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Service specification no.26

Bowel Cancer Screening Programme

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Service specification no.26

Bowel Cancer Screening Programme

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Department of Health

Contents

Service specification No.26

This is a service specification within Annex C of the ‘NHS public health functions agreement 2015-16 (the ‘2015-16 agreement’) published in December 2014.

This service specification is to be applied by NHS England in accordance with the 2015-16 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 2015-16 agreement was made between the Secretary of State and NHS England Board. Any changes in other published documents or standards may have effect for the purposes of the 2015-16 agreement in accordance with the procedures described in Chapter 3 of the 2015-16 agreement

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

The 2015-16 agreement including all service specifications within Annex 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[i]:

- 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 set out in Appendix 1 and 2
- 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 safety concerns, safety incidents and serious 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. Minimum data requirements for NHS England are shown in Appendix 1 and 2.

- 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 NHSBSCP EQA scheme
- ensure that pathologists reporting material on behalf of the NHSBCSP adhere to RCPath/ NHSBSCP 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 3, 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.

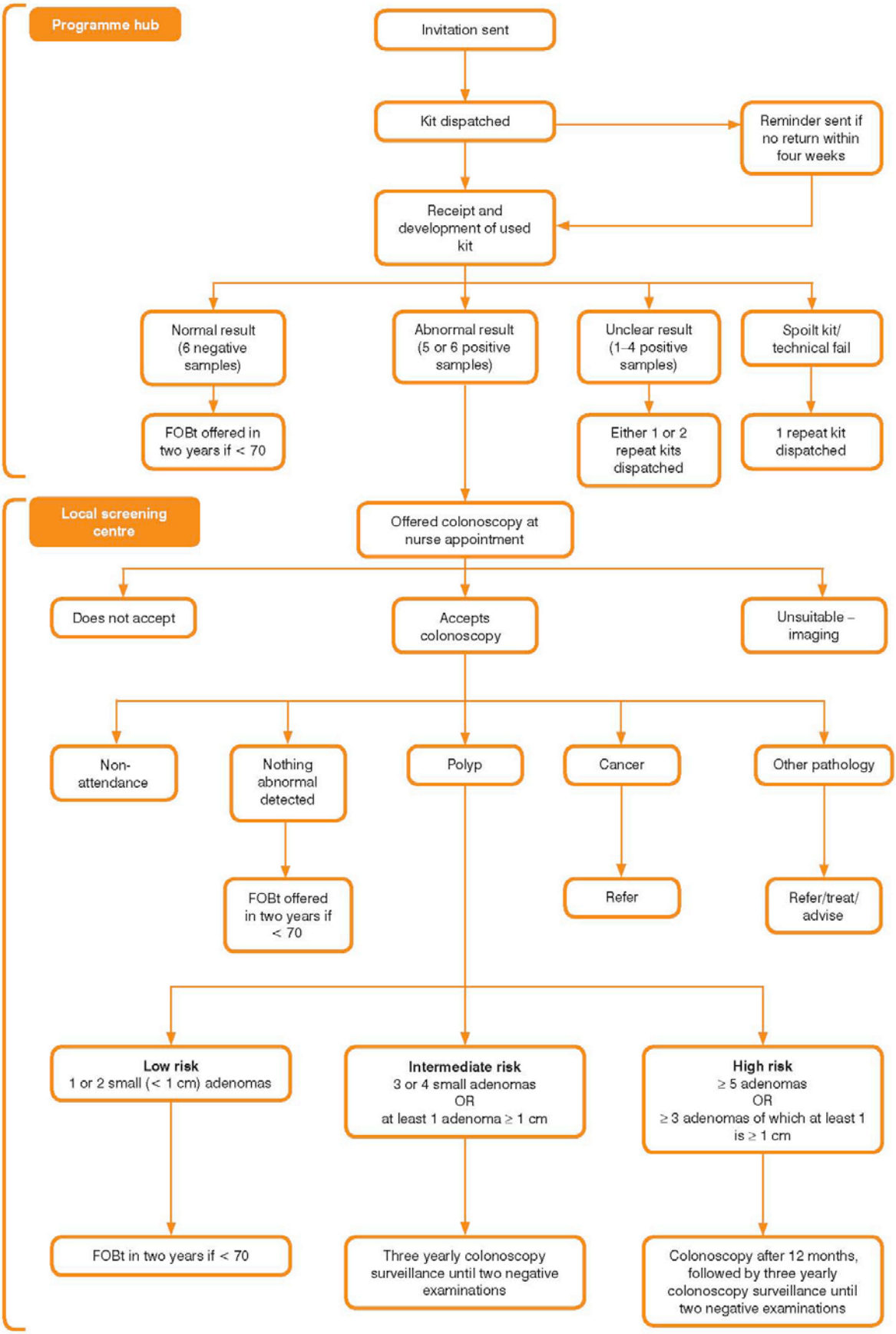
Accreditation, training, guidance, research

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.


Programme hub
Invitation sent
Kit dispatched
Reminder sent if no return within four weeks
Receipt and development of used kit
Normal result (6 negative samples)
Abnormal result (5 or 6 positive samples)
Unclear result (1–4 positive samples)
Spoilt kit/ technical fail
FOBt offered in two years if < 70
Either 1 or 2 repeat kits dispatched
1 repeat kit dispatched
Local screening centre
Offered colonoscopy at nurse appointment
Does not accept
Accepts colonoscopy
Unsuitable – imaging
Non-attendance
Nothing abnormal detected
Polyp
Cancer
Other pathology
FOBt offered in two years if < 70
Refer
Refer/treat/ advise
Low risk
1 or 2 small (< 1 cm) adenomas
Intermediate risk
3 or 4 small adenomas
OR
at least 1 adenoma ≥ 1 cm
High risk
≥ 5 adenomas
OR
≥ 3 adenomas of which at least 1 is ≥ 1 cm
FOBt in two years if < 70
Three yearly colonoscopy surveillance until two negative examinations
Colonoscopy after 12 months, followed by three yearly colonoscopy surveillance until two negative examinations

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 safety concerns, safety incidents and serious 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.

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

2.13. 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 fluctuations 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 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

3.7. 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

3.8. The provider of screening will:

- ensure that staff co-operate with, and are represented on, the local screening oversight arrangements/ structures.
- 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 safety concerns, safety incidents and serious 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

3.9. 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.

3.10. 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.

3.11. 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

3.12. 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.

3.13. Up to 20 screening centres are linked to each programme hub (see 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.

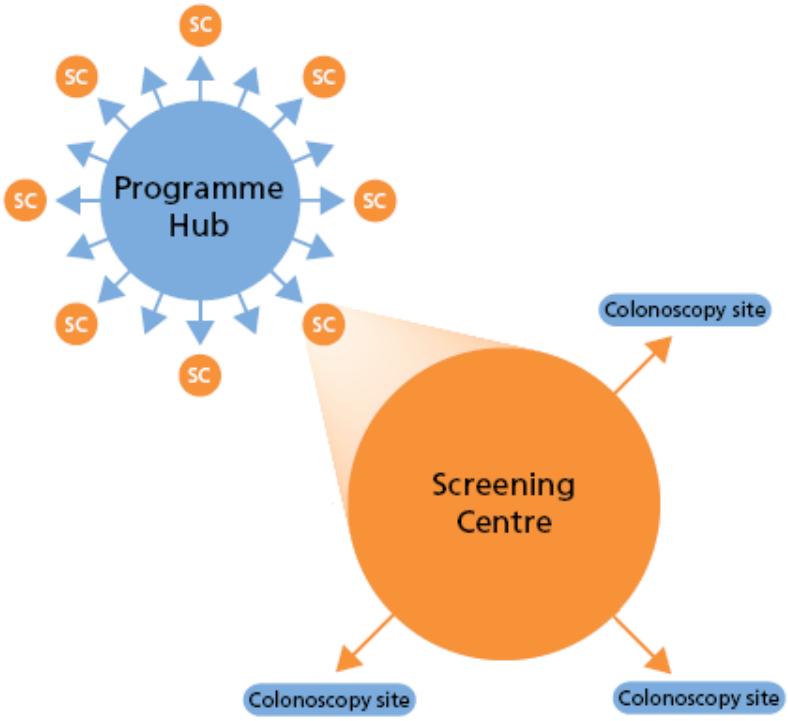


Figure 2. Relationship of Programme Hubs and Screening Centres

Days/ hours of operation

3.14. 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

3.15. 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.

3.16. 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

3.17. 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.

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

Information on test/screening programme

3.19. 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)

3.20. 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

3.21. 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

3.22. 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

3.23. 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

3.24. 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

3.25. 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 total colectomy or other bowel surgery which prohibits screening
- Symptomatic referrals
- Post cancer diagnosis follow-up and management
- Cancer treatment and staging.

3.26. 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

3.27. 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

3.28. 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

3.29. 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

3.30. These are set out in Appendix 1.

Data collection and monitoring

3.31. The provider will

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

Data reporting

3.32. The Quality Assurance service, in liaison with the providers, will:

- Report data to NHS England and Public Health England on a quarterly and annual basis. Appendix 2 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 2,
- 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

Safety concerns, safety incidents and serious 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 safety concerns, safety incidents or serious 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 safety concern or 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 safety concerns, safety incidents or 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 safety 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 the national guidance for the management of safety concerns and incidents in screening programmes and NHS England guidance for the management of serious incidents http://www.screening.nhs.uk/incidents provide all reasonable assistance to NHS England and the cancer screening quality

assurance team within Public Health England in investigating and handling an safety concern, safety incident or serious incident

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

Continual service improvement

4.13. 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.

7. Appendices

Appendix 1 – Key Performance Indicators

Key Performance Indicators (KPIs) for cancer screening programmes are produced and validated by the Quality Assurance Service and are available for Area Teams, Commissioners, Screening Programme Personnel and QA Professionals to assess the performance of their programmes. The reporting period is variable depending on the individual indicator and may be reported in arrears to ensure that the data is valid and reliable.

Some indicators are reported quarterly, although data is generated monthly to allow for monitoring of trends and more indepth analysis.

Commissioners of screening centres are advised to analyse KPIs 1-8

Commissioners of programme hubs are advised to analyse KPI 1-7

Appendix 2 – Performance Indicators

These indicators are used for quality assurance purposes. Whilst achievement of at least the minimum standard is required, they are not generally considered KPIs for contract monitoring purposes.

The cancer screening programmes have published guidelines for all disciplines involved in the three services (bowel, breast and cervical). The Quality Assurance service provides on-going monitoring of the numerous indicators associated with the guidance and these are formally reported at QA visits. Commissioners who require confirmation on the quality of any aspect of their screening services can access this information readily from the regional QA service.

Appendix 2 data will only be produced at screening service level.

* NB: The BCSS (IT system) is about to undergo a re-write of the cancer audit dataset (CAD) which will affect the detailed reporting of cancer findings for a short time period

Appendix 1: Key Performance Indicators

KPIs for FOBt Bowel Cancer Screening to be produced at hub and screening centre level				
KPI	**Definition**	**Minimum standard**	**Reporting period**	**Source of report (provided by QA service)**
1. Invitations sent	The total number of invitations sent (including over-age self-referrers)	N/A	Monthly	OBIEE reports >> Screening Centre/Hub Dashboard >> Invitations & test kits tab Report the "Total invitations" count
2. Kits sent	The total number of kits sent, including self refer, retest kits and new kits requested	N/A	Monthly	OBIEE reports >> Screening Centre/Hub Dashboard >> Invitations & test kits tab Report the "Total kits sent" count
3. Kits returned	The total number of kits returned, including self-refer, retest kits and new kits requested	N/A	Monthly	OBIEE reports >> Screening Centre/Hub Dashboard >> Invitations & test kits tab Report the "Total kits returned" count
4. Uptake	Percentage of people adequately screened out of those invited for FOBt screening	52%	Monthly (3 months in arrears)	OBIEE reports >> Screening Centre/Hub Dashboard >> uptake and positivity tab Report the % Uptake
5. Positivity	Percentage of people with a definitive FOBt outcome of "abnormal" out of those who were adequately screened (via FOBt)	Expected value = 2%	Monthly (3 months in arrears)	OBIEE reports >> Screening Centre/Hub Dashboard >> Uptake and positivity tab Report the % Positivity
6. Coverage	Percentage of people adequately screened in the last 2.5 years out of those who are eligible for FOBt screening	Awaiting data	Quarterly (in arrears by 6 months)	GP practice profiles show coverage by GP practice, aggregated by CCG, and grouped by Area Teams.
7. 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% $\leq$ 14 days	Monthly	OBIEE reports >> Screening Centre/Hub Dashboard >> SSP waits tab Report the % within target and actual count
8. Diagnostic test waiting times	Percentage of people where the elapsed time between the "SSP colonoscopy assessment date" falls within the 14 day specified time limit, out of those given a "SSP colonoscopy assessment date"	100% $\leq$ 14 days	Monthly	OBIEE reports >> Screening Centre Dashboard >> Diagnostic test waits tab Report the % within target and actual count

Appendix 2: Part 1/2 Performance Indicators (screening centres only)

Indicator	Definition	Minimum standard	Reporting period	Source of report (provided by QA service)
9. Colonoscopy uptake	Percentage of people who attend at least 1 screening colonoscopy out of those with a definitive abnormal FOBt result (within the same episode)	81%	Quarterly (3 months in arrears)	OBIEE reports >> endoscopy QA standards >> Colonoscopy uptake tab Report the % uptake and actual count
10. Adenoma detection	Percentage of colonoscopies where at least one histologically confirmed adenoma was detected, out of all the "index screening colonoscopies" performed. Expected value $\geq$ 44%	40%	Quarterly	OBIEE reports >> endoscopy QA standards >> Adenoma detection tab Report the ADR % and actual count
11. Colonoscopies performed	Count of the total number of screening programme colonoscopies performed per year, per colonoscopist	$\geq$150 per year (pro rata)	Quarterly	OBIEE reports >> endoscopy QA standards >> Colonoscopies performed tab Report colonoscopies performed /endoscopist
12. Cancers found*	Percentage of confirmed cancers, out of the total number of people who had at least one diagnostic test	8%	Quarterly (annually in arrears)	OBIEE reports >> Pathology dashboard >> Cancer found tab Report the % cancer found and actual count
13. Cancer staging (TNM)*	Percentage of TNM staged cancers out of the total number of confirmed cancers found	100% within 12 months	Quarterly (annually in arrears)	OBIEE reports >> Pathology dashboard >> Cancer staging: TNM (final pre-treat TNM) Report the % TNM staged and actual count
14. Pathologist reporting	Percentage of NHSBCSP pathology samples (polyps and cancers) reported within the target time, out of all the NHSBCSP pathology samples reported	100% $\leq$ 7 days	Quarterly	OBIEE reports >> Pathology dashboard >> Pathologist tabs: "polyps" and "cancers" Report the % within target and actual count

Appendix 2: Part 2/2 Routine Data Requirements to Monitor against Selected Consolidated Standards

Data requirement	Frequency	Source of information (provided by QA service)	Definition
15. Number of individuals attending first SSP clinic appointment	Quarterly	OBIEE reports >> Screening Centre Dashboard >> SSP appointments tab Appointment type = "positive assessment" Report the count given in the "Attended count" column for each appropriate month	Number of attendances at FOBt positive colonoscopy fitness assessment • Where the appointment type is positive assessment
16. Number of individuals who DNA SSP clinic	Quarterly	OBIEE reports >> Screening Centre Dashboard >> SSP appointments tab Report the count given in the "DNA count" column for each appropriate month	Number of SSP clinics that were DNA'ed • include all SSP clinic types: FOBt positive assessment, surveillance, post investigation
17. Number of screening colonoscopies undertaken	Quarterly	OBIEE reports >> Screening Centre Dashboard >> Diagnostic test carried out tab Episode type = "screening" Report the count given in the "colonoscopy" column for each appropriate month	Number of screening colonoscopies undertaken. • Where the episode type is screening
18. Number of individuals DNA at screening colonoscopy	Quarterly	OBIEE reports >> Screening Centre Dashboard >> Diagnostic test attendance tab Episode type = "screening" Report the count given in the "did not attend count" column for each appropriate month	Number of diagnostic test procedures that were DNA'ed • Where the episode type is screening • Include all diagnostic test procedure types
19. Number of other tests undertaken	Quarterly	OBIEE reports >> Screening Centre Dashboard >> Diagnostic test carried out tab Episode type = "screening" Sum the counts for all procedures not in "colonoscopy" column for each appropriate month	Number of screening "other tests" undertaken • Where the episode type is screening

Appendix 3: Professional Best Practice Guidance

NHSBCSP 1: *Reporting Lesions in the NHS Bowel Cancer Screening Programme*
Published September 2007

NHSBCSP 2: *Bowel Cancer Screening Programme Ceasing Guidelines*
Published October 2007

NHSBCSP 3: *Guidance for public health and commissioners*
Published January 2008

NHSBCSP 4: *Evidence summary: patient information for the NHS Bowel Cancer Screening Programme*
Published November 2008

NHSBCSP 5: *Guidelines for the use of imaging in the NHS Bowel Cancer Screening Programme. Second edition*
Published November 2012

NHSBCSP 6: *Quality assurance guidelines for colonoscopy*
Published February 2011

8. 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.