	Re-audit the last 12 months of invasive cervical cancer result disclosure	4	6 months	High	Disclosure audit report and actions taken
9	Develop and implement a whole trust annual audit schedule for cervical screening services	2	3 months	Standard	Annual audit schedule covering colposcopy and histopathology and minutes of the business meeting at which it was agreed
10	Document a reference to national screening incident guidance in the trust policy on managing serious incidents	2	3 months	Standard	A copy of the trust incident policy
11	Ensure all staff are aware of the national 'Managing Safety Incidents in NHS Screening Programmes' guidance	5	3 months	High	Documented evidence such as meeting minutes where staff have been made aware of national guidance

No.	Recommendation	Reference	Timescale	Priority	Evidence required
12	Demonstrate an effective risk management process	2 & 3	3 months	High	Documents detailing the process agreed and evidence that risks are documented on the trust risk register
13	Provide a lead cervical screening histopathologist job description, including a designated time allocation and nominate a deputy	1 & 6	3 months	Standard	Copy of the approved job description and name of the deputy
14	Update the terms of reference for the quarterly colposcopy operational meetings to clarify the arrangements for chairing, reporting and escalation lines into and from the meeting and ensuring representation from all colposcopy team staff	1 & 7	3 months	Standard	Copy of the terms of reference along with the minutes of the most recent meeting

Diagnosis – histology

No.	Recommendation	Reference	Timescale	Priority	Evidence required
15	Incorporate the definition of inadequate biopsies into routine practice and document in a standard operating procedure (SOP)	6	3 months	Standard	SOP
16	Audit the use of levels for biopsies and treatment specimens to demonstrate compliance with national guidance	6	3 months	Standard	Audit report and details of actions taken
17	Put in place an induction and assessment process for locums reporting in the NHS cervical screening programme (CSP)	6	3 months	High	SOP

No.	Recommendation	Reference	Timescale	Priority	Evidence required
18	Implement a SOP to provide regular performance data to pathologists	6	3 months	Standard	SOP

Intervention and outcome – colposcopy

No.	Recommendation	Reference	Timescale	Priority	**Evidence required**
19	Make sure there are enough colposcopy administrative staff to meet the requirements of the NHS CSP	2	3 months	Standard	Colposcopy staffing structure, defined responsibilities and absence cover arrangements
20	The trust should provide suitable administration accommodation which minimises the risk of confidentiality breaches	1	3 months	Standard	Details of arrangements in place
21	Ensure the colposcopy IT system can produce reliable data for the KC65 for each clinic and that there is documented validation process	2	3 months	Standard	Confirmation that IT system can report patient appointments at both sites, depth of excision, single loop excision and the SOP for validating colposcopy data
22	Sample requests must be completed at the time of the sample being taken by the person taking the test	10	7 days	Immediate	Written confirmation that this process is in place
23	Document the process for results and referral for cervical samples taken in hospital but outside of colposcopy	11	3 months	Standard	SOP

No.	Recommendation	Reference	Timescale	Priority	**Evidence required**
24	Update the local trust colposcopy clinical guidelines to reflect current NHS CSP guidance	7	3 months	Standard	Colposcopy guidelines that reflect human papillomavirus (HPV) primary screening, document the role of the lead nurse and how patient consent is obtained and recorded
25	Ensure all colposcopists are following the national HPV primary screening protocol	7 & 8	6 months	High	Audit January to December 2019 and details of actions taken as appropriate
26	Implement SOPs for colposcopy administrative processes and colposcopy clinic arrangements	2	3 months	Standard	SOPs with appropriate reference to new HPV primary screening arrangements, colposcopy failsafe and discharge processes
27	Complete an audit of failsafe processes in the colposcopy service	9	3 months	Standard	Audit report showing failsafe complies with national guidance and details of actions taken
28	Document and implement clinician review of the colposcopy discharge lists prior to sending	9	3 months	Standard	SOP
29	Put in place a process to regularly assess trust, clinic and individual clinician performance data, provide feedback to staff and take appropriate action	7	3 months	High	SOP and evidence of implementation of processes, such as meeting minutes where performance is discussed

No.	Recommendation	Reference	Timescale	Priority	**Evidence required**
30	Ensure that equipment safety and emergency guidelines are up-to-date and easily accessible in the colposcopy clinics	7	3 months	Standard	SOP and confirmation that guidelines are available in the clinics
31	Demonstrate that all colposcopists meet national standards	7	6 months	High	Annual individual colposcopist data request
32	Update trust patient letters to include the result of the screening test	8 & 12	3 months	Standard	Updated appointment letters
33	Establish an annual user survey of colposcopy services	2	6 months	Standard	Audit report by clinic and overall service along with action taken as appropriate

Multidisciplinary team (MDT)

No.	Recommendation	Reference	Timescale	Priority	Evidence required
34	Complete a retrospective 12-month audit of suspected and confirmed glandular cases and their review at MDT meeting, including confirmation of histological diagnosis	7	7 days	Immediate	Detailed audit of all glandular cases
35	Develop MDT meeting SOPs and documentation to ensure effective discussion and clinical management of patients	2 & 7	7 days	Immediate	MDT meeting SOPs
36	Ensure all colposcopists attend a minimum of 50% of MDT meetings	7	6 months	High	MDT meeting attendance records for February 2020 to August 2020 inclusive

No.	Recommendation	Reference	Timescale	Priority	Evidence required
37	Develop a SOP for case selection for the MDT meetings by cervical histology	2 & 7	3 months	Standard	MDT meeting SOP
38	Complete an audit to check that all cases discussed during 2019 have had the agreed MDT meeting action completed	2 & 7	3 months	Standard	Audit report and actions taken

Next steps

The screening service provider is responsible for developing an action plan in collaboration with the commissioners to complete the recommendations contained in 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.