Service specification No. 26A NHS bowel scope screening programme

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Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities

1 Contents

1 Service specification No.26A

This is a service specification to accompany the 'NHS public health functions agreement 2016-17 (the '2016-17 agreement') published in December 2015.

This service specification is to be applied by NHS England in accordance with the 2016-17 agreement. This service specification is not intended to replicate, duplicate or supersede any other legislative provisions that may apply.

Where a specification refers to any other published document or standard, it refers to the document or standard as it existed at the date when the 2016-17 agreement was made between the Secretary of State and NHS England Board, unless otherwise specified. Any changes in other published documents or standards may have effect for the purposes of the 2016-17 agreement in accordance with the procedures described in Chapter 3 of the 2016-17 agreement

Service specifications should be downloaded in order to ensure that commissioners and providers refer to the latest document that is in effect.

The 2016-17 agreement is available at www.gov.uk (search for 'commissioning public health').

All current service specifications are available at www.england.nhs.uk (search for 'commissioning public health').

2 Population Needs

2.1 National and local context and evidence base

2.1.1 Background

Bowel scope screening is an alternative and complementary bowel screening methodology to FOB testing. Evidence shows that for men and women aged 55 - 64 who attend a one-off bowel scope (“bowel scope” in this document refers to flexible sigmoidoscopy screening) screening test mortality from bowel cancer in this age group can be reduced by 43% (31% on an invited population basis) and incidence can be reduced by 33% (23% on a population basis).

A randomised controlled trial funded by Cancer Research UK, the Medical Research Council and NHS research and development leads took place in 14 UK centres, and evaluated screening for bowel cancer using a single bowel scope screening between 55 and 64 years of age, removing small polyps by flexible sigmoidoscopy and providing colonoscopy for "high risk" polyps.

The study concluded that bowel scope screening is a safe and practical test and, when offered only once between ages 55 and 64 years, confers a substantial and long lasting benefit. Based on the trial figures, experts estimate the programme would prevent around 3,000 cancers every year. A similar trial with similar results took place in 6 Italian centres.

The UK National Screening Committee (UK NSC) reviewed the evidence, and in April 2011 concluded that screening for bowel cancer using flexible sigmoidoscopy meets the UK NSC criteria for a screening test. In England, NHS Screening Programmes within Public Health England initially managed its implementation.

2.1.2 Definition – Bowel Scope Screening

The terminology ‘bowel scope screening’ has been selected as the appropriate name from extensive work undertaken with the general public which best describes the flexible sigmoidoscopy screening experience.

The National Health Service (NHS) Bowel Cancer Screening Programme (BCSP) will offer men and women aged 55 (in 56th year) a once-only bowel scope, and the option of self-referral for people aged between 55 and their invitation date for the FOBt screening programme.

This modality of screening is complementary to the existing Faecal Occult Blood test (FOBt) screening programme.

3 Outcomes

3.1 NHS Outcomes Framework Domains & Indicators

This specification will meet the following domains in the NHS Outcomes Framework.

NHS Outcomes Framework

Domain 1	Preventing people from dying prematurely	x
Domain 2	Enhancing quality of life for people with long-term conditions	x
Domain 3	Helping people to recover from episodes of ill-health or following injury	
Domain 4	Ensuring people have a positive experience of care	x
Domain 5	Treating and caring for people in safe environment and protecting them from	x

3.2 Local defined outcomes

Not applicable

4 Scope

4.1 Aims and objectives of service

The aim of the bowel scope screening programme is to offer a one-off flexible sigmoidoscopy to all men and women at the age of 55 and for 56-59 year olds to opt in. It will test for bowel cancer, removing small polyps by flexible sigmoidoscopy and providing colonoscopy for 'high risk' polyps. This screening programme compliments the existing bowel cancer screening programme and aims to reduce mortality from the disease.

The bowel scope screening programme is being rolled out across England.

4.2 Equality and Heath Inequalities

The objectives of the screening programme should include:

Help to reduce health inequalities through the delivery of the programme

Key deliverables:

- Screening should be delivered in a way which addresses local health inequalities, tailoring and targeting interventions when necessary
- A Health Equity Impact Assessment should be undertaken as part of both the commissioning and review of this screening programme, including equality characteristics, socio-economic factors and local vulnerable populations
- The service should be delivered in a culturally sensitive way to meet the needs of local diverse populations
- User involvement should include representation from service users with equality characteristics reflecting the local community, including those with protected characteristics
- Providers should exercise high levels of diligence when considering excluding people with protected characteristics in their population from the programme and follow both equality, health inequality and screening guidance when making such decisions

The provider will be able to demonstrate what systems are in place to address health inequalities and ensure equity of access to screening, subsequent diagnostic testing and outcomes. This will include, for example, how the services are designed to ensure that there are no obstacles to access on the grounds of the nine protected characteristics as defined in the Equality Act 2010.

Guidance on the Equality Act can be found here: https://www.gov.uk/equality-act-2010-guidance

The provider will have procedures in place to identify and support those persons who are considered vulnerable/ hard-to-reach, including but not limited to, those who are not registered with a GP; homeless people and rough sleepers, asylum seekers, gypsy traveller groups and sex workers; those in prison; those with mental health problems; those with drug or alcohol harm issues; those with learning disabilities, physical disabilities or communications difficulties.

The provider will comply with safeguarding policies and good practice recommendations.

Providers are expected to meet the public sector Equality Duty which means considering all individuals when carrying out their day-to-day work – in shaping policy, in delivering services and in relation to their own employees.

It also requires that public bodies:

- have due regard to the need to eliminate discrimination
- advance equality of opportunity
- foster good relations between different people when carrying out their activities

4.3 Service description/care pathway

4.3.1 The invitation process

Providers should roll out bowel scope screening based upon the trajectory agreed with NHS England commissioners. A template for screening centres to calculate the demand and capacity requirements for bowel scope screening is available from the PHE NHS cancer screening programmes national office.

4.3.2 Demand and Capacity

The screening centre uses the 'demand and capacity plan' to inform the roll out of bowel scope screening. The plan will identify which order each GP practice will join the roll out. The screening centre is responsible for maintaining the GP practice list within the Bowel Cancer Screening System (BCSS). Once the GP practice is added to the BCSS, participants are selected to take part in bowel scope screening according to their date of birth.

4.3.3 Generation of invites

The screening centre creates bowel scope screening lists on the BCSS 8 weeks in advance.

The screening centre will generate the invites for each screening site on a regular basis (daily or weekly). The BCSS appoints participants into each slot automatically. The participant with the oldest date of birth will be appointed first. The pre-invitation letter is generated 8 weeks before the participant's appointment date. The letter is printed by the Hub.

4.3.4 The Role of Hubs

Bowel scope screening will be delivered by the screening centres in conjunction with the Screening Programme Hubs.

The role of the Hubs is to:

- Send out pre-invitations and invitations;
- Manage booking and re-booking;
- Provide a telephone help line, with specialist screening practitioner (SSP) support, to answer questions and queries related to suitability assessment; and
- Receive and manage self-referral enquiries.

4.3.5 Self-referrals

Individuals who are aged between 55 and 60 (who have not been selected for FOBt) and are registered with a GP practice that has rolled out bowel scope screening can self-refer. The potential participant can contact the hub who will arrange an appointment no less than 5 days in the future. This is to enable time for the appropriate correspondence to be delivered and the enema to be posted by the enema supplier.

4.3.6 Invitation

Six weeks before the participants appointment the BCSS automatically generates the invitation letter. This is printed by the Hub. This invitation will contain the time, date and location of the

appointment and a response slip. There will also be a leaflet included to facilitate the participant's decision about participating in bowel scope screening. If the participant chooses to take part they must either return the provided response slip or ring the Hub to agree to take part.

4.3.7 Appointments & re-booking

Once the pre-invite has been sent out the participant can contact the hub to accept, change, or decline their appointment. The Hub staff can offer the participant an appointment up to 8 weeks in the future. Beyond that the participant will need to call back.

4.3.8 Suitability

All potential participants are initially presumed suitable. A list of contraindications is sent out with the invitation. Some participants may contact the Hub with questions about their suitability to take part in bowel scope screening. The BCSS has a module to help guide Hub staff in answering participant's questions. If the Hub cannot resolve the query they can escalate it to the screening centre. This information is captured on the BCSS to ensure that no participant is delayed in their pathway. All suitability queries must be resolved before the participant progresses to their appointment. This might necessitate the appointment being rescheduled to achieve this.

4.3.9 Reminders

Four weeks prior to the appointment, participants who have not contacted the Hub to confirm their attendance at the bowel scope screening appointment are sent a reminder letter. This will often result in some of the individuals contacting the Hub to confirm or change their appointment.

4.3.10 Manage bowel scope screening lists

From the time the pre-invite letters are sent to participants, the screening centre may have to change the bowel scope screening lists to achieve the optimal number of participants attending. This optimal number may vary between services but is usually between 10 & 12 people. This means that administrators may need to rearrange some appointments, remove empty appointment(s) and create new appointments. A new module on BCSS has been created to support this function.

4.3.11 Confirmation of lists

Approximately 2 weeks before the appointment date the screening centre will 'confirm' the bowel scope screening list on the BCSS.

This action:

- confirms the screening centre will run the list,
- cancels any participants that have not responded to confirm their attendance; and
- produces the paperwork for the appointment for each participant who has already agreed to attend as follows:
    - a letter confirming the time, date and location of their appointment,
    - a map with the screening centre's contact details,
    - a participant specific consent form; and
    - under separate cover, the enema from a centralised distribution centre

Participants who have not confirmed their attendance will receive a letter informing them that as they did not contact the Hub to agree their bowel scope screening appointment, their provisional appointment has been cancelled and their GP informed. If the participant does wish to be screened they can contact the Hub who will provide an appointment if appropriate.

4.3.12 Text message services

A text message reminder service may be used according to individual Trust guidelines.

4.3.13 Screening Centre attendance

The screening centre must ensure a high level of privacy and dignity for participants.

Attendance for bowel scope screening will require local policies and protocols to cover data entry, coding with local commissioning agreement.

A member of the SSP nursing team will support individuals attending for their bowel scope screening appointment. The SSP and / or SSP assistant practitioner will conduct a nursing assessment to verify the individual's health status and suitability for the procedure. This is the first face to face point of contact and the meet and greet process of individuals attending bowel scope screening is crucial in the management of participants.

Participants will have received written "risk and benefit" information and an appropriate local or national consent form agreed locally by the host Trust clinical governance process. The informed consent process will be finalised and completed together with a participant completed health questionnaire on arrival to the endoscopy unit (See appendix 4 – health questionnaire).

Participants will have self-administered their enema (B.Braun Clyssie) prior to attendance. If the self-administered enema is inadequate or has been unsuccessful, the patient will be given the option of an additional enema in the endoscopy unit. The enema used in endoscopy will be the local Trust formulary enema of choice, and given in accordance with local patient group directives. This could be administered rectally, or if found to be unsatisfactory during the bowel scope screening procedure, administered via the endoscope. The enema should be given at room temperature.

If the bowel preparation remains poor, no further enemas should be given and the endoscopist should perform as accurate and complete examination as possible within the boundaries of safety, comfort and time.

It should be made clear to the individual that 'as far as was seen, the test was negative to the limit of their examination'. This should be recorded in the episode notes.

4.3.14 Participant Comfort

Comfort of the participant during the bowel scope screening procedure is paramount and the endoscopist should only examine the colon as far as the participant's comfort allows.

The bowel scope screening procedure time is expected to be between 5 and 10 minutes.

In any event, examination is not expected beyond the splenic flexure.

Should the participants discomfort lead to cessation of the examination when that point has not been reached, it should be made clear to the individual that their examination has not been optimal and this should be recorded in the individual case notes.

Repeat examinations are not performed within bowel scope screening.

The bowel scope screening procedure will be performed without sedation with an option of Entonox for pain relief. Entonox administration must be available and used in line with local Trust

policy for safe drug administration. Contraindications and potential side effects need to be assessed with participants.

The use CO2 for insufflations generators will also improve participant comfort.

Recovery space with oxygen and suction must be available in the event of any adverse event.

A member of the SSP nursing team or endoscopy nursing team can discharge participants as soon as they are comfortable. They will receive an agreed discharge plan and contact information.

4.3.15 Histology sampling

Patients who have some form of intervention which requires pathology analysis will be informed of the turnaround time for their results and how they will be contacted to deliver the findings and results. Histology sampling in endoscopy will be performed in accordance with local Trust policies and protocols. The process of “right test, right patient, and right result” must be part of this policy.

Bowel scope screening will require sufficient pathology capacity. Pathology reporting must be standardised within the Trust with clear pathways and protocols for the management of pathology specimens, especially if screening is performed on peripheral sites.

Pathology results must be available within 1 week of a participant’s bowel scope screening procedure as is now practice for FOBt bowel cancer screening endoscopy examinations.

4.3.16 Participant discharge

At the end of the screening episode it will be clear that some individuals need further examination, and this may include a need for them to return for a full colonoscopy. These people must be seen by an SSP who can advise and discharge them appropriately.

There may be other individuals who need counselling before discharge, for example if they have had small polyps removed or who are in some discomfort, and they too must be seen by the SSP.

Participants who are subject to biopsy or polyp removal, or otherwise referred for colonoscopy in the screening programme, should be added to the cancer waiting times database of the local Trust. If they are later proven to have cancer, they should receive their first treatment within 62 days of their bowel scope screening procedure.

It is therefore expected that participants are booked into colonoscopy, or for an SSP appointment where required, within two weeks of their bowel scope screening procedure.

4.3.17 Data collection (bowel scope screening pathway)

Bowel scope screening data collection, including bowel scope screening attendance, is the responsibility of the SSP team. SSP and / or assistant practitioners will be required for all episodes and data input.

4.3.18 Equipment provision

The number of endoscopes required will depend on the decontamination facilities available to support each list. Colonoscopes will be the likely instrument of choice, given cost considerations

and overall versatility within the endoscopy service. The endoscope processor must be able to support the capture of photographic images.

4.3.19 Bowel scope screening outcomes and follow-up pathways

(See appendix 5 - Protocol for referring patients for a Screening Colonoscopy)

4.3.20 Normal result at bowel scope screening:

- Discharge, copy of report to GP and BCSS letter, call for FOBt at age 60 years.

4.3.21 Abnormal result at bowel scope screening

(Outside scope of bowel scope screening programme):

- Does not meet criteria for screening follow up
    - Refer to symptomatic service
        - Stricture
        - Polyp surgical excision
        - Polyp EMR
        - Anal lesion
        - Diverticulitis
- Non-neoplastic pathology
    - Inflammatory bowel disease

4.3.22 High risk polyp identification at bowel scope screening:

- Polyp(s) 10+mm in size – biopsy and photograph but do not remove
- Offer screening colonoscopy, add index bowel scope screening to Colon findings (cumulative polyp count and size).

(Outside scope of bowel scope screening programme):

- High risk - 1 year colonoscopy surveillance as per bowel scope screening guidelines until out of risk category. FOBt decision based on status of surveillance. Patients may be in surveillance at the time of FOBt due date (60 years) so will need individual calculation as to when FOBt offered.
- Polyp surveillance patients will be offered FOBt at 60 years despite being in BCSP surveillance.

4.3.23 Intermediate risk polyp identification at bowel scope screening:

- Polyp(s) <10mm in size – photograph and perform Polypectomy on all polyps of less than 10mm in size
- If the endoscopist is confident that a polyp is not an adenoma (e.g. unequivocal hyperplastic polyp in rectum), it need not be removed or biopsied
- In the exceptional case where it is clear that the participant has many adenomatous polyps, clearance polypectomies may be deferred until the completion colonoscopy
- Offer screening colonoscopy, add index bowel scope screening to Colon findings (cumulative polyp count and size – may dictate change in surveillance to high risk).

(Outside scope of bowel scope screening programme):

- Intermediate risk – 3 year colonoscopy surveillance as per bowel scope screening guidelines until out of risk category. FOBt decision based on status of surveillance. Patients may be in surveillance at the time of FOBt due date (60 years) so will need individual calculation as to when FOBt offered.

4.3.24 Low risk polyp identification at bowel scope screening:

- Number of polyps1 or 2 adenomas less than 10mm, discharge, enter FOBt programme at age 60 years. BCSS will close this episode and identify outcome as abnormal result.

4.3.25 Cancer or suspected cancer detection:

- Photograph, obtain multiple biopsies and tattoo lesion

(Outside scope of bowel scope screening programme):

- Refer to Colorectal Cancer MDT – symptomatic service.
- Completion colonoscopy (approximately 5% of patients 1) by symptomatic service. If no polyps or polyps in the low risk category are found then that episode will be closed and the patient recalled for FOBt screening at age 60 years
- If on completion colonoscopy additional adenomas are found, a cumulative count is required and surveillance intervals as per bowel scope screening colonoscopic polyp surveillance guideline by symptomatic service
    - 1 and 5 years for cancer surveillance
    - 3 year intermediate polyps
    - 1 year high risk polyps

4.3.26 Quality Assurance

Quality assurance of bowel scope screening will be in accordance with the existing QA framework for the Bowel Cancer Screening Programme. QA standards are currently under development.

4.4 Workforce

4.4.1 Programme Manager

The addition of bowel scope screening to the bowel cancer screening programme means that there is a need for a dedicated local Programme Manager to the BCSP to oversee both FOBt and bowel scope screening.

4.4.2 Administration staff

The Bowel Cancer Screening System (BCSS) will be set up to allow for 'multiple booking' of bowel scope screening appointments, with subsequent cancellations either explicitly or implicitly due to lack of response within the time limit. It is anticipated that there will be a considerable amount of re- booking of appointments and changes to bowel scope screening lists. Additionally there is a considerable workload for the administrative staff who will be required to manage the booking of bowel scope screening appointments and the bowel scope screening lists locally through the BCSS IT system.

The adequate number of administration staff and bookings staff will be an essential part in the efficient running of the bowel scope screening service.

4.4.3 Endoscopy unit workforce

The endoscopy workforce and the provision of the bowel scope screening service must be organised to ensure lists are not cancelled due to a lack of endoscopy staff. A minimum of 2 x endoscopy nurses must be present during the bowel scope screening procedure. Where the bowel scope screening endoscopist is a nurse practitioner, there is still a requirement of 2 x additional endoscopy nurses.

4.4.4 Bowel scope screening endoscopists

Bowel scope screening endoscopists must undertake the bowel scope screening accredited assessment process (See Appendix 1 – Accreditation of Bowel scope screening endoscopists) and meet the minimum standards and criteria in order to perform bowel scope screening procedures on the screening population.

The Screening Centre will need to determine the workforce required, medical, nursing and non-medical endoscopists, in order to be able to undertake the bowel scope examinations for its local population. This will require planning the workforce at least 18 months in advance of a potential start date for bowel scope screening in order to train appropriate staff for bowel scope screening. Nurse endoscopists working alone for evening sessions (with no medical cover on site) will need local Trust clinical governance protocols to acknowledge autonomous practice. Non-medical endoscopists are required to be registered with the 'Health Professional Council (HPC)'.

Training to achieve the standards necessary to apply for accreditation as a bowel scope screening endoscopists, as for all endoscopists, should be undertaken through the usual JAG recommended training route within the individual's trust, supported by the JETs training and certification website. Screening centres are encouraged to work with Health Education England's Non-Medical Endoscopists (NME) programme.

SSPs may consider undertaking training as bowel scope screeners. Training must be undertaken within a JAG accredited programme, with funding for any training supported by the individuals own trust/screening centre.

4.4.5 Specialist Screening Practitioners

It is particularly important that individuals attending for bowel scope screening are made to feel welcome in the bowel scope screening unit and that any questions either about the procedure or about their health are dealt with appropriately.

A minimum of one specialist screening practitioners should be present at all times during bowel scope screening sessions. The discharge of patients with abnormal findings specific to the screening programme pathways and histology sampling must be managed by specialist screening practitioners.

As with the BCSP programme, any SSP working within screening will be required to be registered to complete or have completed the formal educational programme at John Moores University – Liverpool (JMUL) within a year of commencing in post. Any additional training needs identified as bowel scope screening is rolled out will be planned and managed alongside existing local, regional and national training opportunities (JMUL, Gastrointestinal Nursing (GIN).

4.4.6 Other departments

Consideration should be given to the increase in workload to related departments including pathology services, Colorectal MDT, Colorectal surgical, Gastroenterology and decontamination units (if separate from the endoscopy service).

Bowel scope screening lists performed at evening and weekend sessions need to allow appropriate cleaning services access to allow department cleaning without disruption to patients or lists.

Bowel scope screening lists will generate an increase in the number of medical case notes required either new or requests from medical notes library. 5 x lists per week will need 50 + case notes. This activity will require appropriate resources.

Endoscopy reception and shared waiting areas will also need appropriate endoscopy staff to meet and greet bowel scope screening attendees especially if extended into late evenings and weekends.

4.5 IT Systems

The existing BCSS IT information system will support all elements of bowel scope screening.

The screening centre IT systems, PC terminals and printers must be tested and fully operational prior to confirmed start date.

As yet there is no specific BCSS training for the bowel scope screening module. This will be bespoke training carried out at the time a screening centre goes live for bowel scope screening.

New staff in the programme must undertake BCSS training with HSCIC before training on bowel scope

4.6 Population covered

Screening centres must plan for an appropriate capacity for all their eligible population;

- all men and women at the age of 55
- 56-59 year olds who have not been selected for FOBt and are registered with a GP practice that has rolled out bowel scope screening can self-refer.

Due to the unknown response rate, the actual number of bowel scope screening lists required should be modelled on a range of uptake. The screening centre endoscopy service must be able to provide a flexible service and provide capacity to meet the increase in demand if higher.

The PHE NHS cancer screening programmes national office can provide numbers of 55 year olds over a 2 year period by GP practice.

4.7 Any acceptance and exclusion criteria and thresholds

The criteria for exclusion in once-only bowel scope screening as part of the national screening programme are:

- If the individual has undergone total removal of the large bowel.
- Is already in an active colonoscopy surveillance programme.
- Has opted out of the screening episode understanding that they will be invited to undertake FOBt at age 60 years.
- Has made informed dissent. That is, has signed a request that no further contact be made by the NHS BCSP at any time

Radiological procedures as an alternative to bowel scope screening are unnecessary. Fitness for any subsequent colonoscopic investigation based on findings at bowel scope screening will be judged as per current BCSP imaging guidelines.

4.8 Interdependence with other services/providers

The bowel scope screening programme is dependent on strong working relationships (both formal and informal) between services provided by other providers, the information systems, primary care and specialist professionals. Providers must ensure accurate and timely communication and handover across these interfaces is essential to reduce the potential for errors and ensure a seamless pathway for patients. It is essential that there remains clear named clinical responsibility at all times and at handover of care the clinical responsibility is clarified. The Provider shall ensure that appropriate systems are in place and in operation at all times to

support an inter-agency approach to the quality of the interface between these services. The Provider shall ensure that the above systems are in place to actively support the following:

- Agreeing and documenting roles and responsibilities relating to all elements of the screening pathway across organisations
- Providing strong clinical leadership and clear lines of accountability
- Developing joint audit and monitoring processes
- Agreeing jointly what failsafe mechanisms are required to ensure safe and timely processes across the whole screening pathway
- Contributing to any NHS England Screening Lead's initiatives in screening pathway development in line with UK NSC expectations
- Meeting the national screening programme standards covering managing interfaces

5 Applicable Service Standards

5.1 Applicable national standards (eg NICE)

5.1.1 Criteria for bowel scope screening

To ensure the quality and safety of symptomatic bowel cancer services and the colonoscopy element of the faecal occult blood test programme, Public Health England have set the following criteria for local screening centres expanding or opening in order to participate in both the faecal occult blood test and in the bowel scope screening programme. This is adopted by NHS England in commissioning this service. The operation of bowel scope screening alone will not be considered.

Bowel scope screening sites should have achieved:

I. sustained operation of the faecal occult blood test programme and sustained implementation of the faecal occult blood test age extension (70 up to 75th birthday)2 while meeting the Quality Assurance standards of the Bowel Cancer Screening Programme including waiting times for Specialist Screening Practitioner appointment and screening colonoscopy

II. demonstrable sustainable endoscopy capacity for facilities and staff to deal with the increased workload with the expansion to incorporate bowel scope screening and continued growth in screening colonoscopic surveillance

III. provision of CO2 for insufflation at all sites where bowel scope screening and screening colonoscopy is provided in accordance with European Guidelines for Quality Assurance of Colorectal Cancer Screening and Diagnosis

IV. provision of entonox at all sites where bowel scope screening is provided

V. maintenance of full Joint Advisory Group on GI Endoscopy (JAG) annual accreditation at each endoscopy unit which offers bowel scope screening and screening colonoscopy

VI. maintenance of GRS scores:
- waiting times at level A for a minimum of three months prior to commencing bowel scope screening at all screening sites
- waiting times at all other hospitals within the trust must be at level A before bowel scope screening can commence
- at least level B for all other GRS (Global Rating Scale) scores

VII. sustained achievement of the operational standards for the relevant cancer waiting times commitments:

Commitment	Operational Standard
All cancer two week wait	93%
62 day (urgent GP referral to treatment) wait for first treatment: all cancers	85%
62-day wait for first treatment from consultant screening service referral: all cancers	90%

VIII. agreed direction to work towards the identification of a single pathology laboratory with the capacity to deal with all the polyps arising from bowel scope screening and screening colonoscopy examinations in a screening centre. The laboratory would need two to four nominated consultant histopathologists who participate in the BCSP External Quality

Assurance (EQA) scheme to report these samples. In addition, pathology laboratories which will report suspected bowel cancers arising in the programme should also have an identified BCSP lead with whom the FS polyp reporting pathologists can liaise. Note: a named lead pathology laboratory should at least be identified and evidence that the screening centre is working towards the completion of the processes for a single pathology laboratory

IX. sign off from the regional quality assurance team, trust chief executive(s) and NHS England team which commissions the current faecal occult blood test programme

X. the population size of the screening centre to deliver bowel scope screening would be 500,000 as a minimum and up to approximately 1,000,000 (and to achieve this a small number of screening centres may need to split / reconfigure)

XI. commitment to advance equality of opportunity for groups with poor screening uptake, including identifying where difficulties lie in the local population and considering innovative strategies to engage with people who do not respond to their initial invitation.

The Public Health Commissioning Team within local NHS England teams will assess the proposal from a public health perspective ahead of any site commencing BSS, engaging with local commissioners of related services e.g. CCGs which commission symptomatic services..

In addition to the criteria above, the following detail must be provided ahead of commencing the service and sustained once operation of the service is live

- A capacity/demand plan with the proposed number of bowel scope screening sessions at each of the named sites demonstrating the capacity and demand to roll out bowel scope screening to the screening centres population. The pace of roll out within screening centres will vary dependent upon factors such as JAG accreditation of subsidiary sites. However, all sites must be operational no later than18 months from the commencement of services. A capacity and demand template is available as a separate document from the national office. The national office can also provide individual screening centres population figures by GP practice on request to assist screening centres with their capacity and demand planning
- The screening centre weekly timetable for all screening activity identifying the staffing at all clinical sessions delivered locally and the names of the endoscopists and SSPs where available
- Confirmation that the pathology service will be able to meet the current requirements (as in paragraph 2.2 vii)
- Confirmation of the screening centre named clinical team members with designated sessions in their job descriptions. The director of the screening centre must be a clinician directly involved in the service
- Identification of dedicated screening centre programme manager post (WTE and pay band)
- The screening centre's project plan for delivering bowel scope screening within an agreed timeframe

[2] The Operating Framework for the NHS in England 2011/12, Department of Health (15th December 2010) www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digita lasset/dh_122736.pdf

5.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

To be confirmed

6 Applicable quality requirements and CQUIN goals

6.1 Applicable Quality Requirements

The bowel cancer screening programme is working to develop a set of key performance and quality indicators for the Bowel scope programme. These indicators will be evidence based and available during 2017/2018.

7 Location of Provider Premises

Where possible, bowel scope screening should be delivered locally and as close to the community of the population served.

Consideration for shared provision in local community hospitals, independent treatment centres, mobile screening facilities, and local GP health centres.

APPENDIX 1

(For additional information – see full Accreditation of Bowel scope screening endoscopists guidance)

Accreditation of bowel scope screening endoscopists

All accredited screening colonoscopists are automatically accredited for bowel scope screening

All other endoscopists who wish to undertake bowel scope screening procedures in the BCSP will be required to be accredited for bowel scope screening before they can commence screening. This is a different, more local process for bowel scope screening alone. However, it will be similar to the current accreditation of screening colonoscopists in that applicants will need to meet the criteria to submit an application, undertake an assessment process and subsequently be accredited for bowel scope screening.

The full accreditation guidelines will be circulated to you with this letter and placed on the BCSP website.

Eligibility

To be able to apply to be accredited as a bowel scope screening endoscopist, individuals must meet the following criteria:

- A minimum of 300 lifetime lower GI endoscopies
- Be able to remove lesions <10mm including by submucosal lift (confirmed by colleague)
- Be able to place endoscopic tattoos
- Be able to accurately assess the size of the lesion
- Be skilled in lesion recognition

Application criteria

The application form requires confirmation of the following criteria:

- Lifetime lower GI numbers > 300
- Lifetime perforation rate
- In preceding 12 months:
- No of Lower GI procedures > 150
- Polyp detection rate
- Polyp removal rate
- Complication rate

PLUS: 4 formative DOPyS to be submitted

Formal assessment

All assessments for bowel scope screening will be held in the candidate's local screening centre. The assessment will be conducted by one internal mentor and one external mentor, one of whom must be an accredited screening colonoscopy assessor. The internal mentor must not be the candidate's local mentor.

The assessment will comprise of a one hour MCQ, followed by DOPS and if appropriate,

DOPyS assessment of 2 consecutive cases.

Provisional accreditation will be awarded initially. Full accreditation will be awarded once the KPIs for 100 B bowel scope screening cases reach the required standard and are signed off by external assessor.

If the KPIs are not reached after 300 procedures or within 9 months, provisional accreditation will expire and the candidate will be required to make a new application and will be unable to undertake examinations in the BCSP in the meantime.

Unsuccessful candidates will be allowed to re-sit the assessment twice in a 12 month period only.

It is expected that bowel scope screening endoscopists will undertake at least 400 bowel scope screening procedures per annum which equates to one bowel scope screening.

APPENDIX 2

National Consent Form - Bowel Scope Screening

[NHS organisation name]
Consent Form 1

Adults

Participant's agreement to
NHS Bowel Scope (flexible sigmoidoscopy) screening

Participant's details (or pre-printed label)

Participant's surname/family name.……

Participant's first names …….

Date of birth ……..

Responsible health professional……..

NHS number (or other identifier)……..

☐ Male ☐ Female

To be retained in participant's medical case note

Participant Copy

Planned Bowel Scope Screening Test (Flexible Sigmoidoscopy or FS Screening Test)

The bowel scope screening test is an examination of the left side of large bowel using a flexible video camera.

Depending on findings, the procedure may include biopsies (small samples from bowel lining) and polypectomy (removal of growth called a polyp from the bowel wall).

Statement of health professional (to be signed by health professional in your presence at your appointment).

I have explained the procedure to the participant. **In particular, I have explained:**

1) The intended benefits:

Screening assessment of the left side of the large bowel to look for any signs of lower bowel cancer or for polyps, which may / could develop into cancer if left in place. Trials have shown that removing polyps significantly reduces the future risk of developing lower bowel cancer (colorectal cancer).

2) Serious or frequently occurring risks:

Serious bleeding after biopsy or polypectomy – uncommon (1 in 3000); Missing serious pathology – uncommon (1 in 1000); Perforation of the bowel wall – rare (1 in 40,000).

3) Any extra procedures which may become necessary during the procedure:

- Subject to findings, a follow-up full colonoscopy may be recommended in order to allow a full view of the whole large bowel. A colonoscopy is sometimes needed to safely remove certain polyps (for which a separate appointment will be arranged).
- Samples for histology - the procedure may involve biopsy of tissue and/or polypectomy (removal of polyps) for diagnostic purposes. Following diagnosis this tissue will form part of the clinical record.
- Blood transfusion - uncommon (1 in 3,000) in the event of serious bleeding
- Operation (1 in 10,000 or rare) may be required if there is life threatening bleeding or if a hole is made through the bowel wall (perforation).

4) Retention of tissue samples for training and research:

- Any tissue samples taken may be retained and used for teaching purposes and for research aimed at improving diagnosis and treatment of bowel cancer in line with the relevant local Trust policy. To refuse permission for this, the choice options in the “Statement of Participant” (Page 4) can be completed.

I have also discussed what the procedure is likely to involve and the fact that the national screening programme does not offer an alternative to this particular test for bowel cancer screening for individuals in this age range. I have explained that a different test (FOBT) is available only from age 60 to age 74. I have also discussed any particular concerns the participant has raised.

- The national standard “**Bowel scope screening**” leaflet has been provided.
- This procedure will not involve any general or local anaesthesia or any sedation other than the possible use of Entonox (gas and air) with your prior agreement

Signed :…….……(Health professional) Date... ……..

Name (PRINT) ……. ……. ……. …. Job title …….. ……..……

5) Contact details (if participant wishes to discuss options later) ….……

Statement of interpreter (where appropriate)

I have interpreted the information above to the participant to the best of my ability and in a way in which I believe s/he can understand.

Signed ……..…… Date ……..……

Name (PRINT) ……..…….

Copy for medical case notes

Planned Bowel Scope Screening Test (Flexible Sigmoidoscopy or FS Screening Test)

The bowel scope screening test is an examination of the left side of large bowel using a flexible video camera.

Depending on findings, the procedure may include biopsies (small samples from bowel lining) and polypectomy (removal of growth called a polyp from the bowel wall).

Statement of health professional(to be signed by health professional in your presence at your appointment). I have explained the procedure to the participant**. In particular, I have explained:**

1) The intended benefits:

Screening assessment of the left side of the large bowel to look for any signs of lower bowel cancer or for polyps, which may / could develop into cancer if left in place. Trials have shown that removing polyps significantly reduces the future risk of developing lower bowel cancer (colorectal cancer).

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- Samples for histology - the procedure may involve biopsy of tissue and/or polypectomy (removal of polyps) for diagnostic purposes. Following diagnosis this tissue will form part of the clinical record.
- Blood transfusion - uncommon (1 in 3,000) in the event of serious bleeding
- Operation (1 in 10,000 or rare) may be required if there is life threatening bleeding or if a hole is made through the bowel wall (perforation).

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- The national standard “**Bowel scope screening**” leaflet has been provided.
- This procedure will not involve any general or local anaesthesia or any sedation other than the possible use of Entonox (gas and air) with your prior agreement

Signed :……..(Health professional) Date... ……

Name (PRINT) ……. …… ……. Job title …….. ……..……

5) Contact details (if participant wishes to discuss options later) …..…….……

Statement of interpreter (where appropriate)

I have interpreted the information above to the participant to the best of my ability and in a way in which I believe s/he can understand.

Signed ……. Date ……..……....

Name (PRINT) ……..……..

Copy accepted by participant: yes/no (please circle)

Statement of participant:

Please read this form carefully and in particular, page 2 above which describes the benefits and risks of the Bowel Scope screening test. If you have any further questions, you will have the opportunity to discuss these with a screening health professional when you arrive at your appointment. We are here to help you. You have the right to change your mind at any time, including after you have signed this form.

I agree to the procedure or course of treatment described on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I have been told about additional procedures which may become necessary during my treatment. I have listed below any procedures **which I do not wish to be carried out** without further discussion.
……
……

I understand that unless I refuse permission by ticking the following options, any tissue samples may be retained and used for teaching purposes and for research aimed at improving diagnosis and treatment of bowel cancer in line with relevant local Trust policy.

My tissue samples are not to be used for teaching ☐ My tissue samples are not to be used for research ☐

To be signed by the participant either in advance of the appointment or at the appointment itself in advance of the bowel scope screening test.

Participant's signature …….. Date……

Name (PRINT) ……

A witness should sign below if the participant is unable to sign but has indicated his or her consent.

Signature …… Date ……..…….

Name (PRINT) ……

Confirmation of consent (to be completed by a health professional when the participant is admitted for the procedure, if the participant has signed the form in advance)

On behalf of the team treating the participant, I have confirmed with the participant that s/he has no further questions and wishes the procedure to go ahead.

Signed:…….. Date .. ……

Name (PRINT) ……. …… …… Job title …….. ……..…

Important notes: (tick if applicable)
☐ See also advance directive/living will (e.g. Jehovah's Witness form)
☐ Participant has withdrawn consent (ask participant to sign here)
Name/Date……..……

APPENDIX 3

BBRAUN Clyssie Enema

The nationally procured enema must be distributed to all participants who agree to take part in the bowel scope screening programme.

Further details of the BBRAUN Clyssie Enema can be provided on request.

APPENDIX 4

Participant identity label **HEALTH QUESTIONNAIRE**

Do you have, or have you ever had any of the following?	**Yes**	**No**	**Comment**
Heart Problems or heart attack in the last 3 months.	☐	☐	
Breathing Problems?	☐	☐	
Abdominal Operations?	☐	☐	
GI Investigation? (examinations or scans of your stomach or bowels)	☐	☐	
Diabetes?	☐	☐	
Have you ever been advised by a Public Health official that you are at risk of developing CJD or vCJD?	☐	☐	
Blood disorders? (Anaemia, clotting disorders etc)	☐	☐	
Have you administered your enema	☐	☐	
Did the enema work i.e. produce a bowel motion?	☐	☐	**Only if answer NO should a second enema be administered.**
Do you take any of the following medication prescribed by a doctor?	**Yes**	**No**	**Comment**
Warfarin	☐	☐	
Clopidogrel (Plavix)	☐	☐	
Aspirin	☐	☐	
Insulin	☐	☐	
Any other prescribed medication (Please list)	☐	☐	

Are you allergic to: ***Latex?*** ☐ ***Any food type?*** ☐ ***Any medication?*** ☐

If Yes, please provide details)

…….……..

Do you have any disabilities or additional needs you would like us to know about?

Learning	
Sight	☐
Hearing	☐
Manual Dexterity	☐
Mobility	☐
Speech	☐
Continence	☐
Other	☐
(please give detail)	☐
	……
	……
	……

(Please tick all that apply)

APPENDIX 5

BCSP - Bowel Scope Screening

Protocol for referring patients for a screening colonoscopy

The following patients should be referred for colonoscopy in the Bowel Cancer Screening Programme:

- Any patient with a polyp ≥10mm

- Any patient with, on a histological report
  - 3 or more adenomas
  - An adenoma with villous or tubulovillous component
  - An adenoma with high-grade neoplasia (dysplasia)

- Patients with 20 or more polyps which are ≥3mm, hyperplastic in appearance and above the distal rectum

The following patients may be referred for colonoscopy in the Bowel Cancer Screening Programme:

- Any patient with **suspected adenomas**, which fit criteria for removal but where this may not be appropriate at initial flexible sigmoidoscopy screening exam
  e.g.
  - On anti-coagulant or antiplatelet therapy (though biopsies can be taken if required)
  - Patient intolerance of procedure / discomfort
  - Multiple suspected adenomas (e.g. >6),
  - At risk of vCJD

- A patient with a polyp which is technically difficult to remove e.g. due to poor access, in an unstable position, or recurrence in a previous polypectomy scar

Notes
Adenomas will be summated from all endoscopy examinations to determine appropriate surveillance interval

Any polyp not retrieved is assumed to be an adenoma

Hyperplastic-looking polyps < 5mm in rectosigmoid area need not be removed where the endoscopist is confident that they are safe to leave in situ