Dear colleague

NHS BOWEL CANCER SCREENING PROGRAMME: FLEXIBLE SIGMOIDOSCOPY SCREENING – BOWEL SCOPE SCREENING

I am writing at the start of the year which will see the commencement of flexible sigmoidoscopy screening within the current bowel cancer screening programme to provide you with additional information to supplement initial DH Guidance which was published a year ago. As we have worked with many of you through the detail of setting the programme up, many things have come forward that had not previously been considered. We thought you would find it helpful to have an update on the current thinking.

The name of the Programme
Work undertaken with the general public indicated a need for the name of the screening programme to indicate the part of the body for which screening is being offered. The name “Bowel scope” screening will therefore be used to distinguish this part of the bowel screening programme from the current FOBt part of the programme which will continue unchanged.

Timeline for rolling out FS screening across England
More detail is now available and it is as follows:

- **March 2013**: Piloting of Flexi-sig screening
- **Commencing September 2013**
  - by 31 March 2014: First wave roll out of Flexi-sig screening (inc pilots)
  - by 31 March 2015: Second wave roll out of Flexi-sig screening complete = 30% country open 
  - 60% country open by 31 March 2015
- **2016**: Roll out to be completed across England

Preparing to deliver Flexi-sig screening (FS screening)
As you are aware, FS screening is a one-off invitation to all people aged 55 years. Self-referrals will be accepted from people up to age 60. After that people will only be able to access FOBt. Experience suggests that demand from such self-referrals will not place an undue strain on programmes. It is likely we will also make FS screening available to visually impaired people aged 60-64 who will not have been invited for FS screening and may be having difficulty with completing and FOBt test.

FS screening requires a different infrastructure and it is essential to have detailed capacity and demand planning in order to cope with the volume of work. FS screening is very similar to primary care in that it is relentless and clinics should not be cancelled other than in extreme circumstances. The service has to meet the demand. At the same time, people do not have to attend and in order to encourage them to participate in the programme the service has to be local and convenient to make it easy to access. Finally, and in contrast to the existing bowel cancer screening endoscopy workload, most patients are completely normal when examined but we want them to have an
acceptable experience in order that the high satisfaction rates and good reputation of the programme encourage future invitees to participate.

**Best estimate of demand and estimating FS numbers**
The initial estimates of demand were 6000 FS examinations per million base population each year. However, based on the current programme it is expected that in some areas uptake could be higher than originally expected and demand could be as high as 8000/million/year.

It will be different in different demographic areas and opt in for 56–59 year olds is an unknown quantity. Nevertheless screening centres should prepare for demand between 6,000 and 8,000 examinations per year per million and should estimate whether they will be a higher acceptance area or a lower one based on the response in their areas for FOBt.

Assuming that 1.6% of population is aged 55 years (highest estimate)

**Invitations:** For a half million population (500,000), the population aged 55 in a 12 month period will generate:
- 8000 FS invites per annum
- 160 FS invites per week (50 weeks)

**Examinations:** Assuming 50% uptake this will require
- 8 FS lists (80 people) per week (10 examinations on a FS list)

**Colonoscopy:** Up to 5% of people examined are expected to be referred for a BCSP colonoscopy. Additional SSP pre-assessment clinic slots for some of those people may be needed. These can be combined with current BCSP patients and lists. Based on a population of 500,000 people there will be a requirement for 4 additional colonoscopy slots per week.

The criteria for referral for colonoscopy from FS are given in Appendix 1. These will be closely monitored during the pilot phase.

**The invitation process**
This will be as follows:

- Having calculated their capacity required to meet the demand for FS screening locally the **Screening Centre** will set up FS screening clinics and appointment slots on BCSS IT system. This is similar to the current system whereby the local centre sets up the SSP clinics. The hubs will not determine when clinics are held
- On a weekly basis the Screening Centres will use BCSS to allocate appointments
- The Hub will then print and send pre-invitation letters to each individual, 8 weeks in advance of the planned appointment, telling them that they will soon be invited
- The Hub will print and send invitations to a timed appointment, with a reply slip, 6 weeks in advance of the planned appointment. Individuals are asked to confirm their attendance (or not) and to phone the hub if they have concerns over their health which might be important (see below) (information about this is included in the invitation materials)
- 2 weeks before the date of the clinic, the appointments will be cancelled for those individuals who have not confirmed their attendance or who have not responded at all confirming cancellation of their appointment. This is in order to allow final confirmation of the clinic list. A letter is sent to those individuals and their GP is informed of their non-participation in the screening programme on this occasion.
- Enemas will be posted from a central point once confirmation of attendance has been received from an individual (up to 2 weeks before).

- The Individual attends for FS screening.

The invitation pathway is given in Appendix 2

**Suitability assessment of individuals invited for FS screening**
All individuals invited for screening are initially presumed suitable for FS screening. A list of contraindications is sent out with the invitation and individuals are asked to phone the hub if they consider something might apply to them, or if they have any other health concerns.

Suitability for FS screening will only be assessed if the individual contacts the Hub to discuss a possible contraindication after receiving their invitation. Suitability is initially assessed by the Hub by telephone but in some cases there will be a need for the Hub to refer to the Screening Centre for a local decision. You will need to identify the initial contact for the hub for these occasional cases, it is expected that this will be an SSP.

All Hub staff working on the telephone helpline will be trained in advance on assessment of suitability and the FS screening process.

**Self-referrals (Opt-ins)**
Individuals who are aged 55 to 59 and registered with a GP practice currently linked to the screening centre which is offering FS Screening can self-refer (opt in) for FS screening by contacting the Hub.

In order to be eligible to self-refer, the individual should:
- not have a FS invitation due date;
- have no previous FS screening episode within the programme
- not already be on surveillance or have further information pending from symptomatic endoscopy

**Local delivery of FS screening**
In order for screening centres to be able to deliver the required volume of work, given the endoscopy capacity issues, consideration should be given to other and innovative ways of working. This ties in with the need to deliver accessible and convenient services to healthy individuals.

Screening Centres should consider the potential of using community sites and ITCs, provided the sites are JAG approved. We are working with JAG to develop protocols for accreditation of temporary facilities.

You should consider running FS lists in evenings and weekends as this age group will mostly be in employment and not able to easily take time off work.

Screening Centres must ensure the FS lists are always available. It is not appropriate to cancel FS appointments which have been offered to individuals after you have invited them in the first place!

The FS invitations are sent out to individuals with booked appointments, listing date, time and venue of the appointment. This will require overbooking of lists so screening centres must have capacity should everyone attend. However, as stated above, unconfirmed appointments will be cancelled two weeks before their date.

**SSPs:** Screening Centres will need to consider the role of their current SSPs in delivering FS screening. It is particularly important that individuals are made to feel welcome in the FS unit and that any questions either about the procedure or about their health are dealt with appropriately.

Experience shows that about 10% of individuals attending will require the clinic based administration of the enema. This might be for clinical reasons where you would not want the
individual self-administering, or it might be because of some difficulty or failure in self-administration of the enema.

At the end of the attendance, it will be clear that some individuals need further examination and for other individuals that there might be a need for them to return for a full colonoscopy examination. These people should be seen by an SSP who can counsel them and discharge them appropriately. There may be other individuals who need counselling before discharge, for example if they have had small polyps removed or who are in some discomfort, and they too should be seen by the SSP.

**Management:** The addition of FS screening to the bowel cancer screening programme means that there is a need for adedicated local Programme Manager to the BCSP. This person will oversee both the FOBt and FS parts of the screening programme and the identification of such a role is a criteria to be approved for FS screening. Setting up and efficient running of clinics, with overbooking and cancellations is a demanding role, as well as ensuring that those patients who require colonoscopy from either start point are managed appropriately. Additionally there is a considerable workload for the administrative staff who will be required to manage the booking of FS appointments and the FS lists locally through the BCSS IT system.

**Timelines:** Patients who are subject to biopsy or polyp removal, or otherwise referred for colonoscopy in the screening programme, should be added to the cancer waiting times database in the Trust. If they are later proven to have cancer, they should receive their first treatment within 62 days of their flexible sigmoidoscopy examination.

It is therefore expected that patients are booked into colonoscopy, or for an SSP appointment where required, within two weeks of their FS examination. Pathology results must be available within 1 week of that FS examination as is practice now in the Bowel Cancer Screening Programme after an endoscopy examination.

**Endoscopy Workforce for FS screening**

This expansion in demand for endoscopy will, of course, require a greater pool of endoscopists to deliver FS screening than the current FOBt only screening programme. The Screening Centre will need to determine the workforce required, both medical and nursing, in order to be able to undertake the flexible sigmoidoscopy examinations for its local population. This will require planning the workforce at least 18 months in advance of a potential start date for FS screening in order to train appropriate staff for FS screening. Services which aim to start in the second wave, from April 2014 onwards, should be planning now. The numbers of endoscopists will be much greater than for the FOBt screening partly because of the larger volume of work on a regular basis but also because it is expected that the number of sites where FS screening will be offered will be greater than currently is the case for endoscopy in the BCSP.

**Accreditation of FS endoscopists**

All accredited screening colonoscopists are automatically accredited for FS screening.

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

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

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

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

**Application criteria**

The application form requires confirmation of the following criteria:

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

PLUS: 4 formative DOPyS to be submitted

**Formal assessment**

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

The assessment will comprise of a one hour MCQ, followed by DOPS and if appropriate, DOPyS assessment of 2 consecutive cases.

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

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

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

It is expected that FS endoscopists will undertake at least 400 FS per annum which equates to one FS list per week.

**Patient Comfort**

Comfort of the patient during the examination is paramount and the endoscopist should only examine the colon as far as the patient’s comfort allows. In any event, examination is not expected beyond the splenic flexure. Should the patient’s discomfort lead to cessation of the examination when that point has not been reached, it should be made clear to the individual that their examination has not been optimal and this should be recorded in the notes. Repeat examinations are not available within Bowel scope screening.
Entonox should be available for those individuals who require it but sedation is not expected to be used at this stage of the Bowel Cancer Screening Programme. As you are already aware, CO₂ should be used for insufflation.

**Enemas**
The enemas have been procured nationally for FS screening and will be posted from a central distribution facility to individuals who have confirmed that they will be attending for their FS screening appointment in advance.

Should an initial or second enema be required at the time of the flexible sigmoidoscopy, endoscopy units are required to follow their local trust policy, using enemas which are already in routine use in the Trust and adhering to local protocols for their administration. Should faecal matter restrict an examination, it should be made clear to the individual that their examination has not been optimal and this should be recorded in the notes. Repeat examinations are not available within Bowel scope screening.

**Funding**
FS screening will be funded at a value of £400.00 per person screened including self-referrals and those individuals arriving at the FS clinic with the intention of having the FS but, after a full assessment, are deemed unfit.

The calculation of this figure is based on the tariff prices for flexible sigmoidoscopy and colonoscopy. It includes additional enemas and further examinations, including colonoscopy and CT imaging, for those who require it. It also includes the additional administration and management time, and additional SSP and clerical tasks.

The costs of the Hub will be contracted separately and will include the self-administered enemas and all pre-attendance correspondence.

I hope you find this information helpful and I look forward to working with you on this exciting but challenging development over the next few years.

With best wishes

Yours sincerely

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Director
NHS Cancer Screening Programmes

Cc  Lynn Coleman
    Richard Winder
    Phil McCorry
    Bowel screening hub directors
    Bowel QADs and co-ordinators
    Endoscopy QA leads
    SSP QA leads

Enc: Appendix 1 – Referral from FS to colonoscopy protocol
    Appendix 2 - FS screening pathway diagram
    Accreditation of Flexible Sigmoidoscopists guidelines – Draft Dec 2012

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