Public Health England

Protecting and improving the nation's health

Screening quality assurance visit report

NHS cervical screening programme
Birmingham Women's and Children's NHS Foundation Trust

2 March 2017

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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 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 Birmingham Women's and Children's NHS Foundation Trust screening service held on 2 March 2017.

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 collected during pre-review visits to the Birmingham Women's and Children's NHS Foundation Trust on 15 February 2017
- information shared with the Midlands and East regional SQAS as part of the visit process

Local screening service

Since 2013 commissioning of cervical screening for the South Birmingham population has been undertaken by the Midlands and East (West Midlands) Screening and Immunisation Team. The Birmingham Women's and Children's NHS Foundation Trust cervical screening programme (the programme) provides screening services for women served by the Birmingham South Central Clinical Commissioning Group. The eligible population for cervical screening in South and Central Birmingham is approximately 100,000.

The cytology laboratory which refers women to the programme is at the Birmingham Heartlands Hospital, Heart of England NHS Foundation Trust. Human papilloma virus (HPV) testing is undertaken by the PHE laboratory located on the Birmingham Heartlands Hospital site. Cytology and HPV testing have been reviewed as part of the QA visit to the Heart of England NHS Foundation Trust in January 2017.

Cervical histology and colposcopy services are provided at the Birmingham Women's Hospital.

Findings

This cervical histology and colposcopy service has undergone a number of changes since the last QA visit in 2012. There has been a major reconfiguration of cervical cytology with work previously undertaken at the Birmingham Women's Hospital transferring to the Birmingham Heartlands Hospital laboratory. An improved cervical screening governance and reporting structure is being established following recent trust re-structuring.

The cervical histology service has a new lead histopathologist and the team are working hard to ensure it is achieving national standards for reporting cervical histology specimens sent from colposcopy. The trust has been successful in recruiting staff despite the nationally recognised problems with recruiting and retaining consultant pathologists. This reflects well on the service.

The colposcopy service has a new lead colposcopist since the last QA visit who has worked hard to remedy the important issues that were identified at the last QA visit. As a result, the service is much improved. There is now a cohesive and forward-looking team approach to clinical practice and an individualised service for patients.
Despite these improvements, there are a number of key priorities. The colposcopy service needs to have sufficient administrative and IT support and comprehensive documentation of clinical and administrative arrangements. The non-screening workload in colposcopy is affecting the service's capacity to offer screening patients appointments within the national standard timeframes. Conflicting work priorities of the hospital-based cervical screening co-ordinator (HBPC) is affecting the prompt completion of cases for the national invasive cancer audit. There is now a backlog of cases which impacts on the disclosure of audit results to women.

The service needs to ensure that the QA visit recommendations are embedded into routine practice. A number of the recommendations made at this visit are repeated from the 2012 visit, including the need for all colposcopists to meet the national standard for attending multi-disciplinary team (MDT) clinical discussion meetings. Although addressed by the trust at the time, achievement of all previous recommendations has not been sustained.

The high priority issues identified are summarised below as well as a number of shared learning. For a complete list of recommendations, please refer to the table of all recommendations or to the related section within the full report.

Immediate concerns

The QA visit team identified no immediate concerns.

High priority

The QA visit team identified 8 high priority findings as summarised below:

- there is a backlog of data collection for the national invasive cervical cancer audit leading to a delay in offering women the results of their case review
- following the resignation of the colposcopy co-ordinator, the level of colposcopy administration resource is not adequate
- IT back-up processes for the colposcopy database are not documented
- the local clinical colposcopy clinical guidelines do not reflect current national guidance and local colposcopy practice
- the colposcopy administrative processes are not sufficiently detailed for a person with little or no experience in the service to follow and fully complete the relevant tasks
- waiting times for colposcopy appointments are not meeting national standards; this is partly due to the use of colposcopy clinics for non-screening referrals which is reducing the availability of appointments for screening patients
- attendance for all colposcopists at MDT meetings does not meet the national standard

Shared learning

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

- particularly clear cervical screening business meeting documentation which covers all the important discussion areas and ensures that actions are addressed
- a pathology standard operating procedure (SOP) in place for the use of 'p16' staining of cervical tissue samples
- a comprehensive SOP for identifying and managing poor performance of pathologists, including in external quality assurance schemes
- frequent (3 times a week) multi-headed microscope sessions for pathologists to review and discuss individual cases along with a routine pre-MDT meeting
- production and distribution of a newsletter to all colposcopy staff detailing the most recent performance data so that all staff are aware of how the service is performing
- introduction of a colposcopy-specific world health organisation checklist
- educational sessions for nursing staff working in colposcopy
- the HBPC conducts a monthly audit of actions from the last MDT meeting to ensure they have been carried out

Recommendations

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

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority	Evidence required
R6.1	Establish annual and 6 monthly reporting to a senior Trust clinical governance committee	1	6 months	S	Document detailing the arrangements agreed, a copy of the first report given and minutes of the meeting where it was presented
R6.2	Data collection for the national invasive cervical cancer audit should be up to date	2	6 months	H	Evidence that all invasive cervical cancer audit cases are up to date
R3.1	Establish processes for routine disclosure of invasive audit findings to women	2	3 months	S	A copy of relevant standard operating procedure (SOP)
R12.1	Ensure that the disclosure of invasive cervical cancer audit findings to women takes place routinely	2	12 months	S	A copy of the report from the first annual disclosure audit undertaken, the findings and any action(s) taken as a result
R3.2	Document the formal appointment of the lead colposcopist	3	3 months	S	Evidence of formal appointment of lead colposcopist and Trust job description
R12.2	Establish routine colposcopy operational team meetings	3	12 months	S	Copies of the minutes of meetings that have taken place since the QA visit

No.	Recommendation	Reference	Timescale	Priority	Evidence required
R6.1	Establish annual and 6 monthly reporting to a senior Trust clinical governance committee	1	6 months	S	Document detailing the arrangements agreed, a copy of the first report given and minutes of the meeting where it was presented

Diagnosis – histology

No.	Recommendation	Reference	Timescale	Priority	Evidence required
R3.3	All minimum data set items should be included in all cervical loop excision reports	4	3 months	S	Evidence that audit of inclusion of all minimum data set items has been undertaken; a copy of the audit report and details of the action(s) taken as a result
R6.3	Pathologists should routinely receive departmental and individual workload, Royal College of Pathologists workload scores (or equivalent) and turnaround time data	5 and 6	6 months	S	Copy of the performance data provided and confirmation of the frequency these data are produced

Intervention and outcome – colposcopy

No.	Recommendation	Reference	Timescale	Priority	Evidence required
R3.4	A suitable level of colposcopy administration resource should be in place	3	3 months	H	Details of the colposcopy administration resources implemented
R3.5	Ensure IT back-up processes for the colposcopy database are in place and formally documented	3	3 months	H	Copy of the SOP
R3.6	Update colposcopy clinical guidelines to reflect national guidance and local clinical practice	3	3 months	H	Copy of updated clinical guidelines and copy of minutes of meeting at which they have been discussed

No.	Recommendation	Reference	Timescale	Priority	Evidence required
R3.7	Update colposcopy administration procedure documents so that any member of staff can do the tasks involved and that the management of referrals covers all screening patients	3	3 months	H	Copy of updated colposcopy administration procedures covering all referrals (not just those directly referred)
R3.8	National waiting time standards for first offered colposcopy appointment should be sustainably achieved	3	3 months	H	Performance data, for the period since the QA visit, indicating achievement of national waiting time standards

No.	Recommendation	Reference	Timescale	Priority	Evidence required
R3.9	Performance data should be fully validated and an action plan developed to address any areas where performance falls outside of national standards	3	3 months	S	Full validation of the QA visit dataset along with a copy of the action plan developed to address areas where performance is outside of national standard, specifically: • individual colposcopist annual screening workload • selection of cases for ablative treatments • high grade referrals biopsied • outcome of treatment at first visit for women referred with low grade cytology • histological confirmed high grade cervical intraepithelial neoplasia cases treated within 4 weeks • depth of excisional specimens • reasons for referral for colposcopy under general anaesthetic

No.	Recommendation	Reference	Timescale	Priority	Evidence required
R12.3	Service and individual colposcopist performance data meet national standards	3	12 months	S	Data for the most recent 12 month period (since the QA visit) against all national standards and details of actions taken where performance is outside of standard(s)
R3.10	Establish a routine colposcopy audit programme	3	3 months	S	Copy of the audit schedule for the next 12 month period and copies of audits already undertaken
R6.4	A routine annual colposcopy-specific patient satisfaction survey established	3	6 months	S	A copy of the report from the first survey and details of any action(s) taken as a result

Multidisciplinary team (MDT)

No.	Recommendation	Reference	Timescale	Priority	Evidence required
R3.11	Establish a process to ensure that all required cases are discussed at the MDT	3, 4 and 6	3 months	S	Copy of the relevant SOPs that cover case selection for MDT
R12.4	Demonstrate that all required cases are discussed at the MDT	3, 4 and 6	12 months	S	Evidence that all relevant cases are being selected and discussed at MDT

I = Immediate
H= High
S = Standard

Next steps

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