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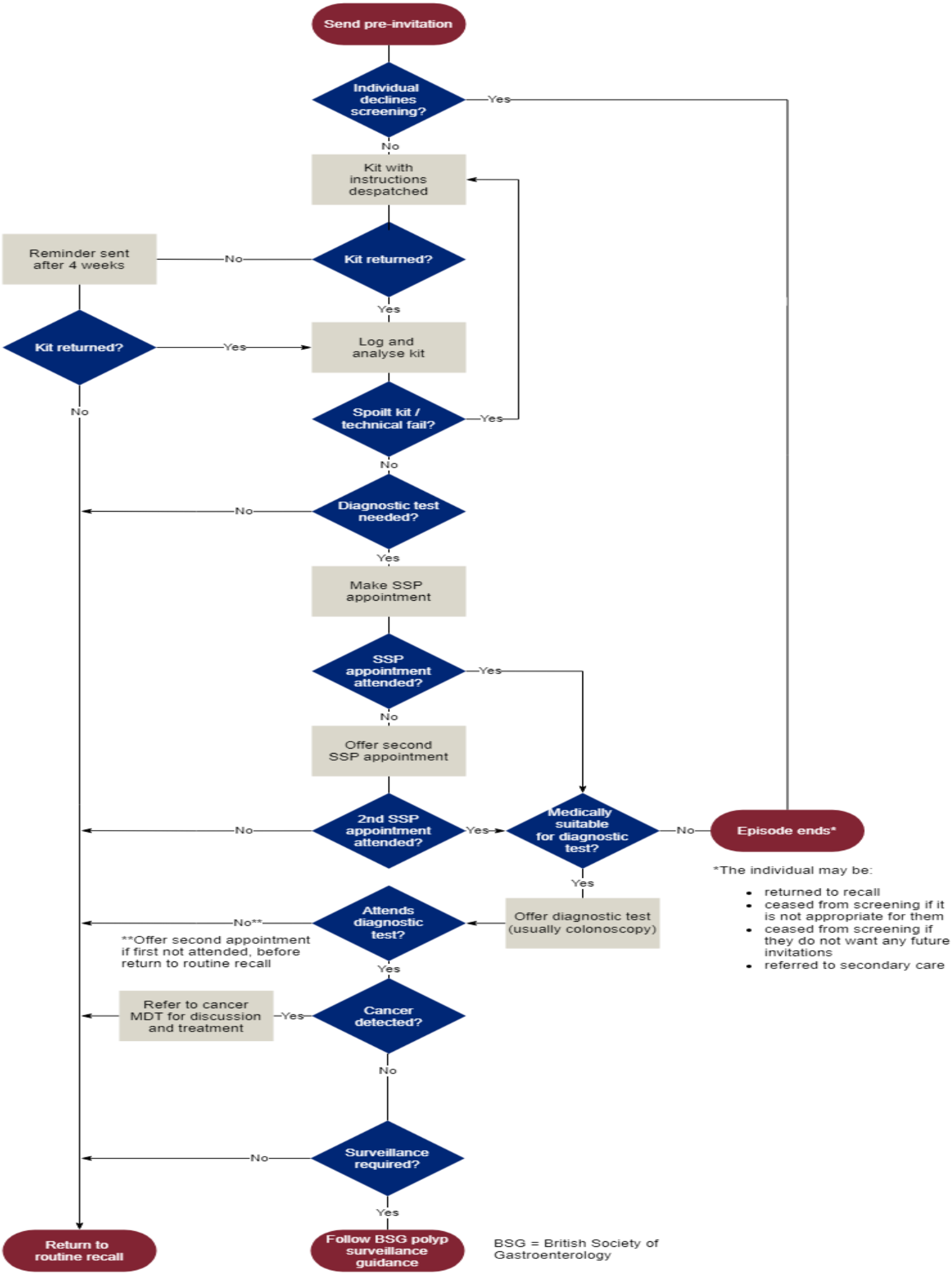
Royal Cornwall Hospitals NHS Trust

Bowel Cancer Screening Programme Procedures Policy

V4.0

July 2022

Summary - Bowel Cancer Screening Care Pathway



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Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

1. Introduction

1.1. Bowel cancer is a major public health problem. It is the second most common cause of cancer death in the United Kingdom. Research has shown that screening men and women aged 45 – 74 for bowel cancer using the faecal occult blood test could reduce the mortality rate from bowel cancer by 15% in those screened.

1.2. This document supports the national guidelines for the NHS Bowel Cancer Screening Programme.

1.3. The NHS Bowel Cancer Screening Programme offers screening to men and women aged 56-74, with age extension taking place over next three years to reduce this to aged 50-74, every two years using a faecal immunochemical blood test (FIT120). People aged 74 or over can request a FIT120 kit. Participants with an abnormal FIT120 result are invited to see specialist screening practitioner (SSP) in a clinic appointment. They are offered a colonoscopy as the routine investigation within the screening programme. In some instances, they may be offered a CT pneumocolon instead, for example if colonoscopy is not thought to be the most suitable test in the first instance. Depending on the findings, they will be offered screening again in 2 years, entered into the polyp surveillance programme as part of the screening programme, or referred for treatment at a local hospital.

1.4. The Cornwall Bowel Cancer Screening programme covers the entire county for men and women aged 56-74 who are registered with a GP. The clinic and colonoscopy procedures are carried out at West Cornwall Hospital and the Royal Cornwall Hospital.

1.5. This version supersedes any previous versions of this document.

2. Purpose of this Policy/Procedure

2.1. Bowel cancer screening is a process of identifying apparently healthy men and women aged 56-74 who may be at increased risk of bowel cancer. They can then be offered a FIT120 screening kit and if positive for blood they can be offered a colonoscopy or CT scan with appropriate treatment to reduce their risk and / or any complications arising from bowel cancer.

2.2. The purpose of this document is to ensure that Bowel Cancer screening is compliant with the National Quality Assurance Standards and locally developed Standard Operating procedures.

2.3. This document will:

- set out the mechanisms that are in place to identify and invite eligible men and women for bowel cancer screening
- include the patient screening pathway and identify national bowel cancer screening guidelines
- Identify healthcare staff with the authority to authorise/proceed with the screening procedure, including an approved programme of training,

assessment of skills and update training

- ensure that informed consent occurs, though adherence to the national guideline Consent to Cancer Screening and the local RCHT Consent Policy
- ensure that systems are in place to ensure that the sample(s) or screening test/results, where relevant, have been taken, are correctly identified/recorded, and labelled, prepared and transported to comply with the agreed protocols/standard operating procedures
- identify the systems that are in place to ensure the results are reported within timeframes set by national office
- identify the process for the dissemination of results to clinicians and patients
- set out the process of how individuals are informed about the results of their screening procedure
- identify the process for patients that need further follow up/ surveillance and how they have access to a healthcare professional to discuss options and further management
- set out how the outcomes are recorded, including any follow up and identify the audit trail to ensure all data recorded is complete

3. Scope

This policy applies to all those involved in screening procedures in the organisation and those who receive and process screening test results.

4. Definitions / Glossary

- **BCSP**: **Bowel cancer screening programme**
- **FIT120** **Faecal Immunochemical Blood test**
  FIT120 is the screening kit used by men and women for the Bowel Cancer Screening Programme
- **QA** **Quality Assurance**
- **Screening** **Screening** is a process of identifying apparently healthy people who may be at increased risk of a disease or condition
- **SSP** **Specialist Screening Practitioner**
- **SOP** **Standard Operating Procedure**
  A clear, step-by-step instruction of how to carry out agreed actions that promote uniformity to help clarify and augment processes. SOPs document the way activities are to be performed to facilitate consistent conformance to requirements and to support data quality.SOPs promote individuals with the information needed to perform a job properly and consistently.

5. Ownership and Responsibilities

5.1. This section gives a detailed overview of the strategic and operational roles responsible for the development, management and implementation of the policy.

5.2. **Duties within the organisation**

The duties of the directors, committees, clinicians, healthcare and administrative staff with responsibility for managing the processes surrounding screening procedures are outlined below:

5.2.1. **Chief Executive**

The Chief Executive has ultimate responsibility for ensuring that suitable structures, resources and monitoring arrangements are in place to ensure that screening procedures are carried out in a safe and effective way.

5.2.2. **Trust Boards**

The Trust Board must seek assurance that screening procedures are carried out in a safe and effective way.

5.2.3. **Lead Clinician/ Centre Director**

The BCSP Centre Director plays a lead role in the development of organisation- wide and local procedural documents to manage the risks associated with Bowel Cancer screening procedures. This includes ensuring that all tests and procedures are undertaken by authorised staff following training where necessary, developing standard operating procedures or equivalent protocols to an agreed organisational or national standard.

5.2.4. **Screening Staff**

The screening pathway begins when an individual is identified with the 56-74 age group to be offered the opportunity of Bowel Cancer Screening. If the offer is accepted the relevant protocol will be followed. Accurate records will be kept in the event that screening is declined. Responsibilities include adherence to standard operating procedures or equivalent protocols; undertaking training as required and agreed.

5.2.5. **Administrative Staff**

Administrative staff have an important role in ensuring that, for paper based and electronic systems, all records are kept up to date and that administrative protocols are followed.

5.3. **Duties External to the Organisation**

External bodies have a role in providing external quality assurance and protocol guidance and where relevant programme management of the screening service provided. Such bodies include:

- National Screening Committee/NHS Screening Programme Committees
- External Quality Assessment/Assurance schemes (Regional or National)
- NHSE Screening Assurance Service

6. Standards and Practice

6.1. The Bowel Cancer Screening programme will adhere to Bowel Cancer Screening standards (2018)

6.2. **Duties**

All staff working within the local Bowel Cancer screening Programme will adhere to the local SOPs and national guidance developed at the National Office.

6.2.1. Quality assurance in colonoscopy is supported thorough the JAG (Joint Advisory Group on Gastrointestinal Endoscopy) accreditation of Endoscopy units and through rigorous accreditation for colonoscopists working in the BCSP.

6.2.2. The Centre Director, Lead Nurse and Centre Manager are responsible for ensuring that staff follow those processes and procedures described in the Standards and Practice section relevant to the part they play in the screening procedure

6.2.3. The Trust Screening lead is responsible for the development, approval, communication of this policy and monitoring compliance with it by use of the Annual Audit Tool

6.2.4. All staff members are responsible for being aware of the policy and any documents referred to within it pertaining to their part in the screening pathway; adhering to any requirements described within the policy and documents described within the policy and documents described in the standards and practice section pertaining to their role in the diagnostic pathway.

6.2.5. The Centre Director and Lead Nurse are responsible for screening governance which includes the reporting of any deviation or errors arising from the screening procedures using the RCHT Trust reporting system and governance processes including reporting adverse incidents to the national bowel cancer screening office.

6.3. **Process for Requesting Screening Procedures**

6.3.1. The NHS Bowel Cancer Screening Programme offers screening to men and women aged 56-74 every two years using a faecal immunochemical blood test (FIT120). People over 74 can request a kit. Participants with an abnormal FIT120 will be offered an appointment with a Specialist Screening Practitioner where they will be assessed as to their suitability for an investigation within the Screening Programme, preferably a colonoscopy or if decided to be more appropriate a CT of the bowel.

6.3.2. Valid consent must be given prior to a screening investigation being undertaken; this is in line with RCHT Consent Policy. If the patient does not have the mental capacity to decide whether to have the test, a best interest decision should be made as described in The Mental Capacity Act 2005. Written consent is usually gained at the time of the colonoscopy appointment by Endoscopy staff who have completed the RCHT Consent training. People attending for surveillance colonoscopy or a repeat procedure who have a telephone consultation with an SSP will sign consent on admission with the endoscopy staff before entering the procedure room. The consent will be completed by the clinician doing a repeat colonoscopy if the risks are increased due to the size of the polyp or procedure required.

6.3.3. All staff within the screening programme must also adhere to Consent to Cancer screening, January 2009, Cancer Screening Programmes.

6.4. Process for the Receipt of the Results of a Screening Test

The process for the receipt and recording of the results will adhere to the NHS Bowel Cancer Screening SOP 'Right Results Pathway' which includes the following:

- The process for recording the receipt of the results
  - All results are entered onto the Open Exeter system any delay in obtaining results is highlighted in an alerts column. The SSPs check Maxims every day for new results
- The interpretation of the result
  - Once the results have been entered onto the Open Exeter system by the SSP, an outcome is automatically recorded. This follows the patient pathway in Appendix 1
- The management plan is recorded
  - All data is recorded on Open Exeter. An Episode note is written on Open Exeter to record all patient contacts. A maxims letter is written to record the episode outcome. Further documentation is then filed in the patient's medical notes
- Safety measures are in place to ensure that results are not inadvertently missed
  - Open Exeter has an alerts system to highlight patients that have not yet had a result entered into the system. The alerts are checked by the SSPs on a daily basis. The BCS right results policy is adhered to

6.5. Process for Taking Action on Screening Results

- Identified actions are documented
- The method of communication is recorded, i.e. face to face contact, phone call, letter, email etc.

- Missed or incorrect diagnosis must be reported using the Trust incident reporting system and reported on an AVI form to the National bowel Cancer Screening Office

- Monitoring action taken following screening results, including timescales

6.6. **Process for Documentation of Screening Results**

6.6.1. All results from a colonoscopy or CT procedure are recorded on Open Exeter by the Specialist Screening Practitioner.

6.6.2. The SSP will ensure that patients who attend a colonoscopy are also given a discharge form and a copy of the colonoscopy report to take home with them. A copy of the colonoscopy report is also sent to the GP by the administrator.

6.6.3. Open Exeter produces a patient letter when they are discharged from the screening episode explaining the outcome and recall period. This is checked by the SSP to ensure the correct result matches the discharge letter. The GP is sent a copy of the letter. A Maxims BCS episode letter is generated by the SSP to ensure the screening activity is noted and recorded on the trust system.

6.6.4. All nursing documentation is filed in the medical notes upon discharge.

6.7. **Process for the communication of Screening Results**

6.7.1. Individuals who attend a colonoscopy will be verbally informed of the likely outcome on the same day by the SSP. If there is any histology the results will be given either by telephone or face to face within one week of the colonoscopy date. The histology result will confirm the episode outcome. For individuals that attend a CT, results will be given by the SSP either by telephone or face to face within one week of the CT date.

6.7.2. The GP is informed via colonoscopy reports and a discharge letter explaining the final result and outcome which is generated by Open Exeter. A copy of the CT report is sent to the GP to follow up on any incidental findings and for completion of record keeping. The patient is also sent a letter when discharged confirming the results of the procedure.

6.7.3. The SSP checks Maxims for histology results and CT reports daily. Any discrepancy or cause for concern the SSP will discuss with the responsible clinician. The clinician responsible for the colonoscopy will sign off the histology results on Maxims.

7. Dissemination and Implementation

7.1. The document will be placed on the Cornwall & Isles of Scilly Health Community Documents Library. It will also appear on Screening Testing A-Z of Services Intranet pages as well as a link on the individual screening programme intranet pages. A global email will be sent to all Service Users.

All staff are required to be trained and competent in those elements of the screening pathway within the scope of their role.

7.2. All bowel cancer screening Colonoscopists must be accredited.

7.3. All Specialist Screening Practitioners must complete and pass the Liverpool John Moores or Torbay/Plymouth University Bowel Cancer Screening course.

7.4. All staff must be up to date with the Trust mandatory training

8. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	That local evidence is available which includes meeting QA standards set by NHSE for Bowel Cancer Screening. All outcomes are reported back to a quarterly stakeholder meeting. Local documentation and SOPS will include: Actions to be taken following the screening results, including timescales Process for recording who is informed of the screening results Process for recording actions See Sections 2 and 6 of this policy
Lead	Bowel Cancer Screening Centre director, Lead Nurse and Programme Manager
Tool	Audit Right Results Pathway SOP QA audits
Frequency	Compliance with Screening Quality Assurance Service BCSP right results audit and pathways monthly and quarterly
Reporting arrangements	Evidence of monthly Right Results audit will be provided. Following BCSP guidance in errors are identified the sample size that is audited should increase by 20% and if reoccurring trend that Screening Quality Assurance Service (SQAS) need to be notified for advice. Adverse incident reports will also be assessed by Screening Quality Assurance Service.
Acting on recommendations and Lead(s)	Cornwall BCSP will undertake recommendations and action planning for any or all deficiencies and recommendations within reasonable timeframes as instruction by SQAS.

Information Category	Detail of process and methodology for monitoring compliance
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within three months (where reasonable). A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all relevant stakeholders.

9. Updating and Review

9.1. This policy will be reviewed every two years or sooner if circumstances suggest this may be necessary.

9.2. Where the revisions are significant and the overall policy is changed, the author will ensure the revised document is taken through the standard consultation, approval and dissemination processes.

9.3. Where the revisions are minor, e.g. amended job titles or changes in the organisational structure, approval can be sought from the Executive Director responsible for signatory approval, and can be re-published accordingly without having gone through the full consultation and ratification process.

9.4. Any revision activity is to be recorded in the Version Control Table as part of the document control process.

10. Equality and Diversity

10.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Inclusion & Human Rights Policy' or the Equality and Diversity website.

10.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Bowel Cancer Screening Programme Procedures Policy V4.0
This document replaces (exact title of previous version):	Management of Procedures within the Bowel Cancer Screening Programme Policy V3.0
Date Issued/Approved:	June 2022
Date Valid From:	July 2022
Date Valid To:	July 2025
Directorate / Department responsible (author/owner):	Heidi Duckworth Lead Nurse Bowel Cancer Screening Reviewed by Lisa Ivers Programme Manager
Contact details:	01872 252076
Brief summary of contents:	Outlines the documented process for managing the risks associated with Bowel Cancer Screening procedures and that those risks are managed through locally approved policies that are implemented and monitored Cancer Screening, Bowel cancer
Suggested Keywords:	measurement health measurement health check periodic health examination screening cancer clinical measurement medical examination bowel cance disease neoplasm cancer intestinal cancer
Target Audience:	RCHT: Yes CFT: No KCCG: No
Executive Director responsible for Policy:	Medical Director
Approval route for consultation and ratification:	James Bebb Bowel Cancer Screening Director
General Manager confirming approval processes:	Roz Davies

Information Category	Detailed Information
Name of Governance Lead confirming approval by specialty and care group management meetings:	Maria Lane
Links to key external standards:	NHSLA Standards National Bowel cancer Screening Programme Guidelines
Related Documents:	• 2011 NHSLA Risk Management Standards 2012-2013 • Quality Assurance Guidelines for Colonoscopy. • Guidelines for the use of imaging in the NHS Bowel Cancer Screening Programme. • Guidebook for programme hubs and screening centres. • RCHT Consent Policy • Managing Safety incidents in NHS Screening Programmes 2015
Training Need Identified?	No
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet & Intranet
Document Library Folder/Sub Folder:	Clinical / Gastroenterology

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
11th April 2012	V1.0	Initial Issue	Rebecca Warren Lead Nurse
25 July 2012	V1.1	Put in additional info into “Reporting Arrangement” to include right results audit	Rebecca Warren Lead Nurse
27th May 2015	V2.0	Addition of age expansion screening age now 60-74 Addition of changes to right result pathway and reporting results Change of divisional manager	Christine Taylor Interim Lead Nurse

Date	Version Number	Summary of Changes	Changes Made by
12th June 2019	V3.0	Changed all “Quality Assurance” to “Screening Quality Assurance Service” and all “FOBt” to “FIT120”	Rebecca Warren Lead Nurse
16th June 2022	V4.0	Changed remaining references of FOBt to FIT120. Amended age range to 56-70. Change of Lead Nurse & Clinical Director. Updated screening pathway summary.	Heidi Duckworth Lead Nurse

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.
This document is only valid on the day of printing

Controlled Document

This document has been created following the Royal Cornwall Hospitals NHS Trust Policy for the Development and Management of Knowledge, Procedural and Web Documents (The Policy on Policies). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Initial Equality Impact Assessment Form

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity & Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Bowel Cancer Screening Programme Procedures Policy V4.0
Directorate and service area:	Gastroenterology
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Heidi Duckworth, Lead Nurse
Contact details:	01872 252076

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	Sets out an approved documented process whereby the risks associated with the Bowel Cancer Screening procedures are managed through the provision of local policies which are implemented and monitored.
2. Policy Objectives	The risks associated with Bowel Cancer Screening procedures are minimised; compliance with NHSLA Standard 4 – Criterion 3: Screening Procedures is achieved
3. Policy Intended Outcomes	To ensure that Bowel Cancer Screening procedures provide by the organisation have developed, documented local processes and that screening is offered as appropriate, records are accurate and risks are minimised.
4. How will you measure each outcome?	As described in section 8.
5. Who is intended to benefit from the policy?	All individuals being screened with the Bowel cancer Screening Programme.

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Julie Folkard, Head of Audiology. Steering groups.
6c. What was the outcome of the consultation?	Approval for the policy
6d. Have you used any of the following to assist your assessment?	**N/A**

7. The Impact
Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	
Marriage and civil partnership	No	

Protected Characteristic	(Yes or No)	Rationale
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Heidi Duckworth

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis