Public Health England

Protecting and improving the nation's health

Screening Quality Assurance visit report

Peterborough and Hinchingbrooke NHS Bowel Cancer Screening Programme

Executive summary

6 September 2018

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Screening identifies apparently healthy people who may be at increased risk of a disease or condition, enabling earlier treatment or 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. PHE advises the government and the NHS so England has safe, high quality screening programmes that reflect the best available evidence and the UK NSC recommendations. PHE also develops standards and provides specific services that help the local NHS implement and run screening services consistently across the country.

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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 Peterborough and Hinchingbrooke bowel cancer screening service held on 6 September 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 shared with the Midlands and East regional SQAS as part of the visit process

Local screening service

The Peterborough and Hinchingbrooke Bowel Cancer Screening service provides bowel cancer screening services for an eligible screening population of 604,000 across 62 general practices covered by the Cambridge and Peterborough Clinical Commissioning Group.

The Peterborough and Hinchingbrooke Bowel Cancer Screening Service started inviting men and women aged 60 to 69 years of age for faecal occult blood test (FOBt) screening in July 2009. In May 2013 the screening service extended the age range invited up to 74. Bowel scope screening (BoSS) began inviting men and women aged 55 to Peterborough City Hospital in December 2016. The first bowel scope list took place in March 2017.

The service is delivered over 2 sites at Peterborough City Hospital and Hinchingbrooke Hospital. The 2 Trusts merged in April 2017. This should be positive for the bowel

screening service as it should remove the potential barriers associated with 2 separate organisations working together.

Hinchingbrooke Hospital is where programme co-ordination and administration for FOBt and bowel scope takes place. Specialist screening practitioner (SSP) pre-assessment clinics, colonoscopy and computed tomography colonography (CTC) radiology services for bowel screening patients are provided at both Peterborough Hospital and Hinchingbrooke Hospitals. All bowel screening pathology is provided at the laboratory at Peterborough. Bowel scope screening lists take place at Peterborough. Plans to extend bowel scope to Hinchingbrooke are on hold at present.

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

Findings

The service has undergone significant challenges since the last QA visit with its expansion to encompass the provision of bowel scope screening, the loss of long-serving staff, the merger of the 2 Trusts and changing management structures along with difficulties with accreditation and recruitment. The team has been working hard to maintain a service for patients, but these issues and chronic understaffing have severely affected waiting times for patients and the roll out of bowel scope. It is to the credit of staff, that standard clinical outcome measures are being achieved despite these significant issues.

Due to the focus on maintaining the basic service and the lack of staff, there is an absence of appropriate governance structures across the whole service. Substantial work is also required to improve team leadership, communication and working relationships. It is essential to have active engagement from all professional areas involved with the bowel cancer screening programme.

It is important for service quality to have comprehensive systems to ensure the full multi-disciplinary team is engaged and well informed. The sharing of performance, audits, patient satisfaction and issues across the team will help improve learning and enable service improvement.

Significant improvement is required as a matter of urgency to meet the national standards and guidance. This will need corporate Trust support and a creative approach to staffing. SQAS will re-visit the service in the next 12 months to assess progress.

The QA visit team identified 2 immediate concerns. A letter was sent to the chief executive on 7 September 2018 asking that the following items were addressed within 7 days:

- establish an action plan to define lead bowel cancer screening programme (BCSP) management roles and establish a comprehensive BCSP governance structure
- investigate and address all outstanding alerts of the bowel cancer screening system and put in place a daily checking process

A response was received within 7 days. The recommendation to develop an action plan in relation to lead roles and the governance structure is complete. The recommendation in relation to the outstanding alerts is incomplete and further evidence has been requested.

High priority

The QA visit team identified 8 high priority findings as summarised below:

- the roles and responsibilities of the screening director, programme manager and lead SSP are not clearly defined
- effective BCSP meeting, escalation and accountability structure including detail of escalation routes for governance and performance issues is not in place
- how programme performance issues are escalated and managed within the Trusts' governance procedures are not documented
- there is no system whereby programme-wide audit, performance data, incidents and adverse events can be shared and discussed by the whole multi-disciplinary team
- there is no BCSP strategic action plan which includes a 2 year capacity and demand plan
- there is insufficient staff across the programme and not all required activities and tasks (FOBt and BoSS) are taking place
- effective cross-cover arrangements for endoscopists are not in place to avoid cancelling lists
- the BCSP SSP office is not secure at all times to protect confidential information

Shared learning

The QA visit team identified several areas of practice for sharing, including:

- creation of a post graduate certificate in CTC offered in conjunction with University of Suffolk and demonstrable commitment to radiographer continued professional development
- a monthly CTC team meeting at Peterborough to discuss cases and share learning

- a priority identification system in pathology to identify BCSP participants and a BCSP pathologist on the rota every day to ensure rapid reporting
- 6 monthly turnaround time audit in place within pathology
- internal review of pathology cases sent to the expert board to share learning

Recommendations

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

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
1	Establish an action plan to define lead bowel cancer screening programme (BCSP) management roles and establish a comprehensive BCSP governance structure	2 and 3	7 days	Standard	Action plan including timelines and the individuals responsible for each element
2	Define and document the roles and responsibilities of the screening director, programme manager and lead specialist screening practitioner (SSP) such that all necessary activities take place	2 and 3	3 months	High	Job descriptions and standard operating procedures (SOPs) describing roles and responsibilities and how the roles work together
3	Nominate a deputy lead BCSP radiologist, incorporating cross cover for reporting	2 and 3	3 months	Standard	Submit email with nominated individual's name and contact details
4	Develop an effective BCSP meeting, escalation and accountability structure including detail of escalation routes for governance and performance issues	2 and 3	3 months	High	SOP and terms of reference, agendas and schedules for each meeting to be convened

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
5	Document how programme performance issues are escalated and managed within the Trusts' governance procedures	2 and 3	3 months	High	Detailed governance structure showing escalation within each Trust
6	Develop a system where programme-wide audit, performance data, incidents and adverse events can be shared and discussed by the whole multi-disciplinary team	2 and 5	6 months	High	Provide full details of the arrangements in place, including copies of meeting papers and attendees
7	Deliver the BCSP strategic action plan which includes a 2 year capacity and demand plan	3	3 months	High	Action plan including a capacity and demand plan
8	Develop an annual report and present it at an appropriate Trust governance group	2 and 3	3 months	Standard	Copy of report and minutes of meeting where it was presented
9	Update Trust incident policies to include the up to date reference to managing screening incidents in accordance with "Managing Safety Incidents in NHS Screening Programmes"	2 and 5	6 months	Standard	Revised policy for the Trust
10	Ensure that all staff working in the BCSP are aware of incident and adverse event (AVI) processes and document arrangements	2 and 3	3 months	Standard	Written confirmation of update of staff training in incident and AVI processes Updated BCSP incident/ AVI SOP covering faecal occult blood testing (FOBt) and bowel scope
11	Assess completeness of clinical AVI capture, including A&E admissions	2, 3 and 5	3 months	Standard	Copy of SOP and results of assessment

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
12	Put in place a risk management process	2 and 3	3 months	Standard	Risk management SOP
13	Put in place an annual audit schedule covering all professional areas involved in the BCSP including arrangements to share and implement the learning	2 and 3	3 months	Standard	Copy of audit schedule, lead for each audit and minutes of the meeting where it was ratified
14	Establish a system to obtain, investigate and analyse feedback from colonoscopy, computed tomography colonography (CTC) and bowel scope participants	2	3 months	Standard	Copy of SOP(s), including audit of patient feedback data entry quality and agreed feedback forms
15	Establish procedures to manage telephone messages to enable learning and service improvement	11	3 months	Standard	Copy of SOP and evidence of audit
16	Ensure office cover is available for patients covering core hours	2 and 3	3 months	Standard	Copy of staffing cover over core hours
17	Implement a comprehensive quality management system (QMS) and establish a non-conformance log and ensure all staff are aware	2 and 3	6 months	High	Copy of overarching QMS document, index and example procedures, non-conformance log and written evidence of staff training about QMS
18	Document all administration activities on both sites and include in the QMS	2 and 3	6 months	Standard	SOPs to reflect all administration activities

Infrastructure

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
19	Undertake a programme staffing capacity assessment and ensure suitable administration, SSP and clinical staffing is in place to cover all required activities and tasks (FOBt and bowel scope)	2 and 3	3 months	High	Staffing summary as part of the service's capacity and workforce plan, detailing intended recruitment, timescales and training
20	Ensure all SSPs have professional development opportunities in line with revalidation requirements	2	12 months	Standard	Details of arrangements in place
21	Ensure all SSPs have undertaken advanced communication skills training	2	6 months	Standard	Confirmation
22	Develop a BCSP-specific induction programme for SSP and administrative staff	2 and 3	3 months	Standard	Copy of induction documentation
23	Put in place effective cross-cover arrangements for endoscopists to avoid cancelling lists	2 and 3	3 months	High	Copy of SOP
24	Ensure the BCSP SSP office is secure at all times to protect confidential information	4	3 months	High	Confirmation office has been secured appropriately
25	Update Trust IT systems to be able to correctly record bowel scope procedures	2 and 3	3 months	Standard	Confirmation system has been updated

Pre-diagnostic assessment

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
26	Demonstrate that national waiting time standard for waiting times to SSP assessment and response rate following abnormal screening test are met	2 and 9	6 months	High	Sustained achievement of waiting time targets and details of changes made
27	Audit the reasons why individuals with abnormal FOBt tests do not proceed to colonoscopy	2 and 9	3 months	High	Audit of reasons for non-attendance at colonoscopy and evidence of action taken
28	Implement the use of episode notes to record additional clinical information	2 and 3	3 months	Standard	Copy of SOP
29	Document all SSP activities on both sites to ensure consistent practice and include in the QMS	2 and 3	6 months	Standard	Copies of SOPs
30	Investigate and address all outstanding alerts of the bowel cancer screening system (BCSS) and put in place a daily checking process	10	7 days	Standard	Completion of audit and copy of SOP
31	Establish a regular BCSS data accuracy audit	2	3 months	Standard	Copy of the completed data accuracy audit
32	Put in place arrangements so that clinical reviews are always undertaken by a BCSP colonoscopist	11	3 months	Standard	Copy of SOP

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
33	Establish a consent procedure to include assessing and managing patients with leaning difficulties or withdrawal of consent	2, 3 and 7	3 months	Standard	Copy of consent SOP

The Screening Test – Accuracy and Quality

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
34	Put in place processes to increase the efficiency of bowel scope lists	2 and 7	3 months	Standard	Copy of SOP
35	Document all bowel scope activities and incorporate within the QMS	2 and 9	6 months	Standard	Copy of SOPs related to bowel scope, including management of clinician performance

Diagnosis

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
36	Demonstrate that national waiting time standard for colonoscopy is met	2 and 9	6 months	High	Sustained achievement of waiting time targets and details of changes made

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
37	Document local clinical management arrangements	2 and 3	6 months	Standard	Copy of SOPs for management of large colonic polyps, patients taking anticoagulation/ antiplatelet medication and the management of clinical performance
38	Audit the endoscopic management of large colonic polyps and the clinical pathways of BCSP patients with benign pathology at surgery	2	6 months	Standard	Copy of audit reports and evidence of action taken
39	Update all BCSP CTC documentation to encompass both hospital sites, including patient information	2, 3, 5 and 10	6 months	Standard	Copies of clinical and patient documentation(including updated information on acute glaucoma) encompassing both sites and including the procedure for identification and action on AVIs and incidents
40	Ensure CTC reporting formats encompass all required BCSS radiology fields and are the same at both sites	10	3 months	Standard	Copy of reporting format for each sites
41	Ensure reporting numbers per radiologist and CTC audits encompass both sites	2 and 10	6 months	Standard	Reporting numbers and CTC audits encompassing both sites
42	Audit 6 to 9mm polyps identified through BCSP CTC	6 and 10	6 months	Standard	Copy of the audit

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
43	Audit the rate of high grade dysplasia in BCSP cases	6 and 10	3 months	Standard	Copy of the audit

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/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.

Appendix A: References

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