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Protecting and improving the nation's health

# Screening quality assurance visit report

## NHS cervical screening programme Wye Valley NHS Trust

1 November 2016

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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 review of the Wye Valley NHS Trust cervical screening service held 1 November 2016.

## 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 collected during pre-review visits to Wye Valley NHS Trust on 17 October 2016
- 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 Herefordshire population has been undertaken by the Midlands and East (West Midlands) Screening and Immunisation Team (SIT). The Wye Valley NHS Trust cervical screening programme (the programme) provides screening services for women served by the Herefordshire Clinical Commissioning Group and for some Welsh residents in mid-Powys, Wales. The eligible population (25 to 64-year-old women) for cervical screening in Herefordshire is approximately 44,714.

The main referring cytology laboratory for the service is at the Cheltenham General Hospital, Gloucestershire Hospitals NHS Foundation Trust. This laboratory also performs human papilloma virus (HPV) testing for the Herefordshire programme. Cytology and HPV testing for the Herefordshire population is commissioned by the Midlands and East (West Midlands) SIT. The lead commissioner for Gloucestershire is

the South (South West) SIT. Cytology and HPV testing is therefore out of scope for this QA visit.

The cervical histology and colposcopy services are provided at County Hospital, Wye Valley NHS Trust.

## Findings

This small, friendly cervical histology and colposcopy team has been through a number of changes and challenges since the last visit in 2011. As a result, a number of recommendations from this report are similar to those made at the last QA visit. The service needs to embed improvements and changes into routine practice.

The most significant change since the last visit has been the loss of the cervical cytology service and the staff associated with cytology screening. The lead colposcopist has taken over the role of hospital-based cervical screening co-ordinator (HBPC) following these changes, but there is no evidence of formal appointment, accountability arrangements or administrative support. The internal Trust cervical screening business meetings and reporting structures for cervical screening that were in place previously have not continued. Re-establishing these important governance arrangements is a high priority.

The cervical histology service has worked hard to try to meet national standards for reporting cervical histology specimens from colposcopy but the Trust has struggled to recruit consultant pathologists. This has resulted in delays in issuing cervical histology reports and results to women. The successful recruitment of a locum has helped ease the pressure but the service is not yet achieving waiting time standards for results. It remains a high priority to support the service, along with its recruitment and backlog mitigation plans.

The colposcopy service has recruited a nurse colposcopist since the last QA visit. This is a valuable addition to the team. However, there is a skewed distribution of workload between the colposcopists and over-reliance on a single individual. This makes the service vulnerable. It also means that the medical colposcopists are not meeting the minimum annual workload standards required by the NHS CSP. Low screening workload also causes difficulties in maintaining mandatory professional colposcopy accreditation. Non-screening workload in colposcopy clinics is affecting the service's ability to offer screening patients appointments within the national standard timeframes. Reorganising the colposcopy workload across the team and the way non-screening referrals are managed is important.

The high priority issues are summarised below as well as a number of areas 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:

- the HBPC role is not formalised
- there are no formal quarterly multi-disciplinary cervical screening business meetings in place to oversee the trust's cervical screening programme activities and report to the trust
- there is no mechanism for identifying incidents or potential incidents and bringing them to the attention of the HBPC
- cervical histology specimen turnaround times are not meeting national standards
- all colposcopists are not seeing the minimum of 50 NHS CSP referrals per year
- 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 reduces capacity for screening patients
- notification of results to women who have attended colposcopy are not meeting national standards
- attendance of key staff at colposcopy multi-disciplinary team (MDT) meetings does not meet the national standard

## Shared learning

The QA visit team identified several areas of practice that are worth sharing, including:

- production of a comprehensive cervical screening annual report which covers all of the screening pathway, not just those provided by the trust
- a computerised tracking system for histology specimens, allowing specimens to be easily located throughout processing; this ensures that the correct specimens are being worked on at all times
- an additional counselling opportunity for extremely anxious patients and patients with learning difficulties
- easy access to trust-employed interpreters which helps to provide continuity of care for patients who need to attend repeat appointments

- the trust patient advice and liaison service team analysis of responses from the recent colposcopy patient survey; analysis by a team outside of colposcopy reduces result bias
- the use of the PHE colposcopy database to generate case review summaries from the MDT

# Recommendations

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

## Governance and leadership

| No. | Recommendation | Reference | Timescale | Priority | Evidence required |
|---|---|---|---|---|---|
| R3.1 | Establish the hospital-based programme co-ordinator (HBPC) role to cover all responsibilities, confirm clear accountability and allocation of administrative support | 1 | 3 months | H | Copy of the agreed job description and accountability chart, along with confirmation of the time allocation and administrative support in place |
| R3.2 | Establish formal quarterly multi-disciplinary Trust cervical screening business meetings | 1 | 3 months | H | A copy of the terms of reference along with the minutes of the meetings occurring since the QA visit with dates of meetings for the next 12 months |
| 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 |

| No. | Recommendation | Reference | Timescale | Priority | Evidence required |
|---|---|---|---|---|---|
| R12.1 | Establish routine multi-disciplinary team (MDT) meeting discussion and disclosure of invasive cervical cancer audit findings to women | 2 | 12 months | S | Evidence that cases are discussed at MDT meetings prior to disclosure, copy of the report from the first annual disclosure audit undertaken and any actions taken as a result |
| R3.3 | Update Trust serious incident management policy with references to new national screening incident guidance (2015) | 1 | 3 months | S | Copy of the revised Trust serious incident management policy |
| R3.4 | Establish a mechanism for identifying incidents or potential incidents related to cervical screening activities and bringing them to the attention of the HBPC | 1 | 3 months | H | Documentation such as standard operating procedures (SOPs), demonstrating the agreed process and evidence documenting that staff have been made aware |
| R6.2 | Establish routine colposcopy management meetings | 3 | 6 months | S | Copy of terms of reference document, list of meeting dates for the next 12 months and minutes of meetings that have taken place since the QA visit |

## Diagnosis – histology

| No. | Recommendation | Reference | Timescale | Priority | Evidence required |
|---|---|---|---|---|---|
| R6.3 | Update proforma for reporting loop excisions to include presence or absence of cervical glandular intraepithelial neoplasia and re-audit cervical histology 'loop' treatment specimen reporting against the Royal College of Pathologists minimum data set | 4 | 6 months | S | The updated reporting proforma, copy of the audit report and details of the action taken as a result |

## Intervention and outcome – colposcopy

| No. | Recommendation | Reference | Timescale | Priority | Evidence required |
|---|---|---|---|---|---|
| R3.6 | Documented system in place to check that all colposcopists meet the necessary requirements prior to professional reaccreditation | 3 | 3 months | S | Document detailing the system established and evidence of implementation |
| R3.7 | All colposcopy clinics to be staffed by 2 nurses (one of whom is trained) | 3 | 3 months | S | Evidence of clinic staffing over a 3 month period which shows that all clinics were staffed by 2 nurses |

| No. | Recommendation | Reference | Timescale | Priority | Evidence required |
|---|---|---|---|---|---|
| R3.8 | Local clinical colposcopy guidelines include all current national guidance and standards | 3 | 3 months | S | Copy of locally approved colposcopy clinical guidelines including the circumstances in which destructive treatment is used and the management of pregnant patients |
| R3.9 | Nursing operational guidelines include all current national guidance and standards | 3 | 3 months | S | Copy of updated nursing operational guidelines |
| R3.10 | Document all colposcopy administrative and data collection processes | 3 | 3 months | S | Copy of the finalised documentation covering administrative and data collection processes |
| R3.11 | All colposcopists meet the NHS Cervical Screening Programme (NHS CSP) workload standard to see at least 50 new abnormal screening referrals a year | 3 | 3 months | H | Details of action taken and evidence of individual workloads since changes have been implemented |
| R3.12 | Waiting times for colposcopy appointments routinely meet national standards | 3 | 3 months | H | Action taken to reduce the number of non-screening referrals seen within the colposcopy service and data demonstrating sustained achievement of national waiting time standards |

| No. | Recommendation | Reference | Timescale | Priority | Evidence required |
|---|---|---|---|---|---|
| R3.13 | Notification of results to women who have attended colposcopy routinely meet national standards | 1 & 3 | 3 months | H | Action taken and data demonstrating sustained achievement of the national standards for issuing colposcopy results |
| R3.14 | Did not attend (DNA) rates for colposcopy routinely meet national standards | 3 | 3 months | S | Details of changes made to the locally agreed DNA policy and data demonstrating sustained achievement of the national standard for colposcopy DNA rates |
| R3.15 | Audit of colposcopy outcome measures from the QA visit dataset that do not meet national standards and take action as necessary | 3 | 3 months | S | Audit outcomes, action taken and evidence showing national standards are met |
| R3.16 | Ensure colposcopists comply with the NHSCSP algorithm for human papilloma virus (HPV) triage and test of cure. | 6 | 3 months | S | Audit demonstrating compliance to the NHS CSP algorithm for HPV triage and test of cure |
| R3.17 | Establish formal colposcopy audit plan | 1 & 3 | 3 months | S | Colposcopy audit plan and minutes of the meeting at which it was agreed |
| R3.18 | Patient letters and leaflets should be in line with national guidance on text content | 7 & 8 | 3 months | S | Copies of updated patient letters and leaflets |
| R3.19 | Document the results of the recent colposcopy patient satisfaction survey | 1 | 3 months | S | Copy of survey report and evidence of actions taken in light of the findings |

## Multidisciplinary team (MDT)

| No. | Recommendation | Reference | Timescale | Priority | Evidence required |
|---|---|---|---|---|---|
| R6.6 | The national standards that each colposcopist should attend at least 50% of colposcopy MDT meetings and that there is histopathology representation at 100% of meetings should be met | 3 and 4 | 6 months | H | Meeting attendance records showing the standard is met |
| R3.20 | Develop 1 or more SOPs for identification of case selection for MDT (encompassing cytology, histology and colposcopy case identification) and update MDT documentation to record sample numbers for all laboratory specimens reviewed | 4, 3 and 9 | 3 months | S | Copy of approved SOP(s) and updated MDT documentation |

# 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.