Public Health England

Protecting and improving the nation's health

Screening Quality Assurance visit report

NHS Bowel Cancer Screening Programme Manchester

3 December 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 Manchester bowel cancer screening service held on 3 December 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 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
- information shared with the North regional SQAS as part of the visit process

Local screening service

The Manchester screening centre provides bowel cancer screening services for the registered population of approximately 1.2 million people across 4 Clinical Commissioning Groups (CCG): Manchester; Stockport, Trafford and Tameside and Glossop.

Bowel cancer screening began at Manchester in December 2009, inviting men and women aged 60 to 69 for faecal occult blood test (FOBt) screening. In July 2012, the service began extending the age range covered to 74 and this is now fully rolled out. Bowel scope screening (BoSS) started in March 2014 inviting men and women aged 55. In June 2019, the new faecal immunochemical test (FIT) kit for the screening programme was implemented to replace FOBt.

Manchester University NHS Foundation Trust (MFT) hosts the screening centre at Manchester Royal Infirmary (MRI). Programme co-ordination and administration for FOBt and BoSS takes place at MRI. The FOBt screening service runs 5 to 6 specialist screening practitioner (audit) assessment clinics each week from 5 sites across the geography,

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
Manchester Royal Infirmary	•	•	•	•
Trafford General Hospital	•	•		•
Withington Community Hospital (WCH)	•			

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 Manchester service. Previous visits took place in October 2012 and December 2015.

Findings

This is a service that meets or exceeds many of the key performance indicators and quality standards. The service is currently not meeting the acceptable thresholds for the programme standards relating to specialist screening practitioner (SSP) and diagnostic waiting times. This is mainly due to staffing absences and the extra demand created from FIT implementation. The service has also paused invitations to the BoSS element of the programme. A recovery plan is in the early stages of implementation.

The service has not met the programme standard for diagnostic procedure uptake rate for some years, leading to a significant number of people with positive screening results not completing their pathway to diagnosis.

The screening service has staff in post for all key leadership roles. The clinical director has led the service since its inception, providing consistent and supportive leadership.

Trust governance structures have changed and are still embedding for the service. With recent changes to trust management, it is hoped that the service now has clear lines for escalation, support and scrutiny within the trust.

Due to recent staffing shortages, workstreams such as audit and development and updating of policies, have not been prioritised.

Since the last QA visit to the centre in 2015 all recommendations, except one regarding appropriate SSP office accommodation, have been completed.

Immediate concerns

The QA visiting team identified no immediate concerns.

High priority

The QA visit team identified 10 high priority findings as summarised in the combined points below:

- the reasons for below standard diagnostic uptake rates for the programme must be audited to inform service development and delivery. This audit should help inform the risk and benefit assessment of the decision to continue/discontinue using the WCH endoscopy room
- a comprehensive capacity and demand plan for the next 2 years is required to ensure the service can not only recover its position against standards in the short term, but continue to meet the demands of the programme in the future
- staff must have a clear understanding of the trust's new governance structure and the processes for reporting and escalating screening related incidents and performance issues
- the reporting of computed tomographic (CT) colonography (CTC) cases must be done by clinicians deemed appropriate by the lead radiologist and in accordance with programme guidance
- the service must ensure that patients sent for CTC only have intra venous (IV) contrast administered when appropriate and audit all IV contrast cases annually
- the office accommodation for the SSPs is inadequate for the size of the team
- the policy on managing patients on anticoagulation and antiplatelets needs updating to take account of national programme learning from an incident in another provider

Shared learning

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

- the appointment of a cancer improvement lead to work on increasing screening uptake and reducing health inequalities
- regular one to one sessions for the SSPs providing them with both personal and professional support whilst ensuring a knowledgeable workforce with a consistent team approach to practice
- a thorough administrative user guide
- an email reminder system is in place to ensure a timely return of pathology reports
- double reporting in the pathology department of all cancers and cases of high grade dysplasia

Recommendations

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

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority	Evidence required
1	Investigate the reasons for the service continuing to not meet the diagnostic uptake rate programme standard	3	6 months	H	Copy of the audit and action plan
2	Develop a 2-year capacity and demand plan taking account of staffing for all future activity including demands of the FIT, BoSS and surveillance	2	6 months	H	Copy of the approved plan
3	Clarify and document the new trust governance structure and mechanisms for the escalation of performance issues and adverse incidents to all staff	3	3 months	H	Notes from team meeting where governance structure is disseminated and discussed
4	Ensure the job plan for the lead radiologist has allocated session(s) to undertake the duties and reflects the responsibility of the role	4	6 months	S	Copy of the approved job plan
5	Ensure the SSP and administration teams fully understand adverse event/incident reporting processes and what events need reporting	2	6 months	S	Copy of the training log
6	Update the adverse incident reporting SOP to include: • reference to the trust governance structure and escalation process • reference to ‘Managing Safety Incidents in NHS Screening Programmes’ • types of radiological related events to report	5	3 months	H	Copy of the approved SOP

No.	Recommendation	Reference	Timescale	Priority	Evidence required
7	Implement a service wide schedule of audits to ensure processes and clinical protocols are followed. This must include an annual large or complex polyp audit	3	6 months	S	Copy of the approved schedule
8	Ensure the CTC dose audit includes subdivisions into IV contrast, non-contrast and staging protocols	4	6 months	S	Copy of the audit and any action plan
9	Implement a schedule of service wide and team level meetings to ensure good attendance and provide opportunities for shared learning and service development. This schedule must include (but is not limited to): • service wide meetings (including all staff groups) • clinical director/programme manager/lead SSP joint meetings • SSP only meetings • endoscopist meetings	3	12 months	S	Copy of the approved schedule and copies of 2 sets of minutes of the listed meetings

Infrastructure

No.	Recommendation	Reference	Timescale	Priority	Evidence required
10	Develop a temporary staff SOP, to provide reassurance that accurate data entry processes and correct pathways for patients are maintained by temporary staff	2	3 months	S	Copy of the approved SOP
11	Ensure that CTC is only reported by radiologists approved for BCSP by the lead radiologist. Lead radiologist to provide the service with an updated list of radiologists	4	3 months	H	Confirmation email from the lead radiologist

No.	Recommendation	Reference	Timescale	Priority	Evidence required
12	Ensure that the pathology department has an appropriate staff mix so that consultant pathologists are not required to perform macroscopic examination of BCSP specimens which has previously been undertaken by trained BMS staff	2	12 months	S	Confirmation email from the lead pathologist
13	Ensure the SSP team has access to an adequate office work space for the service to run effectively	3	3 months	H	Provide a confirmed start and planned completion date for the office conversion
14	Review the current IT access provision at all SSP clinic sites to ensure SSPs can login to BCSS and provide live data entry	2	6 months	S	Confirmation email from lead SSP that this has taken place

Pre-diagnostic assessment

No.	Recommendation	Reference	Timescale	Priority	Evidence required
15	Develop the local SSP induction documentation to incorporate more programme specific details i.e. complex pathways, data management and associated processes, QA and BoSS	2	12 months	S	Copy of the approved induction documentation
16	Work with WCH management to ensure BCSP patients are greeted appropriately and SSPs are not interrupted during assessment	2	3 months	S	Confirmation from the lead SSP
17	Update the management of diabetes patients SOP to ensure a safe, timely and consistent approach	2	6 months	S	Copy of the approved SOP
18	Ensure that all SOPs are reviewed and updated. A list of SOPs requiring this will be forwarded with the report	2	12 months	S	Copy of the updated and approved SOPs and inclusion in the Quality Management System (QMS)

Diagnosis

No.	Recommendation	Reference	Timescale	Priority	Evidence required
19	Produce a risk and benefit assessment to inform the service's future use and any potential development of the WCH endoscopy room	3	3 months	H	Copy of the assessment
20	Expand the team of therapeutic colonoscopists to improve access times for complex polypectomy and facilitate a large polyp MDT	3	12 months	S	Confirmation from the clinical director of more colonoscopists with the appropriate skill set
21	Ensure the anticoagulation SOP is updated to reflect current BSG guidance and learning from a serious incident at another screening centre	6	3 months	H	Copy of the approved SOP
22	Ensure the service has a clear process to monitor individual endoscopist performance and manage underperformance	2	6 months	S	Copy of the approved SOP
23	Review the process for recovery and discharge of patients post procedure to ensure a timely pathway for patients	2	6 months	S	Copy of the approved SOP
24	Develop a CTC reporting proforma that fully incorporates the radiology minimum dataset	4	6 months	S	Copy of the approved reporting proforma
25	Ensure that written consent is taken before CTC is performed	4	3 months	S	Copy of the consent form and confirmation from the lead radiologist of use
26	Ensure the use of IV contrast for CTC is appropriate and consistent	4	6 months	H	Copy of the approved SOP
27	Perform an audit of all CTC cases in 2019 when IV contrast was administered	4	6 months	H	Copy of the audit and any action pan

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.