Public Health England

Quality Assurance visit report

St Mark's Bowel Cancer Screening Centre

10 June 2016

Public Health England leads the NHS Screening Programmes

About Public Health England

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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 four UK countries. The Screening Quality Assurance Service ensures programmes are safe and effective by checking that national standards are met. PHE leads the NHS Screening Programmes and hosts the UK NSC secretariat.

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Executive summary

The findings in this report relate to the quality assurance (QA) review of the St Mark's Bowel Cancer screening programme held on 10 June 2016.

1. Purpose and approach to quality assurance

The aim of quality assurance in NHS screening programmes is to maintain minimum 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 is derived from the following sources:

- routine monitoring data collected by the NHS screening programmes
- data and reports from external organisations as appropriate
- evidence submitted by the provider(s), commissioner and external organisations as appropriate
- Information shared with the London regional QA service as part of the visit process

2. Description of local screening programme

The St Mark's Bowel Cancer Screening Programme (the programme) has an eligible screening population of approximately 112,663. Black, Asian and minority ethnicities (BAME) populations make up over 50% of Brent population, just under 50% of Harrow population, 40% of Ealing population and 25% of Hillingdon population. The largest single ethnic population within all boroughs is of Indian origin.

The programme is delivered by St Mark's Bowel Cancer Screening Centre at St Mark's Hospital (SMH) and is commissioned by NHS England (London) locality team.

The programme is hosted by London North West Healthcare NHS Trust (LNWH) providing endoscopy and pathology services at St Mark's Hospital, and a computed tomographic colonography (CTC) service at Northwick Park Hospital (NPH) with CTC administration and reporting taking place at St Mark's Hospital.

St Mark's Hospital was the pilot site for bowel scope screening and has now rolled out bowel scope screening to 85% of its screening population with only 65% of the Hillingdon population remaining.

The management of pathology laboratory was transferred to The Doctors Laboratory with clinical provision provided by London North West Healthcare NHS Trust in May 2012.

There was a trust merger between North West London Hospitals NHS Trust and Ealing Hospital NHS Trust to form London North West London Healthcare NHS Trust on 1 October 2014. There are also future plans for clinically integrating the two endoscopy departments in Ealing and St Mark's Hospital.

3. Key findings

The St Mark's Bowel Cancer Screening Programme is delivered by an excellent team with very strong leadership.

Whilst the programme has seen an increase in activity over the last few years, the facilities have not evolved to accommodate the workload. This is evident in the endoscopy unit. Within CTC radiology, patient dignity and safety issues were identified and raised as areas of immediate concern. Adequate capacity and infrastructure need to be in place for the future in order to maintain service delivery and performance.

There was evidence of old equipment which needs to be replaced. However, there was no clear plan for equipment replacement.

The dedicated programme manager is undertaking the role of endoscopy manager to oversee the operational running of the endoscopy unit. This was due to end in June 2016. If the decision is to extend this support, the trust needs to ensure that a dedicated programme manager is in post to fulfil the bowel screening national standard.

The governance structure between the Director of Screening and the management team within The Doctors Laboratory needs to be strengthened to ensure when issues arise they are escalated and managed in a timely manner.

The quality of colonoscopy is extremely high, with all colonoscopists performing well above the target for all performance-related key performance indicators

The quality of audits presented at this visit need some improvements and an annual audit schedule needs to be developed.

An audit on CTC scan quality demonstrates that a high quality of CTC examinations are performed by the radiology service.

The proportion of first test referrals to CTC within the BCSP appears high with a recent increase in CTC referrals noted. This requires an audit to ensure appropriate referrals are being made.

There was evidence of a good quality management system with good standard documentation.

The immediate and high priority issues are summarised below as well as areas of shared learning.

3.1 Shared learning

The review team identified several areas of practice that are worth sharing:
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- good leadership across the teams
- high performing unit with high standards of endoscopy
- good mentorship of their bowel scope screening (BoSS) endoscopists
- good communication with team meetings held every morning between administrative staff, assistant screening practitioners (ASP) and specialist screening practitioners (SSP) to highlight issues from the previous day, plan the current day and sharing any alerts
- good training courses offered in CTC for radiologists and radiographers
- good standard of paperwork within the CTC department and standard operating procedures are well designed and robust
- high quality of SSP service within the unit aided by excellent support from ASPs
- good standard of pathology reporting

3.2 Immediate concerns for improvement

The review team identified three immediate concerns in relation to the CTC facilities, which compromised patient dignity, had the potential to breach patient confidentiality and increase the risk to patient safety. A letter was sent to the Chief Executive on 14 June 2016, asking that the following issues were addressed as a matter of priority within seven days:

- patient safety: to undertake an immediate risk assessment on patient supervision during early morning CTC appointments
- patient dignity and confidentiality/capacity: to implement an interim resolution and develop a long term plan to improve capacity and facilities taking into account patient dignity and confidentiality

A response was received within seven days, which reassured the Quality Assurance review team that the identified risks had been mitigated and no longer posed an immediate concern.

3.3 High priority issues

The review team identified four high priority issues as grouped below:

- capacity and infrastructure issues within endoscopy and radiology requires addressing to ensure service delivery and performance are maintained
- screening service requires a dedicated programme manager for the screening programme in post with sufficient support of a deputy manager
- governance structure to be reviewed to ensure there are links in place between The Doctors Laboratory (TDL) and Director of Screening
- endoscopy equipment to be reviewed to ensure there is an appropriate maintenance and replacement plan

3.4 Key recommendations

A number of recommendations were made related to the immediate and high-level issues identified above. These are summarised in the table below.

Level	**Theme**	**Description of recommendation**
Immediate	Patient safety	Undertake an immediate risk assessment on patient supervision during early morning CTC appointments
Immediate	Capacity/Facilities	Implement an interim resolution and develop a long term plan to improve capacity and facilities for CTC taking into account patient dignity and confidentiality
High	Leadership	Identify a dedicated programme manager for the screening programme with sufficient support of a deputy manager

High	Governance	Establish a clear governance structure between TDL and the Trust for the management of risks. Invite representatives from TDL to attend the quarterly governance meeting at least once a year
High	Capacity/ Facilities	Increase endoscopy capacity to enable the service to be maintained in light of future changes
High	Equipment replacement	Undertake a review of the endoscopy equipment and ensure that there is an appropriate maintenance and replacement plan
High	Audit	Undertake an audit on reason for delays between first offered and actual CTC test identifying any service improvements required to minimise delays

For more information on expected timeframe for completion of recommendations, please see page 8.

3.5. Next steps

St Mark's Bowel Cancer Screening Centre is responsible for developing an action plan to ensure completion of recommendations contained within this report.

NHS England (London) locality team will be responsible for monitoring progress against the action plan and ensuring all recommendations are implemented.

The regional screening QA service will support this process and the ongoing monitoring of progress.

Recommendations table

Compiled in priority order.

No	Recommendation	Timescale	Evidence required to demonstrate completion
8.2	Implement an interim resolution and develop a long term plan to improve capacity and facilities for CTC taking into account patient dignity and confidentiality	7 days	Written confirmation
8.3	Undertake an immediate risk assessment on patient supervision during early morning CTC appointments	7 days	Outcome of risk assessment
7.1	Identify a dedicated programme manager for the screening programme with sufficient support of a deputy manager	3 months	Written confirmation
7.2	Establish a clear governance structure between TDL and the Trust for the management of risks. Invite representatives from TDL to attend the quarterly governance meeting at least once a year	3 months	Governance Structure and Terms of Reference/Minutes
8.5	Provide a workforce, clinical capacity and sustainability plan for radiology	3-6 months	Workforce, clinical capacity and sustainability plan
8.6	Undertake a review of the endoscopy equipment and ensure that there is an appropriate maintenance and replacement plan	3 months	Written confirmation
10.4	Establish a robust quality control mechanism for slides produced by the pathology laboratory	3 months	Standard Operating Procedure
7.3	Implement a version control numbering system that enables changes to SOPs to be tracked during the year. Reflect this within SOP 010 as well as apply to all documents	3-6 months	Standard Operating Procedure

7.4	Update relevant SOPs/WI with the escalation process for outcomes from the 30 day patient satisfaction questionnaires	3-6 months	Standard Operating Procedure/Work Instruction
8.4	Establish sufficient pathology administrative support to assist in reporting and auditing	3-6 months	Written confirmation
9.2	Undertake an audit on reason for delays between first offered and actual CTC test identifying any service improvements required to minimise delays	3-6 months	Audit
10.1	Produce a revised screening centre audit schedule including pathology and CTC audits and review the format of audits to include commentary and outcomes	3-6 months	Audit Schedule/Example of an audit
10.2	Undertake an audit on waiting times and clinical indications for CTC in BCSP referrals to CTC radiology. Include audit within screening centre audit schedule	3-6 months	Audit
10.3	Produce a SOP outlining the provision of Picolax preparation for patients who have a contraindication to iodinated oral contrast preparation for CTC to ensure compliance with NPSA alert on oral bowel cleansing agents	6 months	Standard Operating Procedure
11.2	Establish a process to ensure that the second list, performed by one colonoscopist, is only used when other lists are full	3-6 months	Standard Operating Procedure/Capacity Plan
11.1	Distribute colonoscopy workload evenly to ensure all colonoscopists are achieving the national standard (minimum of 150 per annum)	6 months	Audit

11.3	Undertake an audit investigating the discrepancy between pathology data provided by BCSS and the pathology department to identify if all specimen reports are regularly entered onto BCSS. The outcome of the audit should be submitted to QA	6 months	Audit
8.1	Plan for an increase in endoscopy capacity to enable the service to be maintained in light of future changes	6-12 months	Written confirmation
7.5	Undertake an annual audit of the patient satisfaction questionnaires to identify trends and learnings	12 months	Audit
8.7	Attendance by BCSC radiology lead to screening centre management meetings at least twice a year to ensure good communication, update on service developments and report CTC outcomes	6-12 months	Minutes
9.1	Undertake a 12 month audit of CTC referrals to identify reasons for increase in referral rate	12 months	Audit