Public Health England

Screening Quality Assurance visit report

NHS Bowel Cancer Screening Programme Pennine
Executive summary

5 June 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 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.

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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 Pennine bowel cancer screening service held on 5 June 2019.

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:

- 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
- information shared with the North regional SQAS as part of the visit process

Local screening service

The Pennine programme provides bowel cancer screening services for the registered population of approximately 830,000 people across 4 Clinical Commissioning Groups (CCG): Bury, Heywood Middleton and Rochdale, Oldham and a small northern section of Manchester CCG.

Bowel cancer screening began at Pennine in April 2008, inviting men and women aged 60 to 69 for faecal occult blood test (FOBt) screening. In September 2012, the service began extending the age range covered to 74. Bowel scope screening (BoSS) started in March 2014 inviting men and women aged 55.

Pennine Acute Hospitals NHS Trust (PAHT) hosts the screening centre from Fairfield General Hospital (FGH). Programme co-ordination and administration for FOBt and BoSS takes place at FGH. The FOBt screening programme runs 5 specialist screening practitioner (SSP) assessment clinics each week from 4 sites across the region, providing access for individuals with abnormal screening results.

The following table identifies the hospital sites involved in providing the other elements of the bowel cancer screening programme (BCSP).

Hospital Site	Colonoscopy	BoSS	Pathology	Radiology
Fairfield General Hospital	•			•
Rochdale Infirmary	•	•		•
The Royal Oldham Hospital			•	•
North Manchester General Hospital				•

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 Pennine programme. Previous visits took place in May 2012 and June 2015.

Findings

This is a service that meets or exceeds many of the key performance indicators (KPIs) and quality standards.

The screening service has staff in post for all key leadership roles. The clinical director has led the programme since its inception, providing consistent and supportive leadership. The programme team have a wealth of knowledge and experience which will be invaluable to support the introduction of faecal immunochemical testing (FIT) and the eventual reduction of the screening age to 50.

Since the last QA visit to the centre in 2015 all recommendations, except one, have been completed.

Immediate concerns

The QA visiting team identified no immediate concerns.

High priority

The QA visit team identified 5 high-priority findings, summarised below.

1. The programme does not meet the acceptable standard for diagnostic procedure uptake rate and it has been declining in recent years.
2. There is poor attendance from the endoscopists at the quarterly multidisciplinary team (MDT) meeting. Frequently the clinical director is the only screening endoscopist in attendance. There is also no separate clinician meeting where KPIs can be discussed.
3. The policy on managing patients on anticoagulation and antiplatelets needs updating to take account of national programme learning from an incident in another provider.
4. Patients requiring advanced polypectomy should remain in the screening programme rather than being referred into the symptomatic service.
5. People referred for a computed tomography colonography (CTC) are not always identified as screening patients. This means that imaging is sometimes undertaken outside of BCSP protocols. In addition, the radiology dataset has a lot of detail missing due to proforma reporting not being used.

Shared learning

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

- the programme has a clear governance structure with several regular meetings through which screening related issues can be escalated
- the adenoma detection rate (ADR) at colonoscopy for the screening centre is amongst the highest in the region and has increased year on year
- a new appraisal and review process, implemented by the trust, has led to quarterly one to one sessions for the Specialist Screening Practitioners (SSPs) – this provides them with both personal and professional support whilst ensuring a knowledgeable workforce with a consistent approach
- the administration team has a thorough tracking process in place for specimens sent to pathology. Daily checks are made to ensure timely action
- the pathology department performs a monthly audit of 2% of cases which are reviewed by other histopathologists

Recommendations

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

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority	Evidence required
1	Perform an audit of patients with an abnormal FOBt result who do not go on for a diagnostic procedure for 2018 and 2019	3	12 months	High	Copy of the audit
2	Develop a health inequalities strategy for the Pennine screening programme	4	12 months	Standard	Copy of the strategy
3	Appoint either a lead colonoscopist or a deputy clinical director. This should be in addition to the clinical director role.	4	12 months	Standard	Confirmation email from the clinical director
4	Ensure job plans reflect individuals BCSP roles: the lead pathologist and lead radiologist need an allocated session to undertake the full range of expected duties reporting pathologists need their BCSP work acknowledged	4 and 5	6 months	Standard	Copy of the job plans
5	Several SOPs and policies need review and amendment. A separate list will be provided to the lead SSP	4	6 months	Standard	Copy of the updated SOPs and policies
6	Improve the adverse incident reporting policy to provide clarity on roles and responsibilities, expected actions and who the reports are to be shared with	4	3 months	Standard	Copy of the updated policy

No.	Recommendation	Reference	Timescale	Priority	Evidence required
7	Perform an audit of the large and/or complex polyps removed by the programme in 2018	4	12 months	Standard	Copy of the audit
8	Perform an audit of benign polyps ending in surgery in 2018	4	12 months	Standard	Copy of the audit
9	Perform a dose audit of CTC cases reported in 2018	6	12 months	Standard	Copy of the audit
10	Put in place regular SSP only meetings to enhance the dissemination of changes to policy, discussion of adverse events and improve shared learning	4	6 months	Standard	Copies of the minutes from 2 meetings
11	Put in place a regular clinicians meeting where KPIs can be openly discussed	4	12 months	High	Copies of the minutes from 2 meetings
12	Ensure that more endoscopists attend the programme wide MDT meetings	4	12 months	High	Copies of the minutes from 2 meetings

Infrastructure

No.	Recommendation	Reference	Timescale	Priority	Evidence required
13	Further develop the local SSP induction document to include complex pathways, data management, quality assurance and BoSS pathways	4	12 months	Standard	Updated induction document
14	Ensure that the radiology information system (CRIS) can store a code to identify BCSP patients	4	6 months	High	Confirmation email from the lead radiologist

Pre-diagnostic assessment

No.	Recommendation	Reference	Timescale	Priority	Evidence required
15	Ensure the SOP, relating to translation and interpretation services, makes it clear that patients receive the appropriate literature in advance of the SSP appointment	4	3 months	Standard	Copy of the revised SOP
16	Ensure the health assessment form lists the appropriate radiological investigation	4	3 months	Standard	Copy of the revised health assessment form
17	Ensure the SOP on managing diabetic patients is in line with trust policy to ensure a safe, timely and consistent approach and to improve patient experience	4	6 months	Standard	Copy of the SOP
18	Ensure the SOP(s) on managing patients on anticoagulation and antiplatelets meets the recommendations detailed in recent programme communication	8	6 months	High	Copy of the SOP
19	Facilitate a continued professional development (CPD) session to ensure all SSPs are up to date on BSG and BCSP guidance in relation to correct data entry and clinical management and episode progression for all aspects of:- piecemeal excision subsequent treatments management of sessile serrated lesions action when no tissue submitted	4	6 months	Standard	Confirmation email from the lead SSP that this session has occurred

Diagnosis

No.	Recommendation	Reference	Timescale	Priority	Evidence required
20	Ensure the removal of large and/or complex polyps at index colonoscopy pathway is clear to provide consistent practice across all colonoscopists and retains patients in the programme for surveillance procedures	4	6 months	High	Copy of the SOP
21	Ensure screening patients can access inpatient bowel preparation when required and remain in the screening programme	4	6 months	Standard	Copy of the SOP
22	Ensure that the vetting of CTC requests is performed by radiologists who understand the requirements of the programme	6	3 months	High	Email confirmation from the lead radiologist
23	Ensure that there is a single clear identifying stamp on the CTC request form to demonstrate it is from the BCSP and it indicates that the patient is to be handled in accordance with programme protocols	6	3 months	High	Copy of a stamped radiology request form
24	Perform an audit of CTC test and reporting times for 2018 and 2019 to investigate recent delays in reporting of cases	6	12 months	Standard	Copy of the audit
25	Ensure all radiology SOPs refer to the lead radiologist by title not by the former lead radiologist's name	4	6 months	Standard	Copy of the updated SOPs
26	Ensure that all CTCs are reported on standardised templates reflecting the BCSP radiology minimum dataset	6	6 months	High	Copy of the template report
27	Ensure that a single standardised template is used for the reporting of all pathology cases	8	6 months	S	Copy of the template report
28	Reduce the proportion of pathology reports classifying polyps as 'normal', by ensuring extra levels are cut through the block when necessary	8	12 months	S	SQAS will monitor the pathology dataset for change in reporting

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 and progress in response to the recommendations made for a period of 12 months after the report is published. After this point the SQAS will send a letter to the provider and the commissioners summarising the progress made and will outline any further action(s) needed.