NHS
Cancer Screening Programmes

Quality Assurance Visit to Gloucestershire Bowel Cancer Screening Programme

8-9 October 2013

South West Quality Assurance Reference Centre

About the NHS Cancer Screening Programmes

The national office of the NHS Cancer Screening Programmes is operated by Public Health England. Its role is to provide national management, coordination, and quality assurance of the three cancer screening programmes for breast, cervical, and bowel cancer.

About Public Health England

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1. Executive summary

South West Quality Assurance Team (QAT) undertook the second QA Visit to the Gloucestershire Bowel Cancer Screening Centre(GBCSC) on the 8 & 9 October 2013. The purpose of the visit was to review the whole multidisciplinary screening pathway and to assess the effectiveness of team working in delivering a service meeting the national quality requirements. The first QA Visit took place in October 2010 and A Right Results Gap Analysis Walkthrough Visit was undertaken by the QA Administration and SSP Leads on 3 July 2012. All recommendations identified from these visits had been addressed and closed.

Specific feedback on individual speciality areas covered during the visit can be found within the body of this report. Statistical data to support the visit was produced by the South West Quality Assurance Reference Centre (QARC) using data from the Bowel Cancer Screening System (BCSS) and information data provided by Southern Hub based in Guilford. The Centre's compliance against the National Programme Standards is located in section 8 page 32 of this document.

The GBCSC covers a population of approximately 615,000. The service is provided by Gloucestershire Hospitals NHS Foundation Trust and is run from Cheltenham General Hospital (CGH) with an additional clinic and colonoscopy site at the Gloucestershire Royal Hospital (GRH). The administrative function is based at CGH and Specialist Screening Practitioner (SSP) clinics and colonoscopy are offered on both sites. All histopathology is reported at a single laboratory based at CGH. CT is currently only performed at CGH.

Screening commenced in Gloucestershire in February 2007 screening 60-69 year age range, with the Centre expanding to include the 70-74 year age group in January 2010.

The team should be congratulated on providing a high quality professional service across all areas. The overall performance of the programme is excellent with FOBt uptake of about 62% and average positivity at 1.7% in 2013. SSP waiting times are excellent with 100% of patients seen within 2 weeks. Colonoscopy uptake for 2013 is about 82% which is slightly under the national average of 84%.

The Centre has submitted a bid to become one of the 'second wave' Bowel Scope Screening sites and is working with the National Office and Regional QA to progress.

The major area of concern which needs to be addressed as a matter of urgency is achieving JAG Accreditation.

2. Action Points

2.1 Recommendations

Recommendation		By	Timescale
1	**Programme Management**		
1.1	QA to receive copy of plan to attain JAG accreditation *Criteria for closure: Plan to QA*	Trust Management Centre Director	6 months
1.2	Endoscopy BCP to include reference to BCSP *Criteria for closure; copy to QA*	Programme Manager	3 months
2	**Admin & Data Collection**		
2.1	Dataset audit to be carried out quarterly on 10% or 10 cases & 100% of all cancers *Criteria for closure: Audit outcomes for 2 quarters to QA*	Centre Director Administrative Lead	6 months (commence Jan 2014)
3	**Nursing/SSP**		
3.1	Provide office accommodation at Cheltenham Hospital which meets the standard requirements for BSCP. *Criteria for closure: confirmation that re-provision has taken place*	Trust Management Centre Director	3 months
4	**Endoscopy**		
4.1	Aim for JAG reaccreditation for both sites in 2014 • GRH – address issues with decontamination • Both sites – maintain level A for timeliness • Ensure business plan addresses workforce issues on GRS *Criteria for closure: JAG accreditation achieved*	Trust Management Centre Director	9 months

Recommendation		By	Timescale
4.2	Provision for CO2 for all procedure rooms where Bowel Scope test will take place *Criteria for closure: written confirmation of provision to QA*	Trust Management Centre Director	12 months
4.3	Provision of Entonox at both sites *Criteria for closure: written confirmation of provision to QA*	Trust Management Centre Director	12 months
4.4	Audit cases where polyps >2cm for 2013, as to whether tattooed or not and if not, does this comply with locally agreed tattoo policy *Criteria for closure - copy of audit and tattoo policy to QA*	Centre Director	3 months
5	**Radiology**		
5.1	Commence screening service at Gloucester subject to assurance of adequate volume of reporting (screening and symptomatic) and double reporting of all screening studies as at Cheltenham (Standards A4.1e) *Criteria for closure: Written confirmation to QA*	Trust Management Lead Radiologist	3 months
6	**Pathology**		
6.1	Pathology resources (lab/secretarial support and consultant sessions) should be included in planning for implementation of Bowel Scope *Criteria for closure: agreed staffing plan submitted through Bowel Scope roll out process*	Trust Management Lead Pathologist	12 months

3. Background

Dr Trevor Brooklyn, Clinical Director

The Gloucestershire Bowel Cancer Screening Centre has been operational since January 2007. Cheltenham General Hospital (CGH) and Gloucestershire Royal Hospital (GRH) Endoscopy Units received full JAG approval in 2005 and the Trust's bid to be part of the first wave of Bowel Screening was accepted by the National Screening Office in 2006. The Screening Centre is based in the CGH Endoscopy Unit and SSP clinics and colonoscopy lists are held in both CGH and GRH.

The Screening Centre was successful in its bid to start the age extension in January 2010 and three year surveillance colonoscopies also added to demand from January 2010. In 2010 and 2011 the centre struggled to meet the demand and SSP and colonoscopy waits were significantly below target. The key reason for this was insufficient SSP hours, but poor service waits also resulted in some screening lists being sacrificed in favour of service lists. In June 2011 invitations for screening were slowed to 25% to allow the centre time to recover. Funding allocated to radiology was diverted to allow an increase in SSP hours and maternity was backfilled at 100%. A fourth screening colonoscopist was appointed in September 2011. In August 2011 the invitation rate was increased to 50% and the centre went back to full invitations in May 2012, several months ahead of schedule. The centre has maintained acceptable waits since this intervention.

The Centre has performed well against key performance indicators and leads the Southwest in many of the endoscopic indicators. The team functions effectively and communication is excellent with good clinical support for the SSPs. At present, the office accommodation for the team is inadequate and this has been escalated onto the Gastroenterology risk register.

Plans to enter the second wave of Bowel Scope Screening have been submitted to the National Office and have the support of the Trust. The rate limiting step for this application is JAG accreditation of the endoscopy units. Investment into endoscopy has improved service waiting times within the county and a plan to refurbish the decontamination facilities in GRH has been agreed. It is hoped that all units will achieve JAG accreditation during 2014 and Bowel Scope Screening aims to begin in CGH in October 2014.

4. Statistical Overview

This statistical overview is based on data from the Bowel Cancer Screening System (BCSS) and the suite of reports produced by the reporting tool Oracle Business Intelligence Enterprise Edition (OBIEE). Global Rating Scores (GRS) were supplied by the Joint Advisory Group (JAG) and made available to the QA Team to support the visit. More detail can be found in the QA speciality sections of this report.

Global Rating Scale (GRS) Scores

During the visit QA Leads consider GRS scores for the service, the scores used to support this visit were between the census dates of October 2010 and April 2013. A score of level B or above is the current standard for an acceptable service.

The most recent census of April 2013 shows that Cheltenham General Hospital scored a level of A or B in all domains with the exception of 'Quality of Patient Experience', which scored a level D for the 'Timeliness' measure/standard.

Gloucestershire Royal Hospital scored a level B or above in all domains with the exception of 'Quality of Patient Experience', which scored a level D for the 'Timeliness' and 'Booking and Choice' measures/standards in the April 2013 census.

Screening Waiting Times

SSP waiting times for the Screening Centre have been 100% within the target of ≤14 days between January 2013 and July 2013. In 2012 there was one month (July) where the Centre was not within 100% of the target; all other months were 100%. Between September 2010 and July 2011 the Centre was more than 10% outside the target ranging from as low as 2% of patients seen within 14 days to 75%. In August 2011 the Centre recovered to 100% of patients seen within target and have remained at 100% apart from the dip in 2012.

Diagnostic test waiting times (FOBt positive assessment to first offered diagnostic test) have fluctuated over the four year period 2010, 2011, 2012 and 2013. Only in January 2010 and September 2011 were 100% of patients seen within 14 days. However between January 2013 and July 2103 for most months more than 90% of patients were being seen, with a blip in July where 86% were seen, within the 14 day target.

Uptake and Positivity

The Southern Hub invited a total of 24,044 individuals to take part in the screening programme for Gloucestershire's Centre during the period January 2013 to June 2013. The latest figures for this period show an uptake of 62% and positivity of 1.7%. Uptake for the whole of 2012 was 64% and positivity 2.1%, 60% uptake and 2.2% positivity for 2011 and 61% uptake and 2.1% positivity for 2010.

Attendance at SSP Clinic

For the period January 2013 – July 2013 there were a total of 439 SSP appointments made in the Screening Centre of which 17% were cancelled overall (ranging from 7% - 28%). 17% were cancelled the previous year, 18% in 2011 and 17% in 2010. April, May and December tended to have the highest number of cancellations across all four years (between 16% and 28%).

Colonoscopy Uptake

At the Gloucestershire Centre during the period January 2013 – July 2013 there were 359 definitive FOBt+ patients recorded of which 296 attended colonoscopy giving a colonoscopy uptake rate (x100) of 82% which is slightly under the national rate of 84%. The overall rate in 2012 was 84%, 83% in 2011 and 83% in 2010.

Number of Colonoscopies Performed

For the full 12 month period between January 2012 and December 2012 all Colonoscopists performed more than the required standard of 150 colonoscopies. For January 2013 – July 2013 all colonoscopists have performed more than the national mean number colonoscopies, which was 70 as at the 22 August.

Caecal Intubation Rate/Photographic Evidence

The National caecal intubation (CIR) rate for January 2013 to July 2013 is 98%. The Gloucestershire Centre achieved in excess of this at 99%. In 2012 the Centre achieved a CIR of 98% (99% in 2011 and 98% in 2010). The national CIR with /photographic evidence rate for January 2013 to July 2013 is 96% with the Gloucestershire Centre once again exceeding this at 97%. CI with photo evidence for Gloucestershire Centre was 90% in 2012, 91% in 2011 but was below the standard in 2010 at 88%.

Adenoma Detection Rate

The Centre's adenoma detection rate is above the National target of $\geq$ 35 per 100 colonoscopies at 54% for the period January 2013 – July 2013 (national adenoma

detection rate is 46% for the same period). The ADR for 2012 was 53%, 54% in 2011 and 53% in 2010, all well above the national rates for the same period.

Withdrawal Times

The national standard is for withdrawal times to be ≥6 minutes. Gloucestershire Centre met the standard in January 2013 – July 2013, 2012, 2011 and 2010. Withdrawal times outside 6 minutes were low per individual Colonoscopist and ranged from a minimum of 0 to a maximum of 9 cases per Colonoscopist between 2010 and July 2013.

Tattooing

The percentage of polyps greater than 2 cm that had been tattooed in the Centre between January 2013 and July 2013 was 64%, 56% for 2012, 78% for 2011 and 57% for 2010.

Polyp Retrieval Rates

The national standard polyp retrieval rate of ≥90 per 100 polyps excised was met and exceeded by all Colonoscopists during the period 2010 – July 2013.

Diagnostic Test Results

Data for the period January 2013 – July 2013 show 15% of diagnostic tests carried out at the Centre had a normal result. Data for 2012 show a normal result percentage of 17%, 18% in 2011 and 20% of tests having a normal result in 2010.

Colonoscopy Comfort

The national comfort rate (no discomfort, minimal, mild) stands at 94% for January 2013 – July 2013, for the same period Gloucestershire Centre also had a score of 94%. One colonoscopist was 6% below the national rate during this time. Between 2010 and 2012 Gloucestershire Centre had comfort scores greater than the national averages of 93% for 2012, 92% for 2011 and 90% for 2010, with only one colonoscopist falling slightly below the national scores in each year.

IV Sedation Rates

The national sedation rate for January 2013 – July 2013 is 73%, 76% in 2012, 78% in 2011 and 80% in 2010. Gloucestershire Centre's % of IV sedation used is below the national rate for each of the corresponding periods at 59% for January 2013 – July 2013, 63% in 2012, 70% in 2011 and 71% in 2010.

Bowel Prep Quality

The national standard is for >90 per 100 bowel preparations to be described as excellent or adequate**.** The Centre as a whole exceeded this standard for the period January 2010 – July 2013.

Patient Episode Outcomes

The Centre detected 32 cancers during the period January 2013 – July 2013. For the 12 months of 2012, 66 cancers were detected, 2011 – 44 cancers and 2010 – 39 cancers.

Dataset Completion

Dataset completion for Colonoscopy Assessment was 100% between January 2013 and August 2013. As to be expected for the same period Investigations, MDT, Cancer Audits and Patient QA Questionnaires are all between 30% and 99% complete as not all cases would have been completed for the patient pathway.

Radiology Tests Performed

During the period January 2013 – July 2013 a total of 11 virtual CT colonoscopies and 3 abdominal CT scans were carried out. A total of 25 virtual CT colonoscopies and 14 abdominal CT scans were carried over a 12 month period in 2012. 3 virtual CT colonoscopies and 6 abdominal CT scans in 2011 and 5 virtual CT's and 1 abdominal CT in 2010.

Dysplasia for All Adenomas

The percentage of low grade dysplasia adenomas at Cheltenham General Hospital during the period January 2013 – June 2013 is 98% with 2% being high grade, Gloucestershire Royal Hospital had 97% recorded as low grade and 3% as high grade during the same period. The highest percentage of high grade was 3% at Cheltenham General Hospital during the 12 months of 2010. (All pathology is reported at a single laboratory).

Dysplasia for Tubular Adenomas

For the most recent period of January 2013 - June 2013 at Cheltenham General Hospital 99% of tubular adenomas were of low grade with 2% being high grade. Gloucestershire Royal Hospital had 100% with low grade dysplasia. Again the highest percentage of high grade was back in 2010 where 2% of cases at Cheltenham General Hospital were of high grade.

Number of Polyps by Subtype

The majority of polyps identified in the period January 2013 - June 2013 at Cheltenham General Hospital were tubular adenomas (62%) followed by hyperplastic polyps (21%) and tubulovillous adenoma (8%). During 2010, 2011 and 2012 the breakdown followed a similar pattern. However the number of polyps with a subtype not stated has increased each year (apart from in 2012) from 5% in 2010 to 8% in 2013.

Gloucestershire Royal Hospital also identified the majority of polyps as tubular adenomas (61%) during the period January 2013 – June 2013 followed closely by hyperplastic polyps (26%) and tubulovillous adenoma (8%). During 2010, 2011 and 2012 the breakdown followed a similar pattern. The % of type not stated across the 3 years ranged between 3% and 5%.

Submission to regional and national audits

The Centre was compliant with National requests to support data cleaning on the BCSS and the regional dataset audit.

5. Specialist Reports

5.1 Programme Management,

Dr Karin Denton, QA Director
Louise Groth, Senior QA Facilitator

The purpose of the Management Meeting is to ensure that there are clear lines of professional and managerial accountability for all staff, integration of the Screening Centre into the wider managerial activity of the Trust(s) (including arrangements for clinical governance) and clearly identified funding for Screening Centre activities.

Quality Assurance arrangements for the NHS Bowel Cancer Screening Programme. Draft Version 2.1 December 2010, section 3.6 page 17.

The following areas were discussed as part of the meeting:

Accommodation

The Gloucestershire Bowel Cancer Screening Centre covers a population of Gloucestershire which is approximately 615,000. The service is provided by Gloucestershire Hospitals NHS Foundation Trust. The Screening Centre office is based in the Cheltenham General Hospital (CGH) and SSP clinics and colonoscopy lists are carried out at both CGH and Gloucester Royal Hospital. Accommodation was reviewed at both sites during the QA visit. Further details can be found in SSP report page 18 and Endoscopy report page 22.

Management & Governance Arrangements

Programme Management arrangements and staff reporting lines were found to be robust. Staff organisational diagrams were forwarded to QA prior to the visit (see appendix 1 page 59)

The Centre Director confirmed that there are regular team meetings held every four to six weeks, which have commissioner and multi-disciplinary team representation from both sites. Copies of the minutes were supplied to QA prior to the visit.

The Centre confirmed that staff at both sites were signed up to the National Cancer Screening Programmes Confidentiality and Disclosure Policies, and Information Security Policies.

Early Warning and Incident Reporting

Early Warning and Incident Reporting Procedures were found to be robust. Incidents are managed in accordance with local Trust Policies and copies of the policies were provided to QA prior to the visit. It was noted that there was no reference to NHS Managing Incidents in National NHS Screening Programmes Interim Guidance (September 2013) and we ask the Trust to include reference to this guidance in the next policy update.

The Centre reports all incidents on NHS BCSP AVI forms, which are completed and forwarded to the QARC. All reported incidents are discussed as a standard agenda item at the team meetings.

Service Specifications and Commissioning

At the time of the visit commissioning responsibilities were being handed over from the former PCT to Screening and Immunisation Team (SIT). This handover was subject to a planned delay due to recruitment delays in the SIT. Commissioners confirmed that the existing service specification which forms part of the contract for the provision of health care services between GHNHSFT and Gloucestershire PCT will be rolled over until March 2014 when new arrangements with the Area Team will come into place.

Finance Arrangements

Trust Management confirmed that symptomatic and screening budgets are held separately. It was highlighted by the Centre Director that the budget for BCSP was used to support other non screening services and at times this meant that there was budget impingement for additional administrative support. Trust Management agreed to review the current alignment.

Relationships with associate organisations

The Trust reported good relationships between symptomatic and bowel cancer screening services at both sites and emphasised that there is flexibility across the Trust.

JAG accreditation

Cheltenham General Hospital and Gloucester Royal Hospital have a ‘not awarded’ JAG status. QA noted that Trust Management have confirmed there are robust plans in progress to address these issues with an expected resolution date of April 2014. QA asks that a copy of the action plan is submitted. It was noted that the Trust has made a significant financial commitment to achieving JAG accreditation including additional staffing and facilities.

Programme Capacity, Expansion and Bowel Scope Screening

The Centre have submitted an application to be a 'Second Wave' Bowel Scope Screening site, to commence screening from XX March 2014. The bid has not yet been approved by Trust Management but it was confirmed that there is Trust Board support and a commitment to support the Centre. The Centre will now work with National Office and Regional QA to progress.

Business Continuity and Disaster recovery plan

Trust Management confirmed that there was no generic Trust Business Continuity Plan, however there is a requirement for each ward/department to develop their own plan. The Endoscopy plan was not supplied prior to the QA visit and therefore it is a recommendation that this is forwarded to QA within 3 months.

Health promotion arrangements

The Centre is active in health promotion. Further details can be found in the SSP report page 18.

Relationships with External Agencies

The Centre reported excellent relationships with the Southern Hub as well as regional QA.

Conclusion

In conclusion, this is a well managed well performing Bowel Cancer Screening Centre. The roll out of Bowel Scope will require the Centre working closely with partner organisations.

Recommendation	Timescale
QA to receive copy of plan to attain JAG accreditation *Criteria for closure: Plan to QA*	6 months
Endoscopy BCP to include reference to BCSP *Criteria for closure; copy to QA*	3 months

5.2 Administration & Data Collection

Mrs Linda Beard, QA Administration & Data Lead

The administration of the Screening Centre is based at Cheltenham Hospital.A Right Results Gap Analysis Walkthrough was undertaken by the QA team on 3 July 2013 and at this visit the team were pleased to report that all action points could be closed.

Points of Good Practice

The Screening Centre is extremely well organised with evidence of good processes in place to meet the Quality Standards and to ensure that data is also collected on PAS for Trust purposes. There has been a good start on their Quality Management system that continues to be developed. There was evidence of good team relationships and mutual respect.

Staffing and Resources

The Screening Centre Manager on 0.85 wte and the Administrator on 0.65 wte. Although this staffing has been adequate this will be subject to change when Bowel Scope is implemented and embedded.

The Endoscopy booking service is now centralised for the Trust and based at Gloucester Royal Infirmary, and on meeting with the Endoscopy Admissions Officer confirmed that there is excellent communication between the Screening Centre and Endoscopy Admissions to facilitate the scheduling of Screening Colonoscopy Lists at both sites and ensuring that best use is made of any under utilisation of screening capacity by the symptomatic service.

Recommendations

A QARC recommendation was made in 17 April 2013 that a quarterly 10% or 10 case audit of datasets and 100% of datasets of cancers be undertaken, this should include a sample of patient satisfaction questionnaires. This is currently being undertaken by the Screening Centre on an annual basis and frequency should be increased to quarterly. This should also be a standing item on the agenda of governance meetings.

Recommendation	Timescale
Dataset audit to be carried out quarterly on 10% or 10 cases & 100% of all cancers *Criteria for closure: Audit outcomes for 2 quarters to QA*	6 months (Commence Jan 2014)

5.3 Nursing/Specialist Screening Practitioner

Ms Julia Heneker, QA Lead Nurse/SSP

The Centre comprises one part-time Lead Specialist Screening Practitioner who has recently returned to her post following a period of maternity leave and five part-time SSP's. The total workforce amounts to 3.4 WTE SSP's.

The team of established SSP's come from varied backgrounds and bring a wealth of knowledge and experience to the Centre which complements the team. Five SSP's have completed their induction programmes and have successfully completed the John Moores University Bowel Screening Course and the Lead SSP is now nearing completion of the course. The SSPs are contracted by the Host Trust and can work flexibly across the two sites.

During the two day visit SSP office accommodation, the Endoscopy suites and SSP policy and documentation were reviewed at both sites. A 'snap shot' audit of data and paper based documentation was carried out during the visit to check for accuracy. 10 sets of medical records from a combination of both sites were reviewed. The FoBt clinic rooms were not viewed during the visit as at both sites the main General Out Patient areas are used and the SSP's report well equipped suitable patient areas used.

Points of Good Practice

The SSPs are an enthusiastic team of practitioners who strive to maintain high standards of practice and care for their patients throughout the screening pathway. The team are to be congratulated on the standards of care provided and data/paper accuracy which was clearly appreciated and evidenced during the visit. There is evidence of good data collection at both the SSP clinics and within the endoscopy setting (evidenced during the visit) which passes through effectively to the patient's medical records held at each Trust.

The completeness and accuracy of BCSP/Endoscopy paperwork was extremely comprehensive and all relevant documents were incorporated into every set of patient notes viewed which described an accurate patient episode. The SSPs regularly meet and use a caseload spread sheet stored on their shared drive to detail patient pathways and regularly meet with the Centre Director and colonoscopists to discuss clinical cases and histological findings. QA noted that there is a good working relationship between the multi-professionals within the screening centre.

The Lead SSP and SSP's have ensured the centre time table works well and allows some time in the SSP programme for health promotion and research. The team have been active in promotion in the past and have been present on the Trust PALS Bus

displaying BCSP Promotional material. The team are keen to promote the service and look forward to being able to participate in further health promotional activities to encourage uptake in local areas, concentrating on areas of deprivation. Further points of good practice will be shared under the specific headings throughout the report.

Staffing & Resources

The Team have two office bases, one small but adequate office space at Gloucester Royal Hospital conveniently situated next to Endoscopy and the main office within the Endoscopy Department at Cheltenham Hospital. The main office space is a small shared space with the Endoscopy Sister and is inadequate. The room has insufficient space for patient records and IT facilities for SSP's. This facility breaches BCSP standard requirements to ensure patient confidentiality and privacy & dignity are maintained during telephone clinics.

There is evidence of good teamwork and communication ensuring that cross cover is provided across both sites and the SSP timetable allows for this. The SSPs have integrated well with the staff in the endoscopy unit at the GRH site and the Senior Endoscopy Sisters report excellent communication between the two services and the BCSP Programme. There is evidence of excellent working relationships between SSPs and the multi-professional groups involved within the screening pathway.

There are clinic slots routinely available with some flexibility when needed.

The Centre is now embarking on Bowel Scope planning for second wave so priority should now be given to the strategic aspects of management of the current service alongside the new plans. This includes ensuring robust cross cover arrangements are in place. Other challenges include maintaining the current standards of care, for both new and surveillance patients, and enabling delivery of the service in a smooth and timely fashion across both sites with limited resource.

Management & Organisational Issues

The programme is managed on a daily basis by the Lead SSP and Programme Manager and their organisation support and guidance is greatly valued by the SSP's and the wider screening team. There has until now been only one occasion where an SSP has not been able to attend an endoscopy session or clinic and an 'emergency pack' has been developed and is ready to use in such isolated occasions if required. The Gloucestershire trust however have very recently requested SSP's to work 'bank' shifts to support areas within the hospital experiencing staff shortages. It is proposed that the Team will potentially lose 3-6 days of SSP time per month. I would ask that the BCSP Programme Manager and Director closely monitor BCSP SSP wait times and

monitor the effect of reduced clinics and SSP results clinic will have on the service. I suspect this will have a disastrous effect on wait times in a very short space of time.

The SSP's do not transport patient identifiable information between sites and use electronic transfer or hospital transport on the rare occasion this is required. The shared drive is used for patient caseloads and can be accessed at both sites.

Training & Development

All members of the team have successfully completed the Induction and Orientation Programme and all SSP's have successfully completed the Bowel Cancer Screening Practitioner Course at Liverpool John Moores University and Trust Breaking Bad News Course. (Lead SSP completes November 13) The Centre is currently working towards a fully functional Quality Management System which will enable Standard Operating Procedures and work instructions to be signed off and reviewed by the SSP's and provide a log of Right Results Training.

Environment, Equipment, Health & Safety

The office accommodation at Gloucester Royal Hospital is adequate for the needs of the SSP team and can be locked protecting patient records. The main office in Cheltenham is not adequate as described above and the Trust should find alternative suitable accommodation for the Team as soon as possible.

No adverse health and safety concerns were observed during the course of the visit and no concerns raised by the SSP team or their management team. Authorised person (AP) certificates for decontamination standards in Endoscopy were witnessed during the visit at both sites and both had been signed off by regional inspectors.

No adverse technical concerns were observed during the course of the visit and no concerns were raised by the SSP Team.

Conclusion

The team are experienced and enthusiastic and QA would like to commend them on their hard work and high standards of care especially given the challenges faced with poor office accommodation at Cheltenham. There is clear evidence of high standards of patient care and safe patient pathways however we feel patient confidentiality, privacy and dignity is breaching BCSP standards within the current office arrangement. QA also have some concerns about the potential erosion of SSP hours during times of Trust staff shortages.

Recommendations	Timescale
Provide office accommodation at Cheltenham Hospital which meets the standard requirements for BSCP. *Criteria for closure: confirmation that re-provision has taken place*	3 months

5.4 Endoscopy Report

Dr Steve Gore, QA Lead Endoscopist

This report is based on information presented to QA, as well as from the formal visit to both Gloucester Royal Hospital (GRH) and Cheltenham General Hospital (CGH) on 8th and 9th October 2013. Interviews were conducted with all 4 screening colonoscopists.

Gloucestershire Bowel Cancer Screening Centre is based in a single Trust but has 2 sites for colonoscopy at GRH and CGH. There is a well renowned national/regional endoscopy training centre within the Trust, which is led by Dr John Anderson, who also provides a "complex polypectomy" service for neighbouring areas as well as the local population. All the screening colonoscopists are faculty members for the Training Centre. The team work well together and across both sites as required and have regular governance meetings.

Gloucester Royal Hospital

Since the last QA visit, GRH Endoscopy Unit has undergone some redesign to comply with Privacy and Confidentiality guidance. There are three purpose built endoscopy procedure rooms, which are fully equipped with modern Olympus scopes. There is currently a "scope guide" in each room and modern diathermy units. There is a CO2 regulator in only one of the rooms and as yet there is no facility for use of Entonox. The decontamination area needs redevelopment before applying for JAG reaccreditation next year (July 2014) and plans for this are in development. The Trust is committed to this capital project.

Cheltenham General Hospital

At CGH, as part of a recently funded development bid, the third procedure room has been commissioned. This has allowed the Trust to release some extra capacity and enabled them to achieve an A on the GRS for timeliness for the first time for a number of years. This is a position which will need to be maintained to achieve JAG accreditation next year (March 2014) prior to starting the Bowel Scope Programme. Once again, the procedure rooms are fully equipped with modern Olympus kit. CO2 is available in all rooms, but Entonox is not yet.

Performance

As a Centre and individually, the KPIs for colonoscopy are excellent. The caecal intubation rate exceeds the National mean and the adenoma detection rates are the highest in the South West region and will compare well with any Centre nationally. There have been very few adverse events with only one perforation and one major

bleeding complication which required surgical intervention since the start of the programme here in 2007.

The Tattoo rates for polyps >2cm appear slightly low, but this is likely to reflect local agreed policy whereby caecal and rectal lesions are not tattooed. An audit of tattooing lesions >2cm should be undertaken locally to prove this assumption. On occasions rates for photographic evidence of caecal intubation are lower than standard, which may reflect problems with polaroid system for producing photographs and consideration should be made to obtain a digital image capture system. All four colonoscopists enjoy their screening lists citing them as the “highlight of the week”, “favourite list” and a quality which all endoscopy lists should aspire to reach.

Points of Good Practice

- High Adenoma Detection Rates – reflects excellent quality colonoscopy
- Complex Polypectomy Service for local population as well as wider community (SW and beyond)
- Effective cross county working, with good cross cover arrangements when required.
- National Training Centre – could consider further “Best practice sharing” event for BCSP screening colonoscopists around the region

Observations

- Consider digital image capture to address issues re capturing photographic evidence of caecal intubation

Recommendations	Timescale
Aim for JAG reaccreditation for both sites in 2014 • GRH – address issues with decontamination • Both sites – maintain level A for timeliness • Ensure business plan addresses workforce issues on GRS *Criteria for closure: JAG accreditation achieved*	9 months
Provision for CO2 for all procedure rooms where Bowel Scope test will take place *Criteria for closure: written confirmation of provision to QA*	12 months
Provision of Entonox at both sites *Criteria for closure: written confirmation of provision to QA*	12 Months

Audit cases where polyps >2cm for 2013, as to whether tattooed or not and if not, does this comply with locally agreed tattoo policy *Criteria for closure - copy of audit and tattoo policy to QA*	3 months

5.5 Radiology Report

Dr Giles Maskell, QA Lead Radiologist

Introduction

A high quality CTC service is provided on the Cheltenham site with committed specialist GI radiologists and skilled radiographers. There were many examples of good practice for example in relation to dietary and laxative preparation, information supplied to patients and rigorous audit including patient satisfaction surveys. Although there is a symptomatic CTC service on the Gloucester site, all NHS BCSP CTCs are currently carried out in Cheltenham. I understand that all facilities and expertise are in place to commence performing screening studies in Gloucester in accordance with all BCSP standards which would be of benefit to patients.

Facilities

The Cheltenham site benefits from state-of-the-art CT equipment, enthusiastic and well trained radiologists and radiographers. The CT department is well provided with the necessary facilities including changing areas, toilets etc. Good quality patient information is available. Radiologists benefit from state of the art reporting technology.

Reporting

All studies are double reported by GI specialist radiologists. Local audit of the screening CTCs shows excellent report turnaround times.

Case review

Six consecutive BCSP CTC cases from Spring 2013 were reviewed.

- All datasets of excellent (5) or adequate (1) quality.
- Prone and supine acquisitions in all cases with appropriate selected decubitus views
- Good quality preparation and faecal tagging employed in all cases
- appropriate use (or non-use) of iv contrast in all cases
- All reported by specialist GI radiologist and all within 7 day time limit
- Excellent and detailed reports augmented by snapshot images of abnormalities

- Occasional reporting of diminutive polyps (current BCSP guidance is not to report polyps less than 6mm in diameter)

Recommendations	Timescale
Commence screening service at Gloucester subject to assurance of adequate volume of reporting (screening and symptomatic) and double reporting of all screening studies as at Cheltenham (Standards A4.1e) *Criteria for closure: Written confirmation to QA*	3 months

5.6 Pathology

Dr Manuel Rodriguez-Justo, QA Pathologist

This report is based on the information obtained from the Bowel Cancer Screening Pathology Quality Assurance visit questionnaire, accompanying audits /documentation and from the meeting held on the day of the visit with Prof Neil Shepherd (Pathology Lead)

Points of good practice

- Cohesive and proactive pathology team
- BCSP pathologists participate in BCSP-EQA and educational meetings
- Double reporting of cancer in polyps and high-grade dysplasia
- Proformas / templates used in all BCSP reports and colorectal cancer resections
- Exemplary performance indicators in cancer resection specimens

Background

The Cellular Pathology department at Cheltenham General Hospital (CGH) undertakes the processing and reporting for the Gloucester Bowel Cancer Screening Centre, including the Royal Gloucester Hospital and CGH. The Histopathology department provides a high class service that is underpinned by good internal audits

There are currently 2 pathologists reporting specimens generated by local BCSP but a 3rd consultant has just been appointed (October 2013) who will also report BCSP cases. The quality of reporting of polyps and cancer resections is excellent and all the pathology indicators are all well above the expected standards. The team is cohesive with a very pro-active lead and an excellent relationship among pathologists allowing discussion of difficult cases and share of good practice.

Accreditation

The department has full CPA accreditation (June 2013) with a surveillance visit expected in May 2014. The number of medical staff sessions in the laboratory complies with Royal College of Pathology guidelines.

Staffing

BCSP duties are specifically recognized in the current lead's job plan, who also has 1 externally funded additional PA to support his role as Regional Lead Pathologist. Although BCSP commitments are not specifically stated in the job plan for the 2nd consultant pathologist, it is understood that reporting BCSP cases is included in the job specifications for GI consultant pathologists. The Lead pathologist reports a significant number of BCSP cases and the workload might need to be redistributed more equally when the 3rd GI pathologist is in post

Secretarial staffing is satisfactory but the level of laboratory (BMS) staff is only just adequate. The Cellular Pathology lab is involved in the LEAN programme to maximize resources but it is not possible to prioritize specimens generated by screening programmes and turn-around times will be impossible to maintain with increased workload from the Bowel Scope programme.

Laboratory process

BCSP specimens are clearly identified with orange stickers on the request forms and are received in an appropriate state for examination. However there have been occasion in which delays transporting specimens from the endoscopy units to the Pathology department have occurred. This problem with transport has been raised in the monthly management screening meetings. There are Standard Operating Procedures (SOPs) in place for handling, cut up and measurement of polyps and pathways to refer / deal with difficult cases

Communication:

Communication across all levels of staff is excellent. Pathologists attend weekly colorectal cancer MDTs where screening detected cancers are discussed and reviewed. There are mechanisms for reporting unexpected cancers to the screening team. The pathology lead attends the monthly management screening unit meetings.

Conclusion:

Overall, a very positive QA visit with very high standards and significant areas of good practice. Since the previous visit, in 2010, the Histopathology Department has complied with all the previous recommendations. There are no areas of concern but adequate resources to support the cellular pathology department must be guaranteed in preparation for flexi-sigmoidoscopy / bowel scope

Recommendations	Timescale
Pathology resources (lab/secretarial support and consultant sessions) should be included in planning for implementation of Bowel Scope *Criteria for closure: agreed staffing plan submitted through Bowel Scope roll out process*	12 months

6. NHSBCSP Guidance

- Guidebook for Programme Hubs and Screening Centres. NHS Bowel Cancer Screening Programme. Version 3. Published 31 March 2008. Appendix 9. Colonoscopy QA Standards.
- General Principles of Quality Assurance for the NHS Bowel Cancer Screening Programme. NHS Cancer Screening Programmes National office. August 2008.
- Quality Assurance Arrangements for NHS Bowel Cancer Screening Programme. Draft Version 2.1 Published 13 Dec 2010
- BCSP Implementation Guide No 4 July 2005NHS Bowel Cancer Screening Programme. Jag Accreditation and Re-accreditation of Endoscopy Units.
- BCSP Implementation Guide no 3. Version 10. June 2010 Accreditation of Screening Colonoscopists.
- NHSBCSP Publication No 1. September 2007.Reporting Lesions in the NHS Bowel Cancer Screening Programme, Guidelines from the Bowel Cancer Screening Programme Pathology Group.
- NHS BCSP Publication No 6 February 2011 Quality Assurance Guidelines for Colonoscopy
- NHSBCSP Publication No 5 Second Edition. November 2012 Guidelines for the Use of Imaging in the NHS Bowel Cancer Screening Programme.
- NHSBCSP Publication No 8. August 2012 Education and Training Requirements for Specialist Screening Practitioners.
- NHSBCSP Publication No 9 Second Edition Adenoma Surveillance.
- NHS Managing Incidents in National NHS Screening Programmes Interim Guidance (September 2013).
- NHSBCSP Publication No 10 Mentoring & Quality Assurance of Screening Endoscopists October 2013.

7. Circulation

Dr Frank Harsent	Chief Executive	Gloucestershire Hospitals NHS Foundation Trust
Dr Trevor Brooklyn	Centre Director	Gloucestershire Bowel Cancer Screening Centre
Professor Julietta Patnick	Director	Cancer Screening Programmes, Public Health England
Mrs Lynn Coleman	Assistant Director (Bowel)	Cancer Screening Programmes, Public Health England
Dr Pamela Akerman	Screening & Immunisation Lead	Public Health England
Dr Shona Arora	PHE Centre Director	Public Health England

8. Standards

- A5 Screening Centres & Additional Colonoscopy Sites
- A8 Admin & Data Collection - Admin Programme Management
- A9 Admin & Data Collection
- A10 I.T. Systems, Data Accuracy, Completeness & Timeliness
- A2 SSP Consultations
- A7 SSPs in Bowel Cancer Screening
- A3 Screening Colonoscopy
- A4 Imaging
- A6 Pathology

A5 Screening Centres and Additional Colonoscopy Sites

National Standard	Objective	Measure	How is the measure assessed?	Minimum screening std evidenced by	Standard achieved
A5.1	There is a health promotion plan with measurable outcomes of acceptance within the local population profile and special groups such as deprived communities, ethnic minority groups, travellers and the homeless, by providing information to the local community.	Measures of uptake of screening. Uptake data by postcode available from national office on request. [*DN - this function may be devolved to the Hub – tbc]*	BCSS report. Measures of kit returned as % of invitation sent by postcode.	Health promotion activities carried out by Centre	✓
A5.2	The interval between receiving a positive screening test result and receiving an SSP consultation is minimised.	The time between the receipt of a positive screening test result and the offered appointment date for an SSP Consultation.	BCSS report on waiting times.	Confirmed at QA Visit	✓
A5.3	Each screening colonoscopy site within a screening centre to be JAG accredited on a 5 yearly programme of accreditation.	JAG accreditation	JAG accreditation records	JAG accreditation	**X**
A5.4	The screening centre has flexibility to meet fluctuations in service demand and meeting the waiting times.		Written contingency plans for SSP's, consultants and screening centre colonoscopy provision	Confirmed at QA Visit	✓
A5.5	The SSP consultation and the colonoscopy are offered at a BCSP site that is most		a) List of SSP clinic sites and screening colonoscopy sites	Confirmed at QA Visit	✓

National Standard	Objective	Measure	How is the measure assessed?	Minimum screening std evidenced by	Standard achieved
	appropriate to the patient		b) BCSS QA reports		
A5.6	Each screening centre to participate in GRS assessments and to maintain scoring of level B or higher.	Scoring in bi-annual GRS assessments	Evidence of GRS a) List of screening SSP clinic sites and colonoscopy sites b) BCSS QA reports	See Statistical Overview	✓
A5.7	Each screening centre has named leads for endoscopy, pathology, nursing, data management/administration, public health, and imaging, to lead on quality issues for their discipline.	Named leads	Evidence of named leads.	Confirmed at QA Visit	✓
A5.8	All adverse incidents are recorded and reported to the national office the QARC and the SHA, using the reporting form on the BCSP website.	Reporting of adverse incidents and near misses	Evidence of an appropriate system for recording adverse incidents and in the case of any incident that there is compliance with Trust's clinical governance policy.	Confirmed at QA Visit	✓
A5.9	All adverse incidents are reviewed on a regular basis by the director of the screening centre.	Regular review	Evidence of regular audit and review	Confirmed at QA Visit	✓
A5.10	There is a policy/process whereby poor performance is brought to the attention of the Trust clinical governance committee and the QARC for the BCSP.	Evidence of policy/procedure	Evidence of policy/procedure that defines poor performance. Evidence of processes for the formal notification process to QARC.	Confirmed at QA Visit	✓

National Standard	Objective	Measure	How is the measure assessed?	Minimum screening std evidenced by	Standard achieved
A5.11	Screening colonoscopy sites within a screening centre are expected to be able to report final outcomes on all patients screened by the programme.	Reporting of final outcomes on BCSS	Evidence of reports of final outcomes for all patients undergoing colonoscopies.	Confirmed at QA Visit	✓
A5.12	Screening colonoscopy sites within a screening centre must liaise with a number of treating hospitals in order to ascertain the tumour character-ristics for all patients referred for cancer treatment.	Reporting of tumour characteristics on BCSS	There is evidence of arrangements being applied to ascertain tumour characteristics of all patients referred to the surgeons for cancer treatment.	Cancer data sets Evidenced by OBIEE	✓
A5.13	All patients diagnosed with cancer are discussed at an MDT at which all appropriate specialities are represented.	Outcomes of discussion, care plan intent, and consultant details are documented.	Evidence of MDT meetings and decisions can be demonstrated.	MDT attendance provided. Case note review	✓
A5.14	There is a formal protocol for the handing over of patients to a named surgeon for treatment.	Protocol for handing patients over of patients to a named surgeon.	Evidence of adherence to the formal protocol can be demonstrated.	Confirmed at QA Visit	✓
A5.15	All patients undergoing colonoscopy are asked to fill in a patient satisfaction questionnaire within the required time period. These questionnaires are entered onto the BCSS.	Patient satisfaction questionnaires on BCSS	BCSS patient satisfaction reports are sent out at 30 days. Evidence of audit of patient satisfaction questionnaires and evidence that issues are acted upon can be demonstrated.	Confirmed at QA Visit	✓
A5.16	All patients who are found to have polyps at colonoscopy	a) patients with low risk polyps	There is evidence of a procedure where patients	Confirmed at QA Visit	✓

National Standard	Objective	Measure	How is the measure assessed?	Minimum screening std evidenced by	Standard achieved
	are put into the surveillance system and followed up for the appropriate period.	1 or 2 small (<1cm) adenomas)	classified as low risk have FOBt in two years, if <75.		
		b) patients with intermediate risk polyps 3 or 4 small adenomas OR At least 1 adenoma ≥ 1 cm	There is evidence that patients classified as intermediate risk have 3 yearly colonoscopy surveillance until two negative examinations.	Confirmed at QA Visit	✓
		c) patients with high risk polyps, ≥ 5 adenomas or ≥ 3 adenomas of which at least 1 is ≥ 1cm.	There is evidence that patients classified as high risk have colonoscopy at 12 months followed by 3 yearly colonoscopy surveillance until two negative examinations.	Confirmed at QA Visit	✓
A5.17	There is a protocol to ensure that the data on the outcomes of screening colonoscopies and treatment for patient diagnosed through the screening programme are collected for audit and evaluation of the screening prog and allow screening episodes to be closed.	Audit and evaluation of screening programme	There is evidence that there is a formal protocol in place and evidence that audit and evaluation takes place at regular intervals and involves all clinical staff.	Checked at QA Visit Collected on OBIEE/BCSS	✓
A5.18	Regular clinical team meetings to discuss management of screening patients take place.		Minutes/notes of the meeting with list of attendees.	Confirmed at QA Visit Minutes supplied	✓

National Standard	Objective	Measure	How is the measure assessed?	Minimum screening std evidenced by	Standard achieved
A5.19	Regular service review meetings involving all interested parties to review the screening centre.		Minutes of the meeting, attendees list and action notes.	Confirmed at QA Visit	✓

A8 Administration & Data Collection – Admin Programme Management

National Standard	Objective	Measure	How is the measure assessed?	Minimum screening std evidenced by	Standard Achieved
A8.1	There is clearly identified funding for the bowel cancer screening programme.	A financial budget for each bowel cancer screening centre	Documented evidence of allocated budget	See Programme Management section	✓
A8.2	To ensure that SLA's are in place across the Screening Centre and its associated colonoscopy sites	Annual SLA	Evidence of SC and PCT agreement of SLA	See Programme Management section	N/A
A8.3	There is a Quality Management System in place in the Screening Centre to accurately document policies, procedures, work instructions and forms, that govern the operation of the service		Documented evidence	Evidenced at QA Visit. Continues as a WIP	✓
A8.4	There are at least quarterly screening centre review meetings		Documented evidence	Confirmed at QA Visit	✓
A8.5	There is a right result to right patient policy	A standard operating procedure exists to ensure that the right result is sent to the right patient.	Quality Management System policy in place	Confirmed at QA Visit	✓
A8.6	There is a designated person to ensure that policy guidelines from National Office are followed and implemented.	There is a designated person	Documentation as evidence	Confirmed at QA Visit. Lead Administrator	✓
A8.7	All relevant cancer screening personnel including data	Evidence of PIAG training and	Signed declaration forms and training	Confirmed at QA Visit	✓

National Standard	Objective	Measure	How is the measure assessed?	Minimum screening std evidenced by	Standard Achieved
	controllers and IT departments comply with the national policies and that all declaration forms are appropriately signed and retained by the organisation. Exemption from section 60 PIAG is conditional and subject to the programme's implementation and sign-up to the following national policies on an annual basis:	compliance	records.		
A8.8	There is a designated person to monitor reports and targets such as waiting time and to liaise with national office with respect to monitoring of alerts.	There is a designated person	Documentation as evidence	Confirmed at QA Visit. Lead Administrator	✓
A8.9	The screening director is responsible for ensuring that all staff are up to date with all BCSS releases.	Attendance at BCSS courses	Documentary evidence of staff attendance of BCSS courses	Confirmed at QA Visit. Lead Administrator	✓
A8.10	To ensure all three KC returns are complete and accurate	Screening Centre Director sign off each KC return prior to submission		NB – KC's are not scheduled to be operational	N/A
A8.11	There is a two year capacity plan for the screening centre		Documentation as evidence	Confirmed at QA Visit	✓
A8.12	To ensure that there is a clearly documented communication strategy identifying all of the key stakeholders		Documentation as evidence	Confirmed at QA Visit	✓
A8.13	There is appropriate administrative infrastructure to ensure core		Documentation as evidence. Resource	Confirmed at QA Visit	✓

National Standard	Objective	Measure	How is the measure assessed?	Minimum screening std evidenced by	Standard Achieved
	operational hours are maintained and adequate cover is provided for annual leave and sickness		plan.		

A9 Administration and Data Collection

National Standard	Objective	Measure	How is the measure assessed?	Minimum screening standard evidenced by	Standard Achieved
A9.1	There is a timely and accurate exchange of information between the screening centre and the commissioning PCT.	Evidence of protocol for communication between screening centre and PCT.	Evidence of protocol for communication between Screening Centre and PCT.	Confirmed at QA Visit	✓
A9.2	GPs and PCTs are encouraged by the screening centre to promote bowel cancer screening effectively for the patients as part of a health promotion strategy.	The percentage uptake and coverage for each practice screened.	Documented plan on health promotion and social marketing	Confirmed at QA Visit	✓
A9.3	There are designated and separate workspaces for admin and the SSPs which enable patient confidentiality and secure patient records.	Office space layout of screening centre	QA visit	Confirmed at QA Visit See Admin & data section Admin, SSPs sharing office, to be resolved	**X**
A9.4	There is a designated person who will review periodically the patient information leaflets available.	There is a designated person	Documentation as evidence	Confirmed at QA Visit	✓
A9.5 & A5.15	There is a designated person who will monitor patient satisfaction questionnaires and feedback findings to the screening centre meetings.	There is a designated person	Documentation as evidence	Confirmed at QA Visit. Administrator	✓
A9.6	There is a designated person who ensures that policies and procedures are consistently implemented across any satellite sites.	There is a designated person	Documentation as evidence	Confirmed at QA Visit. Lead SSP/Lead Administrator	✓

National Standard	Objective	Measure	How is the measure assessed?	Minimum screening standard evidenced by	Standard Achieved
A9.7	GPs are informed of all individuals with a positive screening test result who do not proceed to colonoscopy.	This measure will involve those patients who: a) DNA at the SSP consultation stage b) Attend for an SSP consultation screening but who do not accept colonoscopy following SSP consultation. c) Attend for an SSP consultation but are found to be unsuitable on clinical grounds.	Evidence that GPs are advised in all cases. Evidence of BCSS report.	Confirmed at QA Visit	✓
A9.8	An agreed protocol exists for the engaging of translation and interpretation services, including visual and hearing impairment.	There is an agreed protocol	Evidence of protocol at QA visit and pre-visit dataset	Confirmed at QA Visit	✓
A9.9	The administrator has successfully completed a period of induction and orientation within their screening centre and associated sites.	Qualifications are demonstrated and evidence of induction and orientation.		Confirmed at QA Visit	✓
A9.10	The admin job description meets the requirements of the national		Job description	No national admin job profile	N/A

National Standard	Objective	Measure	How is the measure assessed?	Minimum screening standard evidenced by	Standard Achieved
	outline job profile recommended by the BCSP.				
A9.11	The administrator undergoes annual appraisal with a personal development plan that is S.M.A.R.T.		Training Logs	Confirmed at QA Visit	✓
A9.12	The administrator ensures that the patient is given written information inviting them to participate in surveillance		Audit. Review Health check for printing log	Confirmed at QA Visit	✓
A9.13	Each administrator has developed a working relationship with key members of the screening team e.g. SSP, Colonoscopist, Hub		Induction & orientation documentation. Evidence of screening centre meetings	Confirmed at QA Visit	✓
A9.14	Each administrator follows their agreed local policies and protocols for the management of the screening centre		Evidence of protocol at QA visit and pre-visit dataset Interview to assess that Administrator understands and follows protocols	Confirmed at QA Visit	✓
A9.15	Where appropriate the administrator ensures that all screening datasets are completed accurately and outcomes from all screening episodes are entered onto BCSS.		BCSS QA reports	Confirmed at QA Visit	✓
A9.16	The administrator attends all		Certificate of	Confirmed at QA Visit	✓

National Standard	Objective	Measure	How is the measure assessed?	Minimum screening standard evidenced by	Standard Achieved
	applicable update training for the BCSS.		attendance		
A9.17	To promote effective telephone communication with participants thereby ensuring that unambiguous information is given about the bowel screening process			Confirmed at QA Visit	✓
A9.18	Telephone message that are left on the answer phone will be dealt with by the end of the next working day		Audit	Confirmed at QA Visit	✓
A9.19	Ensure that all reports and alerts are acted upon to ensure timely progression of a client/patient episode	Number of clients/patients on BCSS reports	Monitoring the report on BCSS which identifies the last time all reports were run. Audit.	Confirmed at QA Visit	✓
A9.20	Ensure that all letters are acted upon to ensure timely progression of a client/patient episode	Number of clients/patients on BCSS reports		Confirmed at QA Visit	✓
A9.21	The Screening Centre will maintain core office hours 9am – 5pm, Monday-Friday		Documented evidence of rota	Confirmed at QA Visit	✓

A10 IT systems, data accuracy, completeness and timeliness

National Standard	Objective	Measure	How is the measure assessed?	Minimum screening std evidenced by	Standard Achieved
A10.1	There is a designated person to ensure the completion, accuracy and timeliness of the data entered onto the BCSS	There is a designated person	Documentation as evidence	Confirmed at QA Visit. Lead Administrator	✓
A10.2	There is a designated person to monitor reports and targets such as waiting time and to liaise with national office with respect to monitoring of alerts.	There is a designated person	Documentation as evidence	Confirmed at QA Visit. Lead Administrator	✓
A10.3	The screening director is responsible for ensuring that all staff are up to date with all BCSS releases.	Attendance at BCSS courses	Documentary evidence of staff attendance of BCSS courses	Confirmed at QA Visit.	✓
A10.4	All relevant cancer screening personnel including data controllers and IT departments comply with the national policies and that all declaration forms are appropriately signed and retained by the organisation. Exemption from section 60 PIAG is conditional and subject to the programme's implementation and sign-up to the following national policies on an annual basis:	Evidence of NIGB (PIAG) training and compliance	Signed declaration forms and training records.	Confirmed at QA Visit.	✓

A2 SSP Consultations

National Standard	Objective	Measure	How is the measure assessed?	Minimum screening standard evidenced by	Standard Achieved
A2.1	The SSP assessment clinic environment is fully equipped.	Equipment should include: Instruction leaflet for bowel preparation Visual aids for explaining colonoscopy Consent forms for colonoscopy Information leaflets on healthy eating and bowel cancer symptom recognition Weigh scales, height measurement and BP & pulse oximeters.	Questionnaire and QA visit	Both clinic areas situated in General Outpatient on both sites. SSP's report suitable patient areas with appropriate facilities and equipment.	✓
A2.2	The SSP follows local Trust policy for the provision of bowel preparations	Patient group directive and process for issuing bowel preparation	Evidence of agreed protocol being followed	All SSP's signed up to PGD	✓
A2.3	The clinic environment is safe and secure for patients and staff and should meet trust health and safety standards		Questionnaire and QA visit	As A2.1	✓
A2.4	The clinic environment supports patient privacy and confidentiality		Patient feedback and QA visit	As A2.1	✓

National Standard	Objective	Measure	How is the measure assessed?	Minimum screening standard evidenced by	Standard Achieved
A2.5	The SSP Consultation is carried out by a healthcare professional with the appropriate skills, knowledge and experience and following national guidance.	SSPs undergo specific training and education for colonoscopy assessment, and skills are assessed during annual appraisal.	Evidence-based audit of practitioners CPD files and record of appraisals. Evidence that temporary staff get the appropriate training on BCSS as well as induction and orientation.	Confirmed at QA Visit. All SSP Appraisals up to date and include PDP's	✓
A2.6	An agreed protocol exists for the engaging of translation and interpretation services in the visual and hearing impaired		Evidence of the agreed Protocol being followed	Confirmed at QA Visit. Trust policy used effectively	✓
A2.7	A clear and appropriate patient pathway is followed for individuals with a positive screening test who are found to be unfit for colonoscopy.	Evidence of written patient information.	Examples of written patient information and evidence that it is distributed to patients Patient satisfaction survey	QA Visit/Medical Record Review. Joint referral with Colonoscopist	✓
A2.8	There is an agreed pathway for patients who are found to be unfit for colonoscopy		Protocol for patients unfit for colonoscopy	SOP Seen	✓
A2.9	FAILSAFE ARRANGEMENTS: A clear and appropriate patient pathway is followed for individuals with a positive screening test result, who refuse to	The number of individuals who attend an SSP consultation but who do not accept colonoscopy following SSP Consultation	a) documented policies and protocols in place and being applied b) Evidence of procedure to ensure that patients with positive FOBt not accepting colonoscopy are referred	SOP Seen	✓

National Standard	Objective	Measure	How is the measure assessed?	Minimum screening standard evidenced by	Standard Achieved
	proceed to colonoscopy.		back to their GP. Patients are advised by the SSP and risks explained, Written in episode notes on BCSS. Letter to GP automatically generated by BCSS. Evidence of regular audit of patients who refused colonoscopy.		

A7 Specialist Screening Practitioners in bowel cancer screening

National Guidance	Objective	Measure	How is the measure assessed?	Minimum screening std evidenced by:	Standard Achieved
A7.1	The SSP has successfully completed a period of induction and orientation within their screening centre and associated sites.	Qualifications are demonstrated and evidence of induction and orientation.	Induction booklet signed	Centre Records. All inductions complete	✔
A7.2	All SSP's must be either enrolled / undertaking or have successfully completed the BCSP recognised formal education programme within the stipulated time frame.		Evidence of: a) Letter of offer of place on course b) Attendance c) Certificates	Centre/National Records Lead SSP due to complete Nov 13, all other SSP's completed JMU	✔
A7.3	The SSP job description meets the requirements of the national outline job profile recommended by the BCSP.		SSP Job Description	QA Visit. JD's current	✔
A7.4	The SSP undergoes annual appraisal with a personal development plan that is S.M.A.R.T.	Evidence of ongoing professional development, an annual development plan is available.	a) Evidence of annual appraisal b) Copies of CPD plans c) Evidence of DOPS assessment	QA Visit See A2.5	✔
A7.5	Each SSP is able to competently assess and address the communication needs of each screening patient.		Each SSP has a selection of learning resources available to them to meet the communication needs of the individual	QA Visit DOP's assessments not undertaken to date but planned for 2014	✔

National Guidance	Objective	Measure	How is the measure assessed?	Minimum screening std evidenced by:	Standard Achieved
			patient. Evidence of DOPS assessment		
A7.6	The SSP assesses the patient's requirement for information and offers appropriate verbal and written information as required.	a) The patient record b) Patient satisfactions surveys.	a) The patient record will reflect that appropriate information is offered and accepted. b) DOPS assessment c) Patient satisfactions surveys reflect that appropriate levels of information have been received.	QA Visit DOP's assessments not undertaken to date but planned for 2014	✓
A7.7	The SSP ensures that the patient is given the name and contact details of an individual from whom they can get further information/advice regarding their ongoing care.	Evidence from patient satisfaction survey	Patient satisfaction surveys	QA Visit interview Team contact card given to all patients	✓
A7.8	The SSP attends the colonoscopy to support the patient		Local records and an endoscopy reporting system.	QA Visit interview. Paper resource developed in case of SSP absence	✓
A7.9	The SSP working in collaboration with the screening colonoscopists will complete the colonoscopy dataset at the time of the colonoscopy		a) BCSS QA reports b) Lead SSP reviews data and issues monthly report	QA Visit interview/BCSS check	✓
A7.10	The SSP ensures that the patient is given written information concerning the		a) Lead SSP audit practice b) Lead SSP audit	Medical note review	✓

National Guidance	Objective	Measure	How is the measure assessed?	Minimum screening std evidenced by:	Standard Achieved
	results of the colonoscopy		patient results		
A7.11	Following colonoscopy the SSP offers a further consultation with the SSP or another relevant health care professional to discuss the results and to provide individual .		a) BCSS QA reports b) Lead SSP reviews data and issues monthly report c) patient pathway	SOP seen	✓
A7.12	Each SSP has been assessed as being competent in breaking bad news		a) Signed DOPS by appropriately skilled mentor b) Evidence of completion of Advanced Communication Skills Course.	QA Interview. Lead SSP unable to access Advanced Communication Course. All other SSP's have completed	x
A7.13	Each SSP has developed a working relationship with key members of the colorectal / GI team/s in each of their treating hospitals		a) Induction & orientation documentation	QA Interview. SSP's report good relationships with CNS	✓
A7.14 & A5.14	Each SSP follows their agreed local policies and protocols for the / management and hand over of patients diagnosed with a colorectal cancer or other non malignant pathology	Agreed protocol for referral to: CNS Staging Management for each hospital site	Evidence of protocol at QA visit and pre-visit dataset Interview to assess that SSP understands and follows protocols	QA Interview. SSP's always able to attend MDT when required	✓
A7.15 & A5.13	As a member of the MDT the SSP ensures that each suspected or confirmed cancer diagnosis is discussed at the next available MDT at the local		a) Attendance records of MDT b) Lead SSP audits attendance for preceding 3 months.	Medical note review	✓

National Guidance	Objective	Measure	How is the measure assessed?	Minimum screening std evidenced by:	Standard Achieved
	hospital and wherever possible, should attend the MDT in person to present the case.				
A7.16	The SSP ensures that where appropriate the relevant specialist nurse is informed of the patient and their diagnosis to ensure the smooth handover of care.		MDT data Referral letters protocol	SOP Seen	✓
A7.17	The SSP ensures that all screening datasets are completed accurately and outcomes from all screening episodes are entered onto BCSS.		BCSS QA reports Lead SSP provides monthly report	SSP's check patient letters against Histology Reports	✓
A7.18	The SSP attends all applicable update training for the BCSS.		Certificate of attendance	Yes	✓
A7.19	Established links exist between the SSPs and the local health communities collaborative and other health promotion agencies to improve access to screening.		Interview	QA Interview. HP Activities undertaken by Centre	✓

A3 Screening Colonoscopy

National Standard	Objective	Measure	How is the measure assessed?	Minimum screening std evidenced by	Standard Achieved
A3.1	The time between SSP clinic date and first offer of colonoscopy is 14 days		BCSS report	Confirmed at QA Visit	✓
A3.2	Colonoscopy is performed by an appropriately qualified screening colonoscopist in an approved environment	a) Colonoscopy is carried out by an accredited screening colonoscopist.	Certification of accreditation	As Above	✓
A3.3	Investigate individuals with positive FOB test results	Acceptance rate of colonoscopy after positive FOB test	Percentage of positive FOBt who attend for an SSP Consultation who undergo colonoscopy. BCSS report.	Confirmed at QA Visit	✓
A3.4	Entire colon examined	Completion rate with photographic evidence of ileo- caecal valve/appendix orifice (unadjusted)	Completion rate available from the BCSS endoscopy QA report including that there is photographic evidence of caecal valve/appendix orifice	As above	✓
A3.5	Identification of adenoma/cancer present in the population	a)Adenoma detection rate (prevalent screening round)	Polyp information is available from the BCSS endoscopy QA report.	As above	✓
		b)Cancer detection rate (prevalent screening round)	Cancer information is available from the BCSS endoscopy QA report.	As above	✓

A3.6	Examination by pathological examination of all polyps recovered	Polyp recovery	Polyp information is available from the BCSS endoscopy QA report.	As above	✓
A3.7	Planning of surgery	a) Identification of tumour position in correct segment of colon	Cancer information is available from the BCSS endoscopy QA report.	As above	✓
A3.8	Minimising harm to the population	a) Minimum number of screening colonoscopies undertaken per year with full audit data of all standards listed.	Colonoscopy information is available from the BCSS endoscopy QA report.	As above	✓
		b)Perforation rate	Colonoscopy information is available from the BCSS endoscopy QA report.	As above	✓
		c)Post-polypectomy bleeding requiring transfusion	Colonoscopy information is available from the BCSS endoscopy QA report.	As above	✓
		d)Post-polypectomy perforation rate	Colonoscopy information is available from the BCSS endoscopy QA report.	As above	✓
		e)Rate of serious colonoscopic complications requiring unplanned admission	Colonoscopy information is available from the BCSS endoscopy QA report.	As above	✓
A3.9	GPs are notified of the results of colonoscopies	All patients having a colonoscopy have a corresponding letter to their GP.	Evidence of notification sent to GP and measure of interval between results and letter sent. BCSS report.	As above	✓

A4 Imaging

National Standard	Objective	Measure	How is the measure assessed?	Minimum screening standard	Minimum screening std evidenced by	Standard Achieved
A4.1	A completion investigation of the entire bowel is carried out after incomplete colonoscopy	a) A date for imaging is offered on the same day as the colonoscopy appointment.	Radiology details are available from the endoscopy QA report. Investigation dataset. Data available by individual clinician.	80% of patients should be offered imaging on the same day as the initial colonoscopy bowel prep.(DN -this minimum standard is currently under discussion and may be changed)	Not assessed	Not assessed
		b) Imaging is performed and reported by a suitably trained consultant radiologist or radiographer.	Evidence of professional qualifications of radiologist or radiographer.		Visit/case review	✓
		c) Imaging is performed by a suitably trained radiologist or radiographer, and reported by a consultant radiologist.	Evidence of professional qualifications of radiologist or radiographer.		As above	✓
		d) The reports for at least 80% of radiological examinations are authorised within 7	Radiology details are available from the BCSS endoscopy QA report.	≤ 7 days of the examination for at least 80% of cases.	audit	✓

		days of the date of the examination.				
		e) Imaging is offered as far as possible, on the same day as the incomplete colonoscopy, with the exception of when a polypectomy has been performed. In the latter case, imaging must not carried out within two weeks of the incomplete colonoscopy.	Radiology details are available from the BCSS endoscopy QA report.	Same day where appropriate.	No CT screening carried out in Gloucester. Recommendation to commence. See Radiology section	**X**

A6 Pathology

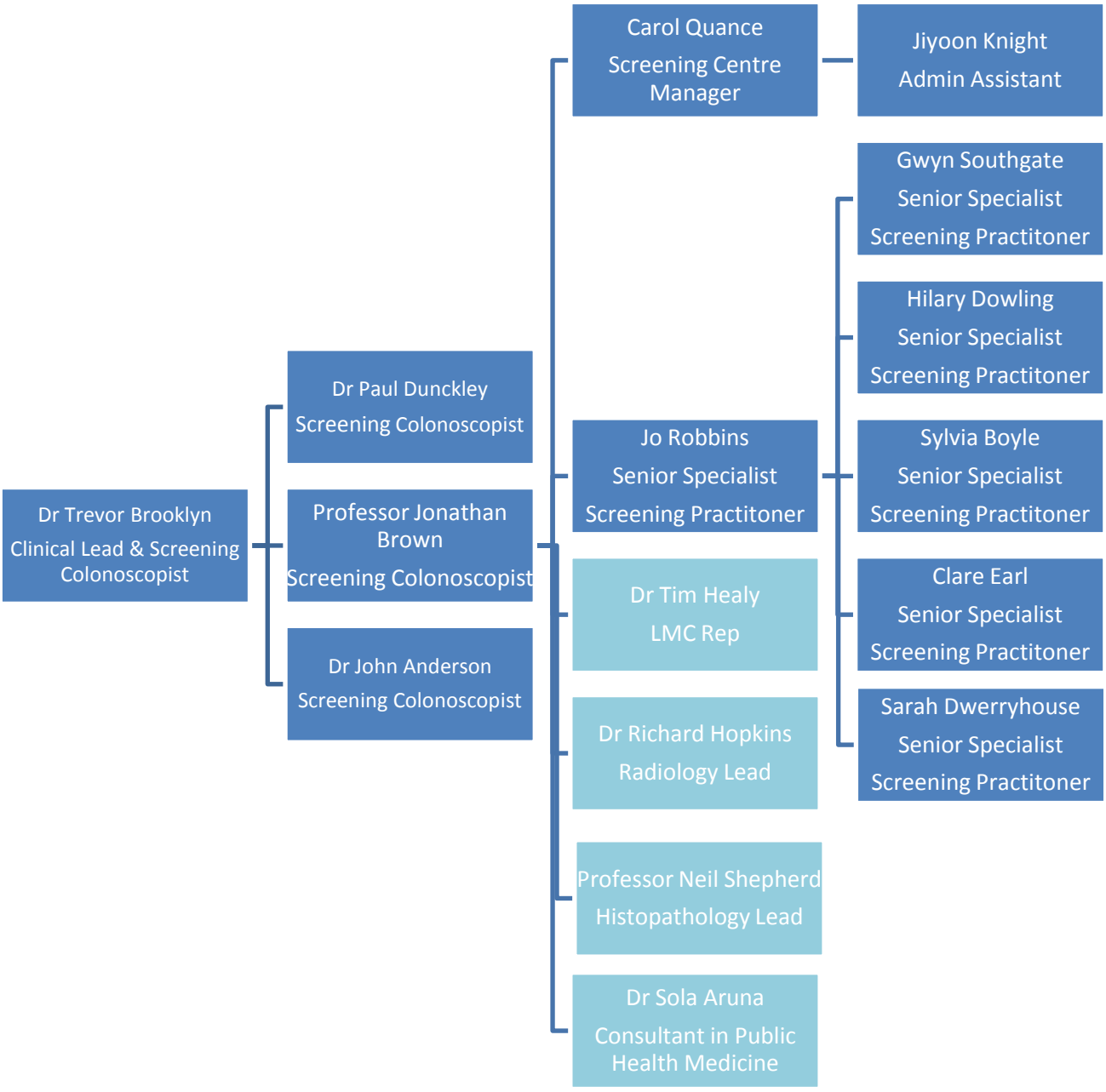
National Standard	Objective	Measure	How is the measure assessed?	Minimum screening std evidenced by	Standard Achieved
A6.1	Histopathology is carried out to an appropriate standard	a) Histopathology reports.	Polyp histology and cancer histology is available from the endoscopy QA report investigation dataset.	RCPath guidelines.	✓
		b) Histopathology reporting	Evidence that guidelines are being followed.	Results validated by named pathologists	✓
		c) The reports for the specimens submitted from colonoscopy are authorised by the histopathology laboratory.	Evidence of internal audit	Histology reports audited	✓
		d) The histopathology laboratory holds accreditation	Evidence of accreditation.	Full accreditation CPA certificate seen	✓
A6.2	There is an internal process for QA of bowel cancer screening histology reports.	QA internal audit	Evidence of QA internal audit.	• Evidence of Internal audits carried out (TATs and compliance with RCPath datasets) • Evidence of procedures for carrying out audits	✓
A6.3	The histopathologists reporting on bowel cancer screening	QA external audit	Evidence of external QA process. (A pilot scheme of EQA for BCSP histopathology is currently being trialled).	EQA list showing schemes participated in	✓

	participate in an external RCPath approved QA process for GI histopathology.				
A6.4	All histopathologists report using the NHS Bowel Screening Programme pathology pro forma for the minimum dataset.	Use of minimum dataset	Evidence of use of the RCPath minimum dataset proforma by the histopathologists. This is the proforma specifically for the BCSP and is intended to be filled in for both polyps and carcinomatous lesions. The data from the proforma is entered directly onto the BCSS by the SSP from the proforma	• RCPath forms have been completed • RCPath forms to see who completes the proforma • Template for polyps and cancer in polyps completed	✓
A6.5			Handling of polyps at cut up	Standard Operating Procedures	✓
A6.6			Protocol for dealing with difficult cases	Protocol for dealing with difficult cases / SOP	✓
A6.7			MDT	Minutes of MDT meeting	n/a

Appendix 1

The Bowel Cancer Screening Team

The Bowel Cancer Screening Team works cross-county with an administration base at Cheltenham General Hospital. Specialist screening practitioner clinics and colonoscopy lists are held at both Gloucestershire Royal Hospital and Cheltenham General Hospital



Appendix 2

BCSP ORGANISATION CHART