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Screening Quality Assurance visit report

NHS Cervical Screening Programme Nottingham University Hospitals NHS Trust

02 April 2019

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About PHE screening

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Published September 2021
PHE publications
gateway number: GOV-9284

PHE supports the UN
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 Nottingham University Hospitals NHS Trust (NUHT) screening service held on 2 April 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 Public Health England (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 Queen's Medical Centre (QMC) on 5 March 2019 and City Hospital (CH) on 7 March 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 Nottinghamshire population has been the responsibility of the NHS England (North Midlands) Section 7a commissioning team. NHS England reorganised on 1 April 2019 and combined with NHS Improvement. There also changes in structure at a regional level which are in progress at the time of this QA visit. The North Midlands Screening and Immunisation Team (SIT) is responsible for ensuring NUHT meets the national cervical screening specification.

NUHT provides screening services for women served by the Nottingham City, Nottingham North and East, Nottingham West and Rushcliffe Clinical Commissioning Groups. The eligible population for cervical screening across these areas is approximately 113,000.

The NUHT 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 services for NUHT are provided at CH and QMC in Nottingham. Colposcopy for NUHT is provided at CH.

Findings

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

There has been progress since the last QA visit and the service has successfully implemented some of the recommendations from that visit. However, there are still some recurring issues of concern.

Cervical histopathology arrangements need urgent attention following the loss of United Kingdom Accreditation Service accreditation which is mandatory for laboratories providing screening services. There is evidence of lone working within cervical histopathology which is still occurring despite the findings of the last QA visit report. The Trust reports that it is taking action to address these pathology issues.

The other urgent priority is to ensure that there is a suitable data collection system for colposcopy. At present, it is not possible for the Trust, commissioners or SQAS to assess the quality and performance of the colposcopy service.

Although there is evidence that the colposcopy team is keen and enthusiastic to improve the service, there is a significant reliance on particular individuals. There needs to be better workforce planning across colposcopy. This will give the opportunity to streamline the clinical and administrative aspects and improve documentation to better support business continuity.

Immediate concerns

The QA visit team identified 3 immediate concerns. A letter was sent to the chief executive on 5 April 2019 asking that the following items were addressed within 7 days:

- cease pathologist lone working at the QMC laboratory so all cervical histology reporting takes place at CH now and in the future
- provide a detailed action plan with timescales for implementation of an accurate and complete colposcopy data collection system with the ability to provide service and individual clinician outcome data
- undertake an infection control risk assessment of the clean and dirty areas within the colposcopy clinic and take appropriate action

A response was received and some action has been taken to mitigate the immediate risks within the programme. Further information has been requested from the Trust for all 3 immediate concerns.

High priority

The QA visit team identified 8 high priority findings as summarised below:

- there are a number of standard operating procedures missing for reporting of histopathology and histology turnaround times are not routinely met
- not all colposcopists meet the annual workload requirement of at least 50 new NHS CSP referrals a year, or the national standard for multi-disciplinary team meeting attendance
- there are no continuity arrangements or documentation in place for colposcopy administrative activities, including patient result management, resulting in over-reliance on specific individuals
- not all colposcopists are following the national HPV primary screening protocol
- the colposcopy information collection system is not suitable and cannot produce reliable data to monitor the quality and performance of the service and individual clinicians

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

- all cervical histologists participate in the national gynaecological external quality assessment scheme
- comprehensive information for clinicians on the chance of a woman going into labour early after previously having had colposcopy treatment, has been developed with obstetricians, to inform patient counselling
- visual aids have been developed with the community learning disabilities team to support women with learning disabilities to attend colposcopy

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 (CSPL) role for this Trust	1	3 months	Standard	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, terms of reference for the cervical screening management meetings and minutes of meetings taken place since quality assurance (QA) visit
2	Develop and implement a whole Trust annual audit schedule for cervical screening	1	6 months	Standard	Annual audit schedule covering all elements of the Trust's screening programme (histology and colposcopy)
3	Ratify the disclosure of the cervical cancer screening audit results policy	1,2	3 months	Standard	Approved policy

No.	Recommendation	Reference	Timescale	Priority	Evidence required
4	Ensure failsafe arrangements are documented across the Trust and are in line with national guidance	3	3 months	Standard	Gap analysis report against the guidance with action taken to address any gaps Copies of ratified standard operating procedures (SOPs)
5	Update the Trust serious incident management policy with reference to the national 'Managing Safety Incidents in NHS Screening programmes' guidance (2018)	2,4	3 months	Standard	Updated policy with links to new guidance
6	Ensure all histology staff are aware of both the national 'Managing Safety Incidents in NHS Screening programmes' guidance and the local screening incident reporting protocol	2,4	3 months	Standard	Evidence of process in place and that all staff have been made aware
7	Put in place a risk management process	2	3 months	Standard	Documented process
8	Confirm that United Kingdom Accreditation Service accreditation has been reinstated	2	3 months	High	Confirmation of accreditation
9	Confirm the time allocation for the lead cervical histopathologist and the name of the nominated deputy	2	3 months	Standard	Job plan with designated time and confirmation of deputy
10	Confirm the official appointment of a lead colposcopist for cervical screening with responsibility for ensuring good practice, compliance with protocols and that NHS standards are met	2, 5	3 months	Standard	Evidence of approved job description Copy of job plan with dedicated time allocation

No.	Recommendation	Reference	Timescale	Priority	Evidence required
11	Document the arrangements for the colposcopy operational meetings and demonstrate regular attendance by all colposcopy staff	5	3 months	Standard	Terms of reference Minutes of the colposcopy operational group meetings recording attendance

Diagnosis – histology

No.	Recommendation	Reference	Timescale	Priority	Evidence required
12	Cease cervical histology lone working at the Queen's Medical Centre laboratory so all reporting takes place at City Hospital now and in the future	6	7 days	Immediate	Confirmation of arrangements put in place
13	Ensure histopathologists have access to cervical cytology reports to correlate with histology findings	6	3 months	Standard	Confirmation of arrangements in place Copy of approved SOP
14	Implement SOPs for second opinions, agreeing difficult cases and first diagnosis of malignancy along with issuing of supplementary reports, the criteria for inadequate biopsy, p16 immunochemistry testing and the management of potential poor performance	6	3 months	High	Approved SOPs
15	Audit reporting of biopsies and treatment specimens against the Royal College of Pathologists' dataset	6	6 months	Standard	A copy of the audit results and actions taken
16	Put in place an action plan and staffing arrangements that maximise achievement of national turnaround time standards for histology reporting	2,7	3 months	High	Action plan and work force plan

No.	Recommendation	Reference	Timescale	Priority	Evidence required
17	Demonstrate that national turnaround times for cervical histology specimens are met routinely	2,7	12 months	High	Data for 12 months demonstrating routine achievement of the standard

Intervention and outcome – colposcopy

No.	Recommendation	Reference	Timescale	Priority	Evidence required
18	Put in place a system to ensure mandatory British Society for Colposcopy and Cervical Pathology accreditation is maintained for all practicing colposcopists	5	3 months	Standard	Document detailing the system established and evidence of its implementation
19	Undertake a workforce planning exercise to ensure all colposcopists routinely meet the annual throughput requirements for 50 new NHS Cervical Screening Programme (CSP) referrals a year, and the national standard for multi-disciplinary team (MDT) attendance	5	6 months	High	Workforce plan Data demonstrating colposcopists are meeting workload and MDT attendance standards
20	Provide a detailed action plan with timescales for implementation of accurate and complete colposcopy data collections system with the ability to provide service and individual clinician outcome data	5	7 days	Immediate	Copy of the action plan
21	Ensure colposcopy IT systems are backed up routinely	2,5	3 months	Standard	Approved SOP

No.	Recommendation	Reference	Timescale	Priority	Evidence required
22	Update the local Trust colposcopy clinical guidelines to reflect NHS CSP guidance and how this is practiced in this Trust including arrangements for patients bringing friends or relatives to clinic	5	3 months	Standard	Approved guidelines with evidence of implementation
23	Put in place continuity arrangements, including SOPs, for the running of all aspects of the colposcopy service	2	3 months	High	Approved SOPs and continuity arrangements
24	Ensure the colposcopy discharge list identifying when women should have their next cervical screening test is validated and signed by a clinician	3,5	3 months	Standard	Confirmation of who is validating and signing off the discharge list and a copy of the SOP
25	Put in place a protocol for cervical sample taking outside colposcopy including arrangements for issuing results	2,5	3 months	Standard	Approved SOP
26	Provide reliable, validated service and individual clinician colposcopy data, as required by National Service Specification No.25	2,5	3 months	High	Validated QA visit dataset and actions taken
27	Ensure all colposcopists are following the national human papilloma virus (HPV) primary screening protocol including discharge to primary care for follow up	8	6 months	High	Copy of audit report and action taken
28	Update the colposcopy appointment letter to include the screening test result and to include information on how to access information in other languages	9	3 months	Standard	Copy of the updated patient invitation letter
29	Complete a specific annual user survey of the colposcopy service	2,5	6 months	Standard	Copy of survey report and actions taken

No.	Recommendation	Reference	Timescale	Priority	Evidence required
30	Undertake an infection control risk assessment of the clean and dirty areas within the colposcopy clinic and take appropriate action	5	7 days	Immediate	Copy of the completed risk assessment and the action taken

Multidisciplinary team

No.	Recommendation	Reference	Timescale	Priority	Evidence required
31	Update the SOP for case selection for the MDT meetings to incorporate HPV primary screening	8	3 months	Standard	Approved SOP
32	Ensure the names and job titles of all participants are recorded along with the names of reviewers of pathology samples on MDT minutes	5	3 months	Standard	Copy of the MDT minutes taking place since the QA visit
33	Document the arrangements for ensuring actions agreed are carried out and that supplementary pathology reports are issued	6	3 months	Standard	Approved SOP
34	Complete an audit to check that all cases indicated in national guidelines have been identified and discussed in a timely manner and that agreed action is taken	2,5,8	6 months	Standard	Audit report and details of 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 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.