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1. INTRODUCTION

1.1 Purpose of this document
The purpose of this document is to provide advice and support for SHAs who have been invited to nominate local endoscopy units to become local screening centres in the first wave of the implementation of the NHS Bowel Cancer Screening Programme (NHS BCSP).

1.2 National office
The national office of the NHS Cancer Screening Programmes will be available to provide advice and support for the implementation process. The national team have set up an intranet site www.bcsp.nhs.uk through which information and experience can be shared and the latest guidance can be disseminated. The site includes a series of implementation guides which give detailed advice and also includes other relevant documents, and links to useful websites. A User Directory gives contact details for those involved in implementation to exchange experience and information.

1.3 DH advice to the NHS
The Department of Health has published advice to the NHS which sets out the scope and delivery strategy for the programme. A copy of the DH advice is available on the NHS BCSP website www.bcsp.nhs.uk.

1.4 Improving endoscopy services
The national office has been working closely with the National Endoscopy Team to develop quality assurance in endoscopy as part of the bowel cancer screening programme. As part of the wider initiative to improve endoscopy services, a national training programme is already in place to expand endoscopy capacity to meet the demands of the screening programme. Three national and seven regional centres to train medical staff, GPs, nurses and other health professionals in endoscopy techniques have been established. Details can be found on the National Endoscopy Team website (www.endoscopy.nhs.uk).

1.5 IT systems
Work has already started in conjunction with Connecting for Health to develop an IT system to support all elements of the NHS BCSP. All programme hubs will be connected to the system. Any local endoscopy units which wish to become local screening centres must be connected to the NHS Net.
1.6 Letters and leaflets
Work is already going on to develop a set of national invitation letters, leaflets for patients, colonoscopy letters and information packs for GPs to support the rollout of the programme.

2. HOW THE PROGRAMME WILL BE ORGANISED

2.1 The screening process
The NHS BSCP will offer men and women aged 60 – 69 a guaiac based FOB test every two years. People aged 70 or over will be provided with an FOB test kit on request. Those testing positive will be offered colonoscopy as the investigation of choice. Where cancer is found, the individual will be referred for treatment as needed. Where an intermediate/high risk polyp is found, the individual will transfer from biennial FOB testing to 3 yearly colonoscopy. If a low risk polyp is found, or nothing abnormal detected, the individual will be offered an FOB test again after 4 years if they are still within the target age range. The process is shown in Figure 1.

2.2 Programme hubs
The programme will be organised around five programme hubs which will provide call and recall for the screening programme and despatch and processing of FOB test kits. These two activities are intimately interlinked due to the entirely postal nature of this initial stage of the screening programme. They can be most effectively carried out for very large populations of around ten million people. For 98% of the population, this is all the contact that there will be with the screening programme. Each programme hub will cover one Local Service Provider (LSP) cluster and link with its own LSP provider and with all the screening centres it serves. Each programme hub will be associated with about 20 screening centres.

2.3 Local screening centres
The local face of the Bowel Cancer Screening Programme will be the screening centres. They will act as the local management point for the programme and provide nurse clinics and colonoscopy for follow up of FOBt positive individuals. They will also act as the major source of information for the local health community and will be expected to take an active role in leading the promotion of the new service to the

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1 www.gutjnl.com

2 Based on National Programme for IT organisations
general public. When the programme is fully implemented, there are expected to be 90 – 100 local screening centres. Services should be planned around a single clinical team which delivers its services to a population of at least half a million people, and possibly up to 2 million people. FOBT screening will require one to two sessions per week of colonoscopy to follow up positive FOBT tests for a population of half a million in size. This team may deliver its service on a number of different sites but should maintain common protocols and a single clinical lead and single MDT at which screening patients and the programme can be discussed regularly.

2.4 Nurse clinics
Since there will be no direct contact between a health professional and an individual with a positive FOBT test, every positive FOBT result will be accompanied by the offer of a local appointment with a screening centre nurse to discuss the implications and to have colonoscopy offered and explained. The nurse will also assess the patient for fitness for colonoscopy. If there is any doubt, the implications and options will be discussed with the patient and, if necessary, their medical team, while maintaining required timescales. The screening centre nurse will be responsible for managing patients through the offer of colonoscopy and through all necessary and appropriate investigations for cancers of the colon or rectum, to the point where the patient can be discharged back to routine screening, discharged to 3 yearly colonoscopy, discharged to the care of their general practitioner or referred for treatment.

2.5 Colonoscopy clinics
Those testing positive will require colonoscopy, or, if unfit for colonoscopy, radiological investigation plus flexible sigmoidoscopy where needed/possible. Approximately 2% of those tested will test positive and it is the experience of the pilot site that very few will be unfit for colonoscopy. A screening centre nurse will attend the colonoscopy clinic and is responsible for ensuring that all patients have an appropriate outcome from the colonoscopy clinic.

2.6 Referral for treatment
Where cancer is found, the screening centre nurse is responsible for ensuring that the patient is referred to the appropriate MDT for in accordance with the local treatment protocols. Depending on the local configuration of services, the screening
Figure 1 BOWEL CANCER SCREENING FLOWCHART

Identification of the eligible population

Invitation

Despatch of kit
- reminder
- failsafe

Receipt and development of used kit

Inform GP

Despatch of results

Normal

Routine recall

Strongly +ve

Weakly +ve/spoilt

Appointment

for nurse clinic

Colonoscopic

surveillance

Weakly +ve/spoilt

Repeat test

Despatch of results

Colonoscopic

surveillance

Nurse clinic

DNA

Attends

Offered colonoscopy

Accept

Non acceptance

Unsuitable

?barium

enema

Clinic booking
(choose & book)
& give preparation

Colonoscopy

DNA

NAD

Polyp

Cancer

Other pathology

Low

Intermediate / high risk

Colonoscopic surveillance

3 yearly

Re-invite for FOBT
screening in 4 years
if <66

Programme hub
(10 million people per annum)

FOBt laboratory
(60% uptake assumed)

98% normal
2% positive

Local screening unit
(0.5 million people per annum)

300 colonoscopies per 0.5 million people per annum
= 1–2 clinics per week

600 colonoscopies per 0.5 million people per annum
= 3 clinics per week
(includes surveillance colonoscopies)
centre may refer patients to one of several local MDTs (see Figure 2). This means that the screening centre nurse may either attend an MDT in person, or may liaise with the CNS on the MDT to ensure handover of the patient from the screening programme to the symptomatic service and to record the outcome.

2.7 Polyps and other findings
Where intermediate/high risk polyps are found, patients will be recalled through the screening programme for surveillance colonoscopy. In time, this will double the amount of colonoscopy needed by the programme. This will build up in years three to six after local programme start up and then reach a steady state. Where a low risk polyp is found, patients will not be entered into surveillance but will be offered an FOBt again after four years if still within the target age range. Incidental non-malignant findings (eg IBD) should be managed according to local protocols.

Figure 2 Possible configuration for screening centres and MDTs

[Diagram showing possible configuration for screening centres and MDTs]

KEY
○ Invitation and testing
△ Nurse clinics and colonoscopy
☐ Treatment
3. TASKS FOR STRATEGIC HEALTH AUTHORITIES

3.1 Identifying first wave screening centres
SHAs have been invited, in collaboration with their PCTs and local endoscopy services, to express an interest in those services becoming local screening centres in the first wave. An effort should be made to locate some of the first wave sites in spearhead PCT areas, reflecting the revised cancer PSA target.

3.2 Local implementation groups
Each SHA should appoint a programme manager to plan the roll out of the programme across their areas over three years. The programme manager should work closely with the SHA endoscopy lead who is already in post (www.endoscopy.nhs.uk) and set up a local implementation group. Membership of the implementation group should include

- the SHA BCSP programme manager
- the SHA endoscopy lead
- the screening lead for each PCT or PCT consortium
- a representative of each trust with an endoscopy unit
- the endoscopy training centre lead
- a finance representative.

3.3 Tasks for local implementation groups
The first task for local implementation groups is to identify endoscopy units which have the potential to become screening centres for the local population. The group must assess the ability of the units to meet the selection criteria within the timescales required for roll out. The three main criteria are

- sufficiently high scores on items of the Global Rating Scale
- an adequate number of accreditation of colonoscopists
- successful JAG accreditation.

Further details are given are given on the NHS BCSP website as follows:
Endoscopy global rating scale (BSCSP Implementation Guide No 2)
Accreditation of colonoscopists (BSCSP Implementation Guide No 3)
JAG accreditation and re-accreditation of endoscopy units (BSCSP Implementation Guide No 4).
3.4 SHA action plans

SHAs are invited, in collaboration with their PCTs and local endoscopy services, to express an interest in those services being included in the first wave (ie during 2006/7). The implementation group is expected to draw up an action plan for achieving the desired programme configuration (eg subject to JAG visits or training of staff) together with bids for funding. Action plans should be available to demonstrate that the required standards will be achieved by 3 months in advance of the anticipated start date. The financial bids should include a breakdown of costs for the different elements of nurse clinics and colposcopy clinics. The costs will include the use of existing endoscopy facilities for screening, the appointment and training of additional staff for nurse clinics, and additional pathology and radiology services. Estimated revenue costs for a population of half a million people are given in Appendix 1.

3.5 Expressions of interest

SHAs should put their initial expressions of interest in writing by 2 September 2005 stating likely start dates, potential screening centres and approximate population size to:

Mrs Julietta Patnick CBE
Director
NHS Cancer Screening Programmes
The Manor House
260 Ecclesall Road South
Sheffield S11 9PS
e-mail: Julietta.Patnick@cancerscreening.nhs.uk

A bid format will be sent out in response to those expressing interest. This should returned electronically by 14 October 2005.

USEFUL LINKS

1. DH Cancer website [www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Cancer]
2. Tackling health inequalities: the spearhead group of Local Authorities and Primary Care Trusts [www.dh.gov.uk]
3. NHS Cancer Screening Programmes website [www.cancerscreening.nhs.uk]
4. National Endoscopy Team website ([www.endoscopy.nhs.uk])
5. Endoscopy Global Rating Scale [www.grs.nhs.uk]
### APPENDIX 1

Estimated revenue costs for local screening centres based on pilot sites costings (per annum based on 0.5 million population)

<table>
<thead>
<tr>
<th>Service</th>
<th>£000s</th>
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<tbody>
<tr>
<td>Admin/management</td>
<td>50</td>
</tr>
<tr>
<td>Health promotion/publicity</td>
<td>37</td>
</tr>
<tr>
<td>Nurse clinics</td>
<td>58</td>
</tr>
<tr>
<td>Endoscopy</td>
<td>125</td>
</tr>
<tr>
<td>Radiology</td>
<td>24</td>
</tr>
<tr>
<td>Histology</td>
<td>83</td>
</tr>
<tr>
<td>Polyp surveillance (from year 4 of the programme)</td>
<td>84</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>461</strong></td>
</tr>
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