Public Health England

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NHS

NHS Cervical Screening Programme
Restoration Guidance

Version Control	
4 (13th July 2020)	Section 7 added to include specific advice for cervical sample taker training providers following advice from PHE, and updates to sections 4.3 and 6 with additional Infection Prevention and Control guidance following advice from the Infection Prevention and Control cell.

1. PURPOSE

In a communication to the NHS on 29 April 2020, NHS England and NHS Improvement (NHSEI) outlined the second phase of responding to the COVID-19 pandemic. This included advice to step up urgent services which includes screening.

In some areas, some providers of NHS Cervical Screening Programme services have, for operational reasons and to minimise risk to patients during the coronavirus pandemic, rescheduled some invitations or appointments to a later date. NHSEI have been working with them to ensure this is managed safely for patients and with a view to rescheduling as soon as possible.

This document provides guidance to NHSEI regional public health commissioning teams to support conversations they are having with providers of NHS Cervical Screening Programme services to ensure that they are restored in a consistent, safe way.

2. BACKGROUND

It is now vital that plans are in place for NHS Cervical Screening Programme services to operate fully as soon as it is safe to do so, and that the restoration is done in a consistent way to minimise risk to individual patients. Service providers must consult with their regional NHSE&I public health commissioner for advice on the best way to manage restoring services. The Public Health England (PHE) Screening QA Service will provide advice to both providers and commissioners on quality and safety issues.

Checklists have been developed to support regional public health commissioners and providers in developing plans for restoring services back to managing normal levels of activity throughout the pathway, in line with routine national screening guidance. These are shown in **Appendix 1** along with a broad approach for their use.

To support the restoration process and to give time for services to recover, invitation and reminder letters for cervical screening were delayed for 8 weeks from 9 April 2020 and are now being posted to women again as of 6 June 2020.

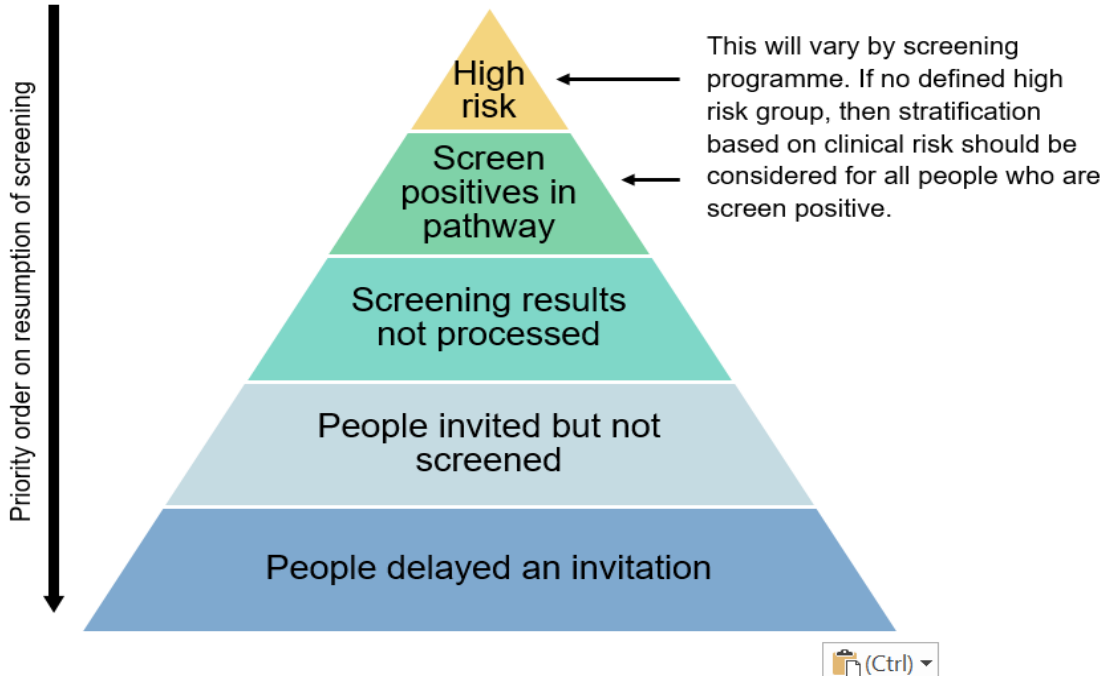
To support staff and employers in providing services, detailed guidance on screening training providers is provided in section 7 of this document.

3. RESTORATION PRINCIPLES

A set of principles to inform restoration has been developed by PHE Screening and agreed with NHSEI.

This hierarchy of restore pyramid shows how screening programmes should prioritise those at highest risk first. (Figure 1):

Figure 1: Hierarchy of restart pyramid



4. COLPOSCOPY PROVIDERS

4.1 Prioritisation Groups

Applying the model in Figure 1 broadly to cervical screening gives the following prioritisation groups in colposcopy services:

High Risk

Colposcopy services should aim to assess and manage high risk cases that have already been referred to them, or are referred over the coming months, in line with published national screening programme guidance on waiting times. This covers the following groups:

- ? invasive and ? glandular neoplasia
- symptomatic 2 week wait urgent referrals
- severe dyskaryosis
- moderate dyskaryosis
- borderline changes in endocervical cells

Patients already under the care of colposcopy having previously been assessed and/or treated should be managed in accordance with programme guidance:

- follow up for CGIN
- conservative management of CIN2
- other agreed follow up requiring colposcopic assessment
- patients requiring treatment for CIN following initial assessment

All patients in the above high risk groups, must not be deferred.

Screen positives already in the pathway

Patients whose appointments may have been deferred should be contacted and an earlier appointment offered where there is capacity to do this. As the length of major disruption to services has been more limited than first envisaged, it is now expected that services should aim to see this group of patients within 3 months of their initial referral if at all possible. This covers patients already referred to colposcopy but not yet examined in clinic (prioritised by result with oldest referrals first) and those having screening test follow up in colposcopy:

- low grade dyskaryosis
- borderline changes in squamous cells
- hr-HPV positive/cytology negative
- inadequate/unreliable result referrals
- non-urgent clinically indicated referrals
- cervical screening tests in colposcopy that have been deferred

4.2 Failsafe

Colposcopy services should ensure that all failsafe activities continue in line with programme guidance. A check should be made of all appointments deferred to ensure all have been acted upon and appointments have now been issued.

In these exceptional circumstances, colposcopy providers must offer an appropriately timed second appointment if patients do not attend (DNA) or cancel their appointments as there may continue to be higher DNA and cancellation rates over the coming months.

Given the high levels of anxiety that patients may have in relation to coming to hospital at present, colposcopy patients should not be discharged without the offer of a further appointment and this should be recorded. Suitable text could be added to second appointments to reassure women that it is safe to attend and to encourage them to contact the service for advice if they have any concerns.

4.3 Clinic environment and equipment

Providers should note that they are responsible for determining local arrangements and should follow local organisational policies and advice for use of personal protective equipment (PPE) and infection control arrangements. This will be informed by national guidance for use of PPE by health and social care workers on COVID-19 https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-personal-protective-equipment-ppe

The British Society of Colposcopy and Cervical Pathology has included advice on PPE in its COVID-19 guidance.

Colposcopy clinics must assess and put in place practical arrangements for management of patients within the clinic area, in line with internal organisational policies, in order to keep patients and staff safe. This may affect capacity to see patients. More details of issues to consider are contained within the restoration checklist for providers and in national programme guidance.

Providers should note that neither taking a cervical screening sample, nor placement of the sample into the pot have been identified as aerosol generating procedure.

The principles of Infection Prevention and Control within the guidance https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control (note Table 4) therefore apply in all care settings wherein a cervical sample would be taken.

5. CERVICAL SCREENING LABORATORY PROVIDERS

5.1 Prioritisation Groups

Screening results not yet processed

Cervical screening laboratory services should continue to screen and report all samples received. HPV testing capacity to achieve this must be available. Laboratories must manage samples such that the 14 day turnaround standard can be met to avoid developing backlogs, either in HPV testing or cytology.

5.2 Failsafe

Laboratories must ensure that laboratory failsafe procedures remain aligned to colposcopy referral scheduling for all clinics they work with.

Screening laboratories should note the guidance to primary care for women on routine recall who could be aged 65 by the time their last screening test is taken due to delays caused by COVID-19. In these exceptional circumstances, laboratories must accept and report these samples. Primary care has been asked to mark the sample request with “test delayed due to COVID-19” in these circumstances.

5.3 Staffing

Laboratory service leads are responsible for making sure all staff are competent to resume their professional duties. During periods of lower workload levels, local management will support staff in maintaining their skills and competence through assessment or other in-house educational activity.

Laboratory training officers, with advice from a cytology training centre, should decide how to manage their staff in training. Local arrangements prevail for those staff returning to work following maternity leave or sickness absence or an absence exceeding 12 months in line with existing national guidance.

Laboratories will note that the April to September 2020 round of the national EQA scheme for gynaecological cytopathology will not take place.

6. SAMPLE TAKING PROVIDERS

This section refers to all sample taking providers: general practice, sexual health and any other setting.

Women who are eligible and due for cervical screening should be offered appointments.

Providers should note that they are responsible for determining local arrangements for use of personal protective equipment (PPE). This will be informed by national guidance for use of PPE by health and social care workers on COVID-19 https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-personal-protective-equipment-ppe and recommended PPE for primary, outpatient and community care https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/877599/T2_Recommended_PPE_for_primary_outpatient_and_community_care_by_setting_poster.pdf

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6.1 Prioritisation Groups

People invited but not screened and people with a delayed invitation

Invitation and reminder letters are being issued as of the beginning of June 2020. The invitation and reminder letters that have previously been held back will be added back into the system incrementally so there may be more individuals than usual requesting a screening test over the catch up period. Individuals with delayed invitations for surveillance are being prioritised for letter production.

People invited for routine screening (due or overdue)

Individuals who request screening should be offered an appointment.

Primary care providers should review their local records or use final non-responder lists to identify individuals whose screening may have been affected by COVID-19 (for example, their appointment has been cancelled and not been rebooked, they have been refused an appointment during the pandemic response, or they have not responded to a reminder letter) and be proactive in contacting them about their screening and giving them opportunity to attend.

Primary care providers should only defer individuals for screening in accordance with programme guidance and may not use the deferral process to postpone invitations for any other reason. The “practice invitation” reason for delaying screening that may have been used initially in the early part of the COVID-19 response, should no longer be used.

6.2 Older women

Some older women who are due, or became overdue in the last 6 months, for their final routine screen may have had limited opportunity to make that appointment due to COVID-19. These are women who are aged between 59 and 64 and they remain eligible to be tested.

Records should be carefully checked to ensure they have the opportunity to attend for this last routine screening test. Final non-responder lists can be used to help with this. Proactive contact could be made to check the woman's intentions in relation to her screening. Where there is any concern that the laboratory may not accept the test due to the age of the woman, the sample request should be marked as "test delayed due to COVID-19".

7. ADVICE FOR CERVICAL SAMPLE TAKER TRAINING PROVIDERS (COVID-19)

Screening training providers must look to restart training provision as soon as reasonably practicable where this can be safely achieved within current government guidance on travel and social distancing.

7.1 Initial theory training

Training providers must make sure their courses continue to meet programme standards. They must determine what interim measures can be put in place to restore training safely, and work with local commissioners to agree their plans for its provision. Alternative methods of delivery can be considered where this would not compromise the quality of training.

Points for consideration include:

- conduct risk assessments to facilitate safe training practices for essential classroom teaching and ensure that any identified risks are mitigated
- the use of virtual web-based platforms for the provision of online face to face teaching of the theoretical course content
- the limitations of an online meetings tool versus a specialist teaching tool when assessing delegates' understanding of course content
- make sure any online learning activity can run on all known supported web browsers, and that content has no software bugs or broken links
- the provision of clear guidance and instructions for course delegates, including what to do if they experience technical issues during any 'real-time' learning activity
- make sure that any changes to course provision remain in accordance with the requirements of the course accrediting organisation

7.2 Practical training

NHS Cervical Screening Programme – Sample Taking Initial Guidance during the coronavirus (Covid-19) pandemic Version 1.0 (6th April 2020)

Training course providers will need to extend, where necessary, their timeframes to enable individuals to attend and complete rescheduled courses and obtain the necessary clinical practice required. Initially, this would be for up to 6 months. Training providers will be required to review this on a case by case basis in light of evolving events.

To allow students already in training to time to complete the required elements of their clinical practice the training interval can be extended for up to one year to June 2021.

7.3 Cervical screening laboratory visit

A virtual tour should be provided where logistics permit; a laboratory presentation must be included in the theoretical course.

Note: If the laboratory is willing to undertake face to face visits, it is the laboratory's responsibility to carry out at risk assessment and to provide appropriate PPE.

7.4 Colposcopy visit for sample taker trainees

The training provider should ask their local colposcopy units if they are receiving visitors/trainees.

Any trainee who would feel uncomfortable visiting, even if allowed, should defer until a later date.

If a colposcopy unit is not able to offer a visit and the trainee has successfully completed all other elements of their clinical practice successfully completed their final assessment, they are deemed competent to take samples

The visit to colposcopy could be deferred until the local colposcopy service are able to facilitate this element of training at a safe time. This will not impact on the trainee's ability to continue to perform cervical screening.

A certificate of completed training would then be issued upon completion of the full education pathway.

Note: If the colposcopy unit is willing to undertake face to face visits it is the colposcopy unit`s responsibility to carry out a risk assessment and to provide appropriate PPE.

APPENDIX 1 - CHECKLISTS FOR RESTORING CERVICAL SCREENING SERVICES

The NHSEI Cervical Screening task and finish group, advised by PHE screening and clinical experts, has developed checklists to be used in conjunction with the prioritisation principles set out above to restore cervical screening in a consistent, planned and safe way.

Local screening providers will be asked to demonstrate that they have met essential quality and safety criteria and provide supporting documentation (where appropriate) which will include as a minimum:

- an implementation plan (including revised infection control measures taking account of COVID 19 disease)
- evidence of sign off of the plan by the provider's governance process

PHE's regional SQAS teams will provide advice to commissioners and providers on other relevant evidence that may be required for assurance purposes.

Within the checklists, "showstopper" questions covering the minimum quality and safety requirements are highlighted in **bold**. However, it is expected that plans will address all areas of the checklist. Plans should give indicative milestones and estimated dates when full recovery of the screening service is expected.

The process must be rigorous in identifying issues that may impact on screening programme safety. The tools developed by the NHSEI task and finish group include restoration guidance and the quality and safety questions in the checklists to aid provider planning.

Commissioners and SQAS will help to minimise the burden on local services of preparing for restoring the programme by liaising jointly and regularly throughout the process. Once completed, provider plans should be discussed at tripartite meetings between commissioners, SQAS and providers.

Commissioners are responsible for overseeing the restoration of screening services. SQAS will provide advice to providers and commissioners at all stages of the process. SQAS teams will assess restoration plans for completeness, safety and quality using a risk assessment process. This assessment will not include financial or contractual issues as these will be handled exclusively by commissioners. Any initial concerns or areas requiring further evidence will be discussed at the tripartite meetings and agreement reached on the actions required and which organisation will do what. The tripartite working at a local level is essential to the timely and safe restore of screening.

Commissioners will confirm with local services and SQAS whether sufficient assurance has been received for a safe restoration of services, or otherwise. Usual escalation routes will be utilised if required. Regional SQAS teams will provide support where needed during the restoration process. Regular monitoring and progress reports will be made within the usual regional reporting arrangements. The NHSEI cervical screening task and finish group will monitor progress nationally.

Governance

Governance arrangements for the restore process have been agreed with the NHSEI Section 7A Public Health Commissioning and Operations team nationally and with NHSEI regionally. The NHSEI strategic coordinating group will oversee the restore process. The NHSEI cervical screening task and finish group will monitor restoration of cervical screening services.

The process should be implemented regionally and be flexible enough to allow for local variations. Well established governance arrangements are already in place for the oversight of local screening services, ensuring delivery of high quality, safe, and equitable services. Wherever possible, these arrangements should be used to provide clear governance to reinstate screening safely. It is essential that there is a local agreement on tripartite working between screening programmes, SQAS and commissioners and that the important principles set out in this document are implemented.

Variation between local screening services identified within regions should be discussed with commissioners and heads of QA initially. If variation persists, SQAS and commissioners should escalate the issue via their usual routes to make sure no local service becomes an outlier in terms of restoring screening. Information on variation should also be reported to the NHSEI cervical screening task and finish group.

Colposcopy Checklist

1. **Does the service have sufficient staff to run a service in line with standard national screening guidance and assurance that staff will not be subject to redeployment?**

    a. leadership? (lead colposcopist and lead colposcopy nurse)
    b. sufficient colposcopists to run the service?
    c. sufficient nursing staffing to support the clinics? (one registered nurse and a second support nurse both trained in colposcopy for every clinic)
    d. clerical and secretarial staff for production of letters (appointment and results to patients and practices)?
    e. administration staff for colposcopy data collection, failsafe and production of national returns?

2. **Do you have suitable accommodation available which includes:**

    a. private area with changing facilities
    b. toilet facilities
    c. a specific room for colposcopy
    d. refreshment facilities
    e. separate waiting and recovery areas
    f. access for individuals with disabilities

3. **Do you have suitable equipment available, including PPE where needed?**

4. How many clinics a week are you able to run compared to normal?

    a. how many appointment slots can you provide each week?
    b. are there any limitations on the type of slots, eg assessment, treatment, follow up?

5. How many referrals are there in a backlog that need to be seen? Please split into:

    a. treatments
    b. colposcopy follow up appointments (patients already under colposcopy care prior to COVID-19)
    c. high grades+
    d. clinical urgent
    e. low grades
    f. other screening
    g. clinical non-urgent
    h. how many appointment slots can you provide each week?

6. If more referrals than you have capacity for are received after restore, what flexibility do you have to run extra clinics?

7. **Have you made any changes to clinic operation to reduce the risk of COVID-19 for patients and staff, such as longer clinic slots to allow for increased cleaning in between patients, social distancing in waiting rooms, restrictions on accompanying people?**

    If yes, what? and what is the impact?

8. **Are you able to run/re-establish your MDT at your normal frequency with all appropriate staff and equipment?**

9. Do you have a backlog of MDT discussion cases? If yes, how many and what is your plan for discussing these?

10. Have you changed anything in your service delivery in order to address potential inequalities?

    Groups of interest being those with:
    a. protected characteristics
    b. socioeconomic differences
    c. geographical variation
    d. under-served / vulnerable groups

11. Are your internal screening governance groups operational?

    a. cervical screening business meetings?
    b. colposcopy operational meetings

12. Has the HPV testing laboratory confirmed plans are in place for accepting cervical screening specimens?

13.a. Has the histology department confirmed plans are in place to manage specimen numbers increasing back to normal levels?

13.b. Is there sufficient staff at all levels within histology?

    a. leadership (lead pathologist)
    b. sufficient pathologists to run the service
    c. sufficient technical staff
    d. sufficient administrative staff

14. If more histology samples than pre-COVID are received during restoration, what flexibility does the histology service have to process and report increased workload?

15. Is there an internally approved restore plan available for discussion with NHSE/I and SQAS?

16. Any additional information / comments from the service

Cervical Screening Laboratory Checklist

1. Does the service have full HPV platform availability, including reagents and consumables and assurance that staff will not be subject to redeployment?

2. Does the service have sample processing capacity at levels each week that is comparable to normal pre-COVID levels?

3. Is specimen transport fully operational?

4.a. Does the service have sufficient staff at all levels on-site to run a service in line with standard national screening guidance?

a. leadership?
b. pathologists
c. biomedical scientists
d. screener/MLAs
e. administration

4.b. What specimen receipt and reporting capacity does this give you?

5. Has screening staff competency been updated, in line with national guidance?

   If not yet fully staffed, please comment on plan for assessing competence during restoration of services?

6. Do you have a backlog of HPV testing and/or screening samples?

   If yes, how many and what is the timeline for these being reported?

7. If more samples than you have capacity for are received during restoration, what flexibility do you have to process and report increased workload?

8. Are your internal screening governance groups operational?

    a. cervical screening business meetings?
    b. laboratory meetings

9. Has the HPV testing laboratory informed all colposcopy clinics and primary care of the plans to restore the accepting of cervical screening specimens?

10. Is there an internally approved restore plan available for discussion with NHSE/I and SQAS?

11. Any additional information / comments from the service