NHS

Cancer Screening Programmes

DH Department of Health

NHS CERVICAL SCREENING PROGRAMME

Achieving a 14 day turnaround time for results by 2010

ADVICE TO THE NHS

April 2008

1. Introduction

Following the 2005 General Election Manifesto commitment, the Prime Minister and Secretary of State for health announced in September 2007 that women can expect to receive the results of their cervical screening test within 14 days of it being taken. The Cancer Reform Strategy (CRS) confirmed that this should be achieved by 2010.

The CRS noted that achieving the new 14-day turnaround time (TAT) will be a challenge for many parts of the country. It will involve all partners in the screening pathway, including GP practices, laboratories and Trusts. Local screening policies and arrangements may need fundamental change.

This document aims to give practical, evidence based advice on achieving the new 14-day TAT, and signpost services to the support available. It is suggested that SHAs work in close collaboration with their PCTS, primary care services, pathology services and screening services to develop plans to deliver the new 14-day TAT in a joined-up approach. Due regard should be given to the DH Best Practice Guidance *Collaborative Commissioning of National Screening Programmes*, issued in December 2007 (Gateway ref: 8829).

The new 14-day TAT is also a deferred **National requirement** which PCT Operational Plans will need to reflect, as set out in the 2008/09 Operating Framework[1].

Background

Currently all women should receive their cervical screening test results within 6 weeks[2]. In 2005-06, this was only met by 56% of SHAs, although this improved to 74% in 2006-07. A breakdown by SHA is shown in the table.

	Time of screening to notification of result	
SHA	**<6 weeks – 2005-06 (%)**	**<6 weeks – 2006-07 (%)**
North East	77	62
North West	46	81
Yorkshire & Humber	63	89
East Midlands	38	61
West Midlands	65	82
East of England	43	76
London	52	61
South East Coast	62	76
South Central	66	68
South West	68	81
England	**56**	**74**

[1] Operational Plans 2008/09 – 2010/11 (implementing the 2008/09 Operating Framework): national Planning Guidance and "vital signs" (31st January 2008)

[2] Quality assurance guidelines for the cervical screening programme NHSCSP Publication No 3 Ed. J Pritchard Sheffield 1996

Source: The Information Centre/ National Statistics - Cervical Screening Programme England 2005-06/2006-07

Due to the relatively poor attainment of the 6 week TAT, the Labour Party Manifesto for the 2005 General Election gave the following commitment – *"We will speed up the results of cervical smears".* An accompanying press release from April 2005 stated that women should receive their cervical screening test results within 7 days.

To work out how best to achieve this commitment, a formal Options Appraisal (OA) was commissioned from the School of Health and Related Research ((ScHARR) at the University of Sheffield[3]. The report stated that a turnaround time (TAT) of 7 days for all women was unachievable without major financial investment.

However, the OA said that a TAT time of 14 calendar days could be achieved for 95% of women with minimal initial investment and major year on year savings, with 50% of women receiving their results within 7 days. The OA set out clear practical options on how this can be achieved, which are set out under part 2 below. NHS Cancer Screening Programmes are publishing the OA along with this document. The OA can be found at: www.cancerscreening.nhs.uk and www.csp.nhs.uk (secure site).

NHS Cancer Screening Programmes also commissioned an OA on streamlining the local administration of the cervical screening service. The report from Beaumont Colson[4] is also being published alongside this document, and can be viewed at the web addresses above. This OA is also discussed in part 2 below.

As part of the development of the Cancer Reform Strategy, a package of proposed measures has been developed with key stakeholders, including representatives from the SHAs. The Advisory Committee on Cervical Screening (ACCS) discussed the ScHARR report, and endorsed the package of measures set out in this document.

Ministers agreed, and this culminated in the CRS stating that all women should receive the results of their cervical screening tests within two weeks by 2010.

2. Achieving the 14 day TAT – the evidence base

This section sets out the evidence base for achieving the new 14-day TAT, including reference to the two specially commissioned OAs.

Implementation of Liquid Based Cytology (LBC)

[3] Option appraisal: Assessment of a seven-day turn-around for the reporting of cervical smear results ScHARR January 2006

[4] Beaumont Colson Options Appraisal and review of the Administration of the NHS Cervical Screening Programme Report to NHS Cancer Screening Programmes 2006

LBC is key to achieving the new 14-day TAT due to the decrease in workload from the reduction in inadequate samples and the improved speed of throughput through laboratories. The NICE Technology Appraisal (TA) of LBC was published in October 2003. At the time, we said it would take up to 5 years for full national implementation due to the major retraining issues.

By November 2007, 88% of laboratories in England had converted to LBC. All PCTs have indicated that they will have introduced LBC by October 2008 in line with NICE/DH guidance. SHAs may wish to ensure that this takes place.

The benefits of LBC are already becoming apparent. Of the four million tests taken each year, the number of inadequate tests fell from 370,000 (9%) in 2004-05 to 173,000 (4.7%) in 2006-07. As a result around 200,000 women did not have to attend a repeat test, with all the anxiety that this involves for women, the additional expense for the NHS and the unnecessary workload for the programme.

ScHARR Option appraisal: Assessment of a seven-day turnaround for the reporting of cervical smear results

ScHARR were commissioned by NHS Cancer Screening Programmes to undertake the above OA following the manifesto commitment. Five cytology laboratories around England were studied in detail and the information provided was validated nationally through questionnaires sent to a sample of 25 further laboratories. This data was used in addition to research papers and other literature to inform a discrete event simulation model representing a typical laboratory.

The model was implemented using the Simul8 package. The conventional Papanicolau smear and LBC method of screening were both simulated in the Cervical Screening Process Model and a number of options for change were evaluated.

The OA said that in order to achieve a major reduction in result TATs, a combination of several of the options considered is required. The options considered were as follows:

i. Limit processing of samples to only those women eligible within national standards
ii. Implement an electronic link from the laboratory to the call and recall office
iii. Despatch results letters by first class post on Monday, Tuesday and Wednesday mornings
iv. Workforce redesign – training of Advanced Practitioners
v. Merge workload from small laboratories

The OA concluded that implementing options i,ii, iii and iv in medium sized laboratories using LBC would achieve around 46% of results being returned within seven days and over 95% in two weeks. However, in small laboratories without LBC staining machines it may not be feasible to process results within

seven days and would take three weeks to return 95% of results. By implementing the above options and merging workload of smaller laboratories it is estimated that around 45% of results could be returned within seven days and over 95% within two weeks.

One of the major causes of delay is samples getting from the sample taker to the laboratory. The OA assumed that there is one van collection each day transporting the samples from the GP surgery to the hospital. In developing their plans to deliver the new 14-day TAT, SHAs and their stakeholders are advised to review sample collection methods.

The following discusses the options in more detail.

i. *Limit processing of samples only to those women eligible within national standards*

ScHARR recommended that local screening programmes should not process samples taken from women who fall outside the programme (ie only screen women aged 25 to 49 every three years and women aged 50 to 64 every five years). Many women are currently screened "opportunistically" outside national standards. Currently 24.7% of samples are provided by women and their doctors at an inappropriate interval in the call and recall programme. Some units already strictly adhere to this policy, and show it can be achieved. Initial national costs would be £100,000, with potential savings of over £10 million per year.

In discussions with stakeholders, there was some concern about the reaction of the service to not processing out of programme samples. The Advisory Committee on Cervical Screening (ACCS) has recommended that there should be a flexible period of six months prior to tests becoming due at which samples can be reported. Evidence from local screening programmes who operate strict policies on reporting out of programme samples has shown that primary care practitioners soon cease sending inappropriate samples for reporting. Local education programmes for GPs would be an important part of this initiative.

ii. *Implement an electronic link from the laboratory to the call and recall office*

ScHARR reported that currently results are recorded on paper and on the computer system. Implementing a lab link would mean that it would no longer be necessary to spend time and money recording results by hand. It would also reduce the potential for discrepancies between the computer and paper records. National initial costs would be £1.5 million (or £500,000 if a web-based IT system was developed), with savings of around £200,000 annually.

iii. *Despatch results letters by first class post on Monday, Tuesday and Wednesday mornings*

ScHARR commented that currently negative results are dispatched by second class post, usually only on a Monday alone to ensure that results are not received at the weekend. By sending them by first class post on Monday,

Tuesday and Wednesday mornings they should still be received before the weekend. This would cost around £400,000 per year.

iv. *Workforce redesign – training of Advanced Practitioners*

ScHARR recommended that at least one Advanced Practitioner (AP) should be trained up at as many labs as possible. There is currently a shortage of pathologists and this delays the reporting of abnormal samples. The role of the AP is relatively new and allows the cytologist to carry out the pathologist's part of the process, hence the sample spends less time waiting at this stage. National initial costs would be around £400,000, but savings of over £8 million per year could be made.

v. *Merge workload from small laboratories*

In order to maintain efficient utilisation of staining machines for LBC, workload from small labs could be combined or transferred to larger labs. There will be initial costs involved with this reconfiguration, but there is the potential for medium and long term cost savings. ScHARR recommended the minimum number should be 35,000 tests per year.

The 2006 report of the Independent Review of NHS Pathology Services, chaired by Lord Carter, highlights the importance of reconfiguring pathology services to improve efficiency and effectiveness and securing the benefits achievable through economies of scale. The evaluation of Phase 2 of the review, which will make further recommendations for service reconfiguration based on data collected from twelve pilot sites, will report shortly to DH.

Summary

The ScHARR recommendations and costs/savings are summarised in the following table:

Recommendation	**National initial costs**	**National running cost per year**
Not processing out of office samples	£100,000	*Saving* of over £10m
Electronic links between laboratory and call/recall centre	£1.5 million	*Saving* of approximately £200,000
Send letters by first class Monday, Tuesday and Wednesday mornings	N/A	Cost of approximately £400,000
Train one Advanced Practitioner at as many laboratories as possible	£400,000	*Saving* of over £8m
Merge workload from smaller laboratories	Reconfiguration costs	Potential cost savings
Total	**Approximately £2 million plus reconfiguration costs**	**Savings of over £18 million**

Streamlining local administration of the service

In addition to the OA from ScHARR, NHS Cancer Screening Programmes commissioned Beaumont Colson Ltd to review the local administration of the NHS CSP. There is currently wide variation and duplication in the administration of the programme in some areas, particularly around local call/recall offices. This OA recommended the streamlining of call/recall offices. This rationalisation would bring the cervical programme more into in line with the breast screening programme and the new bowel screening programme.

Fewer larger offices would be able to offer support to women in a way that is not possible with a larger number of smaller offices running multiple policies. For example, helplines and translation services could be offered, and advice could be given on where cervical screening is accessible for disabled women or available out of normal working hours.

SHAs are advised to decide on the number of screening offices that are appropriate to service the screening programme for their local populations. This could be one or more per SHA, depending on the local circumstances and the effectiveness of current practice. There are obvious financial savings to be made with such rationalisation, and there are clear benefits of all PCTs within an SHA operating a single policy and adhering to national guidelines. Such rationalisation would also help in achieving the 14-day TAT.

Modernising colposcopy

Achieving the 14 day TAT will impact on colposcopy services, at least in the short term. To overcome this local services are advised to adopt direct referral from the laboratory to colposcopy, rather than referral via the woman's GP. Local services are also advised to review policies relating to surveillance of low-grade disease, post-treatment follow-up, treatment policy, and adherence to national guidelines to respond to the increased workload. A national model has been developed and distributed to assist local services in assessing alternative policies**.**[56]

3. Support from NHS Improvement (formerly the Cancer Services Collaborative: Improvement Partnership)

The Cancer Reform Strategy stated that the Cancer Services Collaborative: Improvement Partnership (CSCIP), now NHS Improvement, will offer focused service improvement resources across the cervical screening pathway to support the delivery of faster turnaround times.

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[5] Modelling the Impact of Referral Guideline Changes for Mild Dyskaryosis on Colposcopy Services in England NHSCSP 24 Sheffield 2006

[6] http://www.shef.ac.uk/scharr/sections/heds/modelling/cervical-screening/

NHS Improvement is a national NHS-funded programme designed to drive improvements in the way cancer services are delivered to patients. The programme is designed to provide a practical approach to support local clinical teams to look at their own services and make significant improvements for patients by redesigning the way that care is delivered. This in turn will support the delivery of the Cancer Reform Strategy actions. The CSCIP has some noted successes, particularly in the delivery of the cancer waiting times targets.

The NHS Improvement Pathology Service Improvement team will support process improvement for a number of local teams to use Lean improvement methodology to achieve or surpass the new 14-day TAT in line with the 2005 commitment (see paragraph 1.5). Evidence from testing the lean improvement methodology has demonstrated that a 50% reduction in turnaround times can be achieved without significant additional resources (see www.pathologyimprovement.nhs.uk)

A collaborative approach will be used allowing teams to network and share best practice. We aim to ensure local ownership and sustainability of improvements by clinical teams. A three year programme of work in three phases is envisaged, working with 20 to 30 sites per phase.

The approach will be to ensure local ownership by clinical teams as a way of guaranteeing sustainability.

In order to achieve the maximum effectiveness of this support, which will be funded centrally, a number of criteria have been developed. These are:

i) Laboratories must process over 35,000 samples annually (see paragraph 2.15)
ii) There must be explicit support from the host Trust executive team
iii) A whole pathway (end to end) approach will be used, from samples taken to estimated date of receipt of result by women
iv) The team must include representatives from primary care, laboratory and report delivery agency
v) Baseline data will need to be collected, along with monthly ongoing data collection (date sample taken, sample arrived in lab, lab report sent, expected date of delivery)
vi) A workshop approach will be taken, with bimonthly training and networking for staff
vii) All teams to report progress via web based reporting system (Rapport)
viii) Initial sites to become exemplar sites of excellence and share the learning

In the first instance, SHAs wishing to receive CSC-IP support should send expressions of interest to NHS Cancer Screening Programmes, outlining clearly which local services they wish to receive the support and how those

services meet the above criteria. Expressions of interest should be posted or e-mailed as follows:

Mrs Julietta Patnick
Director
NHS Cancer Screening Programmes
Fulwood House
Old Fulwood Road
Sheffield S10 3TH

e-mail: Julietta.Patnick@cancerscreening.nhs.uk

Expressions of interest should be received by **Friday 23rd May 2008** and will be assessed by NHS Cancer Screening Programmes, NHS Improvement and the Department of Health.

4. Practical details

Monitoring

In order to monitor the new 14-day TAT, NHS Cancer Screening Programmes and the Department of Health are working with the Information Centre and ROCR to amend Part E of the KC53 return.

A new line of "Up to 2 weeks" will be added to monitor time from screening to two new lines measuring the date of dispatch of the results letter and the date of expected delivery. These measures are likely to come in for the 2008-09.

Those local services receiving NHS Improvement support will need to submit monthly data, as in point v) of the criteria above.

The new 14-day TAT has also been included in the NHS Operating Framework for 2008-09 to 2010-11 as a "vital sign", and we are discussing with the Department of Health's Recovery and Support Unit how best to monitor trajectories to meet the 14-day TAT.

Local monitoring is also essential. The Cancer Reform Strategy (paragraph 3.12) stated that the new 14-day TAT should be monitored locally and commissioners should intervene if the 14-day TAT is not being met.

Funding

No central funding is available to support the new 14-day TAT. All appropriate funds have been allocated in PCT baselines. The ScHARR OA said that major financial savings can be made by adopting the proposed actions to achieve the 14-day TAT with minimal initial investment.

The support of NHS Improvement will be funded centrally, but local services will be expected to cover any service expenditure locally.

5. Other cervical screening actions in the Cancer Reform Strategy

In redesigning their services to achieve the 14-day TAT, SHAs and local screening services will wish to take into account the other cervical screening actions outlined in the Cancer Reform Strategy. These are:

- Reducing the variation of coverage between PCTs
- Action to tackle the falling participation of younger women aged 25 to 35

6. Further details and support

Further support and advice can be obtained directly from NHS Cancer Screening Programmes, or from Regional QA Directors and SHA Screening Leads. Details are in Annex A and B respectively.

Annex A

Regional Quality Assurance Directors

Region	QA Director	Contact
East Mid	Dr D Slater	david.slater@sth.nhs.uk The Royal Hallamshire Hospital Department of Histopathology Floor E Glossop Road Sheffield S10 2JF
EoE	Mr Jem Rashbass	Jem.Rashbass@esqa.nhs.uk East of England Breast & Cervical QA Reference Centre Compass House Vision Park Chivers Way Histon Cambridge CB4 9AD
London	Dr Kathie Binysh	k.binysh@imperial.ac.uk QA Reference Centre London Cancer Screening Programmes# 4th Floor 50 Eastborune Terrace London W2 6LX
NE & Yorks and Humber	Dr Keith Faulkner	keith.faulkner@nhs.net QA Reference Centre Unit 9, 9 Kingfisher Way Silverlink Business Park Wallsend Tyne & Wear NE28 9ND
NW	Dr Lesley Turnbull	lesley.turnbull@rlbuht.nhs.uk Liverpool Cytology Training Centre Royal Liverpool University Hospitals NHS Trust 6th Floor, Duncan Building Daulby Street Liverpool L69 3GA
S Central	Dr Monica Roche	monica.roche@ociu.nhs.uk QA Reference Centre Oxford Intelligence Unit 4150 Chancellor Court Oxford Business Park South Oxford OX4 2JY
SE Coast	Dr Linda Garvican	linda.garvican@scn.nhs.uk South East Coast Breast & Cervical QARC 77a High Street Battle TN33 0AG

SW	Dr Karin Denton	Karin.Denton@north-bristol.swest.nhs.uk South West Regional Cytology Training Centre Department of Cellular Pathology Southmead Hospital Bristol BS10 5NB
W Mids	Dr Gill Lawrence	gill.lawrence@wmciu.nhs.uk West Midlands Cancer Intelligence Unit The Public Health Building University of Birmingham Birmingham B15 2TT

Annex B

SHA Screening Leads

SHA	Lead	Contact
East Mid	Jane Woodland	Jane.Woodland@eastmidlands.nhs.uk Head of Screening and Public Health Programmes Directorate of Public Health NHS East Midlands Octavia House, Bostocks Lane Sandiacre Nottingham NG10 5QG
EoE	Pam Hall	pam.hall@eoe.nhs.uk Pam Hall East of England SHA Victoria House Capital park Fulbourn Cambridge CB21 5XB
London	TBC	Awaiting confirmation copy in Simon Tanner – simon.tanner@dh.gsi.gov.uk Government Office London 5th Floor Riverwalk House 157-161 Millbank London SW1P 4RR
NE	Madeleine Johnson	Madeleine.johnson@dh.gsi.gov.uk Acting Head of Public Health Delivery 7th Floor Citygate Gallowgate Newcastle upon Tyne NE1 4QH
NW	Judith Richardson	judith.a.richardson@northwest.nhs.uk Screening Lead NHS North West 7th Floor Gateway House Piccadilly South Manchester M60 7LP
S Central	John Newton	John.Newton@southcentral.nhs.uk RDPH South Central SHA First Floor Rivergate House Newbury Business Park London Road, Newbury Berkshire RG14 2PZ

SE Coast	Quentin Sandifer	quentin.sandifer@southeastcoast.nhs.uk RDPH South East Coast SHA York House 18-20 Massetts Road Horley Surrey RH6 7DE
SW	Julia Verne - Antenatal and Child Health Screening Jim O'Brien Karen Denton	Julia.Verne@swpho.nhs.uk Deputy RDPH Government Office for the South West 2 Rivergate Temple Quay Bristol BS1 6EH Breast Cancer Screening Cervical Cancer
W Mids	Rowena Clayton	Rowena.Clayton@dh.gsi.gov.uk Government Office West Midlands 5 St Philip's Place Birmingham B3 2PW
Yorks and Humber	Liz Henley	Liz.Henley@yorksandhumber.nhs.uk Screening Lead NHS Yorkshire and Humber Blenheim House West One Duncombe Street Leeds LS1 4PL