Public Health England

NHS

Screening Quality Assurance visit report

NHS Bowel Cancer Screening Programme South Yorkshire and Bassetlaw Bowel Cancer Screening Service

28 and 29 September 2017

Public Health England leads the NHS Screening Programmes

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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. The Screening Quality Assurance Service ensures programmes are safe and effective by checking that national standards are met. PHE leads the NHS Screening Programmes and hosts the UK NSC secretariat.

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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 South Yorkshire and Bassetlaw screening service held on 28 and 29 September 2017.

QA purpose and approach

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 review visits to the screening centre office at Hydra House, the radiology and pathology departments at Doncaster Royal Infirmary and Royal Hallamshire Hospital and the pathology departments at Barnsley General Hospital and Rotherham District Hospital
- information shared with the North regional SQAS as part of the visit process

Local screening service

The South Yorkshire and Bassetlaw (SYB) programme provides bowel cancer screening services for the current registered population of 1,536,386 across Sheffield, Rotherham, Barnsley and Doncaster. The Clinical Commissioning Groups (CCGs) covered by the centre include Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield.

The SYB programme started in February 2008 inviting men and women aged 60 to 69 years of age for the faecal occult blood test (FOBt) screening. In April 2010, the screening service extended the age range covered to 74. Bowel scope screening (BoSS) began in October 2014 inviting men and women aged 55.

Sheffield Teaching Hospitals NHS Foundation Trust (STH) hosts the screening centre. The associated trusts are Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH), Rotherham NHS Foundation Trust (RFT), Barnsley Hospital NHS Foundation Trust (BHFT).

Trust	Site	Service provided as part of BCSP				
		SSP Clinic	Bowel Scope	Colonoscopy	Pathology	Radiology
STH	Northern General Hospital (NGH)	•	•	•		
	Royal Hallamshire Hospital (RHH)				•	•
DBTH	Doncaster Royal Infirmary (DRI)	•	•	•	•	•
	Mexborough (also known as Montagu)	•				
BHT	Barnsley Hospital (BH)	•	•	•	•	
RHT	Rotherham District Hospital (RDH)	•		•	•	

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

This is a complex and large screening centre, with 3 associate trusts involved in the delivery of the programme. Staff communicate well with each other and are led by an engaged and committed clinical director, who works hard to create a culture of continuous improvement, embedding quality assurance into everyday practice.

Immediate concerns

The QA visit team identified no immediate concerns.

High priority

The QA visit team identified 3 high priority findings as summarised below:

- there are some significant staffing issues within pathology

- there is a shortage of endoscopy capacity across the whole programme, which is variable across trusts. This is impacting on waiting times and the roll out of bowel scope
- the current agreements between the host trust and associated trusts do not cover governance, roles and responsibilities, incidents or performance evaluation

Shared learning

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

- a red, amber, green (RAG) rating system is used to highlight endoscopist KPI changes from quarter to quarter
- DRI have a very effective database for BCSP pathology audit and update this database weekly
- to ensure staff read team meeting minutes the centre have a ‘find the hidden word’ game
- the team have access to a ‘sound-proofed’ cubicle for making confidential calls
- the centre have developed a local letter to send to bowel scope patients to encourage them to contact the service in advance of their attendance

Recommendations

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

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority	Evidence required
1	Individual data should only be shared with the programme board by exception, and anonymised where possible	10	3 months	Standard	Confirmation from CD
2	SLAs between the host trust and associated trusts should be agreed	5	6 months	High	Copy of SLA between host trust and each associated trust
3	Screeners should attend at least 50% of the clinicians' meetings annually	5	12 months	Standard	Minutes documenting attendees or attendance lists for meetings
4	Produce a health promotion strategy	5	12 months	Standard	Health promotion strategy document
5	Produce an annual report	1	3 months	Standard	A copy of the annual report
6	Update the programme organisational chart to identify all management roles and the lines of responsibility and accountability	5	3 months	Standard	Updated organisational chart
7	Ensure the AVI/screening incident policy details the governance mechanisms in each of the trusts associated with the service	5	3 months	High	A copy of the updated AVI/SI policy

No.	Recommendation	Reference	Timescale	Priority	Evidence required
8	An audit of CTC PPV compared with endoscopy for the whole of 2017 should be carried out for BaSH/DRI	11	12 months	Standard	A copy of the audit for screening and symptomatic cases (100 cases, including all BCSP CTC; there should be separate analysis for the CTC as a first test)
9	Implement regular meetings (at least annually) involving lead pathologists from each site	5	12 months	Standard	Evidence of a meeting (1 x agenda and minutes)
10	Update the capacity and demand plan	5	6 months	High	Up to date Capacity and demand plan

Infrastructure

No.	Recommendation	Reference	Timescale	Priority	Evidence required
11	Arrangements for cross-cover of colonoscopy lists should be improved to optimise list utilisation	5	6 months	Standard	SLAs agreeing cross cover arrangements.
12	Establish sufficient colonoscopist and endoscopist workforce so that waiting time standards can be met and bowel scope can continue to be rolled out	5	6 months	High	Workforce plan confirmation from CD of new appointments
13	Ensure that BCSP pathology requests from RDGH are reported by accredited BCSP pathologists	5	1 month	High	Confirmation from the clinical director

Pre-diagnostic assessment

No.	Recommendation	Reference	Timescale	Priority	Evidence required
14	An audit of colonoscopy uptake should be added to the audit schedule	5	12 months	Standard	Copy of the audit

The screening test – accuracy and quality

No.	Recommendation	Reference	Timescale	Priority	Evidence required
15	Ensure there is consistent practice regarding management of patients who unexpectedly need translation services in BoSS	5	3 months	Standard	Copy of SOP
16	Ensure BoSS screeners receive a copy of the colonoscopy report and histology details for every case they advance to colonoscopy.	5	3 months	Standard	Copy of SOP

Diagnosis

No.	Recommendation	Reference	Timescale	Priority	Evidence required
17	Ensure the criteria for describing bowel preparation as inadequate is agreed between colonoscopists	4	3 months	Standard	Statement from CD confirming discussion and outcomes

No.	Recommendation	Reference	Timescale	Priority	Evidence required
18	Consultants performing ESD or using hybrid or knife-assisted techniques for EMR should be registered with the BSG ESD Interest Group and this activity should be audited	13	12 months	Standard	Letter confirming contact with BSG ESD Group. Brief details of all cases in which ESD knives used in past 12 months, showing any complications and outcomes
19	Conduct an audit of the BCSP CTC waiting times from referral to receipt of the report.	11	6 months	Standard	Audit from each site which should be done both retrospectively and prospectively for 2017
20	RHH pathology department to ensure that the names of both pathologists reporting BCSP pT1 polyp cancers are always indicated on the histopathology report	5	3 months	Standard	Confirmation from lead pathologist
21	Ensure all BCSP pathology cases at RDGH during 2017 have been reported by accredited BCSP pathologists. Where this has not happened, those cases should be reviewed by a BCSP pathologist	5	3 months	High	Confirmation from lead pathologist and notification of number and outcome for any cases reviewed

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.