Public Health England

Protecting and improving the nation's health

Screening Quality Assurance visit report

NHS Cervical Screening Programme
The Dudley Group NHS Foundation Trust

18 May 2018

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-leading science, research, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services.
We are an executive agency of the Department of Health and Social Care, and a distinct delivery organisation with operational autonomy. We provide government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific and delivery expertise and support.
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.

www.gov.uk/phe/screening Twitter: @PHE_Screening Blog: phescreening.blog.gov.uk
For queries relating to this document, please contact: phe.screeninghelpdesk@nhs.net

Published
PHE publications
gateway number: GW-8572

PHE supports the UN
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 Dudley Group NHS Foundation Trust held on 18 May 2018.

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 Dudley Group NHS Foundation Trust on 27 April and 8 May 2018
- 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 Dudley population has been undertaken by the Midlands and East (West Midlands) Screening and Immunisation Team (SIT).

The Dudley Group NHS Foundation Trust cervical screening programme (the programme) provides services for women covered by the Dudley clinical commissioning group. The eligible population for cervical screening is approximately 76,000 women.

The cervical histology and colposcopy services for the programme are provided at the Russells Hall Hospital in Dudley.

Since June 2013, the cytology laboratory that refers women to the programme has been located at the New Cross Hospital, Royal Wolverhampton NHS Trust. The microbiology department at the New Cross Hospital provides human papilloma virus (HPV) testing for the programme. Cytology and HPV testing was reviewed as part of a QA visit to the Royal Wolverhampton NHS Trust in April 2018.

Findings

At the time of the last QA visit in 2013, the Dudley cervical cytology service had just transferred to Wolverhampton. This significant change has been well managed and there is evidence of a good working relationship with the cytology service. The colposcopy team is working hard to prioritise access for patients and the service meets national standards for waiting times and for notifying patients of the outcome of their appointments.

However, some issues of concern need to be addressed. There is evidence of a lack of Trust management support for the service and for the QA process. There were significant issues with submission of pre-visit evidence and lack of representation from the histology service. Despite SQAS and the service's commissioners raising these issues with the Trust prior to the visit, no response was received. This has resulted in a number of immediate recommendations being made. In addition, a number of recommendations from the last visit have had to be made again. Ensuring that changes in practice are embedded into routine activity is essential.

There is a lack of governance for the cervical screening programme within the Trust. Essential leadership roles are either absent or not documented by the Trust resulting in a lack of leadership and governance for the service and essential meeting systems not established. There are no clear lines of escalation to the Trust Board.

There are significant concerns around the cervical histology service provision due to insufficient pathologist staffing. Although the provision of cervical pathology services is planned to move to the Black Country Pathology Service around April 2019, it is a high priority that plans are put in place to ensure the service prior to this transfer meets national guidance.

Due to the governance and histology issues identified at this visit, a follow up visit to the Trust will be arranged.

Routine collection of screening history data for women diagnosed with invasive cervical cancer is not happening. As a result, disclosure of the information to patients is not occurring. This is outside national guidance and an urgent priority to put in place.

The immediate and high priority issues identified are summarised below as well as 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 3 immediate concerns. A letter was sent to the Chief Executive on 21 May 2018, asking that the following items were addressed within 7 days:

- confirm that all women diagnosed with cervical cancer are openly and routinely offered the results of an audit of their screening history
- put in place arrangements to avoid lone pathologist working including an appropriate informal and formal second opinion process
- ensure that histology material reviewed for multi-disciplinary team (MDT) meetings is reviewed by a different person to whom reported it originally

A response was received and actions have been taken to partially mitigate all 3 immediate concerns. Further information has been requested for all 3 concerns.

High priority

The QA visit team identified 16 high priority findings as summarised below:

- the role of cervical screening provider lead is not in place within the Trust
- there is a significant backlog in data collection of screening history information for women diagnosed with cervical cancer and there is no policy or process in place to ensure women are offered their screening history information
- not all staff appear to be able to recognise screening incidents in accordance with national guidance
- there is no documented risk management process covering all areas of the screening programme
- there is no lead histopathologist for cervical screening nor has the lead colposcopist been officially appointed
- provision of the cervical histopathology service does not meet national guidance in relation to staffing levels, working arrangements or processes for use of locums or monitoring and feedback of staff performance
- not all colposcopists are meeting the annual requirements for minimum workload or key performance indicators
- not all colposcopists are following the national clinical practice protocols, including the need for prompt discharge to primary care
- not all colposcopists are meeting the minimum of attending 50% of the MDT

Shared learning

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

- a clearly documented incident tracker and comprehensive escalation process in relation to incident management within the SIT
- the SIT is prioritising work on increasing screening attendance through commissioning sample taking in community and sexual health clinics and running local sample taker workshops
- patient information stickers are used to create a list of those women due for discharge back to their GP to correlate against the colposcopy discharge report so that no-one is incorrectly discharged
- text messaging reminders have been put in place for colposcopy patients to reduce non attendance

Recommendations

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

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
1	Implement the new national guidance on the cervical screening provider lead role	1	3 months	High	Evidence of appointment and role description. Gap analysis against the guidance with evidence of action taken to address any gaps
2	Develop and implement a whole Trust audit schedule for cervical screening services	1,2	6 months	Standard	Evidence of the audit schedule and the minutes of the meeting where it was approved
3	Ensure the national invasive cancer audit is up to date	3	3 months	High	Completion of registered cases for time period 01 April 2013 to 31 March 2018
4	Establish a Trust policy on invasive cervical cancer audit and disclosure	3	3 months	High	Evidence of the ratified policy which includes clearly defined roles and responsibilities and the minutes of the meeting where it was approved

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
5	Confirm that all women diagnosed with cervical cancer are openly and routinely offered the results of an audit of their screening history	3	7 days	Immediate	Details of the arrangements in place to offer screening history audit review results and confirmation that the process is in place for all women diagnosed with cervical cancer from now
6	Complete an audit to demonstrate offer of disclosure of invasive cervical cancer audit	3	3 months	High	A copy of the report from the annual disclosure audit undertaken, the findings and any action(s) taken as a result
7	Recognise and manage all screening patient safety incidents and serious incidents in accordance with 'Managing Safety Incidents in NHS Screening Programmes' and ensure staff awareness	2,4	3 months	High	Evidence of process in place and evidence of how all staff have been made aware
8	Put in place a risk management process	2	3 months	High	Documentation of process in place
9	Identify a lead histopathologist for cervical screening with responsibility for ensuring good practice, compliance with protocols and that NHS Cervical Screening Programme (CSP) standards are met	2	3 months	High	Confirmation of appointed lead histopathologist with a job description and job plan with dedicated professional activity allocated

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
10	Demonstrate evidence of the appointment of the lead colposcopist for cervical screening with responsibility for ensuring good practice, compliance with protocols and that NHS CSP standards are met.	2, 5	3 months	High	Job description, job plan with dedicated professional activity allocation
11	Put in place 3 monthly colposcopy operational meetings	5	3 months	Standard	Terms of reference, meeting schedule

Histology laboratory

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
12	Put in place arrangements to avoid lone pathologist working and include an appropriate informal and formal second opinion process	6	7 days	Immediate	Details of the reporting arrangements for cervical histology specimens including the standard operating procedure (SOP) established for requesting informal and formal second opinions
13	Document the arrangements for specimen reporting in the absence of the lone pathologist	6	3 months	High	Evidence of process in place and confirmation staff are aware of this
14	Put in place an action plan that meets national guidance for provision of cervical pathology services prior to the move to the Black Country Pathology Service	6	3 months	High	Copy of the action plan
15	Document the procedure for the assessment and acceptance of locum	6	3 months	High	Copy of the SOP

	and new consultant staff prior to appointment				
16	Ensure histopathologists have access to cervical cytology reports to correlate with histology findings	6	3 months	Standard	Details of the arrangements for accessing and correlating cervical screening results and the associated SOP
17	Audit the use of the Royal College of Pathologists data set in all reports	6	3 months	Standard	Audit of results and action taken
18	Implement an annual audit schedule for cervical screening histology as part of the Trust cervical screening audit schedule	2	3 months	Standard	Annual audit plan and actions
19	Put in place a process to monitor performance and provide comprehensive individual performance data to pathologists	6,7	3 months	High	Copy of the SOP Evidence of regular provision of performance monitoring data to staff

Colposcopy

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
20	Develop and implement a workforce plan for colposcopy	2,5	3 months	Standard	Copy of the workforce plan
21	Demonstrate that there are 2 nurses (at least 1 of whom is trained) available in the colposcopy clinics at all times	5	3 months	Standard	Documented evidence that 2 nurses are in each clinic
22	Implement a protocol for the back-up/recovery of the colposcopy database	5	3 months	Standard	Copy of the SOP

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
23	Update the local Trust colposcopy clinical guidelines to reflect current NHS CSP guidance	5	3 months	Standard	Updated and ratified guidelines for colposcopy and minutes of meetings where these were discussed and signed off
24	Update administrative documentation to ensure it covers all aspects of the service	5	3 months	Standard	Updated document, including the inclusion of a clinical review of the colposcopy discharge information prior to sending
25	Update the local Trust colposcopy nursing operational guidelines to reflect current NHS CSP guidance waiting times for first offered appointment and details of the process in place for the presence of a friend or relative for the woman about to undergo colposcopy	5	3 months	Standard	Updated and ratified operational guidelines for colposcopy and minutes of meetings where these were discussed and signed off
26	Ensure all colposcopists meet the annual throughput requirements for 50 new NHS CSP referrals a year	5	3 months	High	Data submission showing number of new NHS CSP referrals for each colposcopist in the period 1 April 2017 to 31 March 2018
27	Audit colposcopy treatments and take action on the results	5	3 months	High	Audit results and details of any actions taken for depth of specimen, and number of pieces, positive predictive value, cyto-reversion after treatment, use of general

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
					anaesthetic and recurrence rates
28	Implement a rolling colposcopy audit programme to link with the Trust-wide audit schedule	5	6 months	Standard	Details of the audit programme
29	Ensure all colposcopists are following the national human papilloma virus triage and test of cure protocol including discharge to primary care for follow-up	5, 8	3 months	High	Audit to demonstrate compliance data
30	Establish an annual user survey of colposcopy services	2, 5	12 months	Standard	Outcome of survey and any actions required
31	Establish dedicated recovery space during clinics	5	3 months	Standard	Action plan for addressing issues with facilities

Multi-disciplinary team (MDT)

No.	Recommendation	Reference	Timescale	Priority	Evidence required
32	Ensure all colposcopists attend a minimum of 50% of MDT meetings	5	3 months	High	Meeting attendance records for MDT meetings after the visit showing the standard is met
33	Develop and implement a SOP/ SOPs for case selection (histology and colposcopy)	5, 6	3 months	Standard	Copy of the standard operating procedure and multidisciplinary documentation
34	Establish second opinion for histology material reviewed for multidisciplinary meetings	6	Immediate	Immediate	Confirmation of the process put in place

35	Complete an audit to check that all MDT cases indicated in national guidelines have been identified	5, 6	6 months	Standard	Completed audit and action plan

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 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.