Public Health England

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Screening Quality Assurance visit report

NHS Cervical Screening Programme Sherwood Forest Hospitals NHS Foundation Trust

26 February 2019

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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 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 Sherwood Forest Hospital NHS Foundation Trust (SFHFT) screening service held on 26 February 2019.

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-visits to King's Mill Hospital (KMH) on 7 February 2019 and Newark Hospital (NH) on 25 February 2019
- information shared with the Midlands and East regional SQAS as part of the visit process

Local screening service

Since 2015, commissioning of cervical screening for the Derbyshire and Nottinghamshire population has been the responsibility of the NHS England (North Midlands) Section 7a commissioning team. The North Midlands Screening and Immunisation Team (SIT) is responsible for ensuring SFHFT meets the national cervical screening specification.

SFHFT provides screening services for women served predominantly by the Newark and Sherwood and Mansfield and Ashfield Clinical Commissioning Groups. The eligible population for cervical screening across these areas is approximately 80,500.

The SFHFT population converted to human papilloma virus (HPV) primary screening in June 2018. This is part of a major change to the cervical screening programme which will see HPV primary screening being rolled out across England by the end of 2019. In

HPV primary screening the initial test is for high risk HPV and if this is present, a cervical cytology slide is made and looked at under the microscope to identify if there are any abnormal cells. This is the opposite to the existing cervical screening programme where all tests are looked at under the microscope initially and only a small proportion then undergo an HPV test where this is indicated in the national protocol.

Histology for SFHFT is provided at the KMH. Colposcopy services for SFHFT are provided at KMH and NH.

Findings

Since the last QA visit in 2014, there have been changes to lead roles and the implementation of HPV primary screening. The service has adapted well to these changes.

The previous QA visit identified the need to establish a single Trust-wide service between the 2 colposcopy clinics (KMH and NH) as the 2 clinics were operating independently. It is encouraging to see much greater engagement between the 2 colposcopy clinics at this QA visit. However, whilst the histopathology department has successfully implemented the recommendations from the previous QA visit, recommendations for the colposcopy department do not appear to have been embedded into practice.

The priorities are to ensure effective meeting and governance structures are in place and to document and standardise systems, processes and failsafe across the programme. There needs to be better use of colposcopy clinics and deployment of colposcopist skills to maximise capacity to see women referred with abnormal screening results whilst minimising their need to attend multiple appointments. Collection and reporting of colposcopy data has been challenging for the service. The Trust needs to urgently put in place improved colposcopy data collection and reporting to enable the quality and performance of the colposcopy service to be accurately assessed.

Immediate concerns

The QA visit team identified 1 immediate concern. A letter was sent to the chief executive on the 28 February 2019 asking that the following items were addressed within 7 days:

- put in place immediate access to resuscitation equipment in all KMH colposcopy clinics

A response was received within 7 days which assured the QA visit team the identified risk has been mitigated and no longer poses an immediate concern.

High priority

The QA visit team identified 12 high priority findings which are summarised below:

- the new national guidance on the cervical screening provide lead role has not yet been fully implemented and a quarterly cervical screening management group meeting, as defined in national guidance is not in place
- failsafe arrangements outlined in national guidance are not documented across the Trust
- not all staff appear to be aware of the national 'Managing Safety Incidents in NHS Screening Programmes' guidance
- colposcopy waiting time standards are not met routinely, with clinic capacity and staffing not being used as effectively as it could be
- the colposcopy IT system is not suitable for its intended purpose and cannot produce reliable data to monitor the quality and performance of the service and individual clinicians
- colposcopy administrative activities are not standardised, coordinated or documented across the Trust
- not all colposcopists are meeting national standards and validation of individual colposcopy data performance is required

Shared learning

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

- activity by the SIT to improve cervical screening attendance and reduce inequalities including a project for women with learning disabilities, work to improve screening attendance with general practices and other partners, active promotion of the PHE general practice coverage data tool and visiting general practices with less than 70% coverage to provide training
- a link to the national screening incident assessment form is provided within the Trust's incident reporting policy
- a visual invasive cervical cancer audit process using a tracking form and individual, colour-coded folders for each case
- biomedical scientists are used to undertake all specimen dissection in the histology laboratory
- comprehensive standard operating procedure on the use of p16 immunochemistry testing to assist with grading of histology specimens and the clinical management of women being seen in colposcopy is being finalised
- use of a World Health Organisation checklist in colposcopy to improve patient safety

- reasonable adjustments are made for women with learning disabilities and there is the opportunity for these women to visit the clinic prior to the appointment

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 commissioner should ensure there is an agreed mechanism for liaising with clinical commissioning groups (CCGs) for contracting of the cervical screening service	1	3 months	Standard	Signed collaborative agreement with CCGs
2	Implement the new national guidance on the cervical screening provider lead (CSPL) role	2	3 months	High	Gap analysis report against the guidance with action taken to address any gaps, including updated CSPL job description with accountability arrangements, time allocation and administrative support
3	Ensure quarterly cervical screening management meetings include appropriate representation from all elements of the cervical screening pathway	2	6 months	High	Terms of reference Membership Minutes of meetings taken place since quality assurance (QA) visit
4	Develop and implement a whole Trust annual audit schedule for cervical	2	3 months	Standard	Annual audit schedule covering all elements of the Trust's screening programme

No.	Recommendation	Reference	Timescale	Priority	Evidence required
5	Ratify the disclosure of the cervical cancer screening audit results policy	1,2	3 months	Standard	Ratified policy
6	Ensure failsafe arrangements are documented across the Trust and are in line with national guidance	3	3 months	High	Gap analysis report against the guidance with action taken to address any gaps and updated ratified Trust failsafe procedures
7	Ensure all staff are aware of the national 'Managing Safety Incidents in NHS Screening Programmes' guidance and can recognise issues that need investigation	1,4	3 months	High	Evidence of process in place and that all staff have been made aware
8	Put in place a risk management process	1	3 months	Standard	Documented process and copy of risk register(s)
9	Establish a Trust-approved role description for the lead cervical histopathologist	1	3 months	Standard	Trust job description
10	Establish a Trust-approved role description for the lead colposcopist	1,5	3 months	Standard	Trust job description
11	Establish routine quarterly colposcopy operational meetings	5	6 months	Standard	Terms of reference for the meeting and minutes

Diagnosis – histology

No.	Recommendation	Reference	Timescale	Priority	Evidence required
12	Establish a standard operating procedure (SOP) for covering the definition of an inadequate punch biopsy	6	3 months	Standard	Approved SOP

Intervention and outcome – colposcopy

No.	Recommendation	Reference	Timescale	Priority	Evidence required
13	Ensure that all colposcopy clinics are staffed by at least 2 nurses, at least one of whom needs to be registered	5	3 months	Standard	Confirmation of nurse staffing for colposcopy clinics at King's Mill Hospital
14	Ensure colposcopy IT system can produce reliable data as outlined in National Service Specification 25 and QA requirements and that the data is backed up routinely	5	6 months	High	Evidence of colposcopy database in place that collects and reports all required data accurately and SOP for routine back-up
15	Update the local Trust colposcopy operational and clinical guidelines to reflect existing NHS cervical screening programme (NHS CSP) guidance	5	6 months	Standard	Ratified, updated guidelines
16	Put in place an action plan to standardise and co-ordinate all colposcopy administrative activities	5	3 months	High	Copy of action plan and progress to date
17	Implement SOP for colposcopy administrative processes	5	6 months	High	Copy of administrative SOPs covering all administration and data-related activities
18	Ensure all colposcopists meet the annual throughput requirements for 50 new NHS CSP referrals a year	5	6 months	Standard	Details of actions taken Data submission showing achievement of standard and estimated workload for the next 12 month period
19	Establish an action plan to ensure that waiting time standards for referrals and results are routinely met	5	3 months	High	Action plan

	and that staff skills and clinic capacity is used effectively				
20	Demonstrate that waiting time standards for referrals and results are routinely met and that staff skills and clinic capacity is used effectively	5	6 months	High	Evidence of achievement and maintenance of waiting time standards for referrals and results since the QA visit Copy of appointment schedule and colposcopist allocated to each clinic
21	Demonstrate that 'do not attend' (DNA) rates routinely meet the national standard	5	12 months	Standard	Details of action taken Evidence of achievement and maintenance of DNA standard since the visit
22	Audit compliance with national guidance on discharge to primary care	5, 7	6 months	Standard	Audit report and details of actions taken
23	Validate individual colposcopist data where this indicates performance outside the national standards	5	3 months	High	Validated QA visit dataset
24	Demonstrate achievement of national standards by individual colposcopists on all sites	5	12 months	High	Evidence of validated colposcopy data that meets national standards
25	Update patient invitation letter and implement a leaflet explaining what to expect at appointment	8	6 months	Standard	Copy of the updated patient invitation letter Confirmation that the human papilloma virus leaflet is sent with all invitations Copy of leaflet
26	Complete a comprehensive annual user survey of colposcopy services	1,5	3 months	Standard	Copy of survey report and actions taken

	for both sites and take action on the findings				
27	Put in place immediate access to resuscitation equipment in all King's Mill Hospital colposcopy clinics	5	Immediate	High	Details of the arrangements put in place

Multidisciplinary team (MDT)

No.	Recommendation	Reference	Timescale	Priority	Evidence required
28	Document cytology representation and the reviewers of laboratory samples at the MDT meetings	5	3 months	Standard	Copy of 3 sets of meeting minutes
29	Develop and implement a SOP for case selection for the MDT meetings	5	3 months	Standard	Ratified SOP
30	Complete an audit to check that all cases identified for MDT have been discussed and all cases discussed at MDT have been acted on	5	3 months	Standard	Completed audit and actions taken

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 / 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.