Public Health England

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Screening Quality Assurance visit report

NHS Cervical Screening Programme

Mid Essex Hospital Services NHS Trust

6 February 2020

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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.

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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 Mid Essex Hospital Services NHS Trust (MEHT) screening service held on 6 February 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, commissioner and external organisations
- information shared with the Midlands and East regional SQAS as part of the visit process

Local screening service

MEHT provides NHS cervical screening services to an eligible population of approximately 98,000 individuals, covered by the Mid Essex Clinical Commissioning Group. The service is commissioned by NHS England and NHS Improvement supported by the East of England Screening and Immunisation Team.

MEHT provides colposcopy and cervical histology from Broomfield Hospital in Chelmsford.

The cytology and human papillomavirus (HPV) testing service is provided by the Cambridge Cytology Network but will transfer to the Norfolk and Norwich University Hospitals NHS Foundation Trust on 29 February 2020 as part of the national rollout of HPV primary screening across England. HPV primary screening was implemented for the population covered by MEHT in June 2018.

Findings

This is a screening service with a large workload which is due to merge with 2 other local trusts imminently to create a much larger and more complex service operating over multiple sites. Significant leadership and detailed and careful planning will be essential for this to be successful. SQAS is scheduled to visit the newly merged trust in 2021.

There has been no cervical screening provider lead (CSPL) in post for over 6 months which has led to a service with no internal governance or oversight arrangements and previously established meeting structures have broken down. When a new CSPL is appointed, they need to re-establish the cervical screening business meetings and clear processes for incident reporting, the escalation of risks and issues and governance reporting for cervical screening matters within the trust. It was reported that the new CSPL will operate across the 3 trust sites, which should assist the development of a single, cohesive cervical screening service once the merger has taken place.

There is evidence of a lack of leadership, direction and governance in the departments involved in the cervical screening pathway. There is also evidence of a lack of awareness and understanding of current screening programme guidance and practice.

Based on the evidence presented, the QA visiting team could not be assured of the quality of the colposcopy service being provided and a number of immediate recommendations have been made to assess this further.

The colposcopy service needs to update all aspects of its documentation. It is a priority to establish processes to routinely assess and audit the service, individual colposcopist performance and the effectiveness of multi-disciplinary team (MDT) meetings.

Colposcopy nursing and administration staff are working hard in challenging circumstances, such as inadequate staffing provision and cramped, confined accommodation.

Immediate concerns

The QA visit team identified 6 immediate concerns. A letter was sent to the chief executive on 10 February 2020 asking that the following items were addressed within 7 days:

- provide an action plan for implementing a comprehensive and effective cervical screening governance process with immediate effect and the plans for the arrangements from 1 April 2020

- provide SQAS with a list of NHS numbers for all individuals diagnosed with cervical cancer during 2019
- document and implement clinician review of the colposcopy discharge lists prior to sending
- clarify the process for completing specimen requests during colposcopy clinics
- complete a retrospective 12-month audit of suspected and confirmed glandular cases and their review at the MDT meeting
- complete a retrospective audit of each case discussed at the May, June, July 2019 MDTs and their management against national guidelines, with their outcome to date and whether this was in line with the MDT recommendation

A response was received within 7 days which gave information on the trust's plans to address the immediate concerns and mitigate the identified risks. SQAS and its professional and clinical advisors have undertaken a detailed assessment of all the information provided. The retrospective audits raised further queries. As a result, 2 further immediate recommendations were issued to the trust:

- engage external support to oversee the undertaking of an urgent review of clinical practice across the colposcopy service
- complete the audit of cases of invasive cervical cancer where there is a history of colposcopy attendance prior to diagnosis

The trust's response to the immediate recommendations was delayed due to the COVID-19 pandemic and remains outstanding at the time of report publication.

High priority

The QA visit team identified 22 high priority findings as summarised below:

- there is no CSPL or nominated deputy in place
- the organisational accountability structure for cervical screening activities within the trust, including details of escalation routes for governance and performance issues and reporting, is not established and quarterly cervical screening business meetings chaired by the CSPL with representation from all service leads along with annual and 6-monthly reporting to a high-level trust governance committee are not in place
- the invasive cervical cancer audit has a significant backlog
- not all cervical screening staff are aware of how to identify incidents or potential incidents and who they should be escalated to and there is no process to ensure that cervical screening risks are placed on the risk register and discussed at relevant meetings
- the lead histopathologist does not have a job description or time allocated for the role, not all the responsibilities of the lead colposcopist role are being carried out and the role of the lead colposcopy nurse is not accurately documented

- the 2019 NHS CSP histopathology guidance has not been implemented
- the colposcopy service has insufficient workforce and resources for the workload
- colposcopy accommodation does not provide a separate recovery area for patients, does not provide suitable administration office space and risks breaches of patient confidentiality
- the local colposcopy guidelines do not comply with NHS CSP guidelines, not all colposcopy failsafe processes are documented, the failsafe system has not been audited and there are no comprehensive guidelines and work instructions covering colposcopy clinic management and administration
- there is no standard operating procedure in place to regularly assess trust, clinic and individual colposcopist performance and no action is taken on any standards that are not met
- appointment waiting times and receipt of result letter standards have not been met for several quarters and national standards for MDT meeting attendance have not been met by all of the colposcopists
- there are significant concerns with the functioning of the colposcopy MDT meeting and how patients have been managed

Shared learning

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

- a Mid and South Essex University Hospitals Group incident policy with a clear and comprehensive section on the need to inform NHS England and SQAS if a screening incident is suspected and the rationale for this
- clearly documented histopathology reports which include a section requesting MDT discussion (Yes or No)

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	Minutes of the programme board at which the patient satisfaction survey is presented and discussed
3	Provide an action plan for implementing a comprehensive and effective cervical screening governance process with immediate effect and the arrangements from 1 April 2020	2 & 3	7 days	Immediate	A copy of the action plan. More detail on what the action plan should include has been provided to the trust separately
4	Appoint a cervical screening provider lead (CSPL) with an agreed job description that includes accountability to the Chief Executive Officer, dedicated time and administrative support and nominate a deputy	2 & 3	3 months	High	Confirmation of appointment, job description, job plan and details of the deputy

No.	Recommendation	Reference	Timescale	Priority	Evidence required
5	Document how programme performance issues are escalated and managed within the trust governance system and develop an organisational accountability structure	2 & 3	3 months	High	Documented and ratified process including organisational chart and escalation pathway
6	Re-establish quarterly cervical business meetings chaired by the CSPL with representation from all cervical screening service leads	2 & 3	3 months	High	Terms of reference, meeting schedule and minutes of all meetings held since the QA visit
7	Make sure an annual performance report and 6-monthly update to cover all NHS Cervical Screening Programme (CSP) services within the trust is provided to the overall governance committee	2 & 3	6 months	High	Annual performance and 6-monthly report with circulation list and minutes of the meetings at which it was presented
8	Put in place an overarching invasive cancer audit protocol	3 & 4	3 months	Standard	Overarching standard operating procedure (SOP) to include discrete departmental protocols for review of cases
9	Ensure the national invasive cancer audit data collection is up to date	2, 3 & 4	3 months	High	Completion of registered cases for time period to 6 February 2020
10	Provide the Screening QA Service (SQAS) with a list of NHS numbers for all individuals diagnosed with cervical cancer during 2019	4	7 days	Immediate	NHS numbers of all individuals diagnosed with cervical cancer in 2019 sent securely to SQAS
11	Complete the audit of cases of invasive cervical cancer where there is a history of colposcopy attendance prior to diagnosis	4	1 month	Immediate	Completed invasive cancer audits sent securely to PHE.esqa@nhs.net

No.	Recommendation	Reference	Timescale	Priority	Evidence required
12	Complete an audit to demonstrate offer of disclosure of invasive cervical cancer audit	4	6 months	Standard	Audit report and details of actions taken
13	Develop and implement a whole trust annual audit schedule for cervical screening services	2 & 3	3 months	Standard	Annual audit schedule covering colposcopy and cervical histology
14	Ensure all staff are aware of the national 'Managing Safety Incidents in NHS Screening Programmes' guidance	2 & 5	3 months	High	Documented evidence such as meeting minutes where staff have been made aware of national guidance Evidence of incidents being discussed routinely at relevant trust screening meetings (cervical screening business, histology and colposcopy meetings)
15	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 Evidence of risks being discussed at relevant trust screening meetings (cervical screening business, histology and colposcopy meetings)
16	Provide a lead cervical screening histopathologist job description, including a designated time allocation and nominate a deputy	2 & 6	3 months	High	Copy of the approved job description and name of the deputy
17	Assess the role and responsibilities of the lead colposcopist against national guidance	2 & 7	3 months	High	Gap analysis and a copy of the updated, approved job description

No.	Recommendation	Reference	Timescale	Priority	Evidence required
18	Define and document the role and time allocation of the lead colposcopy nurse	2 & 7	3 months	High	Copy of the approved job description
19	Develop terms of reference for the quarterly colposcopy operational meetings, including clarify the arrangements for chairing, reporting and escalation lines into and from the meeting	7	3 months	Standard	Terms of reference, meeting schedule and minutes of all meetings held since the QA visit

Diagnosis – histology

No.	Recommendation	Reference	Timescale	Priority	Evidence required
20	Put in place an induction and assessment process for locums reporting in the NHS CSP	6	3 months	Standard	Standard operating procedure (SOP)
21	Implement the 2019 NHS CSP histology guidance	6	3 months	High	Copy of updated cervical histology guidelines that reflect current NHS CSP guidance and evidence of implementation
22	Implement SOPs for use of ‘p16’ staining and definition of inadequate biopsies	6	3 months	Standard	SOPs
23	Audit the use of levels for treatment specimens to demonstrate compliance with national guidance	6	6 months	Standard	Audit report and details of actions taken
24	Implement a SOP to provide regular performance data to pathologists	6	3 months	Standard	SOP
25	Provide data on pathologist performance, including workload and turnaround times	6	6 months	Standard	Data report and evidence of provision to pathologists

No.	Recommendation	Reference	Timescale	Priority	Evidence required
26	Implement an annual clinical audit schedule for cervical screening histology as part of the trust cervical screening audit schedule	6	3 months	Standard	Copy of audit schedule

Intervention and outcome – colposcopy

No.	Recommendation	Reference	Timescale	Priority	Evidence required
27	Demonstrate the action taken to ensure the colposcopy service has workforce and resources sufficient for the workload	2 & 7	3 months	High	Action plan
28	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
29	Provide accommodation that includes a dedicated recovery area during all colposcopy clinics and which minimises the risk of confidentiality breaches	2 & 7	3 months	High	Details of the arrangements in place
30	Put in place suitable administration accommodation which minimises the risk of confidentiality breaches and ensures safe storage of confidential information	2 & 7	3 months	High	Details of the arrangements in place
31	Implement changes to the IT system to ensure that the new fields required for annual reporting on national standards to SQAS are in place.	2 & 7	3 months	Standard	Submission of annual individual colposcopist data set including depth of excision and excision by number of pieces in specimen

No.	Recommendation	Reference	Timescale	Priority	Evidence required
32	Clarify the process for completing specimen requests during colposcopy clinics	8	7 days	Immediate	Detailed confirmation of the process in place
33	Undertake a gap analysis against the newly published national guidance and update the colposcopy guidelines to cover the newly merged trust	7 & 9	3 months	High	Colposcopy guidelines that reflect current NHS CSP guidance with evidence of implementation
34	Complete an audit of failsafe processes in the colposcopy service	10	3 months	High	Audit report showing failsafe complies with national guidance and details of actions taken
35	Document and implement clinician review of the colposcopy discharge lists prior to sending	10	7 days	Immediate	Written confirmation that this process is in place
36	Put in place a process to regularly assess trust, clinic and individual clinician performance data, provide feedback to staff and take appropriate action	2 & 7	3 months	High	SOP
37	Document the process for results and referral for cervical samples taken in hospital but outside of colposcopy	11	3 months	Standard	SOP
38	Put in place comprehensive guidelines and work instructions covering colposcopy clinic management and administration	2 & 7	3 months	High	SOP
39	Implement and monitor a plan to achieve national standards for colposcopy appointment and treatment waiting times	7	3 months	High	Agreed action plan with evidence of regular monitoring

No.	Recommendation	Reference	Timescale	Priority	Evidence required
40	Ensure individuals receive their results within 4 weeks of the colposcopy clinic receiving a diagnostic biopsy report	7	3 months	High	Agreed action plan with evidence of regular monitoring
41	Demonstrate that all colposcopists meet national standards and are following the human papilloma virus (HPV) primary screening management protocol	2 & 7	6 months	High	Annual individual colposcopist data request
42	Update patient letters and leaflets to reflect HPV primary screening and comply with national guidance	9 & 12	3 months	Standard	Letters and leaflets

Multidisciplinary team (MDT)

No.	Recommendation	Reference	Timescale	Priority	Evidence required
43	Complete a retrospective 12-month audit of suspected and confirmed glandular cases and their review at the MDT meeting, including confirmation of histological diagnosis	7	7 days	Immediate	Detailed audit of all glandular cases, to include all ?glandular and borderline change in endocervical cell cytology referrals to colposcopy and all histologically confirmed cases of cervical glandular intra-epithelial neoplasia reported in the year 2019
44	Ensure all colposcopists attend a minimum of 50% of MDT meetings and histopathologists a minimum of 3 per year	7	3 months	High	MDT meeting attendance records for January 2020 to June 2020 inclusive
45	Complete a retrospective audit of each case discussed at the May, June, July MDT meetings and their management and outcome to date	7	7 days	Immediate	Detailed audit of all cases discussed at each MDT meeting

No.	Recommendation	Reference	Timescale	Priority	Evidence required
46	Update MDT SOPs, including case selection for colposcopy and histology, documentation to ensure effective discussion and clinical management of patients and alignment with other relevant trust guidance and process for producing MDT outcome letters	7	3 months	Standard	SOP
47	Engage external support to oversee the undertaking of an urgent review of clinical practice across the colposcopy service	7	1 month	Immediate	Written confirmation of action taken. More detail on this has been provided to the trust separately
48	Complete a retrospective audit of each case discussed at all MDT meetings during 2019 and their management and outcome to date	7	3 months	High	Detailed audit of all cases discussed at each MDT meeting

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.