Public Health England

NHS

Screening Quality Assurance visit report

NHS Bowel Cancer Screening Programme South of Tyne

14 and 15 February 2017

Public Health England leads the NHS Screening Programmes

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health, and are a distinct delivery organisation with operational autonomy to advise and support government, local authorities and the NHS in a professionally independent manner.

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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

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 (QA) visit of the South of Tyne screening service held on 14 and 15 February 2017.

Purpose and approach to quality assurance (QA)

Quality assurance 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.

The PHE screening quality assurance service (SQAS) carry out QA visits.

The evidence for this report comes from the following sources:

- routine monitoring of 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 North regional SQAS

Description of local screening service

The South of Tyne (SoT) programme provides bowel cancer screening services for an eligible screening population of 684,906 across Gateshead, South Tyneside, Sunderland and a small part of Durham. The Clinical Commissioning Groups (CCGs) covered by the centre include Newcastle Gateshead, South Tyneside, Sunderland and Durham Dales, Easington and Sedgefield.

The SoT programme started in February 2007 inviting men and women aged 60 to 69 years of age for the faecal occult blood test (FOBt) screening. In January 2010, the screening service extended the age range covered to 74. Bowel scope screening (BoSS) began in March 2013 inviting men and women aged 55.

Gateshead Health NHS Foundation Trust (GHFT) hosts the screening centre. The associated trusts are City Hospitals Sunderland (CHS) and South Tyneside NHS Foundation Trust (STFT). Programme co-ordination and administration for FOBt and BoSS takes place at Queen Elizabeth Hospital (QE) in Gateshead. FOBt colonoscopy is carried out at QE, SouthTyneside District Hospital (STDH) and Sunderland Royal

Hospital (SRH). Pathology is carried out at QE. Radiology is carried out at QE and STDH. BoSS services are also provided at QE and STDH.

The screening programme Hub 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 is based in Gateshead and is outside the scope of this QA visit.

Findings

There is evidence of service improvement in all areas of the programme since the last QA visit in May 2013. The service should also be congratulated on being the first programme in the country to roll out BoSS.

The service has an open and transparent culture of sharing learning from incidents. They also actively promote research and audit, both of which have helped the programme ensure they deliver a high quality and safe service.

A robust quality management system underpins the whole patient pathway and this includes a ‘right results to right patient’ policy.

The screening centre covers a large, mainly urban, deprived population. The service employs a part-time health improvement practitioner who is proactive in promoting the programme. Uptake across the four CCGs is above the 52% standard.

Immediate concerns

The QA visit team identified no immediate concerns.

High priority

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

- SLA between screening programme host trust and associated trusts should be signed by all trusts
- Sunderland Royal Hospital JAG accreditation is required for full roll-out of bowel scope and delivery of the FOBt programme
- Adverse Incident (AVI) and screening incident (SI) policy requires updating of SQAS contact names, addresses and reference documents
- clinical leads should have secure nhs.net to nhs.net email address to deal with clinical queries, adverse incidents, and patient identifiable information
- vacancies for SSPs should be advertised and recruited to as soon as possible
- QE radiographers should access mandatory training courses in CTC technique

- improve STDH waiting arrangements for CTC to provide a comfortable, quiet area for patients to relax and recuperate after a procedure
- QE to adopt the BCSP reporting template for radiology

Shared learning

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

- the service use a non-conformance book where administration and SSP staff are encouraged to record minor events or errors and these are shared at the weekly team meeting to continuously improve the service
- the service have a comprehensive audit schedule. This includes unusual, but important, audits eg the filing of BCSP letters in associated trust medical records, and an audit of associated trust endoscopy sites
- as part of the GHFT's implementation of 'making every contact count' the programme gives a 'healthy bowel pack' to all screening patients who require no further follow up
- both QE and STDH radiology departments have participated in regional audits on radiation dose and CTC diagnostic performance
- there is a centralised pathology service for the programme that processes all histopathology from the three FOBt sites

Table of consolidated recommendations

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

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
1	SLA between screening programme host trust and associated trusts should be signed by all trusts	2 and 5	3 months	H	Signed SLA
2	Sunderland Royal Hospital JAG accreditation is required for full roll-out of bowel scope and FOBt programme	5	3 months 12 months	H	Regular updates to commissioners and QA on progress JAG accreditation
3	The Clinical Director and Lead Colonoscopist should have clearly defined job descriptions which specifically outline their duties	5	3 months	S	Copy of the job descriptions
4	Adverse Incident (AVI) and screening incident (SI) policy requires updating of SQAS contact names, addresses and reference documents	2 and 5	1 month	H	Updated AVI/SI policy
5	Clinical leads should have secure nhs.net to nhs.net email address to deal with clinical queries, adverse incidents, patient identifiable information	5	3 months	H	Confirmation of nhs.net email accounts for the CD and lead colonoscopist from Programme Manager

Infrastructure

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
6	Vacancies for SSPs should be advertised and recruited to as soon as possible	5	6 months	H	Confirmation re staff appointments
7	STDH radiographers should access mandatory training courses in CTC technique	11	12 months	H	Written confirmation by Radiology Services Manager at STDH
8	Confirmation required on which pathologists will continue to report BCSP work	5	12 months	S	Participation in BCSP EQA
9	Central photocopier used by all teams poses a confidentiality risk. Each team requires secure log in	5	12 months	S	Update photocopy log in
10	Improve STDH waiting arrangements for CTC to provide a comfortable, quiet area for patients to relax and recuperate after a procedure	11	12 months	H	Written confirmation by STDH Radiology Clinical Director
11	Improve QE waiting arrangements for CTC to provide a comfortable, quiet area for patients to relax and recuperate after a procedure	11	12 months	S	Written confirmation by Radiology Services Manager at QE
12	QE upgrade radiology information system to allow second author reporting	11	3 months	S	Written confirmation by Radiology Services Manager at QE
13	QE to adopt the BCSP reporting template for radiology	11	1 month	H	Written confirmation by Deputy Radiology lead

Pre-diagnostic assessment

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
14	SSPs should have clinical advice and support for patients attending all trusts	5	6 months	S	Minutes weekly meetings x 3 showing clinical attendance

The screening test – accuracy and quality

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
15	BoSS scopers not regularly scoping and meeting standard should either cease or undertake a further period of mentorship followed by re-accreditation	12	6 months	S	Evidence of ceasing or mentorship/re-accreditation

Diagnosis

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
16	Regular clinical meetings to discuss key performance indicators, standards, AVIs and SIs should take place	5	6 months	S	Schedule of meetings, agenda and 2 x minutes of meeting
17	Continue to monitor reportable incidents eg perforations. Ensure documented discussions take place with clinicians who are outliers in clinical performance eg comfort scores	5	6 months	S	Evidence discussion at clinical meetings on KPIs and reportable events

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
18	Coherent large polyp pathway, agreed by all colonoscopists in the centre	5	3 months	S	A copy of final agreed large polyp pathway
19	Develop deputy clinical director role with 0.5PA allocated to a Gateshead based consultant to provide additional clinical support for the programme	4 and 5	6 months	S	Job plan for new deputy CD role
20	QE to offer completion contrast enhanced staging CTC examinations for BCSP patients	11	3 months	S	Written confirmation by Deputy Radiology lead
21	Reduce delay in requesting CTC examinations	9	6 months	S	Written confirmation by programme manager
22	Repeat audit of colorectal cancer specimen lymph node yields and proportion of N1 cases	5	12 months	S	Copy of audit
23	All pathologists should have attended a recognised BCSP continuous professional development event in the preceding three years	5	12 months	S	Attendance at regional study day

*

I = Immediate. H= High. S = Standard.

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 following the issuing of the final report. 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.