6. NHS Boards

There should be a designated consultant in public health medicine (CPHM) or registered specialist in public health identified as the bowel screening coordinator for each NHS Board. There should also be a designated lead clinician for each NHS Board area.

NHS Boards also provide resources to investigate all participants with a positive screening test result where appropriate. Local NHS Board planning and funding arrangements also take account of the following:

- health professionals required for pre-assessment
- additional workload on diagnostic services
- additional workload on surgery and oncology

NHS Boards have responsibility:-

1. to provide support and publicity to encourage uptake (see Chapter 7 for more information),
2. to develop protocols for travellers and homeless people and those in long stay institutions,
3. to establish receiving arrangements for SCI Gateway referrals from BoSS,
4. for pre-assessment for colonoscopy (see Appendix 4),
5. for colonoscopy (see Appendix 5),
6. for collection of minimum dataset for all bowel screening referrals,
7. for submission of data to Information Services NHS National Services Scotland (ISD), and
8. for production of annual reports on the performance of bowel screening in their area.

NHS Boards are required to ensure the quality and performance of care for the patients within their Board area who are referred for further investigation and treatment. Any patient with an overall positive screening test result will be referred into the existing care pathway for patients with bowel symptoms. From April 2010 the 62-day urgent cancer waiting time target was extended to include screened positive patients and all patients referred urgently with a suspicion of cancer. The screening programme should therefore be viewed as an additional urgent referral route and not as a

separate service. Waiting time data definitions can be accessed on the ISD website at **New Cancer Waiting Times Targets**

6.1 Support and Publicity to Encourage Uptake

Effective communication channels and a clear strategy are at the centre of this bowel screening programme to ensure full integration and support from partners and service providers. The main focus of the communications strategy is to raise awareness of the importance of the screening programme in the early detection of bowel cancer. Key target groups in raising awareness of the bowel screening programme are health professionals, partners and the general public. (See Chapter 7)

The communication strategy outlines why we should communicate with the key target groups, what information is appropriate to give, and how and when we communicate with these groups. Monitoring our communication outputs is also to be considered, to ensure we are communicating effectively.

NHS Health Scotland provides a portfolio of communications material and will continue to monitor and evaluate the content of this material. NHS Health Scotland will also brief local coordinators on the aims and objectives of the campaign.

NHS Boards are responsible for ensuring:

- increasing knowledge with clinicians both in primary and secondary care,
- identifying local priority groups and targeting them accordingly,
- identifying local opportunities to increase uptake and promotion of campaign material and information, and
- providing information about follow-up tests and treatment.

(See Chapter 7 – Communication Strategy)

NHS Boards have a responsibility to develop protocols for:

- Travellers/homeless people, and
- Those in long stay institutions.

(See Chapter 8 for more information)

6.2 Referral of Screening Test Positive Individuals

The Bowel Screening call-recall System (BoSS) refers participants with a positive bowel screening result to their local NHS Board via SCI Gateway. When a positive screening test result is recorded for a participant, BoSS sends out a “positive” letter to both the participant and their GP (if they have one). These letters are sent by post.

BoSS also sends a pre-populated message to the participant’s local NHS Board via SCI Gateway to a pre-determined “receiving” address in SCI Gateway.

Individual NHS Boards are responsible for arranging for authorised personnel to have access to the SCI Gateway address specified, and responsibility for ensuring that the SCI Gateway address is checked daily to pick up any referrals received from BoSS.

The authorised personnel can then pick up the BoSS messages and make appointments for the participants accordingly.

If a referral has been received and needs to be forwarded to another NHS Board, this can be done using SCI Gateway (see SCI Gateway flowchart at Chapter 5).

6.3 Pre-assessment for colonoscopy

In order to reduce anxiety, encourage participation and compliance and minimise the risks of colonoscopy all individuals who have a positive screening test result should be offered a pre-colonoscopy assessment by a suitably qualified health care professional.

Managing referrals

Once notification of an individual with a positive result is received by the NHS Board, the NHS Board must ensure that there is a robust pathway to capture and manage referrals.

SCI Gateway must, without exception, be checked every morning Monday – Friday for new referrals from the Bowel Screening Programme. Individuals referred by the Scottish Bowel Programme should be managed, from an administrative perspective, as urgent referrals for colonoscopy[1]. NHS Board protocols should be in place to ensure that pre-assessment and colonoscopy appointments are allocated in a timely manner. Protocols should contain role specific guidance to outline explicitly the responsibilities of colleagues and teams contributing to the management of individuals referred by the Screening Programme. There must be more than one individual responsible for accessing and actioning the referrals.

Reports will be produced for each meeting of the NHS Board's Bowel Screening Group / monthly outlining the number of referrals received from the Screening Centre during the reporting period, describing individuals' progress along their investigative pathway and the actions taken to address any delays. This will ensure that all individuals complete a pathway.

There is evidence that the time interval between receiving a positive screening test result and assessment for colonoscopy can result in significant anxiety. HIS Standard 5, Pre-colonoscopy Assessment, states that this time should be within 14 days for at least 80% of individuals and also that there are arrangements to identify all individuals who do not participate in pre-colonoscopy assessment and offer them a further opportunity to do so.

Health Care Professionals templates and guidance

It is suggested that in all cases a single assessment pro-forma is used to pre-assess patients for colonoscopy (see Appendix 4). The assessment crib sheet and assessment criteria could also be used to assist in undertaking the pre-assessment (see Appendix 4).

[1] 31-day target from date decision to treat to first cancer treatment.
62-day target from receipt of an urgent referral with a suspicion of cancer to first cancer treatment.

Non-responders and un-contactables

If a screening participant does not respond, is un-contactable or does not attend for pre-assessment a reminder should be sent approximately two weeks later, a copy being sent to their GP. This is in recognition that screening participants have had no contact with a health care professional up until the point of pre-assessment. If there is no response to the reminder within approximately two weeks the NHS Board will write to the participant and GP advising that if the participant reconsiders within a six month period the NHS Board can be contacted to undertake the pre-assessment.

If the individual reconsiders or has symptoms they can be referred by their GP through the normal symptomatic service route.

At this stage the screening participant is returned to the National Bowel Screening Programme and will be invited to participate in two years time if not over the age of 75.

Information pathway for patients

There is evidence that providing information about tests and investigations reduces anxiety and encourages participation (*see NHS QIS Standard 5 – Pre-colonoscopy assessment*). NHS Boards may wish to enclose information about colonoscopy (example – Appendix 5) with the letter of contact to the individual. This might include an explanation of the process of colonoscopy, the possible risks and outcomes, and is known to reduce anxiety in individuals awaiting further investigation.

NHS Boards will wish to consider the timing of issue of certain elements of information. The under noted is a suggested pathway.

Notification of positive result:

- Issue letter of notification of positive result (Bowel Screening Centre)
- Clinic appointment letter for pre-assessment (either face to face or telephone appointment dependant on NHS Board) and information about colonoscopy.

At face to face pre-assessment appointment (if the decision is to proceed to colonoscopy).

- Consent form (example – Appendix 5), contact card, next of kin form, bowel prep instructions, day surgery leaflet, diabetic information leaflet (if required), anticoagulation information leaflet (if required) and follow up arrangements.
- Colonoscopy appointment letter.

Following telephone pre-assessment appointment (if the decision is to proceed to colonoscopy):

- Consent form, contact card, next of kin form, bowel prep instructions, day surgery leaflet, diabetic information leaflet (if required), anticoagulation information leaflet (if required) and follow up arrangements.
- Colonoscopy appointment letter.

Following colonoscopy:

- Colonoscopy report.
- Recovery advice.

Clinical assessment/fitness for colonoscopy

The pre-assessment is an essential step to assess health fitness for the procedure. Some individuals may be assessed as high risk for colonoscopy and certain precautions need to be taken to minimise risk during the procedure. Other individuals may be deemed high risk for a screening colonoscopy due to significant co-morbid disease. The assessment criterion (Appendix 4) outlines some of the conditions for consideration. Consideration should be given to the specific follow up of patients where a known risk factor has been identified in the pre-assessment or during the screening colonoscopy procedure. NHS Boards are advised to have protocols in place for dealing with individuals on anticoagulants or who have diabetes and for bowel cleansing/preparation which comply with British Society of Gastroenterology guidance.

If from a telephone assessment there are potential risks/complications a face to face pre-assessment should be offered. If past history/medication has not been requested from the

GP or is difficult to obtain Clinicians responsible may consider best practice to obtain past history from GPs. NHS Boards should have a designated person(s) who makes the final decision on a person's fitness to safely proceed the referral and participants should be seen by this person. The decision and the reasons should be clearly recorded and written communication should be given to the participant and their GP. The participant should be involved throughout the process and clear explanations and information should be given to assist the patient to make an informed choice.

In cases where the individual has decided not to progress with a colonoscopy, however reconsiders, they can be referred by their GP for colonoscopy through the normal symptomatic service route if thought appropriate.

Consent difficulties

See section 8.2.1; procedure for dealing with individuals with physical incapacity or consent difficulties.

Bowel Preparation

There is no national protocol for bowel preparation and its issue. NHS Boards to have local protocols in place.

Exclusions from screening colonoscopy

Individuals who are excluded from having a screening colonoscopy are:

- individuals who have had surgery in the past to remove their entire colon and rectum (Note that individuals who have formation of Ileo Anal pouch should continue to be invited for bowel screening and screened endoscopically as there is a continued risk of bowel cancer developing in the pouch),
- individuals who have had a complete colonoscopy in the previous 12 months,
- individuals who have had a myocardial infarct in the past 3 months (colonoscopy can be delayed to minimise risk), and
- any individual who is experiencing any acute or severe inflammatory process at the time such as ulcerative colitis, Crohn's disease or acute diverticulitis.