Public Health England

NHS

Screening Quality Assurance visit report

NHS Bowel Cancer Screening Programme
Cheshire

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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 Social Care, and a distinct delivery organisation with operational autonomy. We provide government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific and delivery expertise and support.

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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 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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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 visit of the Cheshire bowel cancer screening service held on 28 and 29 June 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 collected during pre-review visits to the screening centre office and radiology department at Leighton Hospital, and the radiology and pathology departments at Countess Of Chester Hospital
- information shared with the North regional SQAS as part of the visit process

Local screening service

The Cheshire programme provides bowel cancer screening services for the registered population of approximately 750,000 people across 4 Clinical Commissioning Groups, Eastern Cheshire, South Cheshire, Vale Royal and West Cheshire.

The screening service started in 2007 as Cheshire and Merseyside, inviting men and women aged 60 to 69 of age for faecal occult blood test (FOBt) screening. The service split in 2009 and Cheshire became a standalone service. In February 2013, the service began extending the age range covered up to age 75. Bowel scope screening (BoSS) started in 2014 inviting men and women aged 55.

Mid Cheshire Hospitals NHS Foundation Trust hosts the screening centre at Leighton Hospital. The Countess of Chester Hospital NHS Foundation Trust and East Cheshire NHS Trust are associated Trusts.

Programme co-ordination and administration for FOBt and BoSS takes place at Leighton Hospital. The FOBt screening programme runs 4 specialist screening practitioner (SSP) assessment clinics each week. These clinics cover a wide geographic area, providing access for individuals with abnormal screening results.

Leighton, Countess of Chester Hospital (CoCH) and Macclesfield District General Hospital (MDGH) provide colonoscopy and radiology services. BoSS takes place at Leighton, CoCH and Victoria Infirmary Northwich. CoCH provide the pathology reporting service for the programme.

The screening programme hub, which 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, based in Rugby, is outside of the scope of this QA visit.

This is the third visit to the Cheshire programme. Previous visits took place in 2011 and 2015.

Findings

Since the last QA visit in 2015, there have been staffing changes to 2 of the key leadership roles, the clinical director (CD) and programme manager. Having these roles filled, along with the lead SSP, means the service is now more stable and cohesive. This is important for the team as they plan for the implementation of the new faecal immunochemical test later this year. The service has worked very hard to deliver bowel scope and consistently meet, or exceed, the majority of key performance indicators and quality standards.

Immediate concerns

The QA visiting team identified no immediate concerns.

High priority

The QA visit team identified 5 high priority findings as summarised below:

- two information governance issues require checking with the Trust's information governance lead to ensure compliance with Trust policy:

  a) the centre stores copies of medical notes at the BCSP office which can be accessed via alternative hospital systems

  b) NHS.net is not routinely used for the transfer of patient identifiable information across Trusts, for example, pathology reports are sent via fax machine

- key meetings both between the bowel cancer screening programme leadership team, and the wider team are irregular and attendance from people in other Trusts is difficult - opportunities for developing consistent approaches, improving communication, learning and sharing are not maximised
- there are no signed service level agreements in place for 2018/2019 between the host Trust and the 2 associate Trusts for the delivery of the programme
- there is a lack of radiology audits carried out across all sites
- the current dual system for managing administration needs simplifying into one user friendly system

Shared learning

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

- a clear process is in place to monitor the inactive episodes and alerts on the bowel cancer screening system
- this ensures proactive, consistent and timely pathway management
- engagement from the SSP team in health promotion activities is impressive and a local health promotion strategy is in place
- embedded into practice, and embraced by the whole SSP team, is the method of live data entry into the SSP assessment dataset
- the pathology department provides a gold standard for audit of all its work with a monthly lookback on a proportion of its specimens and re-reporting
- at MDGH there is a clear pathway for referrals for computerised tomographic colonography in patients who have failed colonoscopy

Recommendations

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

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority	Evidence required
1	Governance arrangements for the screening and immunisation operational group, quality and safety assurance group and programme boards need to be clarified	1	3 months	Standard	Terms of reference (ToR) for the meetings
2	The centre should produce a ToR for the operational programme board to include functions, membership, frequency and standard agenda items for the meetings	1	3 months	Standard	Copy of ToR
3	Update and sign the bowel screening service level agreements (SLAs) between the host Trust and the 2 associate Trusts for 2018/2019. SLAs to include how the Trusts deal with programme risks and the escalation processes	1	3 months	High	Updated SLAs between the host Trust and associate Trusts
4	Provide site specific reports for Trust management at the associate Trusts to enable the monitoring of performance issues at each site	2	3 months	Standard	Copy of the first performance reports

No.	Recommendation	Reference	Timescale	Priority	Evidence required
5	Ensure the clinician level reports for the business review committee meetings are anonymised or that clinicians have agreed for their data to be shared	2	3 months	Standard	Copies of the revised performance reports or written confirmation that all clinicians agree to individual performance data being shared
6	Establish regular meetings between the 3 Trusts involved in the delivery of Cheshire bowel cancer screening programme (BCSP)	1	6 months	Standard	Written confirmation by the host Trust that these meetings have taken place
7	Ensure the clinical director (CD) has sufficient protected time to carry out CD and lead colonoscopist responsibilites	1	3 months	Standard	Written confirmation from the CD and Trust management that this protected time is in place
8	Establish regular meetings between the CD, lead specialist screening practitioner (SSP) and clinical nurse manager (CNM) to oversee the general management and development of the service	2	6 months	High	Confirmation from the CD that these meetings are taking place regularly
9	Define the roles and responsibilities for the lead SSP and CNM, to identify and agree specific duties and responsibilities for both posts	2	3 months	Standard	A list of agreed roles and responsibilities for lead SSP and CNM. Written confirmation that this information has been shared and understood by the BCSP team

No.	Recommendation	Reference	Timescale	Priority	Evidence required
10	Reinstate the weekly team brief meetings	2	3 months	High	Written confirmation from CNM and lead SSP that these meetings have been reinstated
11	Improve teleconferencing facilities so that all the BCSP team can attend meetings	2	3 months	High	Written confirmation that teleconferencing facilities are available to all the BCSP team
12	Ensure the lead radiologist is aware of adverse events/incidents that happen at all sites offering computerised tomographic colonography (CTC)	2	3 months	Standard	Written confirmation from CNM and lead SSP that a notification process is in place
13	Ensure all post colonoscopy bleeds reported to SQAS since 2015 are recorded accurately within the investigation dataset. All members of the team must be aware of their responsibility in the reporting process	2	3 months	Standard	Written confirmation from lead SSP that cases have been checked and are correctly recorded. Minutes from team meeting where this matter has been discussed. Updated standard operating procedure (SOP) (if required)
14	Develop and implement a regular data accuracy audit of the patient questionnaire data entered on to the bowel cancer screening system	2	6 months	Standard	2 separate sets of audit data to demonstrate the audit is embedded in practice

No.	Recommendation	Reference	Timescale	Priority	Evidence required
15	Countess of Chester Hospital (CoCH) department only: Implement consultant level audits showing the standard parameters of colorectal cancer reporting	3	12 months	Standard	Copies of audits
16	Carry out dose and a positive predictive value audits at each radiology site	4	12 months	High	Copies of audits from each site
17	Develop one system to support administration, SSP and clinical work functions that is accessible and used by the whole team	2	6 months	High	Written confirmation from CNM and lead SSP. Copy of user guide index to include a list (index) of the available documents plus authors, reviewers and review dates
18	Amend the clinical pathways, policies and SOPs to ensure consistency and adherence to national guidance. (A separate list will be provided to the lead SSP)	2	6 months	Standard	Copies of updated documents that have been ratified

Infrastructure

No.	Recommendation	Reference	Timescale	Priority	Evidence required
19	Revise the administration, lead SSP and SSP job descriptions to reflect the roles required within the bowel scope element of the service	2	6 months	Standard	Copies of revised job descriptions
20	Revise the CNM job description to include SSP duties	2	6 months	Standard	Copy of revised job description
21	Ensure cross cover is in place for colonoscopy lists at CoCH and Macclesfield District General Hospital (MDGH) when the local screener is absent	2	6 months	Standard	Written confirmation from CD that cross cover arrangements are in place
22	Update the bowel scope capacity and demand plan to reflect the current and planned bowel scope workforce and the backlog	5	6 months	Standard	Copy of updated capacity and demand plan
23	Allocate sufficient time in the lead radiologist job plan for the relevant responsibilities	6	6 months	Standard	Copy of revised job plan
24	Ensure that a) the current storage process for patient information at Leighton and b) the transfer of patient identifiable information across Trusts via methods such as fax machine, are compliant with Trust information governance policy	7	3 months	High	Written confirmation detailing the outcome(s) and feedback from the discussions with the host Trust information governance team

Pre-diagnostic assessment

No.	Recommendation	Reference	Timescale	Priority	Evidence required
25	Update the existing SOP for participants who require translation and interpretation services to ensure that the appropriate BCSP literature is sent to the participant in the required language, in advance of the SSP clinic appointment. The SOP should include updating interpreter requirements on the bowel cancer screening system	2	6 months	Standard	Copy of the revised SOP
26	Formalise the process for the clinical assessment of participants who are of uncertain fitness for colonoscopy	2	3 months	Standard	Written confirmation detailing the arrangements for medical review. 4 examples of SBAR forms signed off by the CD
27	Develop a SOP/policy to cover the provision of general anaesthetic within the service	2	6 months	Standard	Copy of the ratified SOP/ policy

The screening test – accuracy and quality

No.	Recommendation	Reference	Timescale	Priority	Evidence required
28	Ensure that the designated mentors for new bowel scope sigmoidoscopists have undertaken the appropriate training	8	6 months	Standard	Evidence of appropriate mentorship training for designated mentors

Diagnosis

No.	Recommendation	Reference	Timescale	Priority	Evidence required
29	Ensure all colonoscopists screening within Cheshire BCSP achieve the minimum requirement for colonoscopies performed	2	6 months	Standard	SQAS to monitor on bowel cancer screening system
30	Ensure that the decision to refer to a tertiary centre for complex polypectomy is agreed by consensus	2	6 months	Standard	Evidence of BCSP cases being discussed at polyp multi-disciplinary team meeting
31	Ensure that BCSP CTC referrals at Leighton can be easily identified	4	6 months	Standard	Written confirmation from lead radiologist that a new system has been developed
32	Put in place a patient group direction (PGD) at MDGH for radiologists and SSPs so they can issue gastrografin to screening participants	4	6 months	Standard	Copy of PGD

No.	Recommendation	Reference	Timescale	Priority	Evidence required
33	Update the CTC referral pathways and SOPs at all sites	4	3 months	Standard	Written confirmation from lead radiologist that documents have been reviewed and ratified
34	Lead pathologist to address the variation of reporting of hyperplastic lesions and sessile serrated lesions within the department	3	12 months	Standard	Department to provide data to SQAS

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.