



Department
of Health

NHS
England

Public health functions to be exercised by NHS England

Service specification No.26

Bowel Cancer Screening Programme

November 2013

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NHS England INFORMATION READER BOX**Directorate**

Medical	Operations	Patients and Information
Nursing	Policy	Commissioning Development
Finance	Human Resources	

Publications Gateway Reference: 00732

Document Purpose	Resources
Document Name	Public health functions to be exercised by NHS England service specification no 26: bowel cancer screening
Author	NHS England
Publication Date	11 November 2013
Target Audience	NHS England Regional Directors, NHS England Area Directors
Additional Circulation List	CCG Clinical Leaders, Directors of PH
Description	This specification is part of an agreement made under the section 7A of the National Health Service Act 2006. It sets out requirements for an evidence underpinning a service to be commissioned by NHS England for 2014-15. It may be updated in accordance with this agreement
Cross Reference	
Superseded Docs (if applicable)	18372
Action Required	N/A
Timing / Deadlines (if applicable)	N/A
Contact Details for further information	Direct Commissioning NHS England 4-8 Maple Street London W1T5HD 0113 8250550

Document Status

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Public health functions to be exercised by NHS England

Service specification No.26

Bowel Cancer Screening Programme

Prepared by –

Cancer Screening, Early Diagnosis and Skin Cancer Prevention Team

Department of Health

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Service specification No.26

This is a service specification within Part C of the agreement 'Public health functions to be exercised by the NHS Commissioning Board' dated November 2012 and amended by variation dated April 2013 (the '2013-14 agreement'). This service specification thereby comes into effect and supersedes service specification No.26 dated November 2012.

The 2013-14 agreement is made between the Secretary of State for Health and the NHS England under section 7A of the National Health Service Act 2006 ("the 2006 Act") as amended by the Health and Social Care Act 2012.

This service specification is to be applied by NHS England in accordance with the 2013-14 agreement. An update to this service specification may take effect on an agreed date as a variation made in accordance with the 2013-14 agreement.

This service specification is not intended to replicate, duplicate or supersede any other legislative provisions that may apply.

The 2013-14 agreement including all service specifications within Part C is available at www.gov.uk (search for "commissioning public health").

1. Background and introduction

Purpose of the Bowel Cancer Screening Specification

- 1.1. The purpose of this specification is to ensure that there is a consistent and equitable approach to the provision and monitoring of bowel cancer screening across England.
- 1.2. This document is designed to outline the service and quality indicators expected by NHS England from the NHS Bowel Cancer Screening Programme (NHSBCSP) in order to ensure that a high standard of service is provided to NHS England's responsible population. It therefore sets out the specific policies, recommendations, and standards that the NHSBCSP expects services to meet.
- 1.3. The service specification is not designed to replicate, duplicate, or supersede any relevant legislative provisions which may apply, e.g. the Health and Social Care Act 2008, or the work undertaken by the Care Quality Commission. In the event of new guidance emerging, the specification will be reviewed and amended with as much rapidity as possible, but, where necessary, both NHS England and Service providers should work proactively to agree speedy variations of contract ahead of the production of a revised specification.
- 1.4. This service specification needs to be read in conjunction with the current NHSBCSP guidance and recommendations. These can be found on the cancer screening programmes website: www.cancerscreening.nhs.uk

Aims, objectives, and health outcomes

Aims

- 1.5. The aim of the NHSBCSP is to reduce mortality from bowel cancer. This will be achieved by delivering evidence-based, population-based screening programmes that:
 - identify the eligible population and ensure efficient delivery with optimal coverage
 - are safe, effective, of a high quality, externally and independently monitored, and quality assured
 - prevent cancer where possible, and lead to earlier detection, appropriate referral, and improved outcomes
 - are delivered and supported by suitably trained, competent, and qualified, clinical and non-clinical staff who, where relevant, participate in recognized ongoing CME, CPD, and EQA schemes
 - have audit embedded in the service.

Objectives

Activities prior to screening

- 1.6. In line with good management practice and experience and in order to ensure appropriate and efficient use of NHS resources, the programme as a whole should:
- identify and invite those eligible for screening at appropriate intervals
 - provide the invited population with the information they require, in the form in which they require it, so that they are able to make an informed choice about whether or not to participate
 - ensure that GPs are informed of screening in their area and of the final outcomes of screening for each of their patients
 - serve whole populations (all ages) numbering no less than 500,000 and up to about one million.

Primary Screening

- 1.7. The provider should:
- provide people who participate with a high quality, effective, and people-centred service
 - optimise participation rates and maximise accessibility of the service for all groups in the community
 - allow people to opt out of the service, on a single occasion or permanently
 - provide adequate numbers of appropriately trained, qualified, and competent staff to carry out high-quality screening
 - implement screening tests that are acceptable to those who undergo them
 - minimise any adverse physical/ psychological/ clinical aspects of screening (e.g. discomfort, anxiety, unnecessary investigations).

Assessment, diagnosis, referral, follow-up

- 1.8. The provider should:
- detect asymptomatic abnormalities
 - undertake assessment and diagnosis of individuals with abnormal results in appropriately staffed and equipped settings
 - follow up individuals in accordance with national protocols where further investigation is required
 - accurately diagnose invasive cancers and adenomas, discussing cases in MDTs where appropriate, and refer individuals for urgent treatment outside the programme when cancer is detected
 - ensure that test results are communicated clearly and promptly

- follow appropriate protocols to monitor individuals according to BSCP/ BSG guidelines
- ensure that individuals needing neither treatment nor surveillance are returned to routine screening recall, and that individuals with incidental findings are provided with appropriate advice and referral if necessary

Standards

1.9. The programme as a whole should:

- maximise the number of cancers detected
- minimise the number of cancers presenting between screening episodes
- maximise the number of adenomas detected
- maintain minimum standards of screening, whilst aiming for achievable standards (see Appendix 1)
- participate in both approved national routine audits and *ad hoc* audits to evaluate overall programme performance.

Administration, failsafe

1.10. The provider should:

- ensure effective and timely communication with the individuals who are invited, screened, assessed, or treated
- ensure effective and timely communication with clinical multidisciplinary teams, other screening centres, NHS England, the national office of the cancer screening programmes and quality assurance teams within Public Health England (PHE), and the Health and Social Care Information Centre
- work within a seamless and integrated pathway
- build robust failsafe measures into all stages of the pathway
- ensure that the NHSBCSP recommendations for handling incidents are adhered to, in addition to local reporting procedures.

Audit and Quality Assurance (QA)

1.11. The provider and the quality assurance team within Public Health England should work collaboratively to:

- regularly audit and evaluate the programme to ensure that the service is delivered in a safe, effective, timely, equitable, and ethical way, in accordance with national policy and NHSBCSP standards, guidelines, internal and external quality assurance arrangements, and risk assessments
- monitor, collect, and report statistical data and other relevant information to relevant bodies, and use this to: promote continuous improvement in service performance and outcomes; give formal feedback to NHS England and the population served by

the programme; and provide key information and models of good practice/ innovation/ achievement to those working in the area of bowel cancer screening

The provider should:

- participate willingly in multidisciplinary quality assurance visits organised by the cancer screening quality assurance team within Public Health England.

Information Technology

1.12. The provider should:

- use the programme's IT systems to manage people through the screening process, and to capture key screening data/ outcomes promptly and accurately, supporting local and national quality assurance and cancer registration processes and programme evaluation
- comply fully with local, NHSBCSP, and NHS information governance requirements relating to the confidentiality and disclosure of patient information and system/information security.

Accreditation, training, guidance, research

1.13. The provider should:

- ensure that staff are appropriately trained and supported by national continuing professional development and skills frameworks, enabling them to develop their skills, competencies, and potential. Only approved/ accredited training courses should be used
- contribute to nationally-approved research into the screening and diagnosis of bowel cancer, to inform screening practice and policy
- ensure that all pathology laboratories dealing with screening programmes are formally accredited by UKAS or equivalent
- ensure that pathologists reporting patient material on behalf of the NHSBCSP participate routinely in the NHSBCSP EQA scheme
- ensure that pathologists reporting material on behalf of the NHSBCSP adhere to RCPATH/ NHSBCSP reporting guidelines.

Safety and Safeguarding

1.14. The provider should refer to and comply with the safety and safeguarding requirements as set out in the NHS Standard Contract.

Common Health Outcomes

1.15. The programme as a whole aims:

- to reduce the number of people in the target population who die from bowel cancer by 16%
- to maximise detection of bowel cancer at stages 1 and 2 (PHE domain 2)

- to maximise detection of adenomas which, if left untreated, could develop into bowel cancer
- to refer people promptly to treatment services
- to achieve high coverage levels across all eligible groups in society
- to minimise adverse physical/ psychological/ clinical aspects of screening (e.g. anxiety, unnecessary investigation).

2. Scope of the screening programme

Description of the NHSBCSP

2.1. In this section of the document, the following terms are used:

- **NHSBCSP** This describes the entire programme, from identifying subjects to be invited to referral for treatment or return to routine screening as applicable
- **Screening centre** This describes the part of the programme where endoscopy takes place. It may deliver endoscopy in a number of different locations, based even in different provider units (eg different NHS Trusts) (see figure 2)
- **Hub** This describes the laboratory which despatches and develops FOBt kits and deals with the administration of invitations and results. There are currently 5 of these in England (see figure 2)
- **Provider** This is the NHS Trust or private provider which is contracted to provide hub and/or screening centre activities. If a centre comprises more than one provider, one will be the lead and hold the contract with NHS England
- **Eligible population** This describes those who meet the criteria for invitation for screening. Currently this is men and women aged 60-74 who either reside in a defined area or are registered with defined general practices.

Activities Prior to Screening

2.2. In accordance with agreed professional best practice set out in Appendix 4, the provider should:

- invite men and women aged 60 to 74 for routine screening every two years
- enable those aged 75 and over to self-refer for screening
- contribute to health promotion activities to improve access to screening services for all groups within the eligible population
- identify the population eligible for screening, send pre-invitation materials, assemble invitation pack, and despatch test kit
- employ trained and competent staff to provide the NHSBCSP helpline.

Primary Screening

2.3. The provider should:

- Maintain a suitable stock of faecal occult blood test (FOBt) kits ready for despatch to avoid service interruptions
- despatch repeat faecal occult blood test (FOBt) kits as appropriate.
- process received FOBt kits and act on the results

- using the Bowel Cancer Screening System (BCSS), ensure that all individuals with abnormal results are booked into Specialist Screening Practitioner (SSP) clinics within appropriate timescales.

Assessment, diagnosis, referral, follow-up

2.4. In accordance with NHSBCSP standards and protocols, the provider should:

- undertake colonoscopic assessment (or, if indicated, whole colon CT imaging) of individuals who have a suspected polyp or cancer. Carbon dioxide must be used for insufflation of the bowel.
- remove early cancers and precursor lesions and retrieve them for histological evaluation
- biopsy suspected bowel cancer and retrieve material for histological evaluation
- work with MDT and treatment services to ensure appropriate follow-up of results and to facilitate audit
- continue to develop quality assurance processes and procedures to ensure safe and effective delivery of the current FOBt programme
- ensure surveillance for individuals where appropriate, which may include colonoscopic assessment or CT colon imaging.

Standards

2.5. The provider should:

- ensure that all staff working in the NHSBCSP are familiar with relevant and current quality assurance guidelines
- ensure that all staff maintain minimum standards, and also adhere to NHSBCSP guidance and recommendations via internal audit and external quality assurance monitoring
- take prompt action where standards are lower than expected to identify the causes and improve the service to the appropriate level or beyond
- agree early warning systems and triggers with the local quality assurance team within Public Health England
- manage serious failures to provide services to the level specified in the NHSBCSP quality assurance guidelines according to NHSBCSP protocols. Specific colonoscopy guidelines are available in NHSBCSP publication number 6, *Quality Assurance Guidelines for Colonoscopy*
- ensure that all programmes have a multi-disciplinary quality assurance visit at least once every three years
- use nationally developed and agreed letters and leaflets.

Administration, audit, QA, failsafe, IT

2.6. The provider should:

- ensure that all hubs and screening centres meet the necessary criteria to be recognised as part of the NHSBCSP
- record FOBt results on BCSS and despatch these to participants and their GPs within specified timescales
- offer individuals an appointment for a screening programme colonoscopy within 14 days of their SSP appointment where appropriate
- utilize the BCSS IT system to ensure that the care pathway is managed to its planned conclusion
- implement/ operate BCSS for call/ recall, and recording/ distribution of results
- participate in the external quality assurance process, and ensure that robust internal quality assurance processes are also in place.

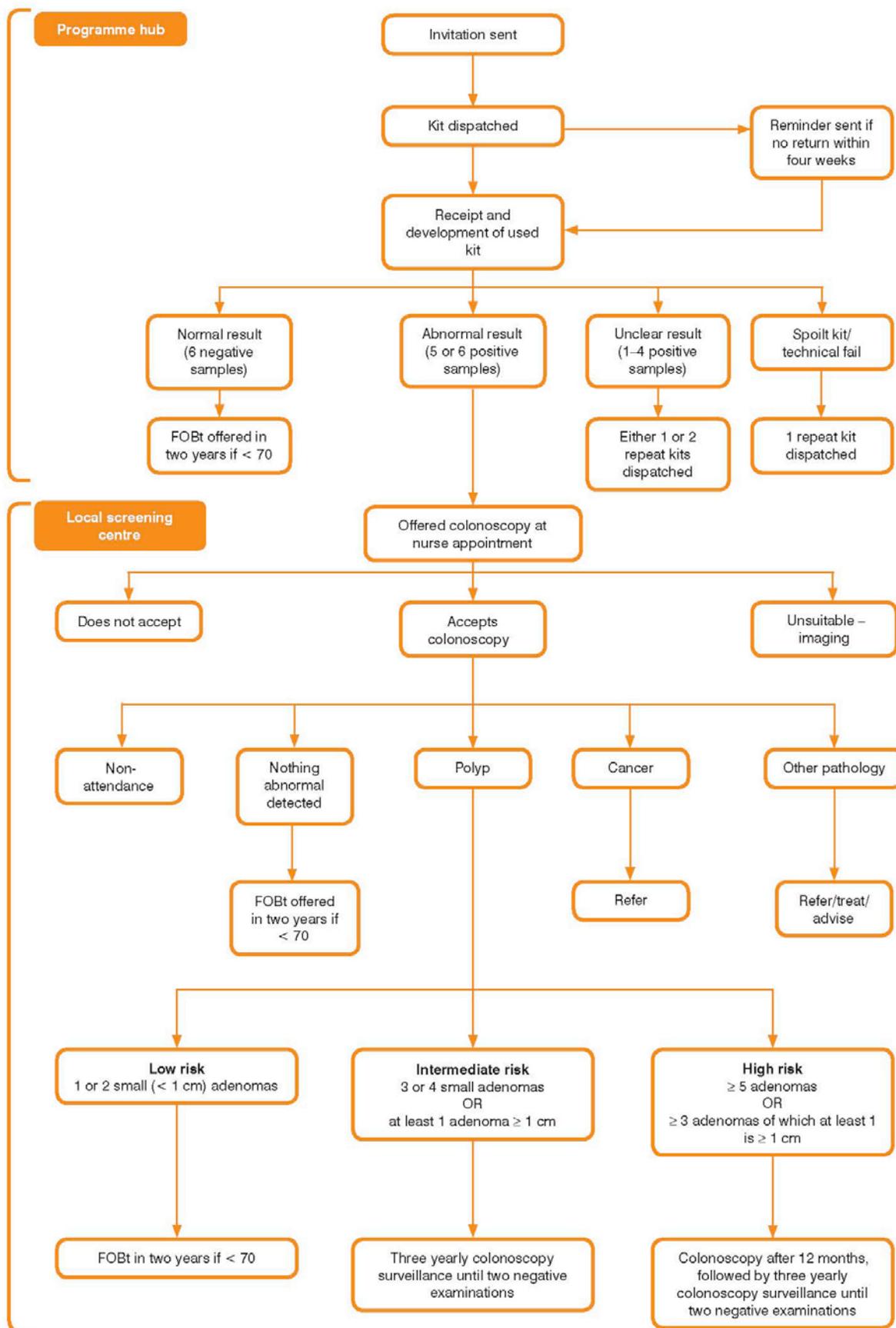
Accreditation, training, guidance, research

2.7. The provider should ensure that:

- hub laboratories are CPA accredited
- screening colonoscopists are appropriately accredited
- endoscopy units are JAG accredited
- SSPs have undertaken the SSP training course within 12 months of starting in post. The course should be successfully completed for the SSP to remain in post.
- pathologists reporting pathology for the programme participate in the EQA scheme and adhere in their reporting to the minimum data set from the Royal College of Pathologists

Care Pathway

2.8. The flow diagram shows the pathway from the despatch of an invitation to the final outcome of the screening examination.



Failsafe arrangements

- 2.9. Quality assurance within the screening pathway is managed by the inclusion of failsafe processes. Failsafes are a back-up mechanism, designed to ensure that, where something goes wrong, processes are in place to identify what is going wrong and what actions are necessary to ensure a safe outcome.
- 2.10. The provider will:
- include appropriate failsafe mechanisms across the whole screening pathway. Details of appropriate procedures are embedded in the guidance and recommendations on the NHSBCSP's websites
 - review and risk-assess local screening pathways in the light of guidance offered by quality assurance teams or the national office of the cancer screening programmes within PHE
 - ensure that appropriate links are made between the programme and internal provider governance arrangements, such as risk registers
 - work with NHS England and local quality assurance teams within Public Health England to develop, implement, and maintain appropriate risk reduction measures
 - ensure that mechanisms are in place for implementation and regular audit of risk reduction measures and reporting of incidents
 - ensure that routine staff training and ongoing development take place.

Roles and accountabilities

- 2.11. The NHSBCSP is dependent on systematic, specified relationships between stakeholders (which include treatment services, the laboratory, external diagnostic services, Primary Care representatives, etc). The provider will be expected to take the lead in ensuring that inter-organisational systems are in place to maintain the quality of the whole screening pathway. This will include, but is not limited to:
- providing coordinated screening across organisations, so that all parties are clear about their roles and responsibilities at every stage of the screening pathway, and particularly where responsibility for a patient is transferred from one party to another.
 - developing joint audit and monitoring processes
 - agreeing joint failsafe mechanisms, where required, to ensure safe and timely processes across the whole screening pathway
 - contributing to any initiatives led by NHS England or PHE to develop the screening pathway in line with NHSBCSP expectations
 - maintaining robust electronic links with the IT systems of relevant organisations across the screening pathway
 - agreeing links with primary care, and with secondary and/ or tertiary care.

- 2.12. The lead responsibility for an individual's care rests with the hub (laboratory) until that individual attends his or her first SSP appointment. At this point, lead responsibility transfers to the local screening centre.

Commissioning arrangements

- 2.13. Bowel cancer screening services will be commissioned by NHS England alongside specialised commissioning of cancer services. Minimum data requirements for NHS England are shown in Appendix 3.

Links with the National Programme and 'Do once and share'

- 2.14. Certain functions of English national cancer screening programmes are managed from PHE by the national office of the cancer screening programmes. National guidance documents can be accessed via the NHSBCSP websites.

3. Delivery of the screening programme

Service model summary

- 3.1. In line with the guidance on bowel cancer screening ^{1, ii} and in accordance with the national standards, the hub will:
- Manage the invitation process so that there is minimal fluctuation in the distribution of invitations, and that they are sent at a rate to ensure that individuals are not invited more than six weeks before or six weeks after their screening due date.
 - deal with telephone queries (regarding any aspect of the screening programme, including bowel disease history and endoscopy)
 - ensure that screening kits are processed in a timely and effective manner
 - ensure that results of FOBt screening kits are communicated in a timely manner (individuals and their GPs should receive written results within two weeks of the laboratory's receipt of the completed kit)
 - enable individuals to be offered an appointment at an SSP clinic within 14 days of a definite abnormal FOBt result.
- 3.2. In accordance with the national standards, the local screening centre will:
- educate and liaise with local primary care and public health services, including engagement with local health promotion activities to improve access to screening across all sectors of society
 - liaise with programme hubs, and monitor workflow in order to adjust invitations and referrals where necessary
 - where intermediate/high risk adenomas or a cancer is detected, communicate directly with individuals to offer an appointment to discuss the results
 - refer individual individuals for further investigation and treatment according to local pre-agreed protocols
 - liaise with MDTs and treatment services, including pathology, to ensure appropriate follow up of results and facilitate audit
 - collect and monitor data about treatment and histology outcome, and adverse events
 - where appropriate, offer individuals an appointment for a screening colonoscopy within 14 days of an SSP appointment.
- 3.3. There must be seamless links between 'screening responsibility' and 'treatment responsibility', so that at the end of the screening process individuals are referred to treatment services, once a diagnosis of cancer is made explicit.

- 3.4. All elements of the screening pathway must be delivered by appropriate staff, to national standards and guidelines.

Population Coverage

- 3.5. NHS England and service providers will work together to:
- optimise coverage and uptake across their catchment area
 - co-operate with regular analysis of screening coverage to identify groups who either access screening at lower levels, or do not access services at all
 - ensure that the participation rates are optimal
- 3.6. NHS England will provide annual estimates of the eligible (resident) population for at least three years ahead, based on the current resident population database.

Programme Coordination

The provider will

- be responsible for ensuring that the part of the programme they deliver is co-ordinated. Where collaboration is necessary, each part of the programme should interface seamlessly with others, particularly in the areas of timeliness and data sharing. This will ensure that the aims and objectives of the NHSBCSP are met.
- ensure that one named individual in each screening centre is responsible for the co-ordination of planning and delivery. This individual should be given appropriate administrative support to ensure timely reporting and response to requests for information.
- appoint a named Director and Programme Manager at each hub and each screening centre. Both must be actively involved in the screening programme, and the provider must provide both with adequate resources to carry out their role effectively.
- ensure that adequate cover arrangements are in place to ensure sustainability and consistency of the programme.
- meet with NHS England at regular intervals (at least annually). The meetings will include representatives from programme management, clinical services, laboratory services, and service management.

Clinical and corporate governance

- 3.7. The provider of screening will:
- ensure that staff co-operate with, and are represented on, the local screening oversight arrangements/ structures. This might include the local office of NHS England, and local authority Health and Wellbeing Boards
 - identify responsibility for the screening programme at Trust Director level, or ensure that the Medical Director delegates this responsibility to a named individual

- ensure that there is appropriate internal clinical oversight of the programme's management and internal governance by both a Clinical Lead and a Programme Manager respectively
- provide evidence of effective clinical governance arrangements on request
- regularly monitor and audit the screening programme as part of organisation's clinical governance arrangements, thus assuring the organisation's Board of the quality and integrity of the service
- comply with NHSBCSP guidance on managing serious untoward incidents
- put arrangements in place to refer appropriate individuals in a timely manner into treatment services (these should meet NHSBCSP standards)
- produce an annual report of screening services, which is signed off by the organisation's board
- have a sound governance framework in place covering the following areas:
 - information governance/records management
 - equality and diversity, as defined by the Equality Act 2010
 - user involvement, experience, and complaints
 - failsafe procedures
 - communications
 - ongoing risk management
 - health and safety
 - insurance and liability

Definition, identification, and invitation of cohort/eligibility

- 3.8. The target population to whom screening is to be offered comprises all individuals in the eligible age group who are registered with a GP in the specified area, entitled to NHS care, and have a functioning bowel.
- 3.9. The target age group for FOBt testing is currently men and women aged 60-74, who are sent an invitation to screening every 2 years. People aged 75 and over can self-refer to the screening programme.

The provider will

- Ensure that non responders are sent a reminder letter. If an individual does not respond to this reminder, he/she will be sent another screening kit in two years. This is in accordance with national policy.
- Make every effort to optimise screening participation from vulnerable and hard-to-reach groups within the eligible population.

Location(s) of programme delivery

- 3.10. The NHSBCSP is organised around five programme hubs, located in Gateshead; Nottingham; Rugby; London; and Guildford. The hubs:

- manage call/recall for the screening programme
- provide a telephone helpline for people invited for screening
- despatch and process FOBt kits
- send test result letters and notify GPs of results
- book the first appointment at an SSP clinic for individuals with a definitive abnormal result.

3.11. Up to 20 screening centres are linked to each programme hub (Figure 2). The clinical tasks for each screening centre are:

- to provide SSP clinics for individuals with a definitive abnormal test result
- to arrange screening colonoscopy appointments for individuals with a definitive abnormal test result, and for those scheduled for polyp surveillance
- to arrange alternative investigations for individuals in whom screening colonoscopy has failed or for whom colonoscopy is inappropriate as the first line diagnostic test
- to ensure appropriate follow-up or treatment for individuals after screening colonoscopy
- to provide information about screening to the local health community, and promote the screening programme to the general public
- to provide information and support for local people completing the FOBt
- to ensure that data are collected to enable audit and evaluation of the screening programme.

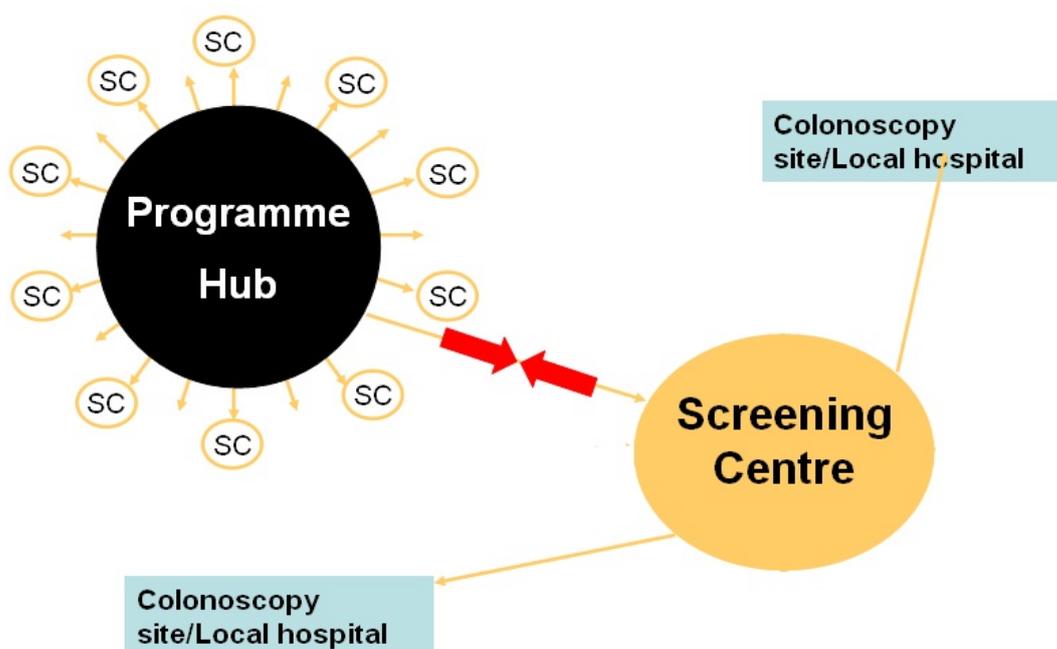


Figure 1. Relationship of Programme Hubs and Screening Centres

Days/ hours of operation

- 3.12. The days and hours of operation will be locally determined. However, timeliness of screening, assessment, and follow-up is essential, and this is a key criterion of quality along all parts of the screening pathway. The provider should therefore be able to:
- demonstrate efficient and effective use of resources.

Working across interfaces

- 3.13. The screening programme is dependent on strong working relationships (both formal and informal) between the professionals and organisations involved in the screening pathway. Accurate and timely communication and handover across these interfaces are necessary to reduce the potential for errors and ensure a seamless care pathway. The provider will
- ensure that there are clear, named lines of clinical responsibility at all times, and particularly where there is handover of care.
 - state these lines of clinical responsibility in an operational policy within the programme.
- 3.14. The provider will ensure that appropriate systems are in place to support an inter-agency approach to the quality of the interface between these services. This will include, but is not limited to:
- 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
 - working to agreed NHSBCSP standards and policies
 - agreeing jointly, between all agencies, on the failsafe mechanisms that are required to ensure safe and timely processes across the whole screening pathway
 - meeting the standards set by the national office of the NHS Cancer Screening Programmes within Public Health England
- 3.15. The provider must ensure that procedures at interfaces should follow these guidelines:
- hubs must send FOBt kits to individuals in the eligible population
 - screening hub staff should send letters to deliver normal results or to recall individuals for further assessment
 - the report of the findings of screening colonoscopy provided on the day of assessment should be given in person by appropriately trained clinical staff at the screening centres, in a manner that meets the needs of the individual concerned

- a failsafe system should be in place at screening centres to ensure receipt by the local Trust pathology laboratory of correctly identified samples from the endoscopy unit
- GPs should be informed of screening outcomes by the hubs.

3.16. In addition, see Care Pathway in Chapter 2.

Information on test/screening programme

3.17. The provider will

- ensure that, at relevant points throughout the screening pathway, those invited are provided with approved information on bowel cancer screening.
- ensure that a trained interpreter is available during appointments for those people whose functional language is not English, along with appropriate written information
- provide appropriate support for people with physical disabilities
- ensure that people with learning disabilities are provided with support to enable them to understand all processes and results

Testing (laboratory service, performance of tests by individuals)

3.18. The provider will ensure that

- hub laboratories follow the policy guidance and standards laid out in condition-specific laboratory handbooks covering screening.
- pathologists reporting specimens from the programme participate in the EQA scheme and report according to the Royal College of Pathologist's minimum dataset.
- Laboratories provide routine data to the screening programme in a timely manner and an agreed format.

Results reporting and recording

3.19. The provider will ensure that

- conclusive results are recorded on the national database at all points of the pathway, for the whole screened population.

Providing results

3.20. The provider will ensure that

- Individuals are notified of a normal result from the screening process by letter, and that their GP is also informed
- The results of any diagnostic tests undertaken are given by appropriately trained clinical staff.

- A Specialist Screening Practitioner will be available to support the individual as required after a benign diagnosis or a diagnosis of cancer.

Scope for cancer screening

3.21. The NHSBCSP includes:

- all investigations necessary to prove or disprove the presence of bowel cancer
- surveillance of individuals deemed to be at high or intermediate risk of cancer following adenoma findings at a previous screening episode.

Transfer of, and discharge from, care obligations

3.22. The screening programme covers the period from identification of the eligible population to diagnosis. The provider will ensure that

- Individuals are transferred efficiently to treatment services on diagnosis. Any post-treatment follow-up will be the responsibility of the treatment services.
- Individuals who have been diagnosed with bowel cancer continue to receive invitations to screening as long as they remain eligible.

Exclusion criteria

3.23. This specification does not include the following, or any work or cost associated with them:

- Screening for people who fall below the current eligible age range
- Screening for people who are not registered on any NHAIS systems
- Screening for people who have had a colectomy
- Symptomatic referrals
- Post cancer diagnosis follow-up and management
- Cancer treatment and staging.

3.24. See Clause 54 of *The Standard Terms and Conditions for Acute Hospitals* (Gateway Reference 15458) for the contractual requirements for equity of access, equality, and the avoidance of discrimination.

Staffing

3.25. The provider will

- ensure that there are adequate numbers of trained, qualified, and competent staff in place to deliver a high-quality bowel cancer screening programme, in line with best practice guidelines and NHSBCSP national guidance.

- Ensure that all staff demonstrate competence in their area, linked to training (qualifications will be specific to the groups of staff delivering the service across the care pathway).
- have in place a workforce plan designed to maintain a sustainable programme, especially where an increase in the eligible population is predicted (generally this is the case until 2027) and/or where there are difficulties in the recruitment of appropriately qualified healthcare staff.
- ensure that professionals involved in the NHSBCSP are required to keep up-to-date with nationally approved training programmes and CPD/CME. They should participate in educational schemes and histopathology EQA where appropriate

User involvement

- 3.26. In accordance with good practice, to gain feedback on services provided and to have public involvement on the provision of services, the provider will collect the views of service users via surveys or questionnaires. It is expected that such surveys will take place on a regular (rather than ad hoc) basis and that the results will be made available to NHS England. The provider will:
- demonstrate that they have collected (or have plans in place to collect) the views of service users (both people invited for screening and those who have attended for a colonoscopy or an appointment with a Specialist Screening Practitioner), in respect of the services they provide
 - demonstrate how those views will influence service delivery for the purposes of raising quality
 - show that all participants are given information about how to provide feedback about services they receive, including the complaints procedure.

Premises and equipment

- 3.27. The provider will ensure that:
- suitable premises and equipment are provided for the screening programme
 - appropriate policies are in place for equipment cleaning, decontamination, calibration, maintenance, and replacement
 - the BCSS IT system is able to support the programme and to supply data for the purpose of auditing performance against national standards and KPIs
 - the BCSS IT system is able to perform failsafe checks
 - laboratories and endoscopy services are accredited by UKAS or JAG, as appropriate.
- only technologies and protocols that have been evaluated and recommended by the national office of the Cancer Screening Programmes within PHE are used in the programme, and that the manner of their use accords with national guidelines. The

provider must make all staff aware that unorthodox use of approved technologies or use of unapproved technologies is prohibited within the NHS Bowel Screening Programme, except as part of a formal national pilot, or a properly constituted and approved research project. The definition of ‘technology’ here is an inclusive one.

Key Performance Indicators

3.28. These are set out in Appendix 2.

Data collection and monitoring

3.29. The provider will

- provide routine data to NHS England, Public Health England, and the Health and Social Care Information Centre, in a timely manner.
- Contribute to national data collection exercises where required
- Provide annual data measuring performance against both standards and the Key Performance Indicators

Data reporting

3.30. The provider will

- Report data to NHS England and Public Health England on a quarterly and annual basis. Appendix 3 shows routine data requirements.

4. Service standards, risks and Quality Assurance

Key criteria and standards

- 4.1. Providers must
- meet at least the minimum NHSBCSP standards found in Appendix 1, and strive for the achievable standards
 - adhere to specific professional standards outlined in NHSBCSP guidance
- 4.2. The national office of the NHSBCSP within Public Health England must
- support health professionals in their efforts to meet these standards and deliver a high quality bowel cancer screening programme.
 - Make available a number of resources to support health professionals on NHSBCSP websites.

Risk assessment of the screening pathway

- 4.3. Providers:
- must have in place an internal quality assurance process that assures NHS England and the quality assurance team within PHE of their ability to manage the risks of running a screening programme.
 - may use the Failures Modes and Effects Analysis (FMEA) method of analysis, which is recommended by the NHS National Patient Safety Agency's risk assessment programme. Risks should be defined in the standard NHS format (where likelihood and severity are multiplied to give a RAG score).
 - must maintain a register of risks, working with NHS England and quality assurance teams within PHE to identify key areas of risk in the screening pathway, and ensuring that these points are reviewed in contracting and peer review processes.
 - Must identify and agree with NHS England on a quarterly basis high scoring risks, and put plans in place to mitigate these.

Quality assurance

- 4.4. The provider will:
- meet national programme standards, or have plans in place to meet them.
 - participate fully in national quality assurance processes and respond in a timely manner to recommendations made

- ensure that data on participation from external quality assurance programmes are available to quality assurance teams within PHE, the national office of the Cancer Screening Programmes within PHE, and NHS England
- collect and submit minimum datasets as required, to assure NHS England and the quality assurance team within PHE of the safety and quality of the services provided
- participate in the quality assurance visit process and provide required data for these visits in a timely fashion.

Serious untoward incidents

- 4.5. Complex screening pathways often involve multidisciplinary teams working across several NHS organisations in both primary and secondary care. Inappropriate actions within one area, or communication failures between providers, can result in serious untoward incidents.
- 4.6. A screening incident is any unintended or unexpected incident(s) that could have or did lead to harm to one or more persons who are eligible for NHS screening, or to staff working in the screening programme.
- 4.7. A screening incident can affect populations as well as individuals, and be the result of an actual or possible failure in the screening pathway or of a problem at the interface between screening and the next stage of care.
- 4.8. Although the level of risk to an individual in an incident may be low, because of the large numbers of people offered screening, this may equate to a high corporate risk. It is important to ensure that there is a proportionate response based on an accurate investigation and assessment of the risk of harm.
- 4.9. Potential serious incidents or serious near misses in screening programmes should be investigated with the same level of priority as actual serious incidents.
- 4.10. Whether a “serious incident” should be declared is a matter of professional judgement on a case by case basis. It should be a joint decision by the key stakeholders informed by protocol and advice from experts and quality assurance teams.
- 4.11. In distinguishing between a screening incident and a serious screening incident, consideration should be given to whether individuals, the public or staff would suffer avoidable severe (i.e. permanent) harm or death if the problem is unresolved.
- 4.12. The provider will:
- comply with screening incident handling guidance developed by the national office of the Cancer Screening Programmes, including joint guidance developed with the UK National Screening Committee
 - provide all reasonable assistance to NHS England and the cancer screening quality assurance team within Public Health England in investigating and handling an incident

- regularly review their processes and procedures against NHSBCSP programme standards to reduce the likelihood of incidents occurring

Continual service improvement

The provider will:

- in the event that national recommendations and core and/or developmental standards are not currently fully implemented, use service plans to indicate the changes and improvements that will be made over the course of the contract period
- develop a CSIP (Continual Service Improvement Plan) on the basis of the findings of the KPIs and the results of internal and external quality assurance checks. The CSIP will respond to any performance issues highlighted by NHS England, paying due regard to concerns raised via feedback from both people invited for screening and those who have attended. The CSIP will contain action plans with defined timescales and responsibilities, and will be agreed with NHS England.

5. Costs

- 5.1. Funding for bowel scope screening will be provided centrally by the national office of the cancer screening programmes within Public Health England.
- 5.2. Funding for faecal immunochemical testing (FIT) will be provided by national office of the cancer screening programmes within Public Health England.

6. Teaching and research activities

- 6.1. Research activities are encouraged, but must have the appropriate approvals, including the NHSBCSP Research Committee.

APPENDIX 1: Consolidated overview of the current NHSBCSP national minimum standards

	Objective	Measure	How is the measure assessed?
1	Identify cohort	100% of eligible population to be invited at appropriate intervals	All individuals listed on population database to be invited (monitor using BCSS)
2	Inform	100% of invited individuals to be offered informed choice	All individuals to be sent bowel cancer screening information leaflet with invitation and further information about colonoscopy if appropriate Helplines to have translation facilities into main languages. SSP Clinics to have translation/interpreter facilities into main languages available Local PCT/screening centre health promotion strategy should be in place
3	Invite	90% of eligible population who receive an invitation letter to be sent kit	Monitor invitations issued. Monitor kits sent Exclusion criteria appropriate applied according to national guidance Make available, and use, hub helplines Monitor coverage and uptake rates by gender, locality, ethnicity, and index of multiple deprivation
4	Test	100% FOBt kits reported within date Reporting profiles of laboratory and individual screeners in line with national standards (under development)	Adherence to SOPs Achievement and maintenance of CPA accreditation Monitor reporting profiles of laboratory and individual screeners
5	Minimising harm	100% of results sent to participant to be received in 14 days 100% of first offered clinic appointments to be offered within 14 days of abnormal test result Trained specialist screening practitioners' assessments to be completed according to national guidelines	BCSS BCSS Training/clinic records

Public health functions to be exercised by NHS England

6	Diagnose	<p>100% of colonoscopists to be accredited to BSCP</p> <p>100% of colonoscopy sites to be JAG accredited</p> <p>Achievement of endoscopy standards</p> <p>Adherence of pathology reporting standards</p>	<p>Individual JAG/clinic records</p> <p>JAG/clinic records (62 day wait)</p> <p>BCSS</p> <p>BCSS</p>
7	Treat/Intervene	<p>Endoscopic polypectomy undertaken by accredited screening colonoscopists</p> <p>Timely referral for operative polypectomy</p> <p>Timely referral to appropriate MDT for cancer treatment</p> <p>Appropriate referral for management of incidental findings where needed</p>	<p>Individual JAG/clinic records</p> <p>BCSS/clinic records (18 week wait)</p> <p>BCSS/clinic records (62 day wait)</p> <p>BCSS/clinic records (18 week wait)</p>
8	Outcome	<p>16% reduction in mortality in population invited for screening</p>	<p>NCIN data</p>
9	Staff	<p>All staff to be appropriately trained and qualified</p>	<p>Staff accreditation, CPD, EQA records</p>
10	Commissioning and Governance	<p>Commissioning of services according to DH collaborative commissioning guidance</p>	<p>SLAs with Commissioners in place for all screening colonoscopy sites within a screening hub</p> <p>Audit reports</p> <p>Regular financial reporting</p> <p>Clear clinical governance accountability within Trusts</p>

APPENDIX 2: Key Performance Indicators (KPIs)

KPI Name	KPI Description	Min Standard	Reporting	Report available?
Invitations Sent	The total number of invitations sent, including over-age self-referrers	N/A	Monthly	✓ OBIEE Report
Kits Sent	The total number of kits sent, including: self-refer kits, retest kits, and new kits requested	N/A	Monthly	✓ OBIEE Report
Kits Returned	The total number of kits returned, including: self-refer kits, retest kits, and new kits requested	N/A	Monthly	✓ OBIEE Report
Uptake	Percentage of people adequately screened ¹ out of those invited ² for FOBt screening ³	52%	Monthly	✓ OBIEE Report
Positivity	Percentage of people with a definitive FOBt outcome of 'abnormal' out of those who were adequately screened ^{1,4} (via FOBt). Expected value = 2%	N/A	Monthly	✓ OBIEE Report
Coverage	Percentage of people adequately screened ¹ in the last 2.5 years out of those who are eligible ⁵ for FOBt screening	Awaiting data	Quarterly	Awaiting KC73
SSP Waiting Times	Percentage of people where the elapsed time between the definitive abnormal FOBt date (booked date) and the first offered 'SSP colonoscopy assessment date' falls within the 14 day specified time limit, out of those given an 'SSP colonoscopy assessment date'	100% ≤14 days	Monthly	✓ OBIEE Report
Diagnostic Test Waiting Times	Percentage of people where the elapsed time between the 'SSP colonoscopy assessment date' ⁶ and the first offered diagnostic test date falls within the 14 day specified time limit, out of those offered a first diagnostic test	100% ≤14 days	Monthly	✓ OBIEE Report
Colonoscopy Uptake	Percentage of people who attend at least 1 screening colonoscopy ^{7,8} , out of those with a definitive abnormal FOBt result (within the same episode).	81%	Quarterly	✓ OBIEE Report

¹ Adequately screened: reaching a definitive FOBt outcome of either 'Normal' or 'Abnormal' from potentially multiple FOBt test kits

² Invited: does not include 'over age self-referrers' or 'late responders'. Late responders as those requesting to continue a closed episode ≥ 6 months / 182 days from initial invitation date.

³ No adjustment is made for undelivered letters and test kits

⁴ Positivity is calculated for the invited population only

⁵ People eligible: everyone registered and live on BCSS less those 'clinically ineligible'. The main reason for clinical ineligibility is: absence of a functioning bowel.

NOTE: People who withdraw from the programme, for example due to 'informed dissent' or under MCA 2005, remain 'eligible' but are not sent invites. Subjects ceased as 'under active treatment for bowel cancer' also remain 'eligible' as long as they retain any part of a functioning bowel.

⁶ If a patient attends more than one colonoscopy assessment appointment within an episode, the most recent (latest) date should be used in the calculation.

⁷ Attended colonoscopies include: colonoscopies where consent was withdrawn during the procedure and incomplete colonoscopies (caecum not reached).

⁸ Attended colonoscopies exclude: flexible sigmoidoscopies and limited colonoscopies, colonoscopies where consent was refused before the procedure started

Public health functions to be exercised by NHS England

Adenoma Detection	Percentage of colonoscopies where at least one histologically confirmed adenoma was detected, out of all the 'index screening colonoscopies' ⁹ performed. Expected value $\geq 44\%$	40%	Quarterly	✓ OBIEE Report
Colonoscopies performed	Count of the total number of screening programme colonoscopies ¹⁰ performed per year, per colonoscopist	≥ 150 per year (pro rata)	Quarterly	✓ OBIEE Report
Cancers Found	Percentage of confirmed cancers, out of the total number of people who had at least one diagnostic test	8%	Quarterly	✓ OBIEE Report
Cancer Staging: TNM	Percentage of TNM staged cancers ¹¹ , out of the total number of confirmed cancers found	100% within 12 months	Monthly	✓ OBIEE Report
Pathologist Reporting	Percentage of NHS BCSP pathology samples (polyps and cancers) reported within the target time, out of all the NHS BCSP pathology samples reported ¹²	100% ≤ 7 days	Monthly	✓ OBIEE Report

⁹ Index screening colonoscopy: each patient's first screening colonoscopy

¹⁰ Screening, surveillance, diagnostic and therapeutic tests. Multiple tests per patient. Incomplete tests (caecum not reached). Tests where consent was withdrawn during the procedure

¹¹ Final pre-treat TMN values

¹² Pathology turnaround times were only added into BCSS on the 2nd April 2013. No data is available for this report before this date.

APPENDIX 3: Routine data requirements

The Screening Programme Manager will provide NHS England with the following information:

Quarterly (to monitor against standards in Appendix 1)

Data required will include

- number of individuals attending first SSP clinic appointment
- number of individuals who DNA at SSP clinic
- number of screening colonoscopy sessions run
- number of screening colonoscopies undertaken
- number of individuals DNA at screening colonoscopy
- number of other tests undertaken
- time from SSP clinic appointment to first offered screening colonoscopy appointment (excluding “stop the clock” individuals)
- number of follow-up clinics run
- number of individuals seen at follow up clinics
- details of all cancers found including pathology and initial treatment even if not treated at the same Trust;
- data to meet quality assurance endoscopy standards

References

ⁱ *Guidance for Public Health and Commissioners*. NHSCSP Publications No **3**, January 2008.

ⁱⁱ *Reporting Lesions in the NHS Bowel Cancer Screening Programme*. NHSCSP Publications No **1**, September 2007.