Public Health England

Protecting and improving the nation's health

Screening Quality Assurance visit report

NHS Bowel Cancer Screening Programme
West Hertfordshire

27 February 2020

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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 West Hertfordshire screening service held on 27 February 2020.

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 shared with the Midlands and East regional SQAS as part of the visit process

Local screening service

The West Hertfordshire bowel cancer screening service provides NHS bowel cancer screening services to an eligible population of approximately 627,000 drawn from the NHS Herts Valley Clinical Commissioning Group. The service is commissioned by NHS England and NHS Improvement supported by the East of England Screening and Immunisation Team.

The West Hertfordshire bowel cancer screening service started inviting men and women aged 60 to 69 years for faecal occult blood test (FOBt) screening in March 2008. In October 2010 the screening service extended the age range invited to 74. The faecal immunochemical test (FIT) began to replace FOBt from May 2019.

Bowel scope screening began inviting men and women aged 55 in the West Hertfordshire area in 2015. The service has only 10 GP surgeries still needing to ‘go live’ with bowel scope until it is fully rolled out to the screening service’s population.

The West Hertfordshire Bowel Cancer Screening Programme (BCSP) is hosted by Hemel Hempstead General Hospital (HHGH). It is delivered by HHGH and Watford General Hospital (WGH). Specialist screening practitioner (SSP) pre-assessment clinics for individuals with a positive screening test take place at the Hemel Hempstead site. All administration and most colonoscopy procedures take place at HHGH.

Bowel scope takes place at WGH with an occasional list being undertaken at HHGH.

Computed tomography colonography (CTC) is an option when colonoscopy has been unsuccessful or is unsuitable for an individual. CTC procedures take place at both sites, but mainly at HHGH. Histopathology specimen processing and reporting take place at HHGH.

The Eastern Bowel Screening Hub undertakes the invitation (call and recall) of individuals eligible for screening, the testing of FOBt and FIT samples and onward referral of individuals needing further assessment to the screening centres. This is based in Nottingham and is outside the scope of this QA visit.

Findings

The evidence and discussions at this QA visit demonstrate that this is a high performing bowel screening service with outstanding leadership. Everyone works in a collaborative way, both across the screening service and with the wider endoscopy departments. This brings direct benefits to patients as they are able to access the service promptly and receive clinical care that is informed by the latest evidence and research.

The whole team is demonstrably engaged, motivated, proactive and works cohesively together. Staff are constantly looking to improve the service and ensure it is always looking to the future. Of particular note is the approach to staff succession planning and developing staff roles so they are varied and interesting while being relevant to service needs now and in the future. This supports staff development, engagement and retention.

The main priorities for the Trust are outlined below and relate to the immediate need for fit-for-purpose IT and the urgent need to have suitable equipment. Addressing both these issues will ensure staff can care for patients safely and efficiently.

Immediate and urgent concerns

The QA visit team identified 1 immediate and 1 urgent concern. A letter was sent to the chief executive on 2 March 2020 asking that the following items be addressed within 7 and 14 days respectively:

- immediate concern – put in place an action plan to ensure reliable access to both the bowel cancer screening system and digital image storage
- urgent concern – undertake a risk assessment and document a business continuity plan to deal with endoscope stack system failure after it is no longer maintained from 1 April 2020

A response was received to the immediate concern which assured the QA visit team an action plan was in place and the risks have been mitigated. The response to the urgent concern confirmed that new equipment was due to be received on 31 March 2020. A business continuity plan was in place should there be any delivery delays.

High priority

The QA visit team identified no high priority findings in addition to the urgent and immediate issues above.

Shared learning

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

- providing training and development opportunities across the endoscopic nursing workforce to support skill mix for sustainable future service provision
- the screening director regularly summarises and shares new research and guidance with the whole team and with the wider endoscopy service to drive quality improvement forward
- comprehensive endoscopy audits including analysis of complex polyps and polyp cancers, investigation of cases of benign disease undergoing surgery, and interval cancers after colonoscopy
- use of specific codes for BCSP patients referred to CTC to ensure correct identification and clinical management
- follow up appointments are issued by SSPs for patients to discuss results of CTC investigations
- introduction of a polyp cancer dataset in pathology
- double reporting all high grade dysplasia in polyps

Recommendations

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

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority	Evidence required
1	Recognise the bowel cancer screening programme (BCSP) leadership roles for pathology and radiology in job plans along with appropriate time	2	3 months	Standard	Copies of updated pathology and radiology leads job plans
2	Update the bowel screening documentation for the governance structure and escalation to clarify groups and reporting arrangement	2 and 3	3 months	Standard	Terms of reference, agenda and minutes of meetings, governance structure diagram
3	Put in place an effective risk management process	2 and 3	3 months	Standard	Minutes of meetings, risk register showing bowel screening risks
4	Establish a system to agree the annual audit schedule covering all professional areas involved with the BCSP and the arrangements to assess the audit programme each year	2 and 3	3 months	Standard	Audit schedule covering all professional areas (clinical and non-clinical)
5	Develop the quality management system (QMS) further to include a full suite of policies covering all areas and associated work instructions including an index and version control	2 and 3	6 months	Standard	Copy of QMS
6	Develop a capacity and demand plan to meet fluctuation in demand for BCSP screening including surveillance	2 and 3	3 months	Standard	Copy of capacity and demand plan which includes surveillance

Infrastructure

No.	Recommendation	Reference	Timescale	Priority	Evidence required
7	Put in place an action plan to ensure reliable access to both bowel cancer screening system (BCSS) and digital image storage	2 and 3	7 days	Immediate	Copy of action plan
8	Reliable access to both the BCSS and digital image storage in place	2 and 3	3 months	Standard	Confirmation email confirming both are in place
9	Undertake a risk assessment and document a business continuity plan to deal with endoscope stack system failure after it is no longer maintained from 1 April 2020	2 and 3	14 days	Urgent	Copy of risk assessment Copy of business continuity plan
10	Demonstrate that there is an endoscope equipment replacement programme in place	2 and 3	3 months	Standard	Copy of replacement programme
11	Put in place access to 3D software via the patient archiving and communication system at all 3 sites	4	6 months	Standard	Confirmation that software is available on all 3 sites

Pre-diagnostic assessment

No.	Recommendation	Reference	Timescale	Priority	Evidence required
12	Update the patient group direction (PGD) to issue bowel preparations for screening participants	5	3 months	Standard	Signed and dated PGD so non-consultant staff can prescribe bowel preparations

No.	Recommendation	Reference	Timescale	Priority	Evidence required
13	Establish live data entry for specialist screening practitioner (SSP) clinics	6	12 months	Standard	Confirmation that live data entry is in place on all SSP sites and updated standard operating procedure (SOP) for timely completion of datasets

Diagnosis

No.	Recommendation	Reference	Timescale	Priority	Evidence required
14	Support all BCSP radiologists to carry out 120 computed tomography colonoscopy (CTC) cases per year (symptomatic and screening)	4	3 months	Standard	Pro rata reporting figures on trend to reach required level. Annual reporting numbers available subsequently
15	Document all BCSP-related CTC procedures in line with local QMS requirements	4	6 months	Standard	Copies of CTC SOPs

Next steps

The screening service provider is responsible for developing an action plan in collaboration with the commissioners to complete the recommendations contained in this report.

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 SQAS will send a letter to the provider and the commissioners summarising the progress made and will outline any further action(s) needed.