NHS Cervical Screening Cytology Services
January 2017

Introduction and purpose:

This paper aims to summarise and clarify the position in relation to current cytology backlogs in the cervical screening programme.

Factors relating to the pending HPV primary screening implementation are known to the cytology workforce in England and have meant that the specialty has been losing members and struggling to recruit in sufficient numbers. This has led to a loss in cytology capacity and some cytology services being too small to cope with any extra demands. Over the last five years there has been a decline in numbers of people enrolling in the mandatory cytology screening training course. No students have enrolled for 2016 course to date and only five students are enrolled in 2015, in comparison 36 students enrolled in cytology training in 2010.

NHS England and PHE issued a mitigation document in August 2016. The mitigation document is an interim solution to backlogs caused by the current national shortage of cytology capacity which is affecting the 14 day turnaround time in the cervical screening programme. **It is not the first stage of wider HPV primary screening implementation.**

Current initiatives to reduce TAT:

The 14 day turnaround time Vital Sign target is monitored on a monthly basis and is available to public health commissioning teams. In addition, screening public health teams will have contract monitoring in place for the laboratory component of the cervical screening pathway.

A number of options have always been available to address cytology backlogs, and many of these will already be in use. The options include:

1. Laboratories may offer staff overtime to increase cytology capacity if this is feasible

2. Cervical screening laboratories can enter into a provider-provider arrangement with laboratories with available capacity to deliver the screening via the existing s7a specification – cytology primary screening with HPV triage and test for cure. This would need to be subject to a clear Service Level Agreement and support from Public Health Commissioning Teams and PHE SQAS.
3. In addition, the HPV Primary screening model uses cytology as the triage test, when HR-HPV is detected. In the current HPV pilot sites only a proportion of their population (20-40%) are currently being screened with HPV Primary Screening. Increasing the proportion of their population screened using the HPV primary pathway by the existing HPV pilot sites will release cytology capacity to support backlogs from other Trusts, where these samples would undergo the cytology primary screening with HPV triage and test for cure.

**Process for current Pilot sites wishing to extend:**

HPV Primary Screening Pilot sites willing to extend primary screening within their population will need to:

i. Agree with public health commissioning teams on the additional population to be converted

ii. Work with Primary Care Support England to identify the correct cohort extension to the HPV Primary Screening population and ensure the correct system set up and patient information, invitation and result letters are sent.

iii. Provide sample taker training resources for any new HPV PS sites (GP practices and CASH services)

iv. Ensure any Colposcopy departments receiving HPV primary screening referrals have had suitable training on the HPV patient pathway and adequate colposcopy provision.

v. Take into account that once the HPV primary screening population is extended this cannot be reversed.

All options for addressing cytology backlogs must remain compliant with the programme standards. It is vital that Public Health Commissioning Teams and laboratory providers work closely to ensure the best service is provided to women eligible for the programme.

It important to note once there is an agreement of the HPV pilot sites to support a reduction of the backlog from another Trust, that backlog from another laboratory would continue to be screened using the conventional cytology model - HPV triage and test for cure, and would not be converted to HPV as a primary screen.

Currently only two of the six HPV Primary screening pilot sites have agreed to provide additional backlog capacity. Discussions are underway in 3 other pilot sites and it would be helpful if screening public health teams could progress these.

Providers which require help with their cervical screening capacity should work with Public Health Commissioning Teams and SQAS to agree a way forward in line with the mitigation process. The HPV programme will provide an implementation guide to sites once mitigation has been agreed, to assist the process.
Update on the National Implementation of HPV Primary Screening.

A separate piece of work to implement HPV primary screening is being undertaken via the national HPV implementation group chaired by Dr Anne Mackie. There are a wide variety of stakeholders on the group, including representatives from PHE and NHS England central and regions. The national rollout is currently planned for completion in 2019.

Implementing HPV as a primary screening test into the existing section 7a national cervical screening programme is highly complex and there are a number of variables that need to be considered. Whilst it is recognised that some providers will be keen to understand more about how they can bid to become a provider of HPV primary screening in the national rollout, initial steps still need to be completed to ensure that the implementation plan is safe, effective, and compliant with EU procurement rules.

To support the rollout plans an options appraisal has been commissioned, with the aim of identifying the best commissioning route and the laboratory configuration to support the delivery of a high quality service. The options appraisal will report in January 2017, the outcomes of which will be used by PHE, DH and NHS England for the integration of HPV primary screening to the section 7a national cervical screening programmes.

We would like to thank all of you for your continued commitment to providing a high quality cervical screening programme.

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PHE Director of screening

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FAQ’s:

Q. If cytology transfers to pilot sites, how does this affect colposcopy referral routes?
A. If cytology transfers to pilot sites, arrangements/ SOPs for direct referral to colposcopy will need to be established in advance of transfer.

Q. How could this impact on CCGs?
A. In areas where CCGs are funding colposcopy, a 4.2% increase in colposcopy activity will be considered a significant cost pressure. Heads of Public Health would need to flag this to CCGs.

Q. What is the guidance regarding IT systems and linking between sites?
A. If all cytology for HPV positive samples also transfers to the pilot sites, the importance of IT links between expanded pilot sites and local colposcopy sites (pathology, PAS) for failsafe is really important and will need to be in place before transfer.