Public Health England

NHS

Screening Quality Assurance visit report

NHS Bowel Cancer Screening Programme
Lancashire

28 and 29 November 2018

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About PHE Screening

Screening identifies apparently healthy people who may be at increased risk of a disease or condition, enabling earlier treatment or better informed decisions. National population screening programmes are implemented in the NHS on the advice of the UK National Screening Committee (UK NSC), which makes independent, evidence-based recommendations to ministers in the 4 UK countries.

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Executive summary

Bowel cancer screening aims to reduce mortality and the incidence of bowel cancer both by detecting cancers and removing polyps, which, if left untreated, may develop into cancer.

The findings in this report relate to the quality assurance visit of the Lancashire bowel cancer screening service held on 29 and 29 November 2018.

Quality assurance purpose and approach

Quality assurance (QA) aims to maintain national standards and promote continuous improvement in bowel cancer 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 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 the screening centre office
- information shared with the North regional SQAS as part of the visit process

Local screening service

The Lancashire programme provides bowel cancer screening services for the registered population of approximately 1.4 million people across 7 Clinical Commissioning Groups, Blackburn with Darwen, Blackpool, Greater Preston, Chorley and South Ribble, West Lancashire, East Lancashire and Fylde and Wyre.

Bowel cancer screening began in Lancashire in April 2008, inviting men and women aged 60 to 69 for faecal occult blood test (FOBt) screening. In April 2010, the service began extending the age range covered to 74. Bowel scope screening (BoSS) started in December 2013 inviting men and women aged 55.

Blackpool Teaching Hospitals NHS Foundation Trust hosts the screening centre at Blackpool Victoria Hospital (BVH). Lancashire Teaching Hospitals NHS Trust and East Lancashire Hospitals (ELH) NHS Trust are associated trusts.

Programme co-ordination and administration for FOBt and BoSS takes place at BVH. The FOBt screening programme runs 9 specialist screening practitioner (SSP) assessment clinics each week. These clinics cover a wide geographic area, providing access for individuals with abnormal screening results.

The following table identifies the hospital sites involved in providing the other elements of the bowel cancer screening programme (BCSP).

Trust/Site	Colonoscopy	BoSS	Pathology	Radiology
Blackpool Teaching Hospitals NHS Foundation Trust				
Blackpool Victoria Hospital	•	•	•	•
Lancashire Teaching Hospitals NHS Trust				
Royal Preston Hospital	•		•	
Chorley and South Ribble District Hospital	•	•		•
East Lancashire Hospitals NHS Trust				
Burnley General Hospital	•	•	•	•
Blackburn Royal Hospital				•

The screening programme hub, which undertakes the invitation (call and recall) of individuals eligible for FOBt screening, the testing of screening samples and onward referral of individuals needing further assessment, based in Rugby, is outside of the scope of this QA visit.

This is the third visit to the Lancashire programme. Previous visits took place in February 2012 and December 2014.

Findings

This centre offers screening to the second largest size population in the North of England. Despite its size the screening team have close working relationships and they work well together to deliver a service that meets or exceeds many key performance indicators and quality standards.

The screening service has staff in post for all key leadership roles. They have led the programme since the start, providing consistent and supportive leadership. The wealth of knowledge and experience that the team have will be invaluable to support the introduction faecal immunochemical testing (FIT) and the eventual reduction of the screening age to 50.

Since the last QA visit to the centre in 2014 all recommendations, except 1, have been completed.

Immediate concerns

The QA visiting team identified no immediate concerns.

High priority

The QA visit team identified 6 high priority findings, as summarised below.

1. The centre struggles to meet the acceptable threshold for diagnostic waits. There is insufficient capacity available to the meet demand and the process for managing clinical reviews is causing delays.
2. The centre has a significant backlog of BoSS participants waiting to be invited. At the time of the visit, approximately 6,100 participants had not been invited.
3. There are no signed service level agreements in place for 2018/19 between the host trust and ELH for the delivery of the programme
4. Two information governance issues require checking with the trust's information governance lead to ensure compliance with trust policy

The centre uploads copies of right patient right result and situation, background, assessment, recommendation (SBAR) documentation onto the internal shared drive

NHS.net is not routinely used for the transfer of patient identifiable information across trusts because the recipients do not always have secure email

5. The radiology guidelines for the use of imaging in the BCSP are not being adhered to in some cases due to the incorrect use of intravenous contrast for screening participants
6. There is a lack of radiology audits carried out across all sites

Shared learning

The QA visit team identified several areas of practice for sharing, summarised below.

1. The centre and the health promotion team should be extremely proud of their continued efforts to tackle inequalities in bowel cancer screening. The successful 'call for a kit' scheme has received funding for a further 2 years.
2. The administration team use a daily task sheet to ensure that all tasks are equally distributed and completed. This works well and encourages team work.
3. The weekend SSP on call service that is in place to cover weekend bowel scope lists has ensured that a more robust process is in place to cover lists at times of sickness
4. The large polyp multidisciplinary meeting (LPMDM) has enhanced patient care. A specialist team review each case to ensure the appropriate clinical management of these polyps. LPMDM audit results have shown good clinical outcomes for the patients.

5. The centre check the bowel screening system for histopathology and radiology results 3 times a day. This results in a quick turnaround time when providing procedural outcomes to patients.
6. The pathology turnaround times for the programme are excellent. 96% of samples were reported within 7 days from January to September 2018.
7. The information provided to patients about the computerised tomographic colonography procedure is comprehensive

Recommendations

The following recommendations are for the provider to action unless otherwise stated.

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority	Evidence required
1	Update and sign the bowel screening service level agreements (SLAs) between the host trust and East Lancashire Hospitals (ELH) for 2018/19	1	3 months	High	Updated SLA between the host trust and ELH
2	ELH only – complete and submit the outstanding associated trust questionnaires from the QA visit	1	1 month	Standard	Copy of the questionnaires
3	Add an index to the quality management system to include authors, reviewers and review dates	1	3 months	Standard	Copy of the index
4	Extend the distribution flow chart for the annual report (PROGMAN 08) to include senior management at all 3 trusts	2	3 months	Standard	Copy of the flow chart
5	The host trust and Lancashire Teaching Hospitals (LTH) should amend trust incident policies to include reference to managing screening incidents in accordance with ‘Managing Safety Incidents in NHS Screening Programmes’	3	6 months	Standard	Copies of the amended policies

No.	Recommendation	Reference	Timescale	Priority	Evidence required
6	All 3 radiology departments should establish a process to identify and report bowel cancer screening programme (BCSP) adverse events/incidents	1	3 months	Standard	Copy of protocol(s)
7	Develop a pathology audit programme across each pathology site	2	12 months	Standard	Copy of audit programme and minutes of 2 meetings where outcomes were discussed and any lessons learnt
8	Carry out audits of colorectal cancer resection pathology reports at each pathology site	5	12 months	Standard	Copies of audits from each site
9	Carry out dose and positive predictive value audits at each radiology site	4	12 months	High	Copies of audits from each site
10	Reinstate the monthly administration team meetings	1	6 months	Standard	Terms of reference (TOR), agenda and minutes of 2 meetings
11	Reinstate the monthly specialist screening practitioner (SSP) team meetings	1	6 months	Standard	Copies of the agenda and minutes of 2 meetings
12	Revise the BCSP governance meetings to ensure that all BCSP endoscopists (colonoscopists and bowelscopists) can attend	1	12 months	Standard	Copy of the TOR(s) and minutes of 2 meetings
13	Develop a system to ensure BoSS endoscopists receive the endoscopy report for any patient they refer on for colonoscopy	6	3 months	Standard	Confirmation from the clinical director that this system has been developed

No.	Recommendation	Reference	Timescale	Priority	Evidence required
14	The centre should use the results of the clinical review audit to refine the current policy to reduce any delays in the patient pathway	1	6 months	High	Copy of the policy
15	Include information in the right patient right results pathway about the management of piecemeal excision of sessile/semi-pedunculated adenomas and the impact on the surveillance pathway	1	3 months	Standard	Copy of the revised section of the pathway
16	Formalise the process for the monitoring of inactive open episodes and alerts on the bowel cancer screening system (BCSS)	1	3 months	Standard	Copy of updated standard operating procedure (SOP)

Infrastructure

No.	Recommendation	Reference	Timescale	Priority	Evidence required
17	Finalise the job descriptions (JD) for the programme manager and deputy programme manager (DPM) so they are no longer in draft format. BoSS screening duties need to be included in the JD for the DPM	1	6 months	Standard	Copies of the final JDs
18	Improve utilisation of endoscopy capacity at LTH to improve timeliness to colonoscopy and increase colonoscopists procedure numbers	1	6 months	High	6 months of diagnostic waiting times and colonoscopist procedure data

No.	Recommendation	Reference	Timescale	Priority	Evidence required
19	Ensure the capacity requirements at Burnley General Hospital meet the requirements of the population served	1	6 months	High	Six months of diagnostic waiting times by Clinical Commissioning Group
20	Formalise the arrangement for computerised tomographic colonography (CTC) cases to be reviewed by a reporter at Chorley and South Ribble Hospital when the single reporter at Blackpool Victoria Hospital (BVH) is absent	4	6 months	Standard	Copy of SLA for 2019/20 between the host trust and LTH with details of this arrangement included
21	Ensure that a) the current storage process for patient information on the internal shared drive at BVH and b) the transfer of patient identifiable information across trusts are compliant with trust information governance policy	7	3 months	High	Written confirmation detailing the outcome(s) and feedback from the discussions with the host trust information governance team

Pre-diagnostic assessment

No.	Recommendation	Reference	Timescale	Priority	Evidence required
22	Ensure the clinic site information provided to patients (via the programme hub) is clear and contains all the necessary information	1	6 months	Standard	Confirmation from the lead SSP
23	Revise the work instruction for changing participants' demographics to include all relevant systems and paperwork	1	6 months	Standard	Copy of the revised work instruction

No.	Recommendation	Reference	Timescale	Priority	Evidence required
24	Revise the BCSP letter task work instruction for administrators to ensure that participants receive all system generated letters	1	3 months	Standard	Copy of the revised work instruction
25	Update the existing SOP for participants who require translation and interpretation services to ensure that the appropriate BCSP literature is sent to the participant in the required language, in advance of the SSP clinic appointment. The SOP should include updating interpreter requirements on BCSS	1	6 months	Standard	Copy of the revised SOP

The screening test – accuracy and quality

No.	Recommendation	Reference	Timescale	Priority	Evidence required
26	Update the bowel scope roll out plan (to incorporate how the backlog in invitations will be met) and reflect changes in an updated capacity and demand plan	6	3 months	High	Copy of the updated bowel scope rollout and capacity and demand plans

Diagnosis

No.	Recommendation	Reference	Timescale	Priority	Evidence required
27	Establish a process to ensure that: a) all BCSP CTC referrals are clearly identified b) intravenous contrast (IV) is not given unless indicated c) administration/non-administration of IV contrast is recorded accurately on all CTC reports	4	6 months	High	Copy of audit demonstrating that all processes are embedded into practice
28	Lead pathologist and site leads to address the variation of reporting of serrated lesions within their departments	5	12 months	Standard	Screening quality assurance service to review data at 12 months
29	Cancers should be reported according to the latest Royal College of Pathologists (UK) guidelines	5	12 months	Standard	Confirmation from the 3 pathology site leads that this is happening

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.