Public Health England

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Screening Quality Assurance visit report

NHS Cervical Screening Programme Sandwell and West Birmingham Hospitals NHS Trust

27 April 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 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 Sandwell and West Birmingham Hospitals NHS Trust screening service held on 27 April 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 Sandwell and West Birmingham Hospitals NHS Trust on 6 April 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 Sandwell and West Birmingham population has been undertaken by the Midlands and East (West Midlands) Screening and Immunisation Team. The Sandwell and West Birmingham Hospitals (SWBH) NHS Trust cervical screening programme (the programme) provides screening services for women served by the Sandwell and West Birmingham Clinical Commissioning Group. The eligible population for cervical screening in Sandwell and West Birmingham is approximately 95,000.

The trust provides a cervical histology service at the City Hospital Birmingham. Colposcopy services take place at the Sandwell and City Hospitals.

Since 2013, the cytology laboratories which refer women to the programme are located at the Birmingham Heartlands Hospital, Heart of England NHS Foundation Trust and the New Cross Hospital, Royal Wolverhampton NHS Trust. Human papilloma virus (HPV) testing is

undertaken by the PHE laboratory located on the Birmingham Heartlands Hospital site and at the New Cross Hospital laboratory in Wolverhampton. Cytology and HPV testing undertaken by the Birmingham Heartlands Hospital laboratory were reviewed as part of a QA visit to the Heart of England NHS Foundation Trust in January 2017. Cytology and HPV testing undertaken by the New Cross Hospital laboratory were last reviewed as part of a QA visit to the Royal Wolverhampton NHS Trust in October 2013.

Findings

The trust's cervical screening service has undergone a number of changes since the last QA visit in 2013. There has been a major reconfiguration of the cervical cytology service with this work transferring to 2 other trusts. Cervical histology and colposcopy services remain at the Trust. This significant change has been well managed. There is evidence of good working relationships with both Trusts that carry out the cytology screening that link with the SWBH services. There is also evidence of proactive leadership by the hospital-based cervical screening programme co-ordinator. This has contributed to the stability of the service both during these major changes and subsequently.

A number of different colposcopists have undertaken the lead colposcopist role since the last QA visit. These changes have been well managed and leadership maintained throughout. Although only very recently appointed, the new lead colposcopist is already demonstrating a proactive approach to leading the service.

It is of note that, despite national issues with recruiting and retaining consultant pathologists, the histology service at this Trust is maintaining excellent turnaround times for reporting histology samples for the cervical screening programme.

However, some issues need to be addressed. Documentation across the cervical screening service needs to be up to date and reflect current working practices and national guidance. At present, a lot of documentation refers to the service prior to the reorganisation of cervical cytology. Not all staff are reported to be up to date with mandatory annual information governance training. Audit data for the national invasive cervical cancer audit is not up to date, which potentially delays provision of the information to patients who request it.

Evidence from local documents and the colposcopy performance data suggests that the 2 colposcopy clinics are not operating in the same way. There is therefore potential for women to be treated differently depending on the location of their colposcopy appointment. There is a need to develop a single colposcopy team approach through greater integration. Implementing regular colposcopy team meetings will help with this. Staffing and clinic structures may also need to change.

The high priority issues identified 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 7 high priority findings as summarised below:

- appointment and accountability arrangements for the hospital-based cervical screening programme co-ordinator (HBPC) are not documented
- there is a backlog of colposcopy and treatment data collection for the national invasive cervical cancer audit leading to a delay in offering women the results of their case review
- not all staff are up to date with mandatory Trust information governance training
- the local colposcopy clinical and nursing operational guidelines do not fully reflect current national guidance and local colposcopy practice
- not all of the colposcopy administrative processes are documented. For those that are documented, they do not include sufficient detail to allow a person with little or no experience in the service to follow and fully complete the relevant tasks
- individual colposcopist performance against a number of key performance indicators is not in line with national standards
- attendance for all colposcopists at multi-disciplinary team meetings does not meet the national standard

Shared learning

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

- routine 6 monthly reporting to the Trust Clinical Effectiveness Group
- HBPC delivery of screening-related incident training to Trust screening staff
- regular audit and re-audit of cervical histology reporting, showing improvements as a result
- pathology standard operating procedures in place for the use of ‘p16’ staining of cervical tissue samples and for monitoring poor performance
- all cervical histology slides are quality checked within the laboratory before sending to the pathologist for reporting
- internal Trust specimen turnaround time targets exceed Royal College of Pathologist’s requirements and therefore support timely reporting of samples
- monthly provision of individual pathologist performance information
- all cervical cancer cases or cases where there is suspicion of cervical cancer are sent to the Birmingham Women’s Hospital laboratory for a second opinion

- comprehensive induction processes in place for all colposcopy staff
- routine use of a World Health Organisation checklist in colposcopy to improve patient safety
- improved HPV information implemented in the waiting room at the Sandwell clinic in response to patient survey feedback

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	Update the hospital-based cervical screening programme coordinator job description to reflect current responsibilities and accountability arrangements	1	3 months	H	Copy of the agreed job description and accountability chart
R3.2	Update the terms of reference for the multi-disciplinary cervical screening business meetings to reflect the agreed reporting structure and ensure that all relevant topics are included for discussion	1	3 months	S	Copy of the agreed terms of reference and minutes of the meetings since the quality assurance (QA) visit
R3.3	Produce an annual report covering all aspects of the cervical screening programme within the Trust	1	3 months	S	Copy of the annual report and minutes of the meeting where it was presented
R6.1	Ensure data collection for the national invasive cervical cancer audit is up to date	2	6 months	H	Evidence that all invasive cervical cancer audit cases are up to date
R3.4	Update the Trust policy on the audit and disclosure of invasive cervical cancer audit results to women	2	3 months	S	A copy of the Trust-ratified audit and disclosure policy

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
R12.1	Ensure that the disclosure of invasive cervical cancer audit findings to women is taking 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
R3.5	All staff have completed mandatory Trust information governance training	1	3 months	H	Written confirmation that all staff are up to date with required training
R3.6	Update and ratify the Trust serious incident management policy with references to national screening incident guidance (2015)	1	3 months	S	Copy of the revised Trust serious incident management policy
R3.7	Document the formal appointment of the lead colposcopist	3	3 months	S	Evidence of formal appointment of the lead colposcopist and job description
R12.2	Establish effective routine colposcopy team meetings	3	12 months	S	Copies of the minutes of meetings that have taken place since the QA visit

Colposcopy

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
R3.8	Update colposcopy clinical guidelines to reflect national guidance and local clinical practice	3	3 months	H	Copy of updated clinical guidelines and a copy of minutes of meeting at which they have been discussed
R3.9	Update nursing operational guidelines to reflect national guidance	3	3 months	H	Copy of updated nursing operational guidelines
R3.10	Document all colposcopy administration arrangements encompassing activities across both sites	3	3 months	H	Copy of colposcopy administration procedures covering both colposcopy clinics
R6.2	Re-audit adherence to the national human papilloma virus triage and test of cure algorithm	3	6 months	S	A copy of the audit report and details of any action(s) taken as a result
R3.11	Develop an action plan to ensure all colposcopists meet clinical performance standards	3	3 months	H	Copy of the agreed action plan
R12.3	Evidence that all colposcopists are achieving national clinical performance standards	3	12 months	S	Data for the most recent 12-month period (since the QA visit) against all national standards and details of action(s) to address performance outside of standard

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
R3.12	Develop a comprehensive colposcopy audit plan, including details of how findings are to be shared	3	3 months	S	A copy of the audit schedule for the next 12-month period and details of the process for sharing findings
R12.4	Evidence that a colposcopy audit plan is in place and findings are being acted upon	3	12 months	S	Copies of reports from audits undertaken since the QA visit and details of any action(s) taken as a result
R3.13	Update patient invitation letter to ensure compliance with nationally approved text	3	3 months	S	Copy of updated standard invitation letter

Multi-disciplinary Team (MDT)

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
R3.14	Update standard operating procedures (SOPs) to include all the cases that should be discussed and the process for identifying these cases	3, 4 and 5	3 months	S	Copy of updated and approved SOPs
R12.5	Undertake an audit to demonstrate that all appropriate cases are being discussed at MDT meetings	3, 4 and 5	12 months	S	Copy of audit report demonstrating that all relevant cases are being selected and discussed at MDT

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 following the issuing of the final report. 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.