Public Health England

NHS

Screening Quality Assurance visit report

NHS Bowel Cancer Screening Programme
Harrogate, Leeds and York

18 and 19 March 2019

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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 (QA) visit of the Harrogate, Leeds and York bowel cancer screening programme (HLY BCSP) held on 18 and 19 March 2019.

Quality assurance purpose and approach

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.

QA visits are carried out by the PHE screening quality assurance service (SQAS).

The evidence for this report comes from:

- 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 at Kingswood Surgery, Harrogate, the pathology departments at Harrogate District Hospital (HDH), Leeds General Infirmary (LGI) and York District Hospital (YDH) and the radiology walkthroughs at St James University Hospital (SJUH) and YDH
- information shared with the North regional SQAS as part of the visit process

Local screening service

The HLY BCSP provides screening services for an eligible screening population of 191,520 and a registered population of 1,362,937 across Harrogate, Leeds and York. The Clinical Commissioner Groups covered by the centre include Harrogate and Rural District, Leeds and Vale of York.

The HLY BCSP started in June 2009 inviting men and woman aged 60 to 69 years of age for faecal occult blood test (FOBt) screening. In January 2015, the service extended the age range covered to 74. Bowel scope screening (BoSS) began in December 2016, inviting men and women aged 55.

Harrogate and District NHS Foundation Trust (HDFT) hosts the HLY BCSP. Leeds Teaching Hospitals NHS Trust (LTHT) and York Teaching Hospital NHS Foundation

Trust (YTHFT) are associated providers. The centre has a contract with a private provider, Westcliffe Health Innovations Ltd (Eccleshill Treatment Centre), for BoSS.

Programme co-ordination and administration for FOBt screening and BoSS takes place at HDH. The following table identifies the hospital and health centre sites involved in providing the BCSP.

Service provided as part of the BCSP						
Trust/Site	Admin	SSP	Colon	BoSS	Radiology	Pathology
Harrogate and District NHS Foundation Trust						
Harrogate District Hospital	•		•	•		•
Kingswood Surgery		•				
Leeds Teaching Hospitals NHS Trust						
Leeds General Infirmary			•			
St James University Hospital					•	•
York Teaching Hospital NHS Foundation Trust						
York District Hospital			•		•	•
New Selby War Memorial Hospital		•				
Westcliffe Health Innovations (Private Provider)						
Eccleshill Treatment Centre				•		
Community Health Care Sites						
Parkside Community Health Centre, Leeds		•				
Armley Moor Health Centre, Leeds		•				
East Leeds Health Centre, Leeds		•				
Oakwood Medical Centre, Leeds		•				
Tower Court (York Medical Group)		•				

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, is based in Gateshead and is outside the scope of this QA visit.

Findings

Since the last QA visit in 2015 there have been significant staffing changes to 2 of the key leadership roles and the wider BCSP team, with many new staff joining the administration and specialist screening practitioner (SSP) workforce. There is now a dedicated programme manager in place and 2 lead SSPs, who have separate oversight for FOBt and BoSS screening. Strengthening the clinical leadership at the centre and clarifying the roles and responsibilities of the BSCP management team is vital for the team as they plan for the implementation of the new faecal immunochemical test this year.

HLY is a large centre, providing a screening service across 3 trusts, involving 3 endoscopy units, plus 1 further unit for BoSS. Despite its size, the service has worked very hard to deliver both screening programmes, and consistently meet, or exceed most key performance indicators and quality standards.

Since the last QA visit to the centre in 2015 all recommendations were signed off as complete in June 2018.

Immediate concerns

The QA visit team identified no immediate concerns.

High priority

The QA visit team identified 4 high-priority findings, as summarised below.

1. There are no signed service level agreements in place for 2019 to 2020 between the host trust and the 2 associate trusts for the delivery of the programme.
2. The centre struggles to meet the 90% acceptable threshold for diagnostic waits. There is insufficient capacity available to the meet demand and the process for managing clinical reviews is causing delays
3. The programme lacks clinical leadership as there is no dedicated lead colonoscopist for the centre.
4. SJUH have not met the 90% achievable standard for pathology turnaround times for the past 3 years due to staffing shortages within the department.

Shared learning

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

- the introduction of a daily review of the bowel cancer screening system (BCSS) alerts and development of a failsafe report, which is communicated to the SSPs by the administration team, allowing timely management of the patient pathway
- the team have worked hard to develop a comprehensive quality management system, with the review of standard operating procedures taking place annually or as practice changes
- SJUH is an accredited computerised tomographic colonography (CTC) training centre. The department reports 92% of scans within 7 days and most scans are double reported
- all radiologists at SJUH use the proforma for reporting CTCs, resulting in comprehensive data on BCSS
- all 3 pathology departments audit colorectal cancer resection reporting and have achieved the targets for lymph node yield, serosal infiltration and vessel space invasion. Audit results are shared with each laboratory for learning

Recommendations

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

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority	Evidence required
1	Provide a site-specific report for trust management at the associate trusts to enable the monitoring of performance issues at each site	3	3 months	Standard	Copy of the first performance report
2	Ensure the provider performance report presented at the programme board is anonymised, or that named clinicians have agreed for their data to be shared	3	6 months	Standard	Copy of the revised performance report or written confirmation that all clinicians agree to individual performance data being shared
3	Signed service level agreements (SLAs) between the host and the associate sites for 2019 to 2020 need to be in place. SLAs to include QA standards and key performance indicators	1 and 2	3 months	High	Copies of SLAs between the host trust and associate trusts
4	The centre, in conjunction with the commissioner, should develop an action plan to reduce screening inequalities	3	6 months 12 months	Standard	a) Action plan update at programme board b) Copy of action plan

No.	Recommendation	Reference	Timescale	Priority	Evidence required
5	The centre should ensure they meet the diagnostic test waiting times standard by; a) working with the endoscopy units at the associate sites to ensure there is sufficient capacity b) ensure the timely management of participants who require clinical review	 1 3	 12 months 6 months	 High High	 Sustained achievement of diagnostic waiting time standard Copy of policy
6	Ensure Leeds General Infirmary (LGI) and York District Hospital (YDH) achieve Joint Advisory Group (JAG) accreditation	3	a) 6 months b) 12 months	Standard	a) Action plan for both sites and progress monitored at programme board b) Copy of JAG certificate
7	Define the responsibilities for the programme manager (PM), general manager and operational director to agree duties for the delivery of the service	3	3 months	Standard	Confirmation from the operational director of the agreed responsibilities
8	Produce terms of reference (TOR) for the weekly and quarterly operational meetings to reflect function and governance	3	3 months	Standard	Copy of the TORs
9	Revise the job descriptions (JDs) for PM and lead administrator to reflect current duties and organisational structure (submitted as evidence for GOV 01)	3	6 months	Standard	Copies of revised JDs
10	Appoint a centre-wide lead colonoscopist	3	3 months	High	Confirmation that a lead colonoscopist has been appointed
11	Define the roles and responsibilities for the clinical director (CD), lead colonoscopist and site specific endoscopy leads	3	3 months	Standard	Confirmation from the CD of agreed roles and responsibilities. Confirmation this information has been shared with the team

No.	Recommendation	Reference	Timescale	Priority	Evidence required
12	Update the standard operating procedure (SOP) for adverse events and incidents to ensure processes are in place for feedback of outcomes and lessons learnt	3	3 months	Standard	Copy of the SOP
13	Update the existing audit plan to reflect how the information is used and who the recipients are. The centre should reinstate audits not carried out in 2018	3	6 months	Standard	Updated copy of the audit plan including confirmation that audits have been carried out
14	St James University Hospital (SJUH) and YDH should develop audit schedules to include 1) polyp and cancer detection rates per radiologist, 2) dose and 3) a positive predictive value audits per site	5	12 months	Standard	Copy of audit results from both departments

Infrastructure

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
15	SJUH should ensure that they are meeting the QA standard for pathology turnaround times	1	12 months	High	Sustained achievement of the pathology turnaround time standard
16	Lead radiologist should have dedicated BCSP activity in their job plan sufficient to meet the requirements of the role	1	6 months	Standard	Confirmation from lead radiologist
17	Harrogate District Hospital (HDH) should procure further endoscopes to prevent equipment delays during screening lists	1	6 months	Standard	Confirmation of procurement

Pre-diagnostic assessment

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
18	All specialist screening practitioners (SSP) should have direct observation of procedure skills (DOPs) undertaken in clinic and be assessed as competent at breaking bad news	3	6 months	Standard	Evidence of DOPs
19	Revise the SOPs covering clinical advice and patients who are unfit for colonoscopy	3	3 months	Standard	Updated SOP

The screening test – accuracy and quality

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
20	Ensure that BoSS lists at HDH run on time	1 and 2	6 months	Standard	Update from CD or PM

Diagnosis

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
21	Develop a system to ensure that screening colonoscopists receive regular data about their key performance indicators	1	3 months	Standard	Confirmation that a system has been developed
22	All colonoscopists should ensure compliance with the ≥ 120 standard for colonoscopies performed	1	12 months	Standard	Data showing that all colonoscopists have performed ≥ 120 colonoscopies in 2019
23	All colonoscopists should ensure compliance with the 92% standard for caecal intubation rates (CIR) with photographic evidence at LGI	1	6 months	Standard	Sustained achievement of CIRs with photographic evidence

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
24	Investigate the low comfort scores to ensure that they are captured in accordance with national guidance	1	3 months	Standard	Outcome of the investigation
25	Ensure policies that SSPs follow to ensure the appropriate clinical management of patients are consistent across all sites	3	6 months	Standard	Written confirmation from the lead colonoscopist that polices have been reviewed and ratified at the appropriate trust governance meeting
26	The centre should carry out a complex polyp audit	4	6 months	Standard	Copy of audit
27	The centre should audit computed tomographic colonography (CTC) cases being offered as 1st test in 2018	3	6 months	Standard	Copy of audit
28	Ensure that CTC outcomes for 2018 are shared with the lead radiologist	3	3 months	Standard	Confirmation from the lead radiologist that this information has been received
29	New BCSP pathologists should enroll in the BCSP external quality assurance (EQA) scheme, and participate in the next round	6	6 months	Standard	Confirmation from lead pathologist of participation in the EQA scheme
30	All pathologists should adhere to BCSP guidance for the assessment of polyp size	6	3 months	Standard	Confirmation from lead pathologist that guidance is being followed
31	Update the SOP for referral of difficult cases to national panel	6	3 months	Standard	Copy of updated SOP

Referral

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
NA	None	NA	NA		NA

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 and 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.