Public Health England

NHS

Screening Quality Assurance visit report

NHS Bowel Cancer Screening Programme Bolton

8 May 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-leading 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 4 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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Contents

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 Bolton bowel cancer screening service held on 8 May 2017.

Purpose and approach to 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 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 as part of the visit process

Description of local screening service

In February 2007, the Bolton screening service started inviting men and women aged 60 to 69 years of age for faecal occult blood test (FOBt) screening. In October 2010, the service extended the age range covered to 74. Bowel scope screening (BoSS) began in May 2015 inviting men and women aged 55.

Bolton NHS Foundation Trust (BFT) hosts the screening centre at the Royal Bolton Hospital (RBH). Salford Royal NHS Foundation Trust (SRFT) and Wrightington, Wigan and Leigh NHS Foundation Trust (WWLFT) are associated trusts, as they provide BoSS lists.

Programme co-ordination and administration for FOBt and BoSS takes place at RBH. RBH also provides all colonoscopy, radiology and pathology services for the programme. The FOBt screening programme runs on average 6 specialist screening practitioner (SSP) assessment clinics each week (at RBH, Wigan health centre, Salford Energise, Bolton One, Leigh health centre). These clinics cover a wide geographic area, providing access for individuals with abnormal screening results.

The BoSS programme is still rolling out to the population. At this time, 48% of GP practices have gone live, equating to 4 lists per week performed at RBH (1 list), Leigh Infirmary (LI) (2 lists) and Salford Royal Hospital (SRH) (1 list).

The population invited for screening is from Bolton, Salford and Wigan Borough Clinical Commissioning Groups (CCG).

The screening centre covers a significant proportion of the Greater Manchester (GM) population, which has varying levels of deprivation. The Bolton CCG population is particularly ethnically diverse, including the largest Indian community in the north west of England. The GM Health and Social Care Partnership commission a health promotion team employed by Pennine Care NHS Foundation Trust (PCFT) to undertake initiatives to improve uptake in the programme. The GM screening programmes work closely with the team to support targeted work. Uptake for the FOBt element of the programme in 2016 was 56.5%. Just below the national average of 57.9%.

Findings

Immediate concerns

The QA visit team identified no immediate concerns.

High priority

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

- backfilled colonoscopy lists need more even distribution to enable all colonoscopists to achieve the minimum standard of 150 procedures per year
- the programme requires more consultant pathologists to cover the BCSP workload
- the SSP team require a sufficient number of laptops to enable live data entry
- a standard operating procedure needs to be written for the management of BCSS, clinical alerts to action, incomplete datasets and inactive episode reports, in a timely fashion
- the commissioner and provider should work together to increase the number of approved colonoscopy sites for the screening centre
- endoscopy nurses who support BCSP lists need to be able to provide competent assistance with polypectomy and haemostatic techniques

Shared learning

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

- the programme has a quarterly team meeting they call their ‘QA meeting’ that has a good rate of attendance across all disciplines and staff groups, where they openly discuss performance data and review adverse events and incidents
- joint endoscopy and BCSP governance meetings provide the opportunity for issues to be raised and dealt with quickly and helps with the planning of extra colonoscopy lists when faced with increased demand
- the host trust has, from the very start of the programme, provided great support and encouragement to the screening centre
- the lead SSP ensures that all SSPs have the opportunity to attend the advanced communication course facilitated by the Christie NHS Foundation Trust
- there is a comprehensive policy governing the management of complex polyps which includes discussion at a large polyp MDT meeting and referral to a tertiary centre if appropriate
- the radiology department manages to record all elements of the BCSP radiology minimum data set
- prioritisation of BCSP work resulting in excellent pathology turnaround times in spite of staff shortages

Table of consolidated recommendations

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
1	Programme manager and lead SSP should continue to work together to further develop the operational policy. SOPs that underpin screening centre processes should be updated and incorporated into the policy	2	6 months	S	Copy of the updated operational policy
2	Develop a SOP for the reporting of adverse events/incidents and ensure it is available to all staff and sites and details how learning will be shared	2	3 months	S	Copy of the SOP
3	Develop and implement a regular data accuracy audit of the patient questionnaire data entered on to BCSS	2	6 months	S	2 separate sets of audit data to demonstrate the audit is embedded in practice
4	Develop a SOP to encompass the requesting, storage, monitoring and supply of bowel preparation	2	6 months	S	Copy of the SOP
5	Audit cases sent to surgery for benign lesions	2	6 months	S	Copy of the audit
6	Audit the CTC radiation dose of 100 cases from 2016, to compare the doses of BCSP CTC to symptomatic cases (non-contrast versus post IV contrast)	3	6 months	S	Copy of the audit
7	Ensure all colorectal cancer polyps are double reported and produce an audit to verify this	4	6 months	S	Copy of the audit
8	Produce a consultant level audit of the reporting of colorectal cancers, assessing the criteria as stipulated by the RCPath dataset for colorectal cancer reporting	4	12 months	S	Copy of the audit

Infrastructure

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
9	Update administrative team job descriptions to cover all relevant BCSP and BoSS duties	5	6 months	S	Copy of updated job descriptions
10	Ensure that backfilled colonoscopy lists are more evenly distributed to enable colonoscopists to achieve the annual 150 procedures minimum standard	2	12 months	H	4 quarterly reports submitted to SQAS breaking down colonoscopist numbers and lists
11	Allocate sufficient time in the lead radiologist job plan for the relevant responsibilities (suggested to be 0.25 - 0.5 DCA)	6	12 months	S	Written confirmation from the lead radiologist
12	Ensure the lead pathologist job plan includes reference to BCSP duties and responsibilities Individual pathologist job plans to include reference to BCSP commitment	4	6 months	S	Copy of both job plans
13	Address the shortage of consultant staff in the pathology department	4	12 months	H	Written confirmation from the lead pathologist
14	Ensure all reporting pathologists attend at least 1 BCSP related educational event in a 3 year period	4	12 months	S	Certificate of attendance
15	Ensure the SSP team have sufficient laptops to enable live data entry	7	3 months	H	Confirmation from the lead SSP that sufficient additional laptops are in operation

Pre-diagnostic assessment

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
16	Introduce signage at the Leigh clinic site to help participants locate the SSP clinic room	2	6 months	S	Confirmation from the lead SSP that a sign is in place
17	Audit individual SSP/clinic site conversions to colonoscopy	2	6 months	S	Copy of the audit
18	Develop a SOP for managing BCSS clinical alerts to action incomplete datasets and inactive episode reports in a timely fashion	2	3 months	H	Copy of the SOP

Diagnosis

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
19	Commissioner and provider to work together to increase the number of colonoscopy sites available to the programme	8	12 months	H	Minutes of meetings that show progress towards additional colonoscopy site approval Additional site application forms
20	Ensure endoscopy nurses supporting BCSP lists are familiar with polypectomy and haemostatic techniques and able to provide competent assistance	8	6 months	H	Confirmation from the matron and/or endoscopy training lead that endoscopy nurses are familiar with the techniques

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
21	Ensure all local screening colonoscopist expertise is used before referral to a tertiary centre for complex polypectomy	2	12 months	S	Centre to monitor referrals to the tertiary centre and provide an update to the SQAS
22	Extend the current SOP that ensures a timely turnaround time for histology results to include CTC turnaround management, or develop a separate SOP	3	3 months	S	A copy of the SOP
23	Introduce template reporting of biopsy adenomas and resection cases	4	6 months	S	3 sample reports

Referral

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
24	Develop a SOP detailing roles and responsibilities to ensure the timely completion of the cancer audit dataset	2	6 months	S	Copy of the SOP and the dataset completion report

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.

The 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.