

<b>Meeting Title</b>	<b>Board of Directors</b>		
<b>Date</b>	<b>7 November 2019</b>	<b>Agenda item</b>	<b>Bo.11.19.13</b>

### NHSE Public Health Screening Reports

<b>Presented by</b>	Sandra Shannon, Chief Operating Officer/Deputy Chief Executive		
<b>Author</b>	Screening Programme Leads: Julie Bradman, Vicky Jones, Leah Richardson and Suzanne Taylor Joanne Kennedy – Asst Director, Contracting.		
<b>Lead Director</b>	Sandra Shannon, Chief Operating Officer/Deputy Chief Executive		
<b>Purpose of the paper</b>	As part of the contract for screening services, NHS England - North (Yorkshire and the Humber) Public Health (NHSE PH) requires annual reports highlighting the key achievements and developments in each service in the year.		
<b>Key control</b>			
<b>Action required</b>	For approval		
<b>Previously discussed at/informed by</b>	Quality Committee		
<b>Previously approved at:</b>	<b>Committee/Group</b>	<b>Date</b>	
	Quality Committee	25 September 2019	

### Key Options, Issues and Risks

As part of the contract for screening services, NHS England - North (Yorkshire and the Humber) Public Health (NHSE PH) requires annual reports highlighting the key achievements and developments in each service in the year.

All reports include the following outline:

- Areas of Achievement
- Areas for Development
- Areas of Concern

### Analysis

The Trust provides screening services in the following areas:

- Antenatal & Newborn Screening Programme
- Bowel Cancer Screening
- Breast Screening
- Cervical Cancer Screening

These services are commissioned by NHS England via NHS England - North (Yorkshire and the Humber) Public Health (NHSE PH). As part of the contract for these services the Foundation Trust is required to submit annual reports to NHSE PH providing some background to the service and detailing areas of achievement in the year, areas for development, areas of concern and actions to be taken. NHSE PH asks that these reports are approved by the Board of Directors.

The full reports are available on request. However, the information listed in this report provides an individual executive summary for each of the services.

### Recommendation

The Board of Directors is asked to approve the submission of the reports to NHSE PH.

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Risk assessment						
Strategic Objective	Appetite (G)					
	Avoid	Minimal	Cautious	Open	Seek	Mature
To provide outstanding care for patients			g			
To deliver our financial plan and key performance targets			g			
To be in the top 20% of NHS employers					g	
To be a continually learning organisation				g		
To collaborate effectively with local and regional partners					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	Low		Moderate	High	Significant	
	Risk (*)					
Explanation of variance from Board of Directors Agreed General risk appetite (G)						

Benchmarking implications (see section 4 for details)	Yes	No	N/A
Is there Model Hospital data relevant to the content of this paper?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is there any other national benchmarking data relevant to the content of this paper?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Risk Implications (see section 5 for details)	Yes	No
Corporate Risk register and/or Board Assurance Framework Amendments	<input type="checkbox"/>	<input type="checkbox"/>
Quality implications	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Resource implications	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Legal/regulatory implications	<input type="checkbox"/>	<input type="checkbox"/>
Diversity and Inclusion implications	<input type="checkbox"/>	<input type="checkbox"/>
Performance Implications	<input type="checkbox"/>	<input type="checkbox"/>

<b>Regulation, Legislation and Compliance relevance</b>	
<b>NHS Improvement: (please tick those that are relevant)</b>	
<input type="checkbox"/> Risk Assessment Framework	<input checked="" type="checkbox"/> Quality Governance Framework
<input type="checkbox"/> Code of Governance	<input type="checkbox"/> Annual Reporting Manual
<b>Care Quality Commission Domain:</b> Choose an item.	
<b>Care Quality Commission Fundamental Standard:</b> Choose an item.	
<b>NHS Improvement Effective Use of Resources:</b> Choose an item.	
<b>Other (please state):</b>	

**Relevance to other Board of Director's Committee:**

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<b>(please select all that apply)</b>					
Workforce	Quality	Finance & Performance	Partnerships	Major Projects	Other (please state)
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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## **Antenatal & Newborn Screening Programmes**

### **Aim of Report**

This report is produced to contribute to the ongoing assessment of the quality of the delivery of the six NHS antenatal and newborn screening programmes against NHS Screening Programme requirements. It provides a benchmark for future service planning and quality improvement initiatives.

The NHS screening agenda is driven by a range of NHS and Department of Health policies and standards. For a contemporaneous list of relevant documents please see [www.screening.nhs.uk](http://www.screening.nhs.uk)

The UK National Screening Committee (UK NSC) currently recommends the offer of:

Antenatal screening:

- Infectious diseases screening (HIV, Hepatitis B and Syphilis)
- Sickle cell and thalassaemia screening
- Screening for fetal anomalies:
  - Down's, Edwards' and Patau's syndrome screening;
  - Fetal anomaly ultrasound

Newborn screening:

- Bloodspot Screening (Phenylketonuria, Medium Chain Acyl CoA Dehydrogenase Deficiency (MCADD), Cystic Fibrosis, Congenital Hypothyroidism, Sickle Cell) including extended screening
- Newborn Hearing Screening
- Newborn Physical Examination

### **Areas of Achievement**

#### **Generic**

- We had a quality assurance visit in March which found the service to be patient centred and delivered by a team that is dedicated and committed to continuous quality improvements.
- We have a robust failsafe in place to ensure the screening pathway is complete and a missed screening is identified and escalated in a timely manner whereby reducing the risk of incident recurrence and harm.
- Overall improvement in women's experiences of the antenatal screening programmes compared with the previous year, highlighted in a locally conducted audit.
- KPI data for ID1 (HIV coverage) ID3 (hepatitis B coverage), ID4 (syphilis coverage), ST1 (sickle cell and thalassaemia coverage) and FA2 (fetal anatomy coverage) consistently meets the performance thresholds.
- Charitable funds have been raised to create a suitable environment for women with a diagnosis of a life limiting condition of their baby.

#### **Fetal anomaly**

- Improvement in the Fetal Anomaly Screening Programme (FASP) Standard 8a data. 100% of women referred locally were seen within the timeframe (suspected/confirmed fetal anomalies seen locally within 3 working days).

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- Screening co-ordinator has commenced attending weekly multidisciplinary team (MDT) meeting/clinic for discussion of fetal abnormalities. This provides a link between all the relevant internal and external disciplines and continuity of care for those women who have poor outcomes.
- Commenced reporting data for KPI FA3. No threshold has been set for this KPI as yet.
- Commenced recording trisomy screening results from Leeds laboratory into the woman's maternity record.

### Infectious Diseases

- Women diagnosed with HIV receive an exemplary service with antenatal and often intrapartum care is provided by the screening coordinator to maximise continuity of care
- Robust clear Hepatitis B pathway with 100% Hepatitis B vaccination coverage for babies born to Hepatitis B positive mothers.

### Hearing screening

- The service has been named by Public Health England as one of only a handful of sites nationally that have consistently met and exceeded the KPI standard for NH2 (time taken to see a hearing specialist from the audiology service after referral from the screen).  
<https://www.bradfordhospitals.nhs.uk/2018/03/05/newborn-hearing-programme-among-nations-best/>
- Consistently meet NH1 (proportion of babies eligible for screening whom the screening process is complete by 4 weeks of age).
- The Child Health Records Department (CHRD) informs the NHSP screeners of all babies identified with no concluded result including movers in.

### Areas of Concern

- The palliative care pathway, established within the FASP is not a commissioned service. There is a need to find funds/resources to make this pathway sustainable in the future.
- Annual essential and desirable screening audit schedule devised however not all desirable planned audits were completed due to capacity.
- Current challenge covering Screening co-ordinator planned leave. Formal arrangement to be agreed locally.
- A great improvement in the number of avoidable blood spot repeats performed however the Trust needs to continue driving the recent strategies enforced until the target of <2% is consistently achieved.
- Unable to confirm if all women are notified of their screening blood results at their next appointment. Awaiting Medway upgrade which should address this concern.
- The validation of ST3 (completion of family origin questionnaire) data from the Leeds laboratory has been problematic. Discussions are taking place to move the haemoglobinopathy service from Leeds to our local laboratory which will help with TAT's, reduced the risk of missing samples and improve the accuracy of the KPI ST3 data.
- Capacity for fetal anomaly scanning has been affected as one obstetric ultrasound machine is used for growth scans only.

### Areas for Development / Going Forward

- To monitor the formulated action plan which addresses the recommendations made in the Quality Assurance report. The actions will be reviewed at the local screening governance and core group meetings.

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- Formalise a plan for deputy cover when the screening co-ordinator is on annual leave so standards are consistently met.
- Devise and complete an essential and desirable screening audit schedule for 19-20.
- Discuss and implement a process to ensure newborn outcomes are recorded on SMART4NIPE.
- To conduct a training needs analysis in order to address staff training needs in relation to screening.
- To continue monitoring the avoidable blood spot repeat rate (KPI NB2) and ensure the strategies implemented are consistently enforced, until threshold reached.
- CHRD to explore inputting NIPE results onto SystmOne records.
- Awaiting replacement of one ultrasound machine which will improve the capacity for fetal anomaly scanning.
- To explore means of commissioning the palliative care service within the FASP.

## Bradford & Airedale Bowel Cancer Screening Programme

### Aim of the Programme

The aim of the national bowel cancer screening programme is to reduce deaths from bowel cancer by early diagnosis in the faecal occult blood test screening programme, and by prevention in the bowel scope screening programme. The Bradford & Airedale Screening Centre covers a population of 630,000 across 3 CCGs (Clinical Commissioning Groups), Airedale Wharfedale & Craven, Bradford City and Bradford Districts.

The NHS screening agenda is driven by a range of NHS and Department of Health policies and standards. For a contemporaneous list of relevant documents please see NHS Bowel Cancer Screening Programme (NHSBCSP), <https://www.gov.uk/guidance/bowel-cancer-screening-programme-overview>

The UK National Bowel Cancer Screening Programme (NHSBCSP) currently recommends the offer of:

FOBT (faecal occult blood testing):-

- Automatic invite to screening for the population 60 – 74 years of age
- Self referral available for 75 years and above

Bowel Scope Screening (programme currently being phased in and not yet widely available):-

- Automatic invite for screening for population aged 55 years
- Self referral available 55 – 59 years of age

### Areas of Achievement

In the last year 28 patients were diagnosed with cancer and passed to our MDT (multi-disciplinary team) for surgery/treatment. Over 674 adenomatous polyps which can be pre-cursors of cancer were removed from patients. This is an increase of over 100 on the previous year.

Bowel scope, which is a preventative screening programme for all 55 year olds is now fully rolled out in the Airedale, Wharfedale and Craven CCG. We are currently 50% rolled out in the Bradford City and Bradford Districts respectively.

The Screening Centre has consistently met the following key performance indicators throughout the year for bowel cancer screening by faecal occult blood testing (FOBT) to 60 – 74 year olds:-

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- Waiting times from abnormal faecal occult blood test to clinic assessment less than 14 days.
- Waiting times for colonoscopy examination from clinic assessment less than 14 days.
- Adenoma/polyp detection rates within national guidelines for FOBt and bowel scope.
- Pathology test results reported within 7 days.
- Radiology tests performed within 14 days.

### Areas for Development

- Facilitate full roll out of bowel scope programme to Bradford Districts and Bradford City without compromising the FOBt programme.
- Facilitate capacity & demand for the new FIT (faecal immunochemical test) which replaces the old FOB test kit and has been shown in pilot studies to increase uptake of the programme significantly.
- Expansion in all staffing areas to accommodate the bowel scope programme and increased uptake from FIT if 10% or over.
- Expansion of office accommodation.
- Health promotion across all areas, particularly low uptake areas, learning disability, mental health and ethnic minority sections of the community, to improve knowledge and awareness of the programmes, increasing uptake and ensuring equity across the region.
- Explore service improvements through quality, innovation, productivity & prevention (QIPP) and shared best practice with other screening centres.

### Areas of Concern

- Delay in bowel scope roll-out to enable equity across all 3 CCGs, due to the implementation of FIT, endoscopy capacity and accredited bowel cancer screening sigmoidoscopist. It is also a concern that there has been no official communication from Government regarding bowel scope.
- Endoscopy and clinic capacity with the implementation of FIT. Audit to be performed 3 months post FIT to assess the impact and uptake.
- If FIT increases uptake to unprecedented levels then breaches to clinic and diagnostic tests should be expected in the short term.
- Maintaining accredited/trained staffing levels.
- Pathology shortages – Three pathologists have/due to retire and with FIT there may be breaches to the 7 day reporting KPI short term. Long term plans in place.

## Breast Cancer Screening programme

### Aim of the Programme

Pennine Breast Screening (PBS) serves a population of approximately 202,934 women who are invited once every 3 years. The service covers Airedale, Bradford, Calderdale, Dewsbury and Huddersfield. The population has increased following the implementation of the randomised age trial where women are invited from 47 years - 73 years (previously 50 – 70). Due to age expansion the cohort is set to rise to 222,574 by 2029. Resources will need to be adjusted to meet the increased workload. We have introduced MRI surveillance into the screening programme, for women with a very high risk of breast cancer.

### Programme Review / Areas of Achievement

Pennine Breast Screening (PBS) provides an excellent quality service and this is evidenced by the NHSBSP key performance indicators which are consistently achieved for both radiography and radiology. We also receive good feedback from clients via the National Friends & Family Test, as



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well as local patient satisfaction surveys and comments. The unit screened 45,401 patients between 1 April 2018 and 31st March 2019.

The service is in the final stages of implementing a paperlite pathway for mammography screening. This will enable live work list feeds to the mobile screening units with 3G/4G image transfer. This will enable the images to be available for reading immediately or within 12 hours of them being taken, which will help to maintain the screen to date of first offered assessment and screen to results KPI.

3 new breast ultrasound sets have been procured

The number and severity of mammography set breakdowns at static and mobile sites has increased over the last 12 months. This is partially due to the age of the equipment and the availability of parts and engineers. The service has worked with the Trust procurement team and the external suppliers which has resulted in a reduction in equipment downtime.

The service is working towards equipment replacement which will include the breast picture and archiving system (PACS) and the imaging modalities on the mobile units and at St Luke's hospital. The procurement of a replacement Breast PACS system is in progress with a plan to replace the equipment by 31 March 2020.

The screening office is carrying out a clinical trial on behalf of the national programme to evaluate mammography equipment from a practical perspective. This trial is ongoing with a planned progression to evaluate the Tomosynthesis capabilities of the equipment.

Pennine Breast Screening has continued to achieve certification for the quality management system under ISO9001:2015.

The service was complimented on its efficient and timely management of the women affected by the national breast screening incident.

### **Performance**

Key Performance indicators are consistently achieved. Round length and coverage has dropped due to the ongoing call and re call project. This is expected to continue for 2 rounds of screening.

The number of second timed appointments allocated to women who do not attend initially and managing the increasing population will impact on the services capacity over the next 12 months. The service is considering efficiencies and cost improvement plans in order to manage this.

Accessing suitable sites for mobile screening continues to be difficult. The service is currently reviewing the number and location of mobile sites it uses. This will improve consistency of mobile locations with the long term aim of increasing uptake for screening.

Pressures from the symptomatic service have increased. These are managed internally to reduce the impact on the screening service provision.

Uptake is lowest in the prevalent round which is consistent with the national uptake figures. The health promotion team are working towards improving this. It is important to note that improving uptake is complex as there are many factors which affect a woman's decision to attend for screening. Our dedicated health promotion team have a good understanding of these factors.

### **QA Action Plan**



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All outstanding actions relate to capacity and demand work and multidisciplinary meeting room facilities (including video conference and projection of imaging).

Capacity and demand work has been completed and has identified a need to increase mammography equipment availability, radiographic staffing and Radiology staffing. However, due to the current availability of resources and the uncertainty surrounding the National Breast Screening Review, this cannot be progressed at this time.

Upgrading of MDT facilities will ensure compliance with screening guidance for assessment and referral. The current facilities for multidisciplinary team meetings (MDT), in PBS at St Luke's Hospital require modernisation. The unit has written a business case to improve these facilities which includes video conferencing, high resolution screens for viewing imaging and pathology slides. This will enable surgeons from treatment centres to which we regularly refer women, to be involved directly with MDT discussion. The service will prioritise this development over the next 12 months.

### Health Promotion

The service employs 2 Health Promotion Specialist who both have a clinical background within breast screening. This has been hugely advantageous, enabling the team to address health related questions accurately.

The health promotion specialists have worked well with the Bradford Screening and Immunisation team and the Cancer Research UK facilitators, sharing knowledge and broadening connections with the wider community.

The team have also worked with General Practice Surgeries with a low uptake of breast screening and have identified common factors that impact on uptake. The positive impact of the health promotion team can be seen when reviewing screening uptake with between a 1% and 3% increase.

Stronger connections with the BME community leaders in Bradford have been achieved and the aim is to extend this to other areas covered by the programme.

### Incidents Risk and Issues

There were 20 incidents logged in 2018-2019 which is an increase on the previous year. 11 of these incidents relate to equipment break down. 5 incidents were reported to the Screening Quality Assurance service and to the Commissioning Team. Investigations have been completed and evidence submitted within the required timescales.

### Future Vision/horizon planning

We plan to update the meeting room facilities to enhance the Multidisciplinary team meeting, connecting PBS with all the centres we refer to.

We plan to introduce tomosynthesis into the service. Tomosynthesis capabilities have been included in the replacement equipment specification to facilitate this.

We are training 2 Advanced Practitioners in breast ultrasound and 1 Advanced Practitioner in x-ray guided breast biopsy.

We are developing a new extended role position in response to the anticipated increase in demand as the screening population expands.

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## Cervical Cancer Screening Programmes

### Aim of Report

This report is written to assist organisations in assessing and developing their services in relation to the current national standards for Cervical Cancer Screening Programmes. This will provide a benchmark for future service planning and quality improvement initiatives.

The NHS screening agenda is driven by a range of NHS and Department of Health policies and standards. For a contemporaneous list of relevant documents please see [www.screening.nhs.uk](http://www.screening.nhs.uk)

The UK National Cervical Cancer Screening Programme currently offers:

- 3 yearly cervical smear screening for women aged 25 to 49 years
- 5 yearly screening for women aged 50 to 65 years
- High risk screening according to NHSCSP guidance

### Screening Assessment

Primary cervical screening takes place on the whole in primary care, only opportunistic, difficult to obtain and follow up cervical samples (smears) are obtained within gynaecology and colposcopy. BTHFT runs 30 fixed colposcopy clinic sessions and seven vulval colposcopy session per month. There are also currently four cervical sample (smear) clinics per month for follow up patients. This will however be reviewed in the autumn as from April 2019 women who had large loop excision of the transformation zone and were suitable for test of cure (TOC) cervical sample (smear) at 6 months commenced discharge for TOC at 6 months with their practice nurse. It is expected that the hospital based smear clinics will reduce the sessions provided and that session time will be replaced with colposcopy clinics

The service regularly runs extra flexible colposcopy sessions to ensure referrals are seen within the timeframes set by NHSE and this has shown a sustained improvement in both the achievement of the 2ww and 6ww targets through quarters two three and four. The service currently employs a Lead Colposcopist, Lead Nurse Colposcopist/ Cervical screening programme lead, two Consultant colposcopists both with speciality interest in vulval disease and two trainee colposcopists.

### Health Promotion

The CSPL remains actively engaged in health promotion activities and has provided talks at cervical screening update training and on the cervical screening training courses.

There is close liaison with the screening and immunisation teams and wherever possible the colposcopy service supports any localised initiatives. Primary cervical screening is not performed in secondary care here at BTHFT.

Cervical screening and immunisation team report the following health promotion activities

- Practice visits
- Raising awareness training
- Events at Gillington community centre (cluster of practices invited their patients)
- Raising awareness at sharing voices and Roshni Ghar
- Raising awareness with LD service users and carers
- Presentation at LD Healthy Living board
- Wise up to cancer project
- Cancer Research roadshow 4th and 5th June 2019

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PHE released its latest cervical screening television advert in March 2019. This led to an increase in 7500 samples been received by the Leeds cytology laboratory when compared to the March/April period in the previous year.

### Areas of Achievement

- Positive screening quality assurance visit (SQAS) the service was praised for been organised and well led with staff who are engaged and motivated Excellent training facilities provided for medical students, physician associates, O&G speciality trainees, student nurses, and cervical screeners demonstrated in feedback provided to medical education.
- Good patient friends and family feedback. The clinic provides and excellent facility for women attending for colposcopic examination. The ward environment is clean and spacious with separate counselling and changing facilities ensuring patients privacy, dignity and respect are maintained at all times
- The DNA rates for new, return for treatment and follow up patients have been consistently within the national target throughout the year.
- Biopsies obtained, which are deemed adequate for histological diagnosis, have also been consistently above national standards throughout the year.
- The service has invested in a colposcopy failsafe coordinator with two support administrators to ensure timely management of referrals, appointments, improved tracking and reporting of results and continual monitoring of the patient journey until discharge. The failsafe co ordinator recently received a Trust sustained quality improvement bronze award for the implementation of the results/appointments tracking system which has improved the failsafe process for the service and led to sustained improvement in communication of results to patients and management of new referrals.
- The CSPL and Screening and Immunisation lead Sarah Wighton have successfully achieved repatriation of TOC samples back to primary care from April 2019. This will allow women to have their first follow up smears post LLETZ back with their practice nurse which brings the unit in line with colposcopy services nationally. This change in practice was supported by the CCG following reassurance by the screening and immunisation teams that there were now sufficient cervical screeners across Bradford CCG's to accommodate these cases.
- Implementation of quarterly cervical screening programme management meetings have led to improved working relationships with histopatholgy, cytology, CBU managers, clinical leads, failsafe co ordinators and screening and imms teams. A collaborative approach has improved waiting times for first appointment targets, communication of results to patients, management of patients through MDT, and led to rapid response to SQAS recommendations.
- The Lead Nurse Colposcpist has been employed by SQAS as a professional clinical adviser for colposcopy for the north of England where she will inspect other servical screening services and aid the screening programme with incident responces. This demonstrates the level of expertise the colposcopy service at BTHFT has. This will benefit BTHFT as any best practice noted at other Trusts can be considered for implementation at BTHFT.

### Areas for development

- To improve timely registration of new cases of cervical cancer into the invasive cancer audit and ensure timely completion of the audits and review of cases as required. Audit of offer of audit outcome is in process and has already led to improved patient communication regarding the outcome of the audit and duty of candor.
- Installation of MASEY database

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- To implement an adjunctive technology to the colposcopy service which will improve accuracy of diagnosis of high grade cervical intraepithelial neoplasia, may reduce the amount of patient follow up appointments as more select and treat may be performed and more patients with normal colposcopy and normal adjunctive technology readings will be returned to primary care quicker and will lead to reduced pathology costs as fewer reassurance biopsies will need to be obtained.

### Areas of concern

- Waiting time for first appointment for all referrals within 6 weeks breaches
- Timely communication of results to patients
- Invasive audit of cervical cancers
- Proportion of women not having a biopsy at first visit with high grade cytology has persistently failed to be met. Although quarterly audit reveals patient safety is at the forefront of colposcopic decision not to biopsy at first visit due to pregnancy, active infection, large volume lesions, risk of contact with vaginal wall due to vaginal wall laxity and patient declining out patient LLETZ due to anxiety There has been an increase in patients listed for GA LLETZ following colposcopy. This is under monthly review and the results of the audit are expected to be presented at the BS CCP. It is suspected that as women are failing to attend for regular cervical screening when they do eventually attend their lesions are larger and more advanced. It is also noted that increasing body habitus across the local population is making routine out patient LLETZ more difficult.
- Cervical screening coverage in Bradford remains a concern although screening and immunisation teams are actively engaging with practices and communities where coverage is particularly low.

### QA Action Plan

There were 36 recommendations made in the published SQAS report in August 2018. To date 20 of these recommendations have been closed.

The last recommendations review meeting took place on 21/06/2019. At that review meeting evidence was submitted for review and closure of a further 8 recommendations is expected. The majority of recommendations are expected to be closed by August 2019 in line with SQAS/PHE requirements.

There are 3 recommendations which may lead to escalation through contracting lines:-

Recommendation 18. Histopathology- ensure that the replacement IT system can generate NHSCSP key performance indicators and individual performance data.

SQAS have been informed that the histopathology lead cannot close this recommendation as the replacement IT system is been planned for across several trusts as part of the WYAAT project. Sarah Wighton has agreed to escalate this issue with NHS pathology lead Jane Mills to access a project timeline for implementation of the IT system which would close the recommendation.

Recommendation 23. Colposcopy- ensure all colposcopists have a qualified nurse in each colposcopy room with a second trained member of staff within the department available at all times.

The service provides adequately trained staff for each colposcopy room and there are RN's always available on the WHU when colposcopy clinics operate but there is not at present a qualified nurse in each colposcopy room. This has been escalated to the general manager for the women's clinical business unit and chief nurse. Further staffing review may be required however if a business case is required to increase RN staffing levels further the cervical screening service may not close this recommendation when due in August. There have been no incidents within the

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colposcopy clinic where care has been compromised due to not having a qualified staff nurse in each room.

Recommendation 35. Colposcopy- update trust patient leaflets and trust post treatment leaflets to include standardised translated text in other languages and named contact in colposcopy.

#### **Incidents/risk**

There were three reported incidents linked to the colposcopy service. None of which were reported as serious incidents causing harm to patients. One of these incidents was reported to PHE as a cervical screening incident due to a delay in action of an abnormal result taken in theatre. The incident has led to implementation of an SOP for all laboratory based samples taken outside of colposcopy service.

#### **Future Vision/horizon planning**

We plan to apply to charitable fund to improve the patient waiting area.

We plan to introduce the Masey data base for colposcopy which will improve accuracy of reporting to PHE/SQAS

The business case for adjunctive technology will be submitted in line with the Women's CBU clinical strategy this will improve accuracy of diagnosis at colposcopy.