Public Health England

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Screening Quality Assurance visit report

NHS Cervical Screening Programme Shrewsbury and Telford Hospital NHS Trust

21 November 2017

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About PHE screening

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Published: April 2021
PHE publications
gateway number: GOV-7863

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Sustainable Development Goals

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 Shrewsbury and Telford Hospital NHS Trust screening service held on 21 November 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 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 Shrewsbury and Telford Hospital NHS Trust on 9 November 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 Shropshire population has been undertaken by the Midlands and East (North Midlands) Screening and Immunisation Team. The Shrewsbury and Telford Hospital NHS Trust cervical screening programme (the programme) provides screening services for women served by the Telford & Wrekin and Shropshire clinical commissioning groups. The eligible population (25 to 64 year-old women) for cervical screening in Shropshire is approximately 73,600.

The Trust provides a cervical histology service at the Royal Shrewsbury Hospital. Colposcopy services take place at the Princess Royal Hospital, Telford and Royal Shrewsbury Hospital.

Since 2014, the cytology laboratory that refers women to the programme is located at the Royal Stoke Hospital, University Hospitals of North Midlands NHS Trust (UHNM). The virology department at the Royal Stoke University Hospital provides human papillomavirus (HPV)

testing for the programme. Cytology and HPV testing undertaken by the Royal Stoke Hospital laboratory were reviewed as part of a QA visit to UHNM in October 2017.

Findings

Overall, this is a programme that has been through a number of significant service changes since the last QA visit in 2014. These changes include the transfer of the cytology service to UHNM, changes to all of the lead roles for the programme, a move to new colposcopy accommodation in Telford and centralisation of colposcopy administration activities. There is evidence that these changes have been well managed and there is an enthusiastic team in place that is keen to improve the service further.

Clarification of roles and responsibilities and documenting processes and procedures are the main issues that need to be addressed. A number of the recommendations at this visit were also made at the last QA visit. Satisfactory evidence that these recommendations had been addressed was provided after the visit but the findings at this QA visit indicate that the changes have not been maintained. Ensuring that changes in practice are embedded into routine activity is essential.

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 1 immediate concern. A letter was sent to the chief executive on 24 November 2017, asking that the following item was addressed within 7 days:

- ensure that there is no risk that previous versions of amended and supplementary pathology reports are visible on the hospital’s patient administration system and that all changes to diagnoses are recorded on reports

A response was received on 30 November and actions have been taken to address the risk that multiple versions of reports could be visible on the patient administration system. At the time of issuing the draft report, a response to the actions taken to ensure that all changes to diagnoses are recorded on reports is awaited.

High priority

The QA visit team identified 10 high priority findings which are summarised below:

- the time allocation and administrative support arrangements for the hospital-based programme co-ordinator role is not documented
- the role of the lead pathologist is not documented and does not detail the time allocation to perform the role
- there is no Trust colposcopy lead nurse identified following the retirement of the previous postholder
- the pathology IT system requires an urgent update to ensure that only current versions of histology reports are visible to users
- cervical histology treatment specimen turnaround times are not meeting national standards
- not all colposcopists see the minimum of 50 NHS CSP referrals per year
- attendance of histopathology staff at colposcopy multi-disciplinary team meetings does not meet the national standard
- the facilities at the Royal Shrewsbury Hospital are not of the same standard as the Princess Royal Hospital and there is adverse feedback from patients

Shared learning

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

- patients with post-coital bleeding are not seen in screening colposcopy clinics which maximises clinic capacity for screening patients
- all cervical punch biopsies are labelled as urgent and national standards are being achieved and maintained as a result
- rolling electronic feedback surveys are being established using iPads to collect immediate feedback from patients before they leave the clinic
- colposcopy discharge letters have a box at the beginning entitled ‘GP Action’ which clearly describes what the GP should do regarding the next screening sample

Recommendations

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

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority	Evidence required
1	Ensure the hospital based programme co-ordinator has an agreed job description including dedicated time and administrative support	1	3 months	High	Updated job description including time allocation, and details of the designated administrative support
2	Ensure all relevant topics are discussed at the cervical business meetings and that there are appropriate terms of reference and reporting arrangements for this meeting	1	3 months	Standard	Terms of reference, including requirement for membership of all professional leads, and minutes of the meetings that have occurred since the visit
3	Establish a protocol for the completion of the invasive cervical cancer audit	2	3 months	Standard	Ratified protocol
4	Implement a ratified policy for the offer of disclosure of invasive cervical cancer audit	2	6 months	Standard	Ratified policy
5	Complete an audit to demonstrate disclosure of invasive cervical cancer audit results is taking place routinely	2	12 months	Standard	Audit report and actions taken

No.	Recommendation	Reference	Timescale	Priority	Evidence required
6	Ensure the lead pathologist has an agreed job description including dedicated time	1	3 months	High	Job description, job plan with dedicated professional activity allocation
7	Establish a standard operating procedure (SOP) for the histology review element of the invasive cervical cancer audit that avoids review by the same person who reported the case	2	3 months	Standard	Ratified SOP
8	Confirm interim arrangements for the lead colposcopy nurse role	1,3	3 months	High	Details of the interim arrangements in place including time allocation
9	Appoint a lead colposcopy nurse with responsibility for ensuring good practice, compliance with protocols and NHS Cervical Screening Programme (CSP) standards are met	1,3	6 months	High	Job description, job plan with dedicated time allocation
10	Put in place 3 monthly colposcopy operational meetings	3	3 months	Standard	Terms of reference and minutes of the meetings that have occurred since the visit

Diagnosis – histology

No.	Recommendation	Reference	Timescale	Priority	Evidence required
11	Ensure all pathologists have access to cervical screening results	4	3 months	Standard	Arrangements for accessing cervical screening results in place
12	Ensure that there is no risk that previous versions of amended and supplementary pathology reports are visible on the hospital's patient administration system and that all changes to diagnose-s are recorded on reports	4	7 days	Immediate	Copy of revised SOP for the management of amended and supplementary reports
13	Confirm that the laboratory IT system has been amended to ensure only current versions of reports are visible to clinicians managing patients	4	6 months	High	Details of changes made to IT system
14	Include the Royal College of Pathologist's (RCPath) data set in all cervical histology reports	5	3 months	Standard	Updated reporting proforma or equivalent documentation
15	Audit compliance with the recording of the RCPath dataset	5	12 months	Standard	Audit of results and action taken
16	Establish SOPs for managing amended diagnoses, second opinions, agreeing difficult cases and first diagnosis of malignancy	4	3 months	Standard	Ratified SOPs
17	Establish a SOP for managing poor performance	4	3 months	Standard	Ratified SOPs
18	Develop an action plan to ensure achievement of national turnaround times for treatment specimens	6,7	3 months	High	Agreed action plan

No.	Recommendation	Reference	Timescale	Priority	Evidence required
19	Demonstrate achievement of national standards for treatment specimen turnaround times	6,7	6 months	High	Data showing that cervical histology specimens are being reported in line with national standards and this is being maintained

Intervention and outcome – colposcopy

No.	Recommendation	Reference	Timescale	Priority	Evidence required
20	Update the colposcopy guidelines to include conservative management of cervical intraepithelial neoplasia grade 2	3	3 months	Standard	Ratified guidelines with evidence of implementation
21	Document all aspects of the nursing and administration arrangements for the colposcopy service	3	3 months	Standard	Ratified SOPs
22	Ensure all colposcopists meet the throughput requirements for 50 new NHS CSP referrals a year	3	3 months	High	Data submission showing number of new NHS CSP referrals for each colposcopist
23	Validate the data for women who have definitive treatment for high grade disease within 4 weeks of the colposcopy clinic receiving the diagnostic biopsy result a biopsy and take action on the findings as required	3	3 months	Standard	Reasons established and agreed action plan as appropriate

No.	Recommendation	Reference	Timescale	Priority	Evidence required
24	Ensure all colposcopists are following the national human papilloma virus triage and test of cure protocol including discharge to primary care for follow up	1,3	3 months	Standard	Audit demonstrating compliance and action plan as required
25	Update Trust patient letters to include the cervical screening result in the invitation letter and up to date management protocols in the result letters	3	3 months	Standard	Updated examples
26	Confirm that planned new colposcopy accommodation to meet NHS CSP requirements is in place at Royal Shrewsbury Hospital	3	6 months	High	Details of new accommodation in place

Multidisciplinary team (MDT)

No.	Recommendation	Reference	Timescale	Priority	Evidence required
27	Ensure histopathology representation at MDT meetings	3,4	3 months	High	MDT attendance records after the visit
28	Develop and implement a SOP for case selection for MDT meetings	1,3,4	3 months	Standard	Ratified SOP
29	Complete an audit to check that all cases indicated in national guidelines have been identified and discussed at the meetings	1,3	12 months	Standard	Completed audit and action plan as required

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.