Public Health England

NHS

Screening Quality Assurance visit report NHS Bowel Cancer Screening Programme

Leicester Bowel Screening Centre

23 March 2017

Public Health England leads the NHS Screening Programmes

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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 Leicester screening service held on 23 March 2017.

Purpose and approach to QA

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

Description of local screening service

The Leicester Bowel Cancer Screening Service split from the Leicestershire, Northamptonshire and Rutland (LNR) Bowel Cancer Screening service and started inviting men and women aged 60 to 69 years of age for faecal occult blood test (FOBt) screening in February 2014. The split followed national guidance that to prepare for the expansion of bowelscope screening individual services should not cover a population greater than one million.

Prior to the split, the University Hospitals of Leicester NHS Trust (UHL) provided colonoscopy clinics only. In June 2012, the LNR screening service extended the age range up to 74. Bowelscope screening began in December 2014, inviting men and women aged 55.

UHL hosts the screening centre at Glenfield Hospital where programme co-ordination and administration of FOBt and bowelscope screening takes place, along with FOBt colonoscopy and bowelscope. UHL NHS Trust is partnered with Leicester,

Leicestershire and Rutland (LLR) Alliance to provide bowelscope screening at community sites in Loughborough, Melton Mowbray and shortly extending to Market Harborough. Specialist screening practitioner (SSP) assessment clinics for individuals with abnormal screening tests are held at Glenfield Hospital and at the Melton Mowbray and Loughborough LLR Alliance sites. Histopathology reporting for FOBt and bowelscope is undertaken at the Leicester Royal Infirmary laboratory. Computerised tomography colonoscopy (CTC) takes place at Glenfield and Leicester General Hospitals.

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

- the invitation (call and recall) of individuals eligible for FOBt screening
- the invitation of individuals eligible for bowelscope screening
- the testing of screening samples
- onward referral of individuals needing further assessment

The population invited for bowel screening is from Leicester City, West Leicester and East Leicester and Rutland Clinical Commissioning Groups (CCGs), covering 54 GP practices. The eligible population is 961,060 (Office of National Statistics 2016). In 2016, the screening Hub sent 70,307 invitations for FOBt screening to 60 to 74 year olds with 1,126 definitive abnormal FOBt results. 487 kits have been returned from individuals over 75 years who self-referred in 2016. To date, there have been 5,816 bowelscope attendances.

The population profile across Leicestershire is mixed. The health and life expectancy of people covered by Leicestershire county CCGs (West and East Leicester and Rutland) is better than the England average. Whereas, this is lower for the population covered by the Leicester City CCG. Early deaths from all causes for men and women are higher than the England average in the Leicester City. Leicester City CCG has a black and ethnic minority population of 49.5% and includes one of the most deprived districts in England. Whereas, the county CCGs are amongst the 20% least deprived authorities in England.

Findings

Since the last QA visit, the bowel screening service has undergone significant change. The service is to be congratulated for establishing itself as a new centre, starting bowelscope screening and being one of the first sites in the country to be near full roll-out of bowelscope to its local population.

There is evidence of ongoing service improvement in all areas of the programme since the last visit along with a proactive approach to audit and review. There are effective

day-to-day cross-site working arrangements with LLR Alliance and within the Trust. This is shown by the use of facilities across a wide geography covered to deliver bowel screening and bowelscope services. This improves access for the population.

The service consistently meets and exceeds the expected standards across a range of key performance indicators (KPIs). Notably, adenoma detection rates (ADR) are high which means that the service is good at finding polyps with the potential to become cancerous. The uptake of screening is consistently high. 58% of the population attend FOBt screening compared with the national standard of 52%. There is enthusiastic involvement in health promotion, which encourages continued high uptake.

There are clear accountability and leadership arrangements for the bowel cancer screening service within UHL with evidence of constructive input from Trust management.

The move to ‘cost per case’ funding developed with the NHS England commissioners will encourage the service to maximise screening attendance and is a funding model that has scope for roll out elsewhere.

Immediate concerns

The QA visit team identified one immediate concern. A letter was sent to the chief executive of University Hospitals of Leicester NHS Trust on 28 March 2017 asking that this was addressed within 7 days:

- ensure that all transfer of confidential electronic patient identifiable data between hospital sites is secure **(R9)**

Confirmation was received on 29 March 2017 that assures the QA visit team that confidential electronic transfers between all LLR Alliance and hospital Trust sites are sent and received in accordance with Trust policy and screening programme guidance.

High priority

The QA visit team identified 4 high priority findings as summarised below:

- there is no document to describe the services and responsibilities of the LLR Alliance for the BCSP **(R1)**
- a detailed two year demand and capacity plan for FOBt is not in place **(R4)**
- there is a need to document in more detail the capturing, investigating, reporting and closure of adverse events (AVIs) in the programme **(R6)**
- appropriate translation services for bowel screening patients are not in place **(R7)**

Shared learning

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

- delivery of clinics at a number of community sites for bowelscope screening enables greater access to services for the population and the geography covered
- cost per case contracting arrangements developed with commissioners incentivises the service to maximise screening attendance
- annual service audit meeting is in place
- introduction of a Trust-wide screening committee to improve governance arrangements and share learning and issues common to all screening programmes
- flexibility to provide ad hoc additional screening lists to meet demands
- involvement in a wide variety of health promotion activities including development of a bowelscope learning disabilities DVD
- development of a range of nursing roles within the service which provides a wide range of skills and greater flexibility for the service
- development of a national assistant screening practitioner (ASP) training course in collaboration with the national Bowel Cancer Screening Programme (BCSP)
- live clinical data entry is in place at all sites
- offer of patient choice of male/female nurse endoscopist for bowelscope screening
- comprehensive mentorship of clinical endoscopists which provides ongoing support and performance review
- establishment of a virtual multi-disciplinary team (MDT) to enable discussion of complex clinical cases
- all staff in the endoscopy room are encouraged to view the screen and highlight any polyps or adenomas noted during the procedure which increases the likelihood of identifying potentially abnormal tissue
- British Medical Journal award nomination for the BCSP CTC service
- pioneering the use of non-medical reporting in pathology

Table of consolidated recommendations

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
1.	Document and agree the services provided by Leicestershire, Leicester and Rutland (LLR) Alliance to University Hospital of Leicester (UHL) for faecal occult blood test (FOBt) and bowelscope screening	4 and 5	3 months	High	Develop a service level agreement (or equivalent) between UHL and LLR Alliance compliant with national service specifications 26 and 26A, detailing: • responsibilities of each party for service provision, site accreditation and adequate equipment provision • governance and escalation arrangements • accountability and communication
2	Ensure all professional areas are represented by a lead or deputy at BCSP quarterly and annual meetings	4 and 5	6 months	Standard	Minutes of 2 quarterly meetings demonstrating attendance from each professional area
3	Establish regular feedback of audit findings from all professional areas in quarterly and annual multi-disciplinary meetings	4 and 5	12 months	Standard	Minutes of meetings demonstrating presentation of audits from all professional areas
4	Develop a detailed 2 year FOBt demand and capacity plan alongside the workforce plan	4 and 5	3 months	High	Updated 2 year demand and capacity plan for FOBt screening showing forward planning for projected population increases and fluctuations

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
5	Establish a system to routinely present the annual report to a high-level Trust clinical governance committee	4 and 5	6 months	Standard	Copy of annual report and evidence of presentation at relevant Trust screening and governance committees
6	Document a service-wide standard operating procedure (SOP) for capturing, recording, investigating and closing all adverse events (AVIs)	9 and 10	3 months	High	Finalised SOP
7	Secure translation services for bowel screening patients	4 and 5	3 months	High	Confirmation of translation service provision

Administration and data

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
8	Establish a full quality management system (QMS) encompassing FOBt and bowelscope screening, including a non-conformance process, updated right results audit and QMS audit schedule	6	12 months	Standard	• confirmation of who is responsible for managing the QMS • contents page for the QMS listing all SOPs and work instructions • example SOPs for management of open datasets and computer system alerts, right results pathways and recording of pathology data on the computer system • non-conformance record • right result audit • QMS audit schedule • staff QMS awareness training

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
9	Ensure that all electronic transfers of patient identifiable data between hospital sites is secure	7 and 8	7 days	Immediate	Confirmation that all confidential emails between LLR Alliance and hospital Trust sites are sent and received in accordance with Trust policy
10	Establish a tracking system for medical records going on and off site	7 and 8	3 months	Standard	Revised SOP detailing arrangements for tracking of medical records between all sites (UHL and LLR Alliance)

Pre-diagnostic assessment

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
11	Establish a patient group direction (PGD) for bowel preparation that covers all hospital sites	12	3 months	Standard	PGD

Diagnosis

No.	Recommendation	Reference	Timescale	Priority *	Evidence required

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
12	Improve the system for identification and tracking of BCSP CTC cases to ensure report turnaround times are within national standards	14	3 months	Standard	Revised protocol and evidence of achievement of national standards
13	Meet national standard timescales for reporting BCSP pathology specimens	4, 5, 6 and 17	6 months	Standard	Monthly turnaround times indicating percentage of BCSP pathology cases reported within 7 days
14	Ensure that all pathologists reporting BCSP cases meet national standards for participation in the BCSP EQA	4, 6 and 17	12 months	Standard	Proof of participation in 2 of 3 BCSP EQA rounds for each pathologist

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.